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Strategies to Effectively Manage ID and IDA Throughout the Life Span

Announcer:
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Dr. Munro:
Hello, this is CME on ReachMD. I'm Dr. Malcolm Munro from UCLA, and I'm here with Dr. Wendy Wright from New Hampshire to talk about clinical points in managing individuals with iron deficiency. Wendy, what can you tell us?

Ms. Wright:
So let me just start by introducing myself, and welcome and thank you, Dr. Munro. I'm Wendy Wright. I am an adult and family nurse practitioner and the owner of a nurse practitioner-owned and -operated primary care clinic located in New Hampshire, where I have 11 nurse practitioners and about 6,500 primary care patients, so it's truly my pleasure to be here today.

Let's jump right in, because I know we have limited time, and I know that you asked me to provide a little bit in the way of insights with regard to iron deficiency. The first thing, as a primary care provider, is that if you're not seeing iron deficiency or iron deficiency anemias, you're not looking for them. So it's really important that we're assessing both men and women who are at risk for both iron deficiency and iron deficiency anemia. You know, iron deficiency affects diseases that people already have. For instance, it can make their fatigue worse, it can certainly worsen depression in patients who are already affected. It can also increase the risk of cardiovascular events and disease and make conditions like restless legs syndrome worse. So appreciating how important it is in its own entity but also its impact on other diseases is really imperative for our primary care colleagues.

Second, we often will recommend over-the-counter medications for our patients with iron deficiency. And we'll send them out to the pharmacy to pick up ferrous sulfate or ferrous gluconate. But when we do that, studies have really shown that when we give patients a recommendation to purchase over-the-counter meds, it doesn't feel as important to them as if we actually write a prescription. So one of the suggestions I have is that you take out your EHR system and that you write them a prescription for the oral iron because that really will elevate the importance.

And last, with iron deficiency, we really would expect to see changes in their numbers fairly quickly. I think it's important that you follow up to ensure that, A, they're taking their meds, B, that they are tolerating them okay, and 3, to make sure that you're monitoring those lab indices to make sure that they're truly responding to the iron that we're giving them. I think these are all just some tips on ways that we can improve patient uptake with their medicines and also patient adherence.

Dr. Munro:
So, Wendy, when do you think – just give a little guidance to the appropriate times for reassessing them, perhaps, with ferritin, hemoglobin measurements, as well as how well they're tolerating. When do you do that?

Ms. Wright:
Sure. I know that we begin to see changes within just a couple of weeks. But once you've corrected – if it is an anemia – once you've corrected the anemia, it can take 3 to 6 months to fill that savings account up, or what we call the ferritin – but the savings account. So

it's really important that we educate our patients that their treatment doesn't stop once an anemia is corrected, but that they really continue on with their iron in order to make sure that we're giving them those iron stores.

Dr. Munro:
That's great. Well, this has been a wonderful introduction to how to translate what we've been learning into clinical practice. So that's all the time we have now. Thanks for tuning in.

Announcer:
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