



Kriterien zur Bestimmung der zweckmäßigen Vergleichstherapie

und

**Recherche und Synopse der Evidenz zur Bestimmung der
zweckmäßigen Vergleichstherapie nach § 35a SGB V**

und

**Schriftliche Beteiligung der wissenschaftlich-medizinischen
Fachgesellschaften und der Arzneimittelkommission der
deutschen Ärzteschaft (AkdÄ) zur Bestimmung der
zweckmäßigen Vergleichstherapie nach § 35a SGB V**

Vorgang: 2024-B-193 Sparsentan

Stand: Oktober 2024

I. Zweckmäßige Vergleichstherapie: Kriterien gemäß 5. Kapitel § 6 VerfO G-BA

**Sparsentan
[IgA-Nephropathie]**

Kriterien gemäß 5. Kapitel § 6 VerfO

Sofern als Vergleichstherapie eine Arzneimittelanwendung in Betracht kommt, muss das Arzneimittel grundsätzlich eine Zulassung für das Anwendungsgebiet haben.

Siehe Übersicht „II. Zugelassene Arzneimittel im Anwendungsgebiet“.

Sofern als Vergleichstherapie eine nicht-medikamentöse Behandlung in Betracht kommt, muss diese im Rahmen der GKV erbringbar sein.

Nicht angezeigt.

Beschlüsse/Bewertungen/Empfehlungen des Gemeinsamen Bundesausschusses zu im Anwendungsgebiet zugelassenen Arzneimitteln/nicht-medikamentösen Behandlungen

Keine

Die Vergleichstherapie soll nach dem allgemein anerkannten Stand der medizinischen Erkenntnisse zur zweckmäßigen Therapie im Anwendungsgebiet gehören.

Siehe systematische Literaturrecherche

II. Zugelassene Arzneimittel im Anwendungsgebiet

Wirkstoff ATC-Code Handelsname	Anwendungsgebiet [IgA-Nephropathie]
Zu bewertendes Arzneimittel:	
Sparsentan C09XX01 Filspari®	<u>Anwendungsgebiet laut Zulassung</u> Sparsentan (Filspari™) wird angewendet zur Behandlung von Erwachsenen mit primärer Immunglobulin A-Nephropathie (IgAN) mit einer Ausscheidung von Eiweiß im Urin von $\geq 1,0$ g/Tag (oder einem Protein/Kreatinin-Quotienten im Urin von $\geq 0,75$ g/g).
SGLT2-Inhibitoren	
Dapagliflozin A10BK01 Forxiga®	[...] <u>Chronische Niereninsuffizienz</u> Forxiga ist bei erwachsenen Patienten indiziert zur Behandlung der chronischen Niereninsuffizienz. <i>Stand FI: August 2024</i>
Empagliflozin A10BK03 Jardiance®	[...] <u>Chronische Niereninsuffizienz</u> Jardiance wird angewendet zur Behandlung von Erwachsenen mit chronischer Niereninsuffizienz. <i>Stand FI: Dezember 2023</i>
Glukokortikoide	
Budesonid A07EA06 Kinpeygo®	Kinpeygo® ist zur Behandlung von Erwachsenen mit primärer Immunglobulin A-Nephropathie (IgAN) mit einer Proteinausscheidung im Urin von $\geq 1,0$ g/Tag (bzw. einer Protein/Kreatinin-Ratio im Urin von $\geq 0,8$ g/Gramm) angezeigt. <i>Stand FI: Juli 2024</i>

Quellen: AMIce-Datenbank, Fachinformationen

Abteilung Fachberatung Medizin

Recherche und Synopse der Evidenz zur Bestimmung der zweckmäßigen Vergleichstherapie nach § 35a SGB V

Vorgang: 2024-B-193 (Sparsentan)

Auftrag von: Abt. AM
Bearbeitet von: Abt. FB Med
Datum: 30. August 2024

Inhaltsverzeichnis

Abkürzungsverzeichnis	3
1 Indikation	4
2 Systematische Recherche	4
3 Ergebnisse.....	5
3.1 Cochrane Reviews.....	5
3.2 Systematische Reviews	5
3.3 Leitlinien.....	5
4 Detaillierte Darstellung der Recherchestrategie	12
Referenzen	14

Abkürzungsverzeichnis

ACEi	Angiotensin-converting enzyme inhibitor
AKI	Acute kidney injury
ARB	Angiotensin II receptor blocker
AWMF	Arbeitsgemeinschaft der wissenschaftlichen medizinischen Fachgesellschaften
BMI	Body mass index
BP	Blood pressure
CKD	Chronic kidney disease
ECRI	ECRI Guidelines Trust
eGFR	Estimated glomerular filtration rate
G-BA	Gemeinsamer Bundesausschuss
GIN	Guidelines International Network
GN	Glomerulonephritis
GoR	Grade of Recommendations
GRADE	Grading of Recommendations Assessment, Development and Evaluation
HIV	Human immunodeficiency virus
HR	Hazard Ratio
IgAN	Immunglobulin A Nephropathie
IQWiG	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen
KI	Konfidenzintervall
LoE	Level of Evidence
MCD	Minimal change disease
MEST-C	MEST-C, mesangial (M) and endocapillary (E) hypercellularity, segmental sclerosis (S), interstitial fibrosis/tubular atrophy (T), and crescents (C)
NICE	National Institute for Health and Care Excellence
OR	Odds Ratio
RAS	Renin–angiotensin system
RCT	Randomized controlled trial
RPGN	Rapidly progressive glomerulonephritis
RR	Relatives Risiko
SCr	Serum creatinine
SIGN	Scottish Intercollegiate Guidelines Network
TB	Tuberkulose
TRIP	Turn Research into Practice Database
WHO	World Health Organization

1 Indikation

Behandlung von Erwachsenen mit primärer Immunglobulin A-Nephropathie (IgAN) mit einer Ausscheidung von Eiweiß im Urin von $\geq 1,0$ g/Tag (oder einem Protein/Kreatinin-Quotienten im Urin von $\geq 0,75$ g/g).

Hinweis zur Synopse: „Informationen hinsichtlich nicht zugelassener Therapieoptionen sind über die vollumfängliche Darstellung der Leitlinienempfehlungen dargestellt“.

2 Systematische Recherche

Es wurde eine systematische Literaturrecherche nach systematischen Reviews, Meta-Analysen und evidenzbasierten systematischen Leitlinien zur Indikation *IgA-Nephropathie* durchgeführt und nach PRISMA-S dokumentiert [A]. Die Recherchestrategie wurde vor der Ausführung anhand der PRESS-Checkliste begutachtet [B]. Es erfolgte eine Datenbankrecherche ohne Sprachrestriktion in: The Cochrane Library (Cochrane Database of Systematic Reviews), PubMed. Die Recherche nach grauer Literatur umfasste eine gezielte, iterative Handsuche auf den Internetseiten von Leitlinienorganisationen. Ergänzend wurde eine freie Internetsuche (<https://www.google.com/>) unter Verwendung des privaten Modus, nach aktuellen deutsch- und englischsprachigen Leitlinien durchgeführt.

Der Suchzeitraum wurde auf die letzten fünf Jahre eingeschränkt und die Recherche am 08.08.2024 abgeschlossen. Die detaillierte Darstellung der Recherchestrategie inkl. verwendeter Suchfilter sowie eine Angabe durchsuchter Leitlinienorganisationen ist am Ende der Synopse aufgeführt. Mit Hilfe von EndNote wurden Dubletten identifiziert und entfernt. Die Recherche ergab 203 Referenzen.

In einem zweistufigen Screening wurden die Ergebnisse der Literaturrecherche bewertet. Im ersten Screening wurden auf Basis von Titel und Abstract nach Population, Intervention, Komparator und Publikationstyp nicht relevante Publikationen ausgeschlossen. Zudem wurde eine Sprachrestriktion auf deutsche und englische Referenzen vorgenommen. Im zweiten Screening wurden die im ersten Screening eingeschlossenen Publikationen als Volltexte gesichtet und auf ihre Relevanz und methodische Qualität geprüft. Dafür wurden dieselben Kriterien wie im ersten Screening sowie Kriterien zur methodischen Qualität der Evidenzquellen verwendet. Basierend darauf, wurde insgesamt 1 Referenz eingeschlossen. Es erfolgte eine synoptische Darstellung wesentlicher Inhalte der identifizierten Referenz.

3 Ergebnisse

3.1 Cochrane Reviews

Es wurden keine Cochrane Reviews identifiziert.

3.2 Systematische Reviews

Es wurden keine systematischen Reviews identifiziert.

3.3 Leitlinien

KDIGO, 2021 [1].

Kidney Disease – Improving Global Outcomes

KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases

Zielsetzung/Fragestellung

The objective of this project was to update the evidence-based clinical practice guideline for the management of glomerular diseases.

Methodik

Grundlage der Leitlinie

Update der KDIGO Clinical Practice Guideline for Glomerulonephritis 2012

- Repräsentatives Gremium: trifft teilweise zu (ohne Pat.vertretung)
- Interessenkonflikte und finanzielle Unabhängigkeit dargelegt: trifft zu
- Systematische Suche, Auswahl und Bewertung der Evidenz: trifft zu
- Formale Konsensusprozesse und externes Begutachtungsverfahren dargelegt: trifft teilweise zu
- Empfehlungen der Leitlinie sind eindeutig und die Verbindung zu der zugrundeliegenden Evidenz ist explizit dargestellt: trifft zu
- Regelmäßige Überprüfung der Aktualität gesichert: trifft teilweise zu
(Methodikernummer: Die Leitlinie wird aktuell kapitelweise aktualisiert. Das relevante Kapitel 2 (IgAN) entspricht jedoch noch dem Stand von 2021 und wurde noch nicht aktualisiert.)

Recherche/Suchzeitraum:

- literature search in May 2018 and update in June 2020

LoE und GoR

- GRADE system for grading quality of evidence
- Determinants of the strength of recommendation: balance of benefits and harms, quality of evidence, values and preferences, resource use and costs

NOMENCLATURE AND DESCRIPTION FOR RATING GUIDELINE RECOMMENDATIONS

Within each recommendation, the strength of recommendation is indicated as **Level 1** or **Level 2**, and the quality of the supporting evidence is shown as **A, B, C, or D**.

Grade	Implications		
	Patients	Clinicians	Policy
Level 1 'Strong' "We recommend"	Most people in your situation would want the recommended course of action, and only a small proportion would not.	Most patients should receive the recommended course of action.	The recommendation can be evaluated as a candidate for developing a policy or a performance measure.
Level 2 'Weak' "We suggest"	The majority of people in your situation would want the recommended course of action, but many would not.	Different choices will be appropriate for different patients. Each patient needs help to arrive at a management decision consistent with her or his values and preferences.	The recommendation is likely to require substantial debate and involvement of stakeholders before policy can be determined.
Grade	Quality of evidence		Meaning
A	High	We are confident that the true effect is close to the estimate of the effect.	
B	Moderate	The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.	
C	Low	The true effect may be substantially different from the estimate of the effect.	
D	Very low	The estimate of the effect is very uncertain, and often it will be far from the true effect.	

Empfehlungen

2.3 Treatment

Practice Point 2.3.1:

Considerations for treatment of all patients with IgAN who do not have a variant form of primary IgAN

- The primary focus of management should be optimized supportive care.
- Assess cardiovascular risk and commence appropriate interventions as necessary.
- Give lifestyle advice, including information on dietary sodium restriction, smoking cessation, weight control, and exercise, as appropriate.
- Other than dietary sodium restriction, no specific dietary intervention has been shown to alter outcomes in IgAN.
- Variant forms of IgAN: IgA deposition with minimal change disease (MCD), IgAN with acute kidney injury (AKI), and IgAN with rapidly progressive glomerulonephritis (RPGN) may require specific immediate treatment.

Practice Point 2.3.2:

Algorithm for the initial assessment and management of the patient with IgAN

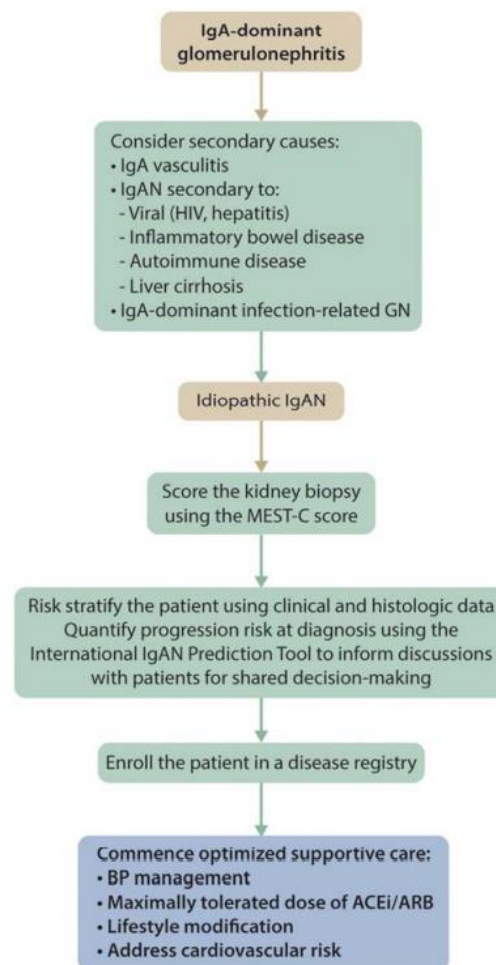


Figure 21 | Initial assessment and management of the patient with IgAN. ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; BP, blood pressure; GN, glomerulonephritis; HIV, human immunodeficiency virus; IgAN, immunoglobulin A nephropathy; MEST-C, mesangial (M) and endocapillary (E) hypercellularity, segmental sclerosis (S), interstitial fibrosis/tubular atrophy (T), and crescents (C).

Recommendation 2.3.1: We recommend that all patients have their blood pressure managed, as described in Chapter 1. If the patient has proteinuria >0.5 g/d, we recommend that initial therapy be with either an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB) (1B).

This recommendation is based on an extensive body of evidence showing that hypertension and proteinuria are major risk factors for progression of CKD and that treatment of hypertension and reduction of proteinuria reduce the risk of progression to kidney failure. Data specifically in IgAN, while not extensive, are consistent with these observations. There are no studies to show dual blockade with an ACEi and ARB is superior to single blockade in IgAN. A post hoc analysis of the STOP-IgAN trial demonstrated no additional benefit with dual blockade.⁸⁹ In the judgment of the Work Group, a strong recommendation is warranted because of the consistency of the benefits for treatment of hypertension and proteinuria observed across the spectrum of kidney diseases, the generally low risk of harm for hypertension and antiproteinuric treatment, and the lack of rationale for a different recommendation for IgAN specifically.

Quality of evidence:

High-quality data support the benefits of BP control and reduction of proteinuria for slowing of kidney disease progression in all CKD populations.⁹² There are limited data

specifically in IgAN, but there is no a priori reason to suspect that the larger body of evidence is not generalizable to people with IgAN. The quality of the evidence for the IgAN population is moderate because of the reliance on the indirect evidence from the general CKD studies. Additionally, the small number of RCTs that have examined antihypertensive medication in patients with IgAN have seldom reported critical and important outcomes such as all-cause mortality, kidney failure, or complete remission, and other outcomes are of moderate quality because of study limitations (lack of allocation concealment, or inadequate blinding of participants, and outcome assessors) or imprecision (only one study or few events).

Recommendation 2.3.2: We recommend that all patients with proteinuria >0.5 g/d, irrespective of whether they have hypertension, be treated with either an ACEi or ARB (1B).

This recommendation is based on the extensive body of evidence across all types of proteinuric glomerular disease, including IgAN, that higher levels of proteinuria are associated with worse kidney outcomes and that a reduction in proteinuria, independent of changes in BP control, is associated with improved kidney outcome. There are no studies to show that dual blockade with an ACEi or ARB is superior to single blockade in IgAN. A post hoc analysis of the STOP-IgAN trial demonstrated no additional benefit with dual blockade.⁸⁹ In the judgment of the Work Group, a strong recommendation is warranted because of the consistency of the benefit for treatment of proteinuria observed across the spectrum of kidney diseases, the generally low risk of harm of antiproteinuric treatment, and the lack of rationale for a different recommendation for IgAN specifically.

Quality of evidence:

The evidence for a renoprotective effect of proteinuria reduction in the setting of normotension is of lower quality than the evidence supporting the treatment of hypertension. However, the individual patient-level meta-analysis by Inker et al. included studies with a range of BP targets and achieved BP, and across all of these studies, a reduction in proteinuria was associated with improved clinical outcome independent of changes in BP.¹⁰⁶ This analysis has subsequently been updated with results from the TESTING and STOP-IgAN trials and affirmed the initial observations of the Inker et al. meta-analysis.³⁶

Practice Point 2.3.1.1

Considerations for treatment of patients with IgAN who are at high risk of progressive CKD despite maximal supportive care

- High risk of progression in IgAN is currently defined as proteinuria $>0.75\text{--}1$ g/d despite ≥ 90 days of optimized supportive care.
- Immunosuppressive drugs should be considered only in patients with IgAN who remain at high risk of progressive CKD despite maximal supportive care (The patients enrolled in the only large randomized controlled trial [RCT] suggesting benefit of immunosuppression had an average of 2.4 g/d of proteinuria).
- In view of the current uncertainty over the safety and efficacy of existing immunosuppressive treatment choices, all patients who remain at high risk of progressive CKD despite maximal supportive care should be offered the opportunity to take part in a clinical trial.
- In all patients in whom immunosuppression is being considered, a detailed discussion of the risks and benefits of each drug should be undertaken with the patient recognizing that adverse treatment effects are more likely in patients with an eGFR <50 ml/min per 1.73 m^2 .
- There is insufficient evidence to support the use of the Oxford Classification MEST-C score in determining whether immunosuppression should be commenced in IgAN.
- There is insufficient evidence to base treatment decisions on the presence and number of crescents in the kidney biopsy.
- The International IgAN Prediction Tool cannot be used to determine the likely impact of any particular treatment regimen.
- Dynamic assessment of patient risk over time should be performed, as decisions regarding immunosuppression may change.

Practice Point 2.3.1.2:

Proteinuria reduction to under 1 g/d is a surrogate marker of improved kidney outcome in IgAN, and reduction to under 1 g/d is a reasonable treatment target.

Recommendation 2.3.1.1: We suggest that patients who remain at high risk of progressive CKD despite maximal supportive care be considered for a 6-month course of glucocorticoid therapy. The important risk of treatment-emergent toxicity must be discussed with patients, particularly those who have an eGFR <50 ml/min per 1.73 m^2 (2B).

In the absence of a rapidly progressive loss of kidney function, supportive therapy is the mainstay of treatment for adults with IgAN. Following 6 months of optimization of supportive therapy, a substantial proportion of patients with >1 g/d of proteinuria considered for enrollment into clinical trials no longer qualify for randomization due to reduction in proteinuria.¹⁰⁰ Shorter periods of 3 months may be considered in patients already receiving RAS blockade prior to biopsy diagnosis. The largest available RCT of glucocorticoids is the TESTING study; investigators halted enrollment prematurely due to safety concerns in the glucocorticoid-treated group.¹⁰⁹ Patients in this study had an average level of proteinuria of 2.4 g/d despite intensive conservative therapy; this level is notably higher than that in the patients enrolled in the STOP-IgAN study, in which patients had 1.6–1.8 g of proteinuria per day. Early analysis suggested efficacy of glucocorticoids, and this underlies the recommendation to consider use of this medication in IgAN. However, there were serious adverse events, including 2 deaths related to infectious complications. In discussion with clinicians, patients may choose not to receive glucocorticoids due to risk.

Quality of evidence:

This recommendation is based upon moderate-quality evidence. The quality of the evidence from 4 RCTs that have compared glucocorticoid therapy with supportive therapy was moderate for critical and important outcomes (all-cause mortality, kidney failure, infection, doubling of SCr, and annual GFR loss) because of study limitations or imprecision (few events). However, the quality of the evidence was low for complete remission because of study limitations and inconsistency ($I^2=60\%$)^{100,109–112}.

Practice Point 2.3.1.3:

Use of glucocorticoids in IgAN

- Clinical benefit of glucocorticoids in IgAN is not established and should be given with extreme caution or avoided entirely in situations listed in [Figure 23](#):

eGFR <30 ml/min/1.73 m ² *
Diabetes
Obesity (BMI >30 kg/m ²) [†]
Latent infections (e.g., viral hepatitis, TB)
Secondary disease (e.g., cirrhosis)
Active peptic ulceration
Uncontrolled psychiatric illness
Severe osteoporosis

Figure 23 | Situations when glucocorticoids should be avoided, or administered with great caution. *The Therapeutic Evaluation of Steroids in IgA Nephropathy Global (TESTING)¹⁰⁹ study included patients with eGFR 20–30 ml/min per 1.73 m², but only 26 patients in total had this range of kidney function. Prespecified subgroup analyses for signals of efficacy and toxicity were underpowered and did not distinguish patients with eGFR <30 ml/min per 1.73 m². [†]High BMI in the TESTING study was not specifically considered an exclusion, but the mean BMI was <24 kg/m². BMI, body mass index; eGFR, estimated glomerular filtration rate; TB, tuberculosis.

- There is insufficient evidence to support the use of the Oxford Classification MEST-C score in determining when any glucocorticoid therapy should be commenced.
- There are no data to support efficacy or reduced toxicity of alternate-day glucocorticoid regimens, or dose-reduced protocols.
- Where appropriate, treatment with glucocorticoid (prednisone equivalent ≥ 0.5 mg/kg/d) should incorporate prophylaxis against *Pneumocystis* pneumonia along with gastroprotection and bone protection, according to local guidelines.

Referenzen aus Leitlinien

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4 Detaillierte Darstellung der Recherchestrategie

Cochrane Library - Cochrane Database of Systematic Reviews (Issue 8 of 12, August 2024)
am 07.08.2024

#	Suchfrage
1	MeSH descriptor: [Glomerulonephritis] this term only
2	Glomerulonephrit*:ti
3	[mh "Glomerulonephritis, IGA"]
4	((Iga OR "Immunoglobulin A" OR berger* OR mesangioproliferative) AND (Nephrit* OR Nephropath* OR Glomerulonephrit* OR Glomerulonephropath*)):ti,ab,kw
5	IgAN:ti,ab,kw
6	(berger* NEXT (morbus OR disease*)):ti,ab,kw
7	#1 OR #2 OR #3 OR #4 OR #5 OR #6
8	#7 with Cochrane Library publication date from Aug 2019 to present

Systematic Reviews in PubMed am 07.08.2024

verwendete Suchfilter:

Konsentierter Standardfilter für Systematische Reviews (SR), Team Informationsmanagement der Abteilung Fachberatung Medizin, Gemeinsamer Bundesausschuss, letzte Aktualisierung am 14.02.2023.

#	Suchfrage
1	Glomerulonephritis[mh:noexp]
2	Glomerulonephrit*[ti]
3	Glomerulonephritis, IGA[mh]
4	((Iga[tiab] OR "Immunoglobulin A"[tiab] OR berger*[tiab] OR mesangioproliferative[tiab]) AND (Nephrit*[tiab] OR Nephropath*[tiab] OR Glomerulonephrit*[tiab] OR Glomerulonephropath*[tiab]))
5	IgAN[tiab]
6	berger*[tiab] AND (morbus[tiab] OR disease*[tiab])
7	#1 OR #2 OR #3 OR #4 OR #5 OR #6
8	(#7) AND (systematic review[ptyp] OR meta-analysis[ptyp] OR network meta-analysis[mh] OR (systematic*[tiab] AND (review*[tiab] OR overview*[tiab])) OR metareview*[tiab] OR umbrella review*[tiab] OR "overview of reviews"[tiab] OR meta-analy*[tiab] OR metaanaly*[tiab] OR metanaly*[tiab] OR meta-synthes*[tiab] OR metasynthes*[tiab] OR meta-study[tiab] OR metastudy[tiab] OR integrative review[tiab] OR integrative literature review[tiab] OR evidence review[tiab] OR ((evidence-based medicine[mh] OR evidence synthes*[tiab]) AND review[pt]) OR (((("evidence based" [tiab:~3]) OR evidence base[tiab]) AND (review*[tiab] OR overview*[tiab])) OR (review[ti] AND (comprehensive[ti] OR studies[ti] OR trials[ti])) OR ((critical appraisal*[tiab] OR critically appraise*[tiab] OR study selection[tiab] OR ((predetermined[tiab] OR inclusion[tiab] OR selection[tiab] OR eligibility[tiab]) AND criteri*[tiab]) OR exclusion criteri*[tiab] OR screening criteri*[tiab] OR systematic*[tiab] OR data extraction*[tiab] OR data synthes*[tiab] OR prisma*[tiab] OR moose[tiab] OR entreq[tiab] OR mecir[tiab] OR stard[tiab] OR strobe[tiab] OR "risk of bias"[tiab]) AND (survey*[tiab] OR overview*[tiab] OR review*[tiab] OR search*[tiab] OR analysis[ti] OR apprais*[tiab] OR research*[tiab] OR synthes*[tiab]))

#	Suchfrage
	AND (literature[tiab] OR articles[tiab] OR publications[tiab] OR bibliographies[tiab] OR published[tiab] OR citations[tiab] OR database*[tiab] OR references[tiab] OR reference-list*[tiab] OR papers[tiab] OR trials[tiab] OR studies[tiab] OR medline[tiab] OR embase[tiab] OR cochrane[tiab] OR pubmed[tiab] OR "web of science" [tiab] OR cinahl[tiab] OR cinhal[tiab] OR scisearch[tiab] OR ovid[tiab] OR ebsco[tiab] OR scopus[tiab] OR epistemonikos[tiab] OR prospero[tiab] OR proquest[tiab] OR lilacs[tiab] OR biosis[tiab])) OR technical report[ptyp] OR HTA[tiab] OR technology assessment*[tiab] OR technology report*[tiab])
9	(#8) AND ("2019/08/01"[PDAT] : "3000"[PDAT])
10	(#9) NOT "The Cochrane database of systematic reviews"[Journal]
11	(#10) NOT (retracted publication [pt] OR retraction of publication [pt] OR preprint[pt])

Leitlinien in PubMed am 07.08.2024

verwendete Suchfilter:

Konsentierter Standardfilter für Leitlinien (LL), Team Informationsmanagement der Abteilung Fachberatung Medizin, Gemeinsamer Bundesausschuss, letzte Aktualisierung am 21.06.2017.

#	Suchfrage
1	Glomerulonephritis[mh:noexp]
2	Glomerulonephrit*[ti]
3	Glomerulonephritis, IGA[mh]
4	((Iga[tiab] OR "Immunoglobulin A"[tiab] OR berger*[tiab] OR mesangioproliferative[tiab]) AND (Nephrit*[tiab] OR Nephropath*[tiab] OR Glomerulonephrit*[tiab] OR Glomerulonephropath*[tiab]))
5	IgAN[tiab]
6	berger*[tiab] AND (morbus[tiab] OR disease*[tiab])
7	#1 OR #2 OR #3 OR #4 OR #5 OR #6
8	(#7) AND (Guideline[ptyp] OR Practice Guideline[ptyp] OR guideline*[Title] OR Consensus Development Conference[ptyp] OR Consensus Development Conference, NIH[ptyp] OR <i>recommendation*[ti]</i>)
9	(#8) AND ("2019/08/01"[PDAT] : "3000"[PDAT])
10	(#9) NOT (retracted publication [pt] OR retraction of publication [pt] OR preprint[pt])

Iterative Handsuche nach grauer Literatur, abgeschlossen am 08.08.2024

- Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)
- Nationale VersorgungsLeitlinien (NVL)
- National Institute for Health and Care Excellence (NICE)
- Scottish Intercollegiate Guideline Network (SIGN)
- World Health Organization (WHO)
- ECRI Guidelines Trust (ECRI)
- Dynamed / EBSCO
- Guidelines International Network (GIN)
- Trip Medical Database

Referenzen

1. **International Society of Nephrology (ISN).** KDIGO 2021 clinical practice guideline for the management of glomerular diseases, supplement to Kidney International. Official Journal of the International Society of Nephrology 2021;100(45):1 - 281.

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- [A] **Rethlefsen ML, Kirtley S, Waffenschmidt S, Ayala AP, Moher D, Page MJ, et al.** PRISMA-S: an extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews. Syst Rev 2021;10(1):39. <https://doi.org/10.1186/s13643-020-01542-z>
- [B] **McGowan J, Sampson M, Salzwedel DM, Cogo E, Foerster V, Lefebvre C.** PRESS Peer Review of Electronic Search Strategies: 2015 Guideline Statement. J Clin Epidemiol 2016;75:40-46. <https://doi.org/10.1016/j.jclinepi.2016.01.021>

**Schriftliche Beteiligung der wissenschaftlich-medizinischen
Fachgesellschaften und der Arzneimittelkommission der
deutschen Ärzteschaft (AkdÄ) zur Bestimmung der
zweckmäßigen Vergleichstherapie nach § 35a SGB V**

- keine eingegangenen schriftlichen Rückmeldungen gem. § 7 Absatz 6 VerfO