Instructions for ASN congress abstract submission:

- **Character limit:** 2500 (including spaces)
    - **For tables:** 50 characters per row
    - **For figures:** Figure count is determined by image height but will not exceed 560 characters
- **Submission deadline:** 2pm Eastern Time, May 24th, 2023
- **Submission fees:** Each abstract submitted has a non-refundable **mandatory EUR $75.00 processing fee by credit-card (Amex, Master card and visa) only**.

Title: C3 Glomerulopathy Current Treatment Options and Real-World Management - Results from a Multi-Country Study

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Background:

Complement 3 glomerulopathy (C3G) is a rare kidney disease, with an estimated incidence of 1-2/million/year. C3G is associated with a high risk of disease progression, approximately 50% of patients reach kidney failure within 10 years of diagnosis. KDIGO guidelines recommend treating with renin-angiotensin-aldosterone system inhibitors (RAASi) and in some patients, corticosteroids (CS) or mycophenolate mofetil (MMF), or eculizumab. This analysis aimed to better understand the treatment of C3G in the US, Europe, and Asia.

Methods:

Data were drawn from the Adelphi C3G Disease Specific Programme, a real-world cross-sectional survey of C3G-treating nephrologists in US, France, Germany, Italy, Spain, UK (EU5), China and Japan from August 2022 to April 2023. Nephrologists completed forms via online links for consecutive patients presenting with C3G. Forms included patients' demographics, clinical characteristics and C3G treatments.

Results:

111 nephrologists completed records for 385 C3G patients (US 100, EU5 189, China 60, Japan 36). 321 (83%) patients were receiving treatment at time of survey. Of these, median patient age was 41 years, and 60% were male. Median proteinuria was 1.3 g/day. 63% of patients had proteinuria ≥1 g/day (Table 1). 70% were receiving RAASi, 49% CS, 27% MMF, and 30% biologics.

Conclusion:

C3G is a rapidly progressing disease with no approved therapy. Most patients in this study were treated with both conventional immunosuppressants and biologics frequently added to RAASi.

Despite this, proteinuria remained high, in most patients ≥1 g/day. This highlights the need for targeted therapies to treat the root cause of C3G.

Table 1: Current therapy and proteinuria levels by region

Treatment status at time of survey	All (n=385)	EU5 (n=189)	US (n=100)	CN (n=60)	JP (n=36)
Currently treated for C3G	321 (83%)	161 (85%)	79 (79%)	53 (88%)	28 (78%)
Not currently treated for C3G, but they have been in the past	34 (9%)	15 (8%)	11 (11%)	2 (3%)	6 (17%)
Have never received treatment for their C3G	30 (8%)	13 (7%)	10 (10%)	5 (8%)	2 (6%)
Treatment of all patients receiving treatment at time of survey	**All (n=321)**	**EU5 (n=161)**	**US (n=79)**	**CN (n=53)**	**JP (n=28)**
ACEi and/or ARB	226 (70%)	116 (72%)	49 (62%)	42 (79%)	19 (68%)
ARB	118 (37%)	46 (29%)	22 (28%)	31 (58%)	19 (68%)
ACE inhibitor	115 (36%)	75 (47%)	27 (34%)	13 (25%)	0 (0%)
Immunosuppressant	250 (78%)	126 (78%)	67 (85%)	39 (74%)	18 (64%)
Corticosteroid	156 (49%)	71 (44%)	38 (48%)	29 (55%)	18 (64%)
Non-steroidal immunosuppressants	111 (35%)	65 (40%)	26 (33%)	14 (26%)	6 (21%)
Mycophenolate mofetil/ mycophenolate sodium	87 (27%)	55 (34%)	23 (29%)	5 (9%)	4 (14%)
Biologics (Eculizumab, Ravulizumab & Rituximab)	97 (30%)	52 (32%)	30 (38%)	14 (26%)	1 (4%)
Eculizumab	54 (17%)	35 (22%)	13 (16%)	6 (11%)	0 (0%)
Time between diagnosis and treatment initiation (Days)	**All (n=291)**	**EU5 (n=152)**	**US (n=61)**	**CN (n=52)**	**JP (n=26)**
Median	1.0	2.5	5.0	0.0	30.0
Proteinuria at time of survey	**All (n=281)**	**EU5 (n=149)**	**US (n=60)**	**CN (n=48)**	**JP (n=24)**
≥ 1 g/24hr	178 (63%)	98 (66%)	40 (67%)	32 (67%)	8 (33%)
Mean (standard deviation)	2.0 (2.5)	2.2 (2.8)	1.9 (2.0)	2.2 (2.5)	0.6 (0.7)
Median	1.3	1.4	1.4	1.3	0.0

Total approx. = 2467/2500 characters