Figure 30 | Clinical criteria for assessing risk of progressive loss of kidney function. eGFR and PCR are used in routine clinical care. Other biomarkers may not be available in all centers; this table provides an overview of useful biomarkers. *Most studies have used serum creatinine (SCr) values to guide management, and SCr values >1.5 mg/dl (133 μmol/l) are often used to define kidney insufficiency. An eGFR value of 60 ml/min per 1.73 m^2 defines kidney insufficiency in a young adult. It is important to realize that eGFR decreases with age, and an SCr value of 1.5 mg/dl (133 μmol/l) reflects an eGFR of 50 ml/min per 1.73 m^2 in a 60-year-old male patient and 37 ml/min per 1.73 m^2 in a 60-year-old female patient. Thus, when using eGFR in risk estimation, age should be taken into account. †Serum albumin should be measured by BCP or immunometric assay. ‡Cutoff values are not validated. Anti-PLA2R antibodies should be measured at 3-to-6-month intervals, the shorter interval being performed in patients with high anti-PLA2R antibodies levels at baseline. Changes in anti-PLA2R antibodies levels during follow-up likely add to risk estimation. Disappearance of anti-PLA2R antibodies precedes clinical remission and should lead to refraining from additional therapy. Detailed data are lacking. §Selectivity index is calculated as clearance of IgG/clearance of albumin. ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; BCP, bromocresol purple; eGFR, estimated glomerular filtration rate; IgG, immunoglobulin G; PLA2Rab, antibodies against the M-type phospholipase A2 receptor.

3.2 Prognosis

Practice Point 3.2.1: In patients with MN, use clinical and laboratory criteria to assess the risk of progressive loss of kidney function (Figure 30).

Because spontaneous remission is relatively common in MN and because immunosuppressive treatment has adverse effects, it is important to assess the risk of progressive loss of kidney function prior to deciding about whether and when to implement immunosuppressive treatment. Figure 30 shows clinical criteria that may be used to divide patients into categories of low, moderate, high, and very high risk of progressive loss of kidney function.

There are caveats to the evaluation of risk in MN. In most patients, it is reasonable to wait 6 months for spontaneous remission while using maximal antiproteinuria therapy. High levels of proteinuria, anti-PLA2R antibodies, or low–molecular weight proteinuria should lead to re-evaluation earlier than 6 months. Patients with deteriorating kidney function or severe unresponsive NS may be considered for immediate immunosuppressive therapy, as the likelihood of progression is 84% in patients with a documented 20% decrease in eGFR within any time period of fewer than 24 months.[162] A survey of the literature shows that there is a 45% chance of spontaneous remission in patients with proteinuria >4 g/d after 6 months of conservative therapy,[163] a 34% chance of spontaneous remission in patients with proteinuria >8 g/d for more than 6 months,[164] a 25%–30% chance despite high urinary excretion of low–molecular weight proteins,[165] a 17% chance in patients in the upper tertiles of anti-PLA2R antibody levels,[166] and a 20% chance in patients with anti-PLA2R antibody levels >275 RU/ml[167] (A. Rousseau, personal communication, January 15, 2019). There is currently no model that combines all of these clinical considerations, but we suggest that in clinical practice it is useful to think about risk as a combination of factors (e.g., high proteinuria in patients with low antibody titers may be judged differently than high proteinuria in the presence of high antibody titers). Even more important is the disease trajectory; thus, changes in any of the above-mentioned parameters should be taken into account.

3.3 Treatment

Practice Point 3.3.1: Considerations for treatment of patients with primary MN:

- **All patients with primary MN and proteinuria should receive optimal supportive care.**
- **Immunosuppressive therapy should be restricted to patients considered at risk for progressive kidney injury (Figure 31).**

Practice Point 3.3.2: Immunosuppressive therapy is not required in patients with MN, proteinuria <3.5 g/d, serum albumin >30 g/l by bromocresol purple (BCP) or immunometric assay, and eGFR >60 ml/min per 1.73 m^2.