cyclosporine was successful in 75% of patients in treating frequent relapses. Mean time to achieve remission was 3.2 months. Overall Tacrolimus was successful in 77% of patients in treating frequent relapses. Mean time to achieve remission was 2.1 months. Out of 15 patients with steroid resistant nephrotic syndrome, 3 patients treated with cyclosporine, 1 achieved partial remission and still continued on CSA where as 2 patients did not respond. Time to achieve remission was 5 months. 2 patients resistant to cyclosporine and 12 steroid resistant patients were treated with tacrolimus (total 14 patients). 11 of 14 (79%) patients achieved complete remission and 2(14%) achieved partial remission. Mean time to achieve remission was 2.5 months. In SRNS patients, tacrolimus was more effective than cyclosporine and was also effective in 1 pt resistant to CSA.

Conclusions: In frequent relapsing nephrotic syndrome patients, both cyclosporine and tacrolimus has comparable efficacy and no significant difference. Overall success rate (CR, PR and infrequent relapses) was 75% and 77% respectively. In steroid resistant nephrotic syndrome patients, tacrolimus was more effective than cyclosporine and also effective in CSA resistant patients. Combined remission rate (CR & PR) of 93% with tacrolimus as compare to only 33% with cyclosporine was achieved in SRNS. Late steroid resistance is associated with better response to CNI therapy as compared to primary CNI resistance.

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ROLE OF CORTICOSTEROID THERAPY IN IgA NEPHROPATHY - WHERE DO WE STAND?

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Introduction: Current guidelines suggest treatment with corticosteroids (CS) in IgA nephropathy (IgAN) with persistent proteinuria >1 g/day despite 3–6 months of supportive care and eGFR >50 ml/min/1.73m2. Whether the benefits of this treatment extend to patients with an eGFR<50 ml/min/1.73m2 is unclear. We retrospectively studied the effect of steroids on disease progression and proteinuria in IgA N patients with eGFR < 50ml/min/1.73m2 compared to those with >50ml/min/1.73m2.

Methods: A cohort of biopsy proven primary IgA N diagnosed between March 2010 and February 2015 who received oral corticosteroids and followed-up for a minimum of six months were included. They were categorized into two groups as per eGFR. (Group 1 – eGFR>50 ml/min/1.73m2, Group 2 – eGFR < 50ml/min/1.73m2). Baseline characteristics were compared between the groups. The eGFR and urine protein creatinine ratio (UPCR) were followed up at entry time, 6 months, 12 months and at the end of follow-up. Outcomes studied were change in eGFR, proteinuria and progression to end stage renal disease (ESRD). Statistical analysis was done using SPSS version 16.

Results: Out of 44 patients, 23(52%) had eGFR< 50 ml/min/1.73m2 (Group1) and 21(48%) had eGFR >50ml/min/1.73m2 (Group 2). The baseline clinical, histopathological, and treatment characteristics of both the groups are shown in table 1. At the end of follow-up, similar reduction of proteinuria (UPCR) (p-0.62) was seen in both the groups. But there was significant difference in change in median eGFR/month (p-0.004) (Table 2). Patients in Group 2 had a median fall in eGFR of -0.46 ml/min/1.73m2 / month, whereas Group 1 had an increase in median eGFR by +0.38ml/min/1.73m2/ month (Table 2). One in each group has reached CKD stage 5(p-0.73). Limitations in our study were retrospective in nature, small cohort and short duration of follow-up.

Table 1.Comparison of baseline characteristics of patients between two groups

Characteristic	Group 1(N=23) (%) (eGFR < 50 ml/min/1.73 m2)	Group 2-(N=21) (%) (eGFR > 50 ml/min/1.73m2)	'p' value
Age	31.22 ± 9.4	32.19 ± 11.2	0.75
Male: Female	20:3	17: 4	0.60
Micro hematuria	22(95.7)	19(90.5)	0.49
Macro hematuria	4(17)	2(9.5)	0.40
Edema	9(39.1)	11(52.4)	0.37
Hypertension	22(95.7)	19(90.5)	0.49
MAP(mm Hg)*	105.88 ± 11.7	108.47 ± 13.8	0.51
Serum Albumin (g/L)*	3.53 ± 0.8	3.2 ± 0.8	0.16
UPCR(g/g)#	2.6(1.8,3.3)	2(1.7,3.1)	0.25
Proteinuria > 1g/day	22(95.7)	18(85.7)	0.25
24hurineprotein(g/day)*	2.9 ± 1.3	2.4 ± 1.1	0.48
Initial eGFR(ml/min/1.73m²)#	25.13(19.33,39.51)	82.7(76,115.85)	0.001
Serum creatinine (mg/dl)*	2.6 ± 1.1	0.95 ± 0.3	0.001
>3 Antihypertensive medication	8(34.8)	6(28.6)	0.22
ACE i/ARBs	22(95.7)	18(85.7)	0.25
Fish oil	14(60.9)	14(66.7)	0.60
Pulse steroids	7(30.4)	6(28.6)	0.89
Cyclophosphamide	3(13)	1(4.8)	0.34
M1	8(34.8)	6(28.6)	0.50
E1	7(30.4)	9(42.9)	0.40
S1	12(52.2)	8(38.1)	0.39
T1	6(26.5)	4(19.0)	0.58
Crescents	6(26.5)	5(23.8)	0.98
Length of follow-up(months)#	12(12,24)	15(12,36)	0.24

Median with interquartile range, *- Mean with standard deviation, estimated glomerular filtration rate (eGFR), Urine protein-to-creatinine ratio(UPCR),angiotensin II–receptor blocker (ARB), angiotensin-converting–enzyme (ACE) inhibitor, Mean Arterial Pressure(MAP), MEST Score(Mesangial hyper cellularity (M1) ,Endocapillary hyper cellularity (E1), segmental glomerulosclerosis(S1) , tubular atrophy and interstitial fibrosis (T1).

Table 2. Outcomes at the end of follow-up between groups

Characteristic	Group 1(N=23) (%) (eGFR < 50 ml/min/1.73m2)	Group 2-(N-21)(%) (eGFR > 50 ml/min/1.73m2)	'p' value
Initial eGFR#	25.13(19.33,39.51)	82.7(76,115.85)	
eGFR at end of follow-up#	20.94(9.36,37.12)	94.43(77.48,129.91)	
Change in eGFR/ month#	-0.46(-0.1,-1.08)	+0.38(+1.06,0.00)	0.004
Initial UPCR#	2.6(1.8,3.3)	2(1.7,3.1)	
UPCR at the end of follow-up#	1.0(0.6,2.0)	1.0(0.6,2.0)	
Change in UPCR#	1.4(0.3,2.0)	1.5(0.55,2.75)	0.61
Patients reaching ESRD	1(4.3)	1(4.7)	0.73

#- Median with interquartile range, *- Mean with standard deviation, estimated glomerular filtration rate (eGFR), Urine protein-to- creatinine ratio(UPCR)

Conclusions: Addition of corticosteroids to conservative treatment in IgA N patients with initial eGFR<50 ml/min/1.73m2 seems to reduce proteinuria but not beneficial in preventing progression of disease as compared to patients with higher eGFR (>50ml/ min/ 1.73m2). However we need large prospective randomized control trials with long term follow-up to confirm role of steroids in this subset of IgA N.

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TAC-TIC USE OF TACROLIMUS-BASED REGIMENS IN LUPUS NEPHRITIS

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