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Introduction

Anti-GBM disease is a rare and rapidly progressive autoimmune condition in which early removal of circulating autoantibodies is crucial to prevent irreversible organ damage. Therapeutic apheresis—mainly plasma exchange (PEX) and immunoadsorption—is central to achieving rapid antibody clearance. While PEX is more commonly used, immunoadsorption offers more selective IgG removal with minimal plasma volume loss. Despite its advantages, it remains underutilized due to limited availability and experience. Wider use may improve outcomes in selected patients.

Methods

We describe a 78-year-old man admitted with subnephrotic proteinuria (2.8 g/24h), progressive renal function decline over six months, and recent outpatient c-ANCA positivity. On admission, serum creatinine was 2.5 mg/dL (eGFR 20 mL/min). The patient also reported fatigue, exertional dyspnea, and dry cough. Chest X-ray revealed bilateral basal infiltrates suggestive of alveolar involvement. During hospitalization, ANCA testing turned negative, but anti-GBM antibodies were positive.

Due to poor peripheral access, a femoral central venous catheter was placed. Immunoadsorption was chosen over PEX to improve efficacy and preserve the hospital's limited plasma and albumin stocks. Treatment was performed with Evaflux 2A columns.

Results

Seven immunoadsorption sessions led to complete anti-GBM antibody clearance. Renal function slightly improved (creatinine stabilized at 2.0 mg/dL), and respiratory symptoms resolved. Chest imaging showed marked improvement. Corticosteroids and anti-CD20 monoclonal antibody were administered concurrently. The patient reported improved quality of life and resumed daily activities.

Conclusion

This case demonstrates the effectiveness and tolerability of immunoadsorption in anti-GBM disease, especially when rapid antibody removal is needed and plasma resources are limited. It may be considered a valid alternative to PEX in selected clinical scenarios.