**Introduction:** Membranous nephropathy is the commonest diagnosis on biopsy in non-diabetic adults presenting with nephrotic syndrome. KDIGO guidelines suggest patients who have persistent high grade proteinuria after 6 months of standard care, should be considered for immunosuppressant (IS) therapy. A calcineurin inhibitor (CNI), with or without steroids, or modified ponticelli regime are used to induce ideally a complete (CR), or a partial remission (PR), where a PR confers a significantly better chance of renal survival than no remission (NR). There is emerging data supporting the use of rituximab (RTX) as an alternative, particularly in patients who are anti-PLA2R positive.We describe 15 patients treated in a single center with RTX (1g at day 1 & 15) over a 5 year period (2012-2017) with between 7 and 62 months (m) follow up.

**Method:** In our15 cases we assessed patients’ age; months between diagnosis (Dx) and RTX use; previous IS therapy; anti PLA2R titre; serum albumin and urinary protein creatinine ratio (uPCR) at the time of RTX infusion. We report length of follow up and clinical outcome: CR, defined as urine PCR <30, PR as 50% reduction in uPCR and to <3.5g/day or no response (NR).

**Results:**  Mean age 59yrs. Mean time to RTX was 7 m (range 1- 108m). 60% of patients had failed previous IS therapies. 9/15 were PLA2R positive, 1 unknown and a further 3 had confirmed linear IgG4 staining on biopsy.

Length of follow up ranged from 6.5 - 62.5 m. RTX achieved a PR in 60%, at mean time of 5.8 m (median 4 m). 20% of these patients went on to achieve CR at mean 12.6m (range 11-17 m). 40% did not respond, even through 2 initially achieved an early PR.

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| Age  | Dx (m) pre RTX  | Prior IS \* | Anti PLA2R Titre  | Pre RTX uPCR  | Length follow up (m) | Time to PR (m) | Final Outcome post RTX |
| 61 | 7 | Tac | Neg | 863 | 63 | 9 | Ongoing PR x 54m  |
| 58 | 4 | Ponticelli | 295 | 1017 | 47 | 12 | Ongoing PR x 35m  |
| 65 | 108 | P, Tac, MMF  | NA | 500-700 | 40 | NR | NR  |
| 66 | 26 | nil | 607 | 1697 | 41 | 3 | CR by 17m- ongoing |
| 60 | 12 | P, Tac | 449 | 1439 | 40 | 7 | CR by 10 - ongoing |
| 47 | 18 | Tac, MMF | 178 | 865 | (27) | 5 | Then relapsed - NR  |
| 49 | 72 | Ponticelli | neg | 703 | (19) | NR | NR |
| 55 | 15 | Tac | 1496 | 667 | (15) | 4 | Then relapsed - NR  |
| 52 | 1 | nil | neg | 3300 | 28 | 1 | CR by 11 - ongoing |
| 35 | 60 | Cya,MMF, P | 821 | 447 | 20 | 3 | Ongoing PR x 20m |
| 70 | 3.5 | nil | 195 | 616 | 11.5 | NR | NR |
| 77 | 3 | nil | neg | 562 | 9 | 2 | Ongoing PR x 9m |
| 41 | 7 | Tac | 640 | 1307 | 8 |  | NR |
| 78 | 4 | nil | neg | 1302 | 7 |  | NR |
| 64 | 2.5 | (Mtx for RA)  | pos | 720 | 6.5 | 4 | Ongoing PR x 6.5m |

\*Tac (Tacrolimus); P (ponticelli); MMF (Mycophenolate Mofetil); Cya (Ciclosporin); Mtx (Methotrexate) for RA (Rheumatoid arthritis)

**Conclusion:** Our 60% response rate compares favorably with published data considering that 60% of ours had failed prior IS. RTX was used early (before 6m) and as first line treatment in patients where there was significantly declining GFR and the desire to avoid a CNI, and or concern re IS risk with modified ponticelli. RTX presents a less toxic option but response times are slow in our experience: 6m to PR & 12m to CR.