Practice Point 1.1.2: The evaluation of kidney tissue should meet standards of biopsy adequacy (Figure 3).

Figure 3 | Evaluation of kidney tissue. AA, amyloid A; GBM, glomerular basement membrane; DNAJB9, DnaJ homolog subfamily B member 9; GN, glomerulonephritis; IgA, immunoglobulin A; IgG, immunoglobulin G; IgM, immunoglobulin M; LECT2, leukocyte cell-derived chemotaxin-2; PLA2R, M-type phospholipase A2 receptor; THDS7A, thrombospondin type-I domain-containing 7A.

Practice Point 1.1.3: Repeat kidney biopsy should be performed if the information will potentially alter the therapeutic plan or contribute to the estimation of prognosis.

1.2. Assessment of kidney function

Practice Point 1.2.1: Obtain 24-hour urine collection to determine total protein excretion in patients with glomerular disease for whom initiation or intensification of immunosuppression is necessary, or who have a change in clinical status.

Practice Point 1.2.2: For pediatrics, 24-hour urine collection is not ideal as it may not be accurate and is cumbersome to collect. Instead, monitor first morning protein–creatinine ratio (PCR).

Practice Point 1.2.3: Random "spot" urine collections for PCR are not ideal as there is variation over time in both protein and creatinine excretion.

Practice Point 1.2.4: First morning urine collections may underestimate 24-hour protein excretion in orthostatic proteinuria.

Practice Point 1.2.5: When feasible, a reasonable compromise is to collect an "intended" 24-hour urine sample and measure PCR in an aliquot of the collection.