Unmet need in IgA Nephropathy (IgAN): Disparity between clinical guidelines and real-world practice in Ireland

Leroy, Jennifer[1]; Zein, Mohamed[1]; Dooley, Brenda[1]; Ramirez de Arellano, Antonio.[2]
1. AXIS Reimbursement Ltd, Dublin, Ireland; 2. HEOR CSL Vifor, Glattbrugg, Switzerland.

01. Introduction

Immunoglobulin A nephropathy (IgAN) is the most common primary glomerulonephritis and a leading cause of kidney failure in young adults.[1,2] In Ireland, approximately 1,600 individuals are affected, with up to 50% classified as high risk due to persistent proteinuria (≥1 g/day) and an increased likelihood of progressing to kidney failure or death within ten years despite optimal supportive care.[3]

Proteinuria is the strongest modifiable predictor of progression.[4] Kidney Disease: Improving Global Outcomes (KDIGO) guidelines[5] have progressively lowered treatment targets from:

- 2021: <1 g/day
- 2025: <0.5 g/day, ideally <0.3 g/day.

Despite treatment with Renin–Angiotensin–Aldosterone System (RAAS) inhibitors and growing use of sodium-glucose cotransporterase-2 inhibitors (SGLT2i), ~66% of Irish patients are reported to have proteinuria levels above 1 g/day after three months of therapy.

The burden is substantial. Demand for renal replacement therapy has increased by 30% in the past decade, costing nearly €1 million daily.[6] Post-transplant recurrence affects up to 23% of patients, while fatigue, depression, and loss of productivity significantly impair quality of life.[7]

Ireland currently lacks national clinical guidance for IgAN, and access to novel therapies such as modified release (MR) budesonide and sparsentan is restricted by reimbursement delays. This misalignment with international standards prolongs conservative management and worsens clinical, economic, and humanistic outcomes.

02. Objectives

This study examined the disparity between international guidelines and real-world practice in Ireland, focusing on:

- Access to disease-specific therapies.
- National reimbursement pathways.
- Timeliness of treatment initiation for high-risk patients.

The aim was to identify barriers at the health system level and highlight the clinical and economic consequences of delayed access.

03. Methods

A narrative synthesis was undertaken using three complementary sources:

1. Comparative review of international treatment guidelines versus Irish clinical practice.
2. Targeted search of treatment access and reimbursement status in Ireland.
3. Qualitative interviews with three consultant nephrologists embedded in Irish clinical practice.

Publicly available data, registry analyses (e.g., RaDaR), and policy documents were reviewed to capture evidence on disease progression, burden, and treatment gaps.

04. Results

International treatment guidelines provide a clear framework for the optimal management of IgAN.

KDIGO Guidelines

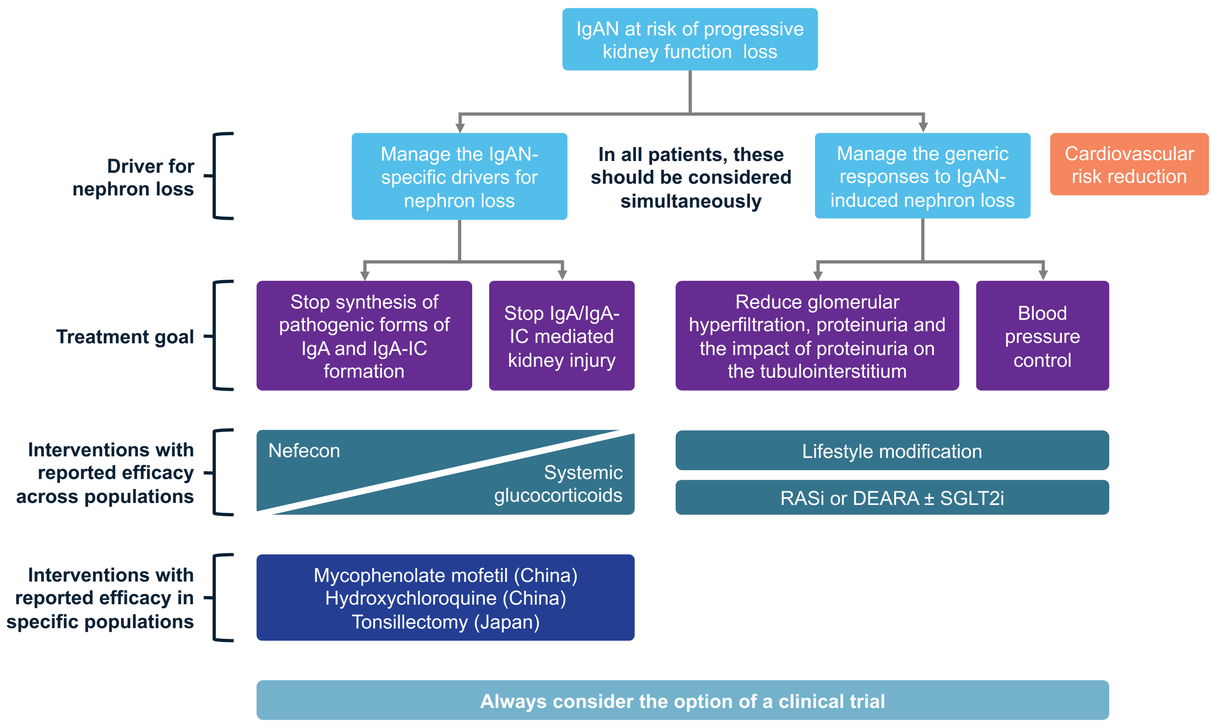
The KDIGO mission is to "improve the care and outcomes of people with kidney disease worldwide through promoting coordination, collaboration, and integration of initiatives to develop and implement clinical practice guidelines."

The 2021 KDIGO guidelines emphasise intensive supportive care, including strict blood pressure control with RAAS inhibitors, and recommend proteinuria reduction as a primary therapeutic goal. Patients with persistent proteinuria above 0.75–1.0 g/day despite supportive care may be considered for glucocorticoids (GC), though use is limited by toxicity.

According to the final 2025 KDIGO guidelines, management of IgAN is structured around early risk stratification and timely therapeutic escalation(Figure 1).[5] Patients with proteinuria ≥0.5 g/day are classified as being at increased risk of progression, prompting initiation or optimisation of supportive care measures. The guidelines emphasise aggressive proteinuria reduction to below 0.5 g/day, and ideally below 0.3 g/day, as a central therapeutic target.

Optimised supportive care includes strict blood pressure control and maximised RAAS inhibition, with the addition of SGLT2 inhibitors as standard therapy for eligible patients. For individuals with persistent proteinuria despite optimised supportive treatment, the 2025 KDIGO recommendations acknowledge the role of emerging disease-modifying agents, including dual endothelin–angiotensin receptor antagonists (DEARAs) such as sparsentan, as targeted options to modify disease course. GCs are reserved for carefully selected patients due to their recognised toxicity burden and are no longer considered the default escalation strategy.

Figure 1: Treatment targets in immunoglobulin A nephropathy (IgAN) and the positioning of drugs included in KDIGO guidelines



Summary: International Guidelines (KDIGO 2021 & 2025 updates)

- 2021: RAASi for proteinuria >0.5 g/day; GC for persistent high-risk cases.
- 2025: Lower threshold for high risk (≥0.5 g/day); new target <0.5 g/day, ideally <0.3 g/day.
  - Endorses SGLT2i as add-on; recognises DEARA* (*sparsentan) as treatment.

Disparity Between International Guidelines and Irish Real-World Practice

By contrast, IgAN management in Ireland remains fragmented and misaligned with international best practice. There are no national clinical guidelines, and management depends on individual clinician practice. Supportive care with RAAS inhibitors is the standard of care, and SGLT2 inhibitors are increasingly used, but uptake varies. Importantly, many patients fail to reach proteinuria targets and a significant number of patients do not achieve <1 g/day even after three months of RAASi therapy,[8] leaving them vulnerable to disease progression. GCs are less favourably prescribed due to safety concerns, and no reimbursed alternatives exist.

This treatment gap is compounded by the lack of reimbursement for disease-modifying therapies. Both MR budesonide and sparsentan have received EU regulatory approval, and sparsentan is already reimbursed in Germany and recommended in the UK. In Ireland, neither therapy is reimbursed, leaving patients reliant on supportive care alone and delaying access to effective treatment.

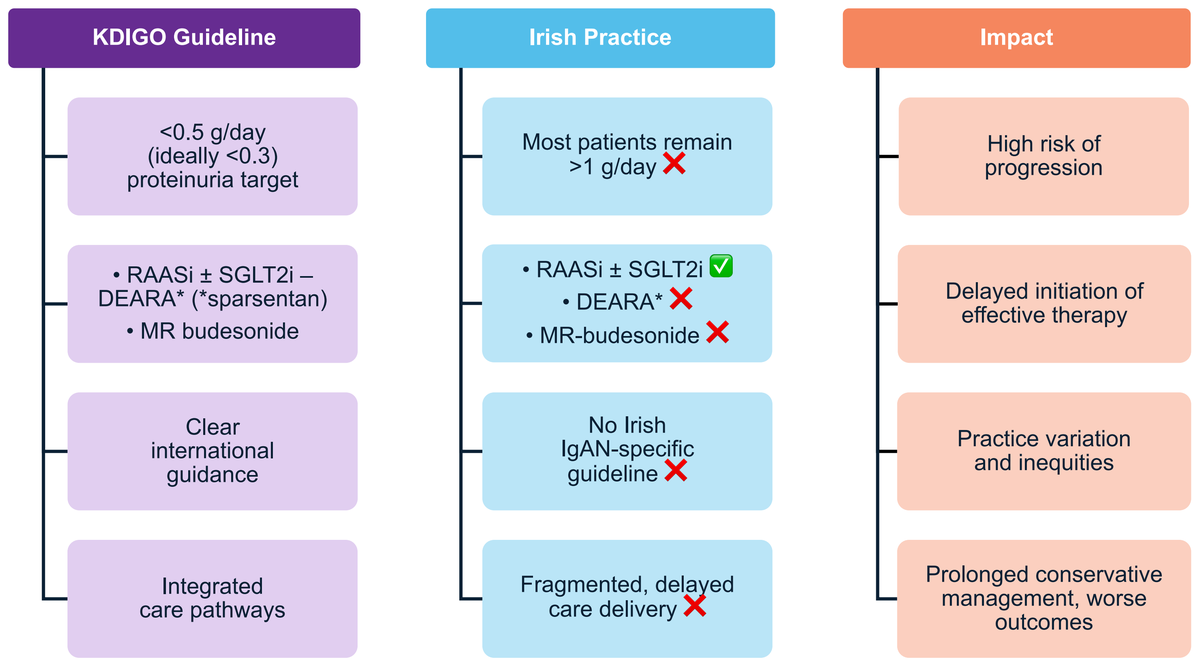
The burden of IgAN is substantial. Approximately half of patients progress to kidney failure or death within 10 years of diagnosis, despite treatment. In Ireland, dialysis and transplant requirements have increased by 30% in the past decade, with annual renal replacement therapy costs approaching €1 million per day. Outcomes after transplantation are also suboptimal, with IgAN recurrence in up to 23% of patients, significantly increasing the risk of graft loss.[9]

Beyond clinical outcomes, IgAN carries a heavy economic and humanistic burden. Healthcare costs rise exponentially with disease progression, with chronic kidney disease (CKD) stage 5 more than 20 times costlier than stage 1.[10] Patients frequently experience fatigue, depression, and anxiety, with significant impacts on productivity and caregiver burden.[11]

Taken together, these findings highlight a clear disparity between evidence-based guideline recommendations and the realities of Irish clinical practice. Restricted reimbursement, absence of national guidance, and delays in treatment initiation drive suboptimal patient outcomes, escalating healthcare costs, and a sustained unmet need in IgAN.

Gaps between 2025 KDIGO recommendations and Irish practice in IgAN lead to delayed treatment, suboptimal outcomes, and higher disease burden (Figure 2).

Figure 2: Consequence of disparity between 2025 KDIGO guidance and Irish clinical practice.



Comparison of the 2025 KDIGO recommendations with current Irish practice highlights major gaps in treatment targets, therapy access, and care pathways. In Ireland, clinical management remains largely supportive, with no national IgAN guideline, fragmented care, and restricted access to novel therapies due to reimbursement delays. This misalignment leads to delayed initiation of effective treatment, suboptimal disease control, and increased clinical and economic burden.

Clinician Perspectives

Three consultant nephrologists in Ireland were interviewed to validate the desk research findings and to provide deeper insights into real-world challenges in managing IgAN. Their perspectives consistently reinforced the existence of a clear gap between international guideline recommendations and day-to-day practice in Ireland, while also identifying additional barriers to optimal patient care.

Clinicians described that IgAN is often detected incidentally through hypertension checks, urine dipstick testing, or antenatal screening, with delays of up to six months for kidney biopsy in some centres. Current treatment pathways rely almost exclusively on RAAS inhibition, with SGLT2 inhibitors increasingly prescribed; however, most patients fail to achieve guideline-recommended proteinuria targets. Steroid use is limited due to tolerability and safety concerns, while MR budesonide and sparsentan remain inaccessible because of reimbursement delays.

"Few patients reach proteinuria targets, and there are no reimbursed alternatives."

"Without a national guideline or registry, care is inconsistent across centers."

"Most patients with IgAN are picked up incidentally, but biopsy delays of several months are common."

Across the interviews, the absence of a national IgAN guideline or patient registry was highlighted as a key gap, contributing to fragmented care and variation in practice. Nephrologists consistently emphasised the need for more effective, disease-modifying therapies, that would address a major unmet need for high-risk patients with persistent proteinuria.

The Cost of Delay: Reimbursement Barriers in Ireland

Although both MR budesonide and sparsentan have received EMA approval for the treatment of IgA nephropathy, neither therapy has yet been reimbursed in Ireland. The Irish reimbursement process is rigorous and often lengthy, with health technology assessments and pricing negotiations frequently extending beyond a year post-approval. This can delay access to funded disease-modifying therapies, leaving clinicians and patients reliant on supportive care in the interim.

From a policy perspective, such lag times reflect a systemic access bottleneck for rare and high-burden conditions. Clinically, delayed access limits opportunities to slow disease progression and prevent kidney failure. Economically, it perpetuates downstream healthcare costs, with dialysis and transplantation representing some of the most resource-intensive interventions in the Irish health system.

05. Conclusion

This analysis reveals a clear gap between international guideline standards and Irish real-world practice in IgAN. KDIGO 2025 emphasises early risk stratification, intensive proteinuria control (<0.5 g/day, ideally <0.3), and timely access to disease-modifying therapies. However, in Ireland, care remains largely supportive, hindered by the absence of national guidance and delayed reimbursement. As a result, many patients face preventable disease progression, kidney failure, and transplant dependence, contributing to escalating clinical and economic burden. Streamlining reimbursement processes or introducing a dedicated fast-track for rare renal diseases could improve access equity and align Irish practice with European peers.

Policy and Practice Implications

- Establishing a dedicated or fast-track reimbursement pathway for rare renal diseases would shorten time to access following EMA approval and ensure earlier availability of disease-modifying treatments for Irish patients.
- Developing Irish-specific guidance aligned with KDIGO 2025 would standardise diagnosis, risk stratification, and treatment pathways, supporting consistent, evidence-based care across centres.

Key Takeaways

- Ireland is not yet aligned with international standards in the management of IgAN, with care still confined to supportive therapy.
- Prolonged reimbursement timelines and the absence of national guidance delay access to proven, disease-modifying treatments.
- Streamlined reimbursement and national guideline development would close the gap between evidence and practice, prevent avoidable kidney failure, and alleviate long-term economic burden.

References

References for this poster can be found by scanning the QR code

Acknowledgement

Clinical insights derived from prior CSL Vifor funded project; no financial support provided for this poster.

CSL Vifor reviewed this poster for scientific accuracy. The concept and development of this poster were initiated independently by the primary author.

AXIS Reimbursement Ltd
22 Lower Baggot Street, Dublin 2, D02 X658
11th Floor, 3 Piccadilly Place, Manchester, M1 3BN, United Kingdom

axisreimbursement.com
+353 (1) 529 2768; +447768740344
info@axisreimbursement.com