Supplemental Files

Supplemental Table 1. Classification scheme of the strength of evidence. (Adopted from: Shekelle P, Woolf S, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. BMJ 999;318:593–596.)

Supplemental Table 2. Overview of available RCTs on the effect of TAC-based regimens in lupus nephritis.

Supplemental Table 1.

Classification schemes	
Category of evidence:	
Ia	Evidence for meta-analysis of randomised controlled trials
Ib	Evidence from at least one randomised controlled trial
IIa	Evidence from at least one controlled study without randomisation
IIb	Evidence from at least one other type of quasi-experimental study
III	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies
IV	Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both
Strength of recommendation:	
A	Directly based on category I evidence
B	Directly based on category II evidence or extrapolated recommendation from category I evidence
C	Directly based on category III evidence or extrapolated recommendation from category I or II evidence
D	Directly based on category IV evidence or extrapolated recommendation from category I, II or III evidence

Supplemental Table 2.

Reference	No. of patients	Type of study*	Duration	Study protocol †	Remission criteria ‡	Outcome (CR/PR/NR)
Chen et al 2011[18]	81	RCT	6 months	TAC-based regimen (n=42): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d TAC: initally 0.05 mg/kg/d (through 5-10 ng/ml) Control arm IVCYC (n=39): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d IVCYC: 0.75 g/m2 for the 1st month, then adjusted to 0.5-1 g/m2	CR: proteinuria <0.3 g/24h, normal urinary sediment, serum albumin ≥3.5 g/dl, stable kidney function (normal range or not >15% more than baseline PR: proteinuria 0.3-2.9 g/24h and a decrease of at least 50% of baseline level, serum albumin ≥3 g/dl, stable kidney function NR: proteinuria >3 g/24h or 0.3-2.9 g/24h, serum albumin <3 g/dl, increase in serum creatinine >30% of baseline	TAC-based regimen: 52/22/26 Control arm IVCYC: 38/43/19
Li et al 2012[19]	60	RCT	6 months	TAC-based regimen (n=20): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d TAC: 0.08-0.1 mg/kg/d (through 6-8 ng/ml) Control arm MMF (n=20): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d MMF: 1.5-2 g/d Control arm IVCYC (n=20): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d IVCYC: 0.5-0.75 g/m^2 monthly	CR: proteinuria <0.3 g/24h with normal urine sediment, serum albumin >3.5g/dl and stabilization (±15%) or improvement of serum creatinine PR: proteinuria 0.3-2.9 g/24h, having decreased by at least 50% from baseline values, with a serum albumin of at least 3 g/dl and relative stabilization (±30%) in serum creatinine	TAC-based regimen: 45/30/25 Control arm MMF: 30/30/40 Control arm IVCYC: 45/30/25

Mok et al 2014[8]	150	RCT	6 months	TAC-based regimen (n=74): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d TAC: initally 0.1 mg/kg/d to 0.06 mg/kg/d if clinical response was satisfactory at month 3 Control arm MMF (n=76): Pred: initial dose 1 mg/kg/d tapered until 10 mg/d MMF: 2-3 g/d	CR: proteinuria <1 g/24h or uP/Cr <1 with stabilization (within 25%) or improvement in serum creatinine, resolution of urinary sediment abnormalities, persistent improvement in C3 and anti-dsDNA levels PR: reduction of proteinuria; if nephrotic at baseline, a 50% decrease but <3 g/24h or uP/Cr <3; if non-nephrotic, a decrease to ≤50% of pre-treatment value but >1 g/24h (or uP/Cr >1), with stabilization (within 25%) or improvement in serum creatinine, improvement of urinary sediment abnormalities (>50% reduction in haematuria and urine RBC (<10/HPF) NR: deterioration of serum creatinine (>25%), an increase in proteinuria, or a reduction in proteinuria but not to the extent of CR of PR	TAC-based regimen: 62/27/11 Control arm MMF: 59/21/20
Bao et al 2008[20]	40	RCT	6 months	TAC-based regimen (n=20): Methylprednisone 0.5 g/d for 3d + pred taper until 10 mg/d TAC: 4 mg/d BID (through 5-7 ng/ml) MMF: 1.5-2 g/d (through AUC 20-45 mg*h/l) Control arm IVCYC (n=20): Methylprednisone 0.5 g/d for 3d + pred taper IVCYC: 0.75 g/m^2 for the 1st month, then adjusted to 0.5-1.0 g/m^2 monthly	CR: proteinuria 0.4g/24h, normal urinary sediment, serum albumin ≥3.5 g/dl, normal serum creatinine or no more than 15% above baseline PR: normal or at least a 50% improvement in proteinuria and haematuria, serum albumin ≥3 g/dl, normal serum creatinine or no more than 15% above baseline	TAC-based regimen: 50/40/10 Control arm IVCYC: 5/40/55

Liu et al 2015[9]	362	RCT	6 months	<u>TAC-based regimen (n=181):</u> Methylprednisone 0.5 g/d for 3d + pred taper until 10 mg/d TAC: 4 mg/d MMF: 1g/d <u>Control arm IVCYC (n=181):</u> Methylprednisone 0.5 g/d for 3d + pred taper until 10 mg/d IVCYC: 0.75 g/m2 for the 1st month, then adjusted to 0.5-1 g/m2	<u>CR</u>: proteinuria <0.4 g/24h, normal urinary sediment, serum albumine ≥3.5 g/dl, normal serum creatinine <u>PR</u>: proteinuria <3.5 g/24h and ≥50% reduction, serum albumin ≥3 g/dl, normal or ≤25% increase in serum creatinine from baseline	TAC-based regimen: 46/38/17 Control arm IVCYC: 26/37/37

* RCT = randomized controlled trial; † TAC = tacrolimus; IVCYC = intravenous cyclophosphamide; MMF = mycophenolate mofetil; pred = prednisone; ‡ CR = complete response; PR = partial response; NR = no response