Table 1. Atypical, Dual Antibody and Drug-Induced Variants of Anti-GBM Disease

Atypical anti-GBM disease ^{30,56}	~5-10% of all Cases of anti-GBM disease have absent circulating anti-GBM antibodies
	Mild clinical and/or histopathological presentation
	Management:
	§ Exclude cases of IgG4-, IgA-, and IgM-mediated anti-GBM disease using modified assays
	§ Thorough evaluation for atypical IgG antibodies using highly sensitive assays and modified assays targeting newer epitopes/antigens
Dual anti-GBM antibody and anti-MPO antibody positive disease ^{21,22,37,53}	~20-40% of all cases of anti-GBM disease
	Older age and more systemic manifestations than classic anti-GBM disease
	Relapse commoner than classic disease Outcomes similar to classic disease
	Management:
	§ Initial phase is similar to classic anti-GBM disease;
	§ Maintenance immunosuppression to prevent relapse akin to AAV
Drug-induced anti-GBM disease ^{57–68}	Anti-CD52 monoclonal antibody (alemtuzumab) is associated with the classic anti-GBM disease after 9-10 months of administration in genetically susceptible patients
	TNF-alpha antagonists (etanercept, adalimumab) are associated with classic anti-GBM disease. The exact pathogenesis is unclear as TNF-alpha blockers are known to prevent/resolve anti-GBM GN in animal models.
	Immune checkpoint inhibitors: Anti-programmed death-1 (nivolumab,
	pembrolizumab), CTLA4 antagonist (tremelimumab), kinase inhibitors (dabrafenib, trametinib) are associated with classic and atypical forms of anti-GBM disease
	 SARS-CoV-2 vaccines: Among all other de novo primary GNs reported, anti- GBM disease is rare after this vaccine. All types of SARS-CoV-2 vaccines such as mRNA, Pfizer-BioNtech, and AstraZeneca are associated with classic anti- GBM disease
	Management: Drug withdrawal + treatment similar to classic anti-GBM disease

Abbreviations: GBM, glomerular basement membrane; GN, glomerulonephritis; Ig, immunoglobulin; MPO, myeloperoxidase; TNF, tumor necrosis factor.

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