COMMENTO LINEE GUIDA: BIOPSIA RENALE (1)

6.1 We recommend biopsy before treating acute rejection, unless the biopsy will substantially delay treatment. (1C)

7.1: We recommend kidney allograft biopsy for all patients with declining kidney function of unclear cause, to detect potentially reversible causes. (1C)

COMMENTO LINEE GUIDA: BIOPSIA RENALE (2)

9.1: We recommend kidney allograft biopsy when there is a persistent, unexplained increase in serum creatinine. (1C)

9.2: We suggest kidney allograft biopsy when serum creatinine has not returned to baseline after treatment of acute rejection. (2D)

9.3: We suggest kidney allograft biopsy every 7–10 days during delayed function. (2C)

9.4: We suggest kidney allograft biopsy if expected kidney function is not achieved within the first 1–2 months after transplantation. (2D)

9.5: We suggest kidney allograft biopsy when there is:

- **new onset of proteinuria (2C);**
- **unexplained proteinuria ≥3.0 g per gram creatinine or ≥3.0 g/24hr (2C)**
- **de novo donor-specific antibodies (2C)**

9.6: We suggest that the option of performing kidney protocol biopsies is considered when organ quality evaluation and immune monitoring is deemed useful for clinical decision making purposes (2D)

COMMENTO LINEE GUIDA: RIGETTO CELLULARE

6.2: We suggest considering treatment of subclinical rejection or of borderline acute rejection. (2D)

6.3: We recommend corticosteroids for the initial treatment of acute cellular rejection, unless the clinical conditions suggest a more aggressive first-line treatment. (2C)

6.3.1: We suggest adding or restoring maintenance prednisone in patients not on steroids who have a rejection episode. (2D)

6.3.2: We suggest using lymphocyte-depleting antibodies for acute cellular rejections that do not respond to corticosteroids, and for recurrent acute cellular rejections. (2C)

COMMENTO LINEE GUIDA: RIGETTO UMORALE

6.4: We suggest treating antibody-mediated acute rejection with one or more of the following alternatives, with or without corticosteroids (2C):

- **plasma exchange or immunoadsorption;**
- **intravenous immunoglobulin;**
- **anti-CD20 antibodies or other B cell modulators**
- **anti-plasma cell agents**
- **lymphocyte-depleting antibody.**
- **Complement blockers and/or splenectomy in selected cases**

6.5: For patients who have a rejection episode, we suggest adding mycophenolate if the patient is not receiving mycophenolate or azathioprine, or switching azathioprine or mTOR-inhibitors to mycophenolate and switching from cyclosporine to tacrolimus. (2D)

COMMENTO LINEE GUIDA: INDUZIONE

1.1: We recommend starting a combination of immunosuppressive medications before, or at the time of, kidney transplantation. (1A)

1.2: We suggest including induction therapy with a biologic agent as part of the initial immunosuppressive regimen in KTRs. (2B)

1.2.2: We suggest using a lymphocyte-depleting agent, rather than an IL2-RA, for KTRs at high immunologic risk. (2B)