pression on the course of GFR could be detected (9). An effect of immunosuppression on inducing full clinical remission was noted in some patients with a baseline GFR above 60 mL/min, but this benefit was offset by a 50% increase in infections and significantly more diabetes induction and weight gain (10). Thus, at present, systemic corticosteroids should be used restrictively in high-risk IgAN patients, only considered after optimization of supportive measures, and probably be reserved for those patients who still exhibit a proteinuria above 2 to 3 g/d despite these measures.

**What novel therapies are on the horizon?**

Given the uncertainty of the value of systemic immunosuppression in IgAN and our in-
creasing knowledge on the pathogenesis of IgAN, alternative approaches are of great inter-
est. On the basis of a small pilot trial (10), the NEFIGAN Phase II Trial recently evaluated effects of budesonide encapsulated to achieve preferential release in the terminal ileum in high-risk IgAN patients. In data presented at ASN Kidney Week 2015, this approach reduced proteinuria and stabilized GFR in the patients. A phase III trial is currently in the planning phase.

**References**

5. Barbour SJ, et al. The MEST score provides earlier risk prediction in IgA nephropa-
9. Rauen T, et al. Intensive supportive care plus immunosuppression in IgA nephropa-
10. Smerud HK, et al. New treatment for IgA nephropathy: Enteric budesonide tar-

**Table 1**

**Risk factors for progression of IgA nephropathy: Importance as judged by an arbitrary score (0 to ++++)

- Clinical data at renal biopsy: reduced GFR (+++), proteinuria >1 g/d (++), hypertension (++)
- Renal biopsy histologic features: MEST score: mesangial hypercellularity (+), endocapillary hypercellularity (±), segmental glomerulosclerosis (+), and tubular atrophy/interstitial fibrosis (+++)
- Crescents affecting >50% of glomeruli (uncontrolled data)
- GFR at renal biopsy considered together with follow-up (time-averaged) proteinuria and time-averaged mean arterial BP over 2 years (+++; see text for explanation)

Abbreviation: MEST = mesangial or endocapillary hypercellularity, segmental glomerulosclerosis, and tubular atrophy/interstitial fibrosis lesions.

**Table 2**

**Supportive measures in IgA nephropathy patients at risk for progressive disease**

- Control each component of the metabolic syndrome
- Restrict NaCl intake/institute diuretic therapy
- Nondihydropyridine calcium channel blocker therapy
- Aldosterone antagonist therapy (adapt dose to OKD stage)
- β-Blocker therapy
- Smoking cessation
- Allopurinol therapy (controversial)
- Empiric NaHCO3 therapy independent of whether metabolic acidosis is present (controversial)
- Avoid NSAIDs if possible (if not, use maximally once or twice weekly)

Abbreviations: CKD = chronic kidney disease; NSAID = nonsteroidal anti-inflammatory drug. Modified from Floege and Fechhali (6).

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**Kidney Disease Markers Reflect Heart Failure Risk in African Americans**

Data on kidney function and microal-
buminuria are associated with the risk of congestive heart failure in an African American population, reports a study in *Nephrology Dialysis Transplantation.*

The researchers present data from 3332 African American participants enrolled in the community-based Jackson Heart Study. All were initially free of heart fail-
ure. Baseline measurements showed that 5% of participants had an estimated glo-
mular filtration rate (eGFR) of less than 60 mL/min/1.73 m2, while 12% had a urine albumin/creatinine ratio (ACR) of 30 mg/g or higher. These kidney disease measures were evaluated for association with later subclinical evidence (based on echocardiography) or clinically assessed heart failure.

In adjusted models, both measures of kidney disease were associated with increased left ventricular mass (LVM): β-coefficient 1.54 per 10 mL/min/1.73 m2 decrease in eGFR and 2.87 per dou-
bling of urine ACR. Neither measure was significantly associated with left ventricu-
lar ejection fraction.

The eGFR was unrelated to the risk of incident heart failure. However, urine ACR was related to clinical heart failure hazard ratio 2.22 per doubling of urine ACR. This association was only slightly weakened by adjustment for left ventricu-
lar mass.

African American and other patients with chronic kidney disease are at high risk of heart failure. This study shows that eGFR and urine ACR are associated with increased LVM in an African American population. Urine ACR is associated with the development of clinical heart fail-
ure, even after adjustment for LVM. The mechanisms of these associations remain to be clarified [Bansal N, et al. Markers of kidney disease and risk of subclinical and clinical heart failure in African Americans: the Jackson Heart Study. *Nephrol Dial Transplant* 2016; 31:2057–2064].

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