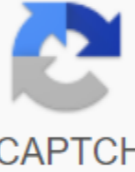


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Management of Nephrotic Syndrome general\_alomedika 2019-11-05T17:00:04-07:00 2019-11-05T17:00:04-07:00 Management of Nephrotic Syndrome (SN) is carried out on the basis of the underlying cause. The purpose of management is to control signs and symptoms, as well as to prevent and treat complications. Medicamentosa Management of Nephrotic Syndrome (SN) in adults depends on basic etiology. Meanwhile, idiopathic SN in children is usually treated with corticosteroids, and immunosuppressive agents if necessary. Corticosteroids are corticosteroids that can be used in the management of nephrotic syndrome (SN) prednison. Prednison is an immunosuppressive agent that can reduce inflammation by increasing capillary permeability and suppressing polymorphonuclear cell activity (PMN). Prednison can be administered as a single dose in the morning or a divided dose. As an idiopathic IC initial therapy without steroid contraindications, based on the International Study of Kidney Diseases in Children (ISKDC) it is possible to administer prednison 60 mg/m<sup>2</sup> area of the body/day or 2 mg/kg/day, a maximum of 80 mg/day, in divided doses for 4 weeks. In the first 4 weeks of remission, followed by the second 4 weeks at a dose of 40 mg/m<sup>2</sup> body surface area or 1.5 mg/kg/day on a variable day, once a day after breakfast. Therapy is said to be a remission when proteinuria is negative or trace (proteinuria < 4 mg/m<sup>2</sup> of the body surface area /hour) 3 consecutive days in 1 week can be said relapse if proteinuria dipstick ≥ 2 (proteinuria > 40 mg/m<sup>2</sup> body surface area/hour) 3 consecutive days in 1 week It is said to depend on steroids when repeated twice consistently during a dose of steroid alternating, or within 14 days after discontinuation of treatment (11) in the case of remission after the introduction of a prednison full dose within 4 weeks can say the steroid. Conversely, if there is no remission of a full dose of prednison treatment within 4 weeks, then the patient is said to be resistant to steroids. Cyclophosphamide immunomodulators are immunomodulators that suppress various humoral immune actions. Cyclophosphamide is converted by cytochrome P-450 in liver into an active metabolite, 4-hydroxy cyclophosphamide. The mechanism of action involves cross-binding DNA, which prevents normal and neoplastic cell growth. This therapy is effective in the recurrence of nephrotic syndrome (SN), steroid dependents, steroid resistance and steroid contraindications. Typically, the dose given to adults and children is 2-3 mg/kg/day up to 12 weeks. Other variants of immunomodulatory agents are cyclosporine and rituximab. Immunosuppressant Mikofenolate mofetil (MMF) suppresses monophosphate dehydrogenase and suppresses the synthesis of de novo purin lymphocytes, thereby suppressing proliferation and Antibodies. This therapy therapy nephrotic syndrome (SN), which does not respond with cytostatic. MMF is administered at a dose of 800-1200 mg/m<sup>2</sup> of the body surface (LPB) or 25-30 mg/kg along with a reduction in the dose of steroids for 12-24 months. Fluid restriction diuretics are highly recommended for severe swelling. Patients may be given a diuretic loop in the form of furosemide 1-3 mg/kg/day. If necessary, it can be combined with potassium-sparing diuretic aldosterone antagonists such as spironolactone 2-4 mg/kg/day. Before administering diuretics, it is necessary to remove the possibility of hypovolemia. Diuretic use for more than 1-2 weeks requires electrolyte monitoring. In the case of fire-resistant swelling, usually due to hypovolemia or severe hypoalbuminemia (≤ 1 g/dL), it is possible to administer an infusion of albumin 20-25% in a dose of 1 g/kg for 2-4 hours, to extract fluid from the interstitial tissue and end with the introduction of intravenous furosemide 1-2 mg/kg. Other inhibitors of angiotensin enzymes (ACEI) and angiotensin receptor blockers (ARB) are used to reduce proteinuria. The second way to reduce proteinuria is to reduce hydrostatic pressure and change glomerular permeability. In addition, ACEI has a renoprotective effect by reducing the synthesis of transformative growth factor (TGF)- $\alpha$ 1 and plasminogen activator inhibitor (PAI)-1, which is an important cytokine in the onion glomerulosclerosis. The group of aces that can be used is captopril 0.3 mg/kg, administered 3 times a day, or enalapril 0.5 mg/kg/day, divided into 2 doses, or lisinopril 0.1 mg/kg of a single dose. The arb group that can be used is a losartan 0.75 mg/kg single dose. [3,11] 1. Nishi S, Ubara Y, Utsunomiya Y, Okada K, Obata Y. Evidence-based clinical practice guidelines for nephrotic syndrome 2014. *Wedge Ex Nefrol.* 2016; 20: 342–370. 2. Tapia C, Bashir K. Nephrotic Syndrome. 2019. . gov/books/NBK470444/ 3. Cohen EP. Nephrotic syndrome. *Medpeif*, 2019. 6. Roth KS, Amaker BH, Chan JCM. Nephrotic syndrome: pathogenesis and management. *Reverend Pediatrician.* 2002; 23(7): 237-248. 8. Codener C. 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