PROTEINURIA

→ Patients with pre-existing proteinuria at levels >800 mg/day eGFR <40 mL/min, should not undergo CNI elimination with conversion to a PSI and if necessary it should be performed cautiously. [1] [2]

→ If massive proteinuria develops upon conversion from CNI to mTOR inhibitor therapy, reintroduction of CNI therapy may reverse urinary protein loss. [1] [2]

→ All patients on mTOR inhibitor therapy should be monitored for increased urinary protein excretion. [1]

→ For managing mild proteinuria associated with Everolimus lowering blood pressure with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) is considered as first line treatment. [1] [2] [4] [5]

→ ARBs & ACEI should be used cautiously as they are associated with several adverse events, especially those that might potentiate the toxicity of other drugs used in kidney transplant patients. Of especial importance are anemia, hyperkalemia, allograft dysfunction and cough, and angioedema. Anemia is a frequent complication in renal transplant patients, and immunosuppressive drugs, especially mTOR inhibitors. [3] [4]

→ If proteinuria increases, drug withdrawal maybe necessary to reduce the risk of acute renal failure. [1]

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