**Supplementary Table S1**. Supportive care in nephrotic syndrome [4-8]

| Complication | Risk factors | Management |
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| Edema | Relapse | *Prevention:* Initiate therapy for relapse promptly<br>*Management*: First exclude hypovolemia; if moderate to severe edema, restrict fluids and $Na^+$ (1-2 mEq/kg/day); begin with oral furosemide (1-4 mg/kg daily); add spironolactone (2-3 mg/kg/ daily); later consider metolazone (0.2-0.4 mg/kg/day) or hydrochlorthiazide (1-2 mg/kg/day); switch oral to IV furosemide (2-4 mg/kg daily) or infusion (0.1-0.4 mg/kg/hr); IV albumin 0.5-1 g/kg over 4 hr with IV furosemide; isolated ultrafiltration |
| Hypovolemia | Relapse; therapy with ACEi or ARB | *Prevention:* Initiate therapy for relapse promptly; examine during relapses to exclude hypovolemia; avoid diuretics if hypovolemic or presenting with vomiting, diarrhea or fever; withhold ACEi/ARB during relapse<br>*Management:* Increase oral fluid intake; IV normal saline or 5% albumin bolus (10-20 ml/kg over 30 min) if in shock; IV albumin 0.5-1 g/kg over 1-4 hr (without diuretic) |
| Hypertension | Prolonged use of steroids; calcineurin inhibitors | *Prevention and detection*: Monitor blood pressure; manage frequent relapses appropriately<br>*Management*: Target blood pressure at 50–75$^{th}$ percentile; lifestyle measures; restrict salt intake; treat with ACEi or ARB |
| Infections | Immunosuppressive agents; ascites; urinary loss of IgG; decreased leukocyte function | *Prevention*: Ensure appropriate immunization; acyclovir if exposure to varicella; manage anasarca<br>*Management*: Prompt antibiotic treatment in suspected bacterial infection; common infections are peritonitis, cellulitis, pneumonia |
| Thromboembolism | Use of diuretics; diarrhea, dehydration; albumin <1.5 g/dL; thrombocytosis | *Prevention*: Optimize hydration; avoid diuretics in hypovolemia and/or severe hypoalbuminemia; avoid central lines; ensure ambulation; use preventive anticoagulation if previous thrombosis<br>*Management*: Low molecular weight heparin or warfarin |
| Acute kidney injury | Hypovolemia; use of ACE-I, calcineurin inhibitors | Attention to fluid intake and electrolytes; avoid use of ACEi or ARB during hypovolemia or relapse; avoid nephrotoxic agents; modify drug doses appropriately; manage complications of AKI |
| Linear growth retardation | Prolonged or frequent use of high dose prednisolone | Regular monitoring of height and height velocity; steroid minimization; consider growth hormone if off steroids |
| Obesity | Exposure to steroids; reduced physical activity | Monitor weight, body mass index; minimize steroid exposure; advise lifestyle measures |
| Dyslipidemia | Prolonged use of prednisone; calcineurin inhibitors; persistent proteinuria | Lifestyle modifications (diet, physical activity); initiate atorvastatin (10-20 mg/day) in patients with LDL cholesterol ≥160 mg/dl, or ≥130 mg/dL with risk factors |
| Hypothalamo-pituitary-adrenal axis suppression | Oral prednisolone for ≥2-weeks within past 1-yr | 'Stress dose' indicated in serious or systemic infections, surgery or shock<br>*Severe illness*: Hydrocortisone 100 mg/m$^2$ initially or preoperatively, then 25 mg/m$^2$ every 6-hr |

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| | | *Less serious illness*: Hydrocortisone 30-50 mg/m$^2$/day or prednisolone 0.3-1 mg/kg in a single daily dose; given during period of stress, tapered thereafter |
| Osteomalacia; hypovitaminosis D | Prolonged steroid therapy | Limit dose and duration of steroid therapy<br>If on long-term prednisolone: Cholecalciferol (400-800 IU) and calcium (250-500 mg/day) daily |
| Hypothyroidism | Urine loss of thyroid binding globulin, transthyretin | No treatment if remission is expected; monitor borderline levels<br>Persistently low T4, elevated TSH: treat with thyroxine |
| Gastroprotection | Corticosteroid therapy | Not required routinely; do not prescribe proton pump inhibitors or histamine H2 antagonists unless symptomatic |

ACEi angiotensin converting enzyme inhibitor; AKI acute kidney injury: ARB angiotensin receptor blockers; CNI calcineurin inhibitor