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"In Any Case?" The Importance of Iron Repletion

Announcer:
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Dr. Cavens:
This is CME on ReachMD. I'm Dr. Arjeme Cavens from Northwestern University, and I'm here today with Dr. Malcolm Munro from UCLA. We're going to get into a few cases that highlight the issues of iron deficiency throughout our patients' life spans.

So, Malcolm, if you had a 25-year-old nonpregnant patient with heavy menstrual bleeding and symptomatic iron deficiency, what would your next steps be?

Dr. Munro:
Thanks so much, Arjeme. What one has to do here is really treat 2 parallel problems simultaneously. So to reduce the iron loss, one has to identify the cause of the bleeding and to treat it. Now, typically a young woman like this, she could have a coagulopathy. More likely she's got AUB-E or AUB-O, and so there are a lot of approaches there. You follow FIGO's systems, and you can get yourself generally to an answer. With respect to the iron deficiency, we want to start off with an iron formulation, oral. There are a number of formulations, there are a number of dosing schedules to optimize absorption, but whatever one selects, one wants to reassess her at 2-4 weeks to determine if she's had a response. She should have a gram response by 4 weeks in hemoglobin, and if she doesn't, then one or a combination of 2 things are happening. A, her bleeding is still going on, or B, she's not taking or absorbing. And so one has to assess which, if any, of those are happening. Otherwise, one has to continue to iron repletion, which means not just normalization of hemoglobin, but normalization of iron stores.

So I have one for you. What about a 9-week menstrual-age pregnancy, and that individual has been identified at her first hemoglobin as having iron deficiency anemia.

Dr. Cavens:
Okay, so not an uncommon scenario at all. You've already done the first step in accordance with ACOG guidelines of screening for anemia in the first trimester or whenever a patient presents for their first visit. And we've already recognized that she has anemia, and the next step there is to determine if it is iron deficiency anemia, so at least getting the ferritin, and presumably in this patient that was low. So this is definitely a patient that you want to initiate iron supplementation in. We know that the daily dietary intake of iron is not sufficient for pregnancy. And in addition to recommending that the patient take an iron formulation, at an appropriate interval you do want to check in with the patient to make sure she's adherent to that. And check in in about 4 weeks to make sure she is having an appropriate increase in her hemoglobin and ferritin as well. And if not, you want to kind of investigate what those reasons might be.

All right. So then I have one final case for you, Malcolm. If you have a 53-year-old, postmenopausal patient, who gets sent to you because her primary care doctor told her she was anemic, what are your next steps?

Dr. Munro:
So these individuals present a different problem. So first of all, that probably recently postmenopausal woman might have carryover

anemia from heavy menstrual bleeding that she experienced in her late reproductive years. But it's also possible that she has another cause, and of course leading those in terms of concern is gastrointestinal sources, including malignancy. So one has to take a very good history there, but it's very likely that she's a candidate for bidirectional endoscopy, as recommended by the American Gastroenterological Association.

Dr. Cavens:
Okay, well, this certainly has been a lot of information into these 3 brief case studies, but I really think we've made the case for why screening and managing iron deficiency and iron deficiency anemia is really important. Thank you all for listening.

Announcer:
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