REBELLIOUS MEDIC · RHEUMATOLOGY ALGORITHM SERIES

Lupus Nephritis: Screening & Treatment

Screening, biopsy, class-specific induction, response-guided adjustment, refractory disease, and renal replacement for lupus nephritis.

2024 ACR Guideline
Guideline for Screening, Treatment, and Management of LN
Sammaritano LR, et al. · Arthritis Care Res 2025;77:1–21

GRADE — Strong · Conditional · Good Practice (GPS)

HCQ = hydroxychloroquine; MPAA = mycophenolate; CNI = calcineurin inhibitor; CYC = cyclophosphamide.

1 Screening & Kidney Biopsy

SCREENING & NEW BIOPSY

- **Strong** — **Screening** — proteinuria q6–12mo, or with extra-renal flares, in SLE without known kidney disease.
- **GPS** — Prompt **biopsy** if LN suspected.
- **Cond.** — Biopsy if proteinuria >0.5g/g and/or unexplained impaired kidney function.

REPEAT BIOPSY & PRE-BIOPSY

- **Cond.** — Repeat biopsy if suspected flare in remission, or ongoing/worsening proteinuria/hematuria/kidney function after ≥6mo treatment.
- **GPS** — Prompt **glucocorticoids** while awaiting biopsy/histopathology.

2 Initial Treatment — Class III/IV (±V)

BASELINE THERAPY

- **Strong** — **HCQ** initiation/continuation unless contraindicated.
- **Cond.** — Add **RAAS-I** with any proteinuria; pulse IV GCs → oral taper to ≤5mg/d by 6mo.

TRIPLE THERAPY SELECTION

- **Cond.** — **Triple therapy** — pulse GCs + MPAA+belimumab, MPAA+CNI, or ELNT low-dose CYC+belimumab; MPAA-based preferred over CYC-based.
- **Strong** — **ELNT low-dose CYC** preferred over high-dose monthly pulse or daily oral CYC.
- **Cond.** — **Extra-renal disease** — belimumab-containing regimen preferred over CNI-containing regimen.

3 Pure Class V LN & Treatment Duration

- **Cond.** — **Proteinuria ≥1g/g** — triple regimen (pulse GCs + MPAA + CNI) preferred over MPAA+belimumab or CYC+belimumab.
- **Cond.** — **Proteinuria <1g/g** — GCs and/or immunosuppressant (MPAA, AZA, or CNI) preferred over no immunosuppression.
- **Cond.** — **Sustained complete response** — total duration of immunosuppression at least 3–5 years.

4 Response-Guided Adjustment

COMPLETE RESPONSE

- **Cond.** — **Triple therapy** — continue same immunosuppressive regimen.
- **Cond.** — **Dual therapy** — continue MPAA preferred over azathioprine.

PARTIAL RESPONSE

- **GPS** — **Triple therapy** — individualize based on clinical factors/response trajectory.
- **Cond.** — **Dual therapy** — escalate to triple immunosuppressive regimen.

5 Non-Response & Refractory Disease

- **GPS** — **First step** — assess medication dose and adherence before escalating.
- **Cond.** — **Nonresponse** (no PRR by 6–12mo) — dual → escalate to triple therapy; triple → change regimen or add anti-CD20 agent.
- **Cond.** — **Refractory** (failed 2 courses) — escalate to more intensive regimen: anti-CD20, triple non-GC combo (MPAA+belimumab+CNI), or investigational therapy referral.

6 Monitoring & Renal Replacement

MONITORING

- **Strong** — **Proteinuria** q3mo if no complete response; q3–6mo in sustained remission.
- **GPS** — **Complement/anti-dsDNA** at each visit, not more than monthly.

RENAL REPLACEMENT

- **Strong** — **Kidney transplant** preferred over dialysis for ESKD.
- **Cond.** — **Preemptive transplant** nearing ESKD (eGFR 15); transplant without requiring remission if no other major organ involvement.
- **Strong** — **Regular rheumatology follow-up** post-transplant/dialysis.

Sammaritano LR, Askanase A, Bermas BL, et al. 2024 American College of Rheumatology Guideline for the Screening, Treatment, and Management of Lupus Nephritis. *Arthritis Care Res.* 2025;77(1):1–21.