EDITORIAL
276 Biomarkers and a tailored approach for immune monitoring in kidney transplantation
Salcido-Ochoa F, Allen JC Jr

REVIEW
285 De novo glomerular diseases after renal transplantation: How is it different from recurrent glomerular diseases?
Abbas F, El Kossi M, Jin JK, Sharma A, Halawa A

301 Recurrence of primary glomerulonephritis: Review of the current evidence
Abbas F, El Kossi M, Jin JK, Sharma A, Halawa A

MINIREVIEWS
317 Hepatocyte transplantation: Consider infusion before incision
Heath RD, Erem F, Romana BS, Ibdah JA, Tahan V

324 Elderly donor graft for liver transplantation: Never too late
Chela H, Yousef MH, Albarrak AA, Romana BS, Hudhud DN, Tahan V

329 Polyoma virus nephropathy in kidney transplantation
Scadden JRW, Sharif A, Skordilis K, Borrows R

339 Human leukocyte antigen typing and crossmatch: A comprehensive review
Althaf MM, El Kossi M, Jin JK, Sharma A, Halawa AM

ORIGINAL ARTICLE
349 Risk factors and clinical indicators for the development of biliary strictures post liver transplant: Significance of bilirubin
Forrest EA, Reiling J, Lipka G, Fawcett J

CASE REPORT
359 Mucocele mimicking a gallbladder in a transplanted liver: A case report and review of the literature
Chaly T, Campsen J, O’Hara R, Hardman R, Gallegos-Orozco JF, Thiesset H, Kim RD
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FLYLEAF

I-IV Editorial Board
Recurrence of primary glomerulonephritis: Review of the current evidence

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Abstract

In view of the availability of new immunosuppression strategies, the recurrence of allograft glomerulonephritis (GN) are reported to be increasing with time post transplantation. Recent advances in understanding the pathogenesis of the GN recurrent disease provided a better chance to develop new strategies to deal with the GN recurrence. Recurrent GN diseases manifest with a variable course, stubborn behavior, and poor response to therapy. Some types of GN lead to rapid decline of kidney function resulting in a frustrating return to maintenance dialysis. This subgroup of aggressive diseases actually requires intensive efforts to ascertain their pathogenesis so that strategy could be implemented for better allograft survival. Epidemiology of native glomerulonephritis as the cause of end-stage renal failure and subsequent recurrence of individual glomerulonephritis after renal transplantation was evaluated using data from various registries, and pathogenesis of individual glomerulonephritis is discussed. The following review is aimed to define current protocols of the recurrent primary glomerulonephritis therapy.

Key words: Recurrent glomerulonephritis; Renal transplantation; Primary glomerulonephritis
Core tip: Renal transplantation is the best-known therapy for end stage renal disease, with the glomerulonephritis represents a major etiology for its prevalence. Unfortunately, recurrence of the glomerulonephritis (GN) disease after renal transplantation represents a real devastating impact on allograft survival. A clear understanding of their pathogenesis, will help not only in ameliorating GN recurrence, but also improves allograft survival.

INTRODUCTION

The impact of glomerulonephritis (GN) recurrence varies widely from mild or negligible effect, e.g., IgA nephropathy (IgAN), to a real detrimental impact on graft survival, e.g., Focal Sclerosing Glomerulosclerosis (FSGS) and membranoproliferative GN (MPGN)\[1\]. Since it has been early recognized, the deleterious impact of the recurrent GN on allograft longevity, continuous efforts have been exerted to determine its real prevalence, clear pathogenesis and to tailor the best strategies for treatment and prevention\[2\]. Recently, several mechanisms have been postulated to address a clear pathogenesis of GN recurrence\[1\]. The prevalence of GN as an etiology of end-stage renal disease (ESRD) was reported to be exceeding 48% in China\[3,4\], 50% in Australian-New Zealand\[2\] and 30% according to USRDS 2015 report\[5\]. The frequent lack of kidney biopsy resulted in underestimation of the real prevalence of the GN recurrence\[6\]. Moreover, the distinction between recurrent GN and the de novo disease is not widely applied. Compared to an early (within the first year) post transplantation assessment of prevalence of about 4%, a value of 13% after 7.5 years\[6\], and 18% in other studies\[7,8\] have been recorded\[2\]. The reported wide variations in prevalence may be attributed to the variability in follow up periods of various studies\[9\].

The advent of the new immunosuppressive strategies in kidney transplantation have been reflected on the rates of acute and chronic rejection, but unfortunately has little (impact on the prevalence rates of GN recurrence as well as the de novo GN disease\[10\]). The expected improved allograft survival rate will be ultimately reflected in the future on the prevalence of the recurrent GN after kidney transplantation. It is noteworthy to mention that GN disease with a seemingly benign course, e.g., IgAN is known to recur in 40% of patients but leads to graft loss only in 10%\[11,12\]. The magnitude of challenge, at times, seems insurmountable despite the progress in understanding the pathogenesis of certain recurrent GN, e.g., permeability factors (suPAR in FSGS and anti-PLA2R AB in MN).

In this review, the authors have identified the most recent progress in understanding the pathogenesis of GN recurrence and its impact on the renal allograft survival. Further insights on the available strategies for treatment and prevention of GN recurrence, particularly so in the main primary GN is will be addressed.

Graft survival in recurrent GN disease after renal transplantation. General Concepts

An assumed underestimation of the real prevalence of the GN recurrence has been proved By application of the “Protocol Biopsy” that defined as: biopsy at fixed time, with no relation to a clinical guide. Protocol biopsy delineates a higher incidence of GN recurrence (5%, 18%, 21%, 35%, 42% at 1, 3, 5, 8 and 10 years respectively)\[3\]. Many explanations have been postulated in this concept to shed the light on the reported discrepancy in prevalence of the GN recurrence: (1) absence of clear native kidney disease diagnosis; (2) absence of valid biomarker for GN recurrence; (3) difficulty in differential diagnosis from other pathological entities, e.g., CAN and drug intoxication; (4) absence of clear stratification and characterization of GN recurrence nature in view of the advent of the new therapeutic approaches\[13-15\]; (5) the decision of biopsy is not always performed routinely whenever indicated (e.g., proteinuria/hematuria, renal impairment); (6) IF/EM techniques are not routinely performed after each biopsy; (7) a wide discrepancy is found in certain diseases, e.g., IgAN, between histopathologic characteristic changes and the appearance of clinical manifestations; (8) a trend to differentiate and isolate de novo disease from a true recurrent disease is usually not eventually attempted; (9) absence of basal data as regard etiology of ESRF and the native renal biopsy in many cases; and (10) data inconvenience may result in misdiagnosis of a recurrent disease as a de novo disease, which is in fact a true recurrence\[2\].

The detrimental impact of GN recurrence on allograft survival is irrefutable. The consideration of this impact relies on three points: (1) impact of recurrence of particular types of GN before transplantation on graft survival, e.g., FSGS and MPGN Type I vs other types of GN. A significantly higher risk of graft failure in these types\[9,16\]. The proper evaluation should involve a fairly large number of patients studied and followed for an enough period of time\[2\]; (2) evaluation of the risk of graft failure in case of GN recurrence: The etiology of graft failure should be considered, membranous nephropathy (MN), for example, has high recurrence rate leading to hazardous effect on graft survival\[17\]; and (3) global allograft GN particularly recurrent disease and its relation
understand primary and secondary GN recurrence, histological recurrence can be titrated with the frequent no hematuria/proteinuria could be observed; only after the confirmation of recurrence in the third month, within 1-2 mo after transplantation. At that time and of transmitted GN diseases of the early course changes in some transmitted GN of the protocol biopsy could be observed in identification 3 years biopsy is performed serially at discharge, then after 3 wk, 3-6 mo, 12 mo and after early anticipated. An intraoperative basal kidney biopsy, discovered and the native GN disease recurrence can be that the earliest changes in allograft histology can be observed with the previously named MPGN II (adapted from Alasfar et al[30] with permission). 

Figure 1 Kaplan-Meier renal allograft survival

| Number at risk | Non-recurrent | Recurrent |
|----------------|--------------|-----------|
|                | 19           | 16        |
| 0              | 17           | 11        |
| 2              | 12           | 8         |
| 4              | 5            | 1         |
| 6              | 1            |           |
| 8              | 1            |           |

Kaplan-Meier renal allograft survival

Probability of remaining free of graft loss

Risk of recurrence is not constant, it should be considered a time-dependent variable for a better and proper evaluation[21]. As reported by Cosio et al[7] in the American Transplant Congress, 2015, Type I MPGN and FSGS showed the highest rate of GN recurrence with subsequent increased risk of allograft loss, followed by IgAN. These data are supported by some studies[12], but not agreed by others[6,9]. It was assumed that 18%-22% of the death-censored kidney allograft losses was attributed to allograft GN (de novo and recurrent)[7], the second most common cause of death-censored graft losses[18] and third most prevalent cause of uncensored graft losses[9,16]. However, Mashaly et al[10] observed that the best allograft survival of kidney transplantation was stage due to polycystic kidney disease followed by those who had urologic disease and then those who had GN as the cause of renal failure. The recurrent GN disease has a wide variety of drawbacks deranging allograft function, which made it occupy the third most common etiology of allograft loss after death with a functioning graft and chronic allograft glomerulopathy, an assumption that was agreed by Fairhead and Knoll[20] (2010) who declared that the recurrent GN disease is a major determinant of the long term graft survival (Figure 1). On the other hand, Toledo et al[21] (2011) denied the presence of any difference between GN recurrence and other causes of allograft dysfunction as regard their influence on long term allograft survival. This discrepancy could be a statistical artefact attributed to the small number of patients in their study, racial impacts and the different immunosuppression strategies.

SIGNIFICANCE OF “PROTOCOL BIOPSY” FOR EARLY DIAGNOSIS OF RECURRENT GN

A full detailed map of allograft deterioration due to GN recurrence, can be obtained through a standard protocol biopsy, a widely applied strategy in many centers, so that the earliest changes in allograft histology can be discovered and the native GN disease recurrence can be early anticipated. An intraoperative basal kidney biopsy, at discharge, then after 3 wk, 3-6 mo, 12 mo and after 3 years biopsy is performed serially[22]. The importance of the protocol biopsy could be observed in identification of the early course changes in some transmitted GN diseases, e.g., IgAN, which accounts for more than 90% of transmitted GN[20]. Early recurrence can be detected within 1-2 mo after transplantation. At that time and after the confirmation of recurrence in the third month, no hematuria/proteinuria could be observed; only histological recurrence can be titrated with the frequent specimens[23].

Japanese pathologists pioneered protocol biopsy to understand primary and secondary GN recurrence, e.g.,

Graft survival in MPGN type I recurrence

Green et al[23,24] (2015) reported that the risk of recurrence is higher in MPGN Type I, with the following factors: (1) the HLA B49, HLA DR4; (2) previous transplantations; (3) acute tubular necrosis after transplantation; (4) shorter duration of dialysis before transplantation; and (5) Arab origin was all associated with decreased graft and patient survival[24].

A better allograft survival is expected in MPGN Type I, with the following factors: (1) unrelated living donors; and (2) absence of recurrence in the first year post transplantation. The advent of the new concepts declaring the role of the alternative complement pathway in the pathogenesis of MPGN was addressed in appearance of the new classification of MPGN. It depends on the mechanism of glomerular injury instead of deposits distribution, which will be ultimately reflected on development of the new therapeutic policies (see therapy of GN recurrence) and its clinical interpretations[26]. So, MPGN will be immune complex mediated (ICGN), encompassing immune complexes and complement compounds, or complement-mediated (CGN) containing only complement, without immune complex (Table 1). Old studies were based on the old classification and data in this subject were very limited owing to the limited number of patients and short follow up durations. The highest prevalence rate has been observed with the previously named MPGN II[26,32].

Risk factors of MPGN recurrence

According to Alasfar et al[30] (2016) (Figure 2), the following risk factors have been proposed to be associated with more liability for MPGN recurrence: (1) preemptive renal transplantation[30]; (2) the living related donation[30]; (3) presence of monoclonal immunoglobulins[30]; (4) diminished complement levels[33]; (5) a higher level of proteinuria[32]; (6) human leukocyte antigen type: HLA B8, DR 3[34]; and (7) evidence of crescents in the original biopsy[34].

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Table 1: The membranoproliferative glomerulonephritis new classification depends on the mechanism of glomerular injury instead of deposits distribution[30]

| No | Type    | Criteria                                                   | Prevalence                                                                 |
|----|---------|------------------------------------------------------------|---------------------------------------------------------------------------|
| 1  | ICGN    | Contains immune complexes + complement compounds          | More common (most of the recurrent cases are ICGN)                         |
| 2  | CGN     | Contains complement compounds only                         | Less prevalent (change from one type to another is possible)               |

ICGN: Immune complex-mediated glomerulonephritis; CGN: Complement-mediated glomerulonephritis.

Impact of HLA typing on prevalence of MPGN recurrence: Green et al.[34] (2013) concluded that the risk of recurrence is higher in MPGN Type I, with certain human leukocyte antigen, i.e., HLA B49, HLA DR4. Andresdottir et al.[30] (1997) reported an increased risk of recurrence of MBGN Type I was observed in patients with the HLA haplotype B8 DR3.

Graft survival in “recurrent MN”

The recurrence of primary MN after renal transplantation is obviously has deleterious impact on graft survival. For better evaluation of the death censored survival, timing of GN recurrence should be considered[17].

Anti-PLA2R autoantibodies in recurrent MN and graft survival: The pivotal role of anti-phospholipase A2 receptor (PLA2R) auto antibodies in the pathogenesis of primary MN before as well as after renal transplantation has an impressing popularity. The prevalence of anti-PLA2R antibodies in primary MN is approaching 70% and nearly the same percentage in RTR (70%-80%)[17,35,36], with about half of the patients are liable for recurrence after renal transplantation[17,37]. Patients with anti-PLA2R antibodies before transplantation have a 60%-76% chance of histologic recurrence, while absence of these autoantibodies decreases their risk of recurrence to less than 30%[17,36,38,39]. After transplantation the anti-PLA2R antibodies absorbed rapidly into the allograft and as a result of decreased antibodies production due to the immunosuppression medications leading to decline of their level in up to 50% of patients[38]. This decline is definitely associated not only by a lower risk of recurrence, but also by a slower rate of progression if MN does recur[36]. On the other hand, the significance of the anti-PLA2R post transplantation is greatly observed in their predictive value of recurrence and disease progression which is exceeding 80%[36], a high anti-PLA2R is usually accompanied by an increased risk of recurrence, rapid disease progression and probably more resistance to drug therapy[36,38].

Impact of anti-PLA2R on graft survival: Serial survey of the anti-PLA2R antibodies titer is of utmost importance for the following indications[2]: (1) evaluating the magnitude of recurrence risk; (2) determining the rate of disease progression; (3) prediction of the response to treatment[2]; and (4) differential diagnosis of proteinuria in recipients with native primary MN.

Non-anti-PLA2R MN recurrence: Not all the patients with primary MN express anti-PLA2R antibodies, 30% of these patients are negative to these antibodies. Instead, few patients have been reported to have antibodies against other types like cationic bovine serum albumin and thrombospondin type 1 [40] but data, however, concerned with the real significance of these mediators are still deficient[40-42].

Of note that if the anti-PLA2R antibody titer is negative, we should search for the “glomerular PLA2R” staining, in such a case there is associated anti-PLA2R MN with negative anti-PLA2R serum level, which is present in 30% of cases[36,43].

Graft survival in recurrent “primary focal segmental”

Primary focal segmental (FSGS) is proved to be one of the highest glomerulonephritis (GN) in recurrence rate after kidney transplantation (KTx), with a percentage of prevalence exceeding 30% in the most recent series[2], with an expected very poor graft survival rate[43]. It can recur immediately post-transplantation, or recur lately, where its diagnosis is usually masked by the secondary FSGS resulting from the reduced total nephron mass, or due to other causes, e.g., iatrogenic[40,44]. Of all causes of the FSGS, “genetic” subtype showed the least incidence of recurrence[10,45,46]. On the other hand, podocin mutations did not show a decreased risk of recurrence[45]. However, revising the recent series, there is consensus about certain clinical parameters that is considered the paramount risk factors for FSGS recurrence: (1) White race[43]; (2) higher level of proteinuria[46,47]; (3) rapid progression to ESRD (< 3 years); (4) younger age (< 15 years old) at time of diagnosis[46]; and (5) the most
The reported incidence if recurrent IgAN is quite variable according to the considered diagnosis and period of follow up. IgAN can remain silent for 5 years before it became clinically evident. So, an average incidence of 30% has been reported[48]. The histologic recurrence is by far more prevalent and discovered earlier before the disease became clinically evident. Rarely, crescentic disease with a rapidly progressing course can occur, which ultimately is associated with poor prognosis[46, 50]

A growing body of evidence that three markers of an active disease indicates a great liability for recurrence:
1. galactose-deficient IgA1;
2. IgA-IgG immune complexes; and
3. lower levels of IgA-soluble CD89 circulating complexes, the myeloid cell receptor for IgA[51]. The only defect in considering these components is that they were considered on a clinically evident base of IgAN recurrence, therefore, silent disease - a quite common IgAN behavior - will be definitely missed, which means an easily missed diagnosis of IgAN recurrence[47].

Risk factors of IgAN recurrence include:
1. young RTR;
2. aggressive course of the disease before transplantation; and
3. lower levels of IgA-soluble CD89 circulating complexes, the myeloid cell receptor for IgA[51]. The only defect in considering these components is that they were considered on a clinically evident base of IgAN recurrence, therefore, silent disease - a quite common IgAN behavior - will be definitely missed, which means an easily missed diagnosis of IgAN recurrence[47].

The advent of a new classification of MPGN including the classic morphology as well as the other features enables not only a better understanding of the course of this disease, but also delineates the best tools of prevention and therapy of recurrence, which will be ultimately reflected on the allograft survival[72, 73]. This fact is evolved from the observed wide discrepancy in the behavior of each subtype (see below) as regard the incidence and the intensity of recurrence as well as its impact on allograft survival[3].

One of the largest series about post-transplant MPGN recurrence in the literature was admitted by Alasfar et al[30], it was the first study that applied the new MPGN classification in evaluating post-transplant MPGN recurrence (Table 1, Figure 3). Despite the absence of worse survival in the recurrent cohort of Alasfar et al[30], the rate of allograft loss was higher (Figure 1).
Abbas F et al. Recurrence of primary glomerulonephritis

Impact of the new classification on therapeutic options

MPGN with Ig deposits: We should focus in suppression of the antibody production, but there are no controlled trials.

MPGN with monoclonal Ig deposits: The anti-CD20 antibodies are proved to be effective in uncontrolled trials in native as well as in allograft recurrence\textsuperscript{74}. Monoclonal deposits are proved to be associated with a higher rate of recurrence\textsuperscript{75}. This association may suggest they have their role in the pathogenesis of MPGN, consequently, two important steps have been suggested: (1) meticulous screening for “monoclonal gammopathy” during preparation of a patient with MPGN for renal transplantation; and (2) a “hematologist consultation” may be advised with strict follow up in such situation for long periods\textsuperscript{30}.

MPGN C3GN: The use anti C5 monoclonal antibodies, eculizumab, is shown to be effective with mixed results\textsuperscript{76,80}, depending on the success of this drug in preventing the recurrence of atypical HUS, which own a similar pathogenesis\textsuperscript{80-83}.

Impact of subtype's behavior on therapeutic options

MPGN with polyclonal Ig deposits: Usually presented late, within the first 5 years, with a relatively benign course as regard low risk of recurrence and slow progression. Interestingly, the morphology of the lately recurred MPGN with polyclonal Ig deposits is difficult to be differentiated from the de novo GN which can behave similarly as regard the late presentation post transplantation as well as the presence of polyclonal Ig deposits\textsuperscript{48}. The former group has C4d deposits in their glomeruli, fortunately help in differential diagnosis. Also, a higher risk of recurrence could be expected with the presence of reduced complement level (C3 and C4) level\textsuperscript{30} (Figure 5).

C3GN: C3 glomerular deposits are abundant with absence or minimal Ig deposits\textsuperscript{84,85}. The risk of recurrence in C3GN is very high, exceeding 70%, can be presented early with a very aggressive course that ultimately ends by graft failure in nearly half of the cases. It is noteworthy to remind that some of the reclassified cases may change their microscopy by time. Unfortunately, the latter change could be difficult to differentiate from a de novo GN disease, which will be ultimately resulted in a difficulty on choosing the mode of therapy\textsuperscript{30}.

They explained this discrepancy by the small sample size. Unfortunately, the response to immunosuppressive therapy in this study was poor, as less than 50% of their patients treated by high dose steroid therapy, rituximab and/or plasmapheresis, or eculizumab could attain allograft function stability and prevent graft loss (Figure 4). An assumed benefit of ACEi/ARBs therapy in prevention of graft loss was suggested by this study, which should be considered cautiously regarding the small number of cases\textsuperscript{30}. Alasfar et al\textsuperscript{30}, however, showed that 43% of their patients who developed MPGN recurrence were of the immune complex-mediated GN (ICGN) type and were complicated by graft loss. On the other hand, one of the two patients with GN recurrence and subtyped as complement-mediated GN (CGN) developed graft loss. The average time of graft loss was 6.5 mo (2-18 mo). Interpreting these results showed non-significant results between recurrent and non-recurrent groups, despite the presence of tendency to worse survival\textsuperscript{30}. Also, no significance could be detected with other factors, e.g., age, race, gender, mismatching degree, graft source, pre-emptive transplantation and degree of proteinuria. In contrary to other factors and despite of non-significance, ACEi/ARB therapy could ameliorate the tendency of graft loss (Figure 4). For more specified specific therapy, all the old biopsies before the advent of the new classification, should be reclassified. The CGN is generally less prevalent, on the other hand, ICGN is more common (Table 1) and most of the native as well as the recurrent MPGN appear to be classified as ICGN. It is noteworthy to remind that some of the reclassified cases may change their microscopy by time. Unfortunately, the latter change could be difficult to differentiate from a de novo GN disease, which will be ultimately resulted in a difficulty on choosing the mode of therapy\textsuperscript{30}.

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Dense deposit disease subtype: The rate of recurrence of this subtype is extremely high (80%-90%), leading to reduced graft survival\cite{32,92}. Two criteria characterize this subtype: It is usually slowly progressive with minimal or absent clinical manifestation, and the timing of recurrence is mostly delayed\cite{92,93}. Both DDD and C3GN usually express an alteration in the alternative pathway with resultant overproduction of the activated C3\cite{94,95}. Recently, polymorphism of the complement...
regulating proteins, especially in alternative pathway, are found to be propagated mostly in all subtypes of MPGN, with a possible alterations related to renal outcome were assumed[86]. In DDD and other C3 glomerulopathies: Eculizumab or anti-auto antibodies activating complement cascade therapy have been suggested[97].

“Monoclonal gammopathy with renal significance”: Both C3 GN and DDD lack C4d, indicating alternative pathway activation[86]. Any MPGN subtype associated with monoclonal Ig deposits usually complicated by GN recurrence in 66% of cases and expressing a very aggressive course often complicated by allograft failure[99]. Interestingly, 70% of these cases do not express monoclonal IG either in serum or in urine, without any evidence of plasma cell dyscrasia in bone marrow and with low risk of progress into multiple myeloma[100,101].

Monoclonal proteins: Monoclonal proteins are present in 30% of cases with MPGN with monoclonal Ig deposits have serum monoclonal proteing[100] despite absence of any evidence of multiple myeloma. A subtype name of this group of patients called “monoclonal gammopathy with renal significance”[100,101], which obviously will express a very high risk of recurrence[104].

Stem cell transplantation: It is noteworthy to declare that in monoclonal gammopathy, stem cell transplantation can reverse the renal dysfunction through elimination of the light chain and immunoglobulins, with an expected general improvement. The observed link between C3GN and monoclonal and the complement (alternative pathway) activation by λ-light chain has been recorded in previous reports[105-107].

Recommendations for a better management
Extrapolating the aggressive behavior of these recurrent diseases, especially in the presence of monoclonal deposits and C3GN, rigorous precautions should be considered to strive against its activity. A prophylactic protocol to guard against MPGN with monoclonal deposits recurrence utilizing an anti-CD20 AB before transplantation is currently under evaluation by Cosio et al[2], with promising preliminary results. It is assumed that the C3GN remains silent until they exposed to a certain event, e.g., ischemia/reperfusion injury of transplantation that results in dysregulation of complement activation with evolution of the pathological events associated to its aggressive course[108-110]. So, it is essential to reclassify the MPGN based on the recent MPGN classification, which will help not only in designing a therapeutic protocol, but also in instituting a prophylactic policy. It is noteworthy mentioning that the clinical course of MPGN pre- and post-transplantation are not the same, i.e., slow preoperative course is not necessarily applied to the post-transplantation behavior[22].

TREATMENT OF RECURRENT MN

RTR with recurrent MN are better to be under RAAS-blockade as well as symptomatic therapy in the form of diuretics, statins and anticoagulants. Other lines include were listed below.

CNI
Referring to its efficacy in MN in the native kidney disease, many RTR with recurrent MN are utilizing CNI therapy relevant to the recent advances in understanding the pathogenesis of MN recurrence[111].

Corticosteroid/alkylating agents (cyclophosphamide or chlorambucil) combination
Again effective in both native and recurrent MN disease[112]. Unfortunately, leukopenia could be quite troublesome, so, holding MMF while commencing the alkylating agents’ therapy is advised[112].

Anti-CD20 antibody
Rituximab is also successful in treating the native as well as the recurrent MN disease[113-117]. More than 80% of cases could achieve partial or complete remission, while 40% of cases could express subendothelial deposits resolution[17,117]. Despite the increased risk of infection with anti-CD20 therapy[17,113], rituximab is generally safe, effective, simpler to utilize and more tolerated as compared to alkylating agents. So, the anti-CD20, rituximab, is recommended as a primary line in treating MN recurrence, without alterations in the immunosuppression protocol and regardless the anti-PLA2R antibody level[3].

Resistant cases
Alternative therapy between rituximab and alkylating agents is suggested, once one of them failed, then shift to the other line[17,115]. As the level change of anti-PLA2R antibodies titre precedes the decline of proteinuria after rituximab therapy, serial follow up of the antibody titre can be used to anticipate the magnitude of response to therapy as well as the possibility of relapse[113].

Timing of therapy
Early intervention-in contrary to native MN[116] - with anti-CD20 therapy is recommended, exactly when the proteinuria approaching one gram per 24 h. A very high rate of success would be expected[17], which will be ultimately reflected on reduction of the rate of death censored allograft failure related to MN recurrence (45%).

Prophylaxis history
The anti-CD20 was used effectively by Cosio et al[2], to prevent MN recurrence in two patients with a previous allograft loss due to MN recurrence, with serial follow up through a protocol biopsy.
TREATMENT OF RECURRENT FSGS

The recent progress in understanding the pathogenesis of FSGS recurrence was unfortunately not supported by evidence-based controlled trials.

Plasmapheresis
In 1985 treating FSGS with plasmapheresis (PE) sessions has been commenced with variable success[119]. Plasmapheresis has the ability to induce remission in 70% of children and 63% of adults as reported by Ponticelli et al.[120]. An overestimation of these reports is postulated due to retrospective nature of the study, short follow up period and lack of controlled design. Once the disease recurrence become clinically evident, we can extrapolate a satisfactory response with commencing the PE sessions early after transplantation. PE is usually prescribed as one to two times plasma volume exchanges, three times per week, with total 8-12 treatments until remission has been established. An intensified course for longer period was suggested by other researchers[121].

Prophylactic PE
Gohh et al.[122] has admitted preoperative PE for eight sessions in ten patients. In case of living donation, the recipient received PE one week before and one week after the operation. In case of deceased donation, PE was only given 24 h preoperatively. No one case of FSGS recurrence has been diagnosed in the high risk group and only half of his patients has had their allograft failed. They concluded these results were less than previous reports[122], while others denied any benefits for the prophylactic PE[121,123]. A combination of PE and immunosuppressive agents has been proposed with limited data[124,125].

Higher dose of CyA
Only the intensified dose of CyA can reduce the proteinuria level, in contrary to the standard dose that can do nothing for FSGS recurrence[126]. Relevant to its lipophilic criteria, CyA has the ability to bind the LDL receptors on the cell surface of the peripheral lymphocytes. As a result of the rich lipid content (LDL cholesterol) in the nervous system, blood level of the drug is reduced, which could only be overcome through a higher dose augmentation. At this base, i.v. CyA 3 mg/kg/d for 3-4 wk, followed by oral route aiming at preserving the blood level at 250-350 ng/mL, have been successful in induction of remission[127]. However, this policy has been hampered by the multiple untoward effects of the high dosage.

Rituximab
An anti-CD20 chimeric monoclonal antibody depleting the B cells with a direct protective effect on the podocytes. It has the ability to abort the downregulation of sphingomyelin phosphodiesterase acid-like 3b (SMPDL-3b) protein and the acid sphingomyelinase (ASMase), both of them were documented to be present in the podocyte exposed to the sera of recipients with recurrent FSGS[128]. In 2006, beneficial benefits of rituximab in treating the recurrent FSGS post transplantation was suggested[129]. A remission rate of 64%, either partial or complete, has been reported with rituximab therapy[129]. A better response is expected with a normal albumin serum level, and fewer administered infusions as well as in young age recipients[130]. It is not well-proved if titrating rituximab dosage will be the best policy to deplete the B-cell or not. The typical published dosage of rituximab is 375 mg/m²/dose/2-6 doses, with 1-2 wk apart.

PE and rituximab combination
An augmented benefit was assumed to be expected with the combined therapy including PE in addition to rituximab[131,132]. Tsagalis et al.[131] utilized one gram rituximab per dose, in two doses with two wk apart with PE not performed before 72 h. Two of his patients commenced complete remission and the other two have a partial remission with a stable renal profile and absence of severe complications for 18-60 mo of follow up.

While the resolution of recurrent FSGS was assumed to be possible[2] through the use of the anti-CD 20 AB, rituximab[133], this efficacy, unfortunately, is not consistent but rather limited to certain subtypes. The use PE proved to be effective in removing the circulating permeability factors[134]. For instance, we cannot rely only on this effect in case of recurrent FSGS disease. On the other hand, rituximab was proved in a small pediatric group with recurrent FSGS to be effective in achieving PE independence successfully. The variability in response of recurrent FSGS to both PE as well as anti-CD 20 AB (rituximab) therapy is widely spread[135-137], which indicates a variable response that varied according to different subtypes. Despite the absence of well-designed randomized prospective studies, some trials attempted to prove an effective response of removing a putative permeability factor through PE sessions to guard against FSGS recurrence, which was not confirmed by others. A new strategy has been tailored by Cosio et al.[2] to evaluate the ability of the anti-CD25, rituximab, before transplantation to prevent/decrease FSGS recurrence rate has been commenced with encouraging early results.

Renin-angiotensin system blockade
Few case reports have proved the efficacity of renin-
angiotensin system blockade on reducing proteinuria in recurrent FSGS, which shed the light on the fact that the recurrent FSGS is not completely pure immunological in origin, but additional factors including the primary as well as the adaptive form of FSGS have been incorporated.

Ability of “galactose infusion” therapy
In ameliorating the toxicity of the circulating permeability factor has been shown in one case series. Galactose therapy has been proposed by Savin et al. as a non-toxic agent for treatment of the FSGS-associated nephrotic syndrome. The focal segmental permeability factor (FSPF) has a high affinity to galactose. The latter has the ability to inactivate and clear FSPF from the circulation. In addition, the FSPF-galactose complex has a high liability to uptake and catabolism.

Cyclophosphamide
In addition to its untoward toxic manifestations with prolonged use, conflicting results have been determined with cyclophosphamide therapy. Kershaw et al. used a high dose of cyclophosphamide in three pediatric patients with recurrent FSGS, two achieved complete remission and the third one have had partial response. Coch et al. reported sustained remission through a regimen composed of pulse steroid, cyclophosphamide and plasmapheresis. Cheong et al. reported sustained remission only in two of six patients with recurrent FSGS through a similar protocol. Dall’Amico et al. achieved sustained remission in seven of eleven pediatric patients through utilization of steroid pulse-free protocol composed of cyclophosphamide and PE only. Three major toxicities hampered the widespread use of cyclophosphamide, the immunosuppression burden, gonadal toxicities and the risk of malignancy.

Resistant recurrent FSGS to PE and rituximab therapy
A case report recorded a complete remission using the T-cell costimulatory protein B7-1 blocker abatacept, which was not confirmed by others.

TREATMENT OF IGAN
There is no recommended specific therapy in treating the recurrent IgAN. Treatment of recurrent IgAN is similar to that in native disease in non-transplant patient. However, the following maneuvers have been reported.

ATG induction
The use of ATG as induction therapy is shown to be associated with less risk of IgA recurrence.

Low-dose steroids after transplantation
A protective impact against IgAN recurrence was reported.

“Tonsillectomy”
As advocated by the Japanese, a better prognosis post-tonsillectomy could be expected.

ACE inhibitors
The use of ACE is proved to be of no benefit in improving the allograft survival. Only the anti-proteinuric effect could be beneficial to the allograft. All patients of the study of Floege et al. received ACEI with graft failure occurred in more the half of them.

Methylprednisolone pulse
In of the study of Floege et al., only 20% of patients received steroid pulses; again more than half have had their graft lost.

Maintenance immunosuppression
No benefit could be expected with any alterations on the immunosuppressive policy in regard to improvement of graft survival. However, Moroni et al. assumed that immunosuppressive protocols including less than three agents is an independent risk factor of recurrence, however, this theory is still debatable. The choice of immunosuppressive strategy members has nothing to do with IgAN recurrence after renal transplantation.

CONCLUSION
One of the most challenges for renal allograft survival is the GN recurrence after renal transplantation. With improving long-term renal allograft survival, recurrent disease has increased prominence as a significant contributor to late graft loss. Knowledge on the risk factors for recurrence, onset time and impact on graft function is prerequisite to informed decisions. There are minimal data on the risk of recurrent disease with new immunosuppressive agents. The early recognition would slow down deterioration of renal function even if it may not slow down the course of progression of GN. Each of the GN types has a very unique natural history in renal allograft. With more advancement in understanding its pathogenesis in the future, prophylactic treatment for prevention of GN recurrence might be effective.

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December 24, 2017 | Volume 7 | Issue 6 | WJTMET | www.wjtmet.com

Abbas F et al. Recurrence of primary glomerulonephritis

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