DOI: https://doi.org/10.4038/tsljh.v17i1.58

SLJH. 2025; **17** (1): 41

Answers for the CME: Monoclonal gammopathy of renal significance

Discussion

Q 1 – F T F F

The specific diagnosis of MGRS is made via a combination of renal histology and diagnostic workup of the underlying clonal disorder. The kidney disease results either directly or indirectly from any B-cell or plasma cell clonal disorder, which has not fulfilled the World Health Organization criteria for a haematological neoplasm. Patients with multiple myeloma (MM) or any B-cell lymphoma including Waldenström' macroglobulinaemia (WM) or chronic lymphocytic leukaemia (CLL) can develop the same renal lesions as those with an MGUS, but the term MGRS currently excludes this group.

Q 2 – F F T F

The primary goal in managing MGRS is to preserve renal function and prevent additional kidney damage. This involves targeting the underlying clonal plasma cell or B-cell disorder to reduce the production of nephrotoxic monoclonal proteins. While achieving hematologic remission and reducing monoclonal protein levels are important, they ultimately serve to protect renal function.

Preventing progression to multiple myeloma is beneficial, however, it is not the immediate goal of MGRS management.

Q 3 – F T F F

IgM-associated MGRS (e.g., cryoglobulinemic glomerulonephritis) is usually linked to B-cell or lymphoplasmacytic disorders, requiring rituximab-based therapy to target the underlying clone. Bortezomib-based therapy is more appropriate for plasma cell-associated MGRS, not IgM-driven disorders. Plasma exchange can help to manage acute cryoglobulinemia, but it is not curative and must be followed by clone-directed therapy. Renal transplantation is contraindicated before controlling the haematological disorder, as the monoclonal protein would still cause recurrent damage to the allograft.

References

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