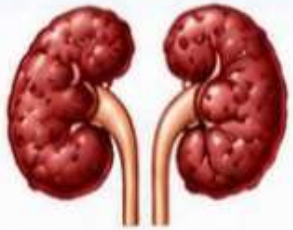
Topic:
Recurrence of FSGS Post Renal Transplant

WHAT IS FSGS?

Focal Segmental Glomerulosclerosis (FSGS) is a podocyte disease causing proteinuria and progressive decline in kidney function.

POST TRANSPLANT RECURRENCE



Native Kidneys with FSGS

Transplanted Kidney

Recurrence of FSGS in the allograft occurs due to a circulating permeability factor.

INCIDENCE

Occurs in ~30–50% of adults and up to 60–80% of children with primary FSGS.

KEY POINTS

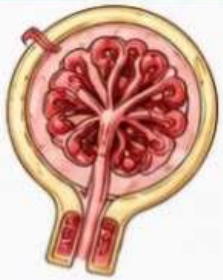
- Early recognition of recurrence.
- Close monitoring of proteinuria in the first 1–6 months is crucial.
- ACTH, Abatacept, Bortezomib, LDL apheresis (centres vary) are therapeutic options.
- Early detection and prompt therapy improve outcomes.

ECNG
Extracorporeal Nephrology Group
An Academic Forum for Nephrologists, DM Trainees, Physicians, and Healthcare Professionals

POST TRANSPLANT RECURRENCE OF FSGS

Early recognition • Close monitoring • Timely treatment to protect the graft

WHAT IS FSGS?



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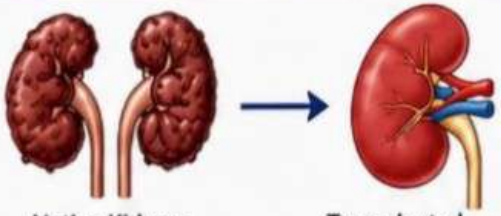

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RISK FACTORS

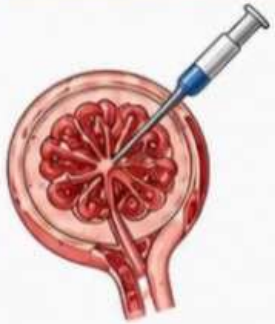
- Younger age at onset (< 15–30 yrs)
- Rapid progression to ESRD
- White race
- Diffuse foot process effacement on EM
- Previous graft loss due to recurrence
- High pre-transplant proteinuria (> 3–5 g/day)

CLINICAL PRESENTATION

Usually presents early (median 1–3 months) with:

- Nephrotic range proteinuria (>3.5 g/day)
- Hypoalbuminemia
- Edema
- Normal or mildly impaired eGFR initially

DIAGNOSIS



- Allograft biopsy shows features of FSGS (segmental sclerosis, hyalinosis, podocyte hypertrophy)
- EM: Diffuse foot process effacement

MANAGEMENT

Plasmapheresis

First line therapy to remove circulating permeability factor

Rituximab

Often used early in combination with plasmapheresis

High dose Calcineurin inhibitors

Tacrolimus/ Cyclosporine

Adjuncts

- ACEi / ARB
- Statins
- Diuretics
- Supportive care

Refractory cases

Consider ACTH, Abatacept, Bortezomib, LDL apheresis (centers with experience)

KEY POINTS

- Recurrence can occur early and may lead to graft loss.
- Close monitoring of proteinuria in the first 1–6 months is crucial.
- Early detection and prompt therapy improve outcomes.

MONITORING

- Check proteinuria weekly for first 1–2 months
- Then monthly up to 6 months
- Monitor albumin, eGFR, and blood pressure

POOR OUTCOME ASSOCIATED WITH

Late recognition

Severe proteinuria at presentation (>10 g/day)

Poor response to plasmapheresis/ rituximab

Delay in intensifying therapy

TAKE HOME MESSAGE

Think FSGS recurrence in any transplant recipient with new onset nephrotic range proteinuria.

Act early, treat aggressively, and protect the graft.