CORRESPONDENCE

Fast Track Anaemia Clinic (FTAC) and Intravenous Iron Administration: Its Relevance and Application Today in India

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Received: 24 August 2017 / Accepted: 13 September 2017 / Published online: 13 October 2017
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Sir,

Quintana-Díaz et al. [1] published a recent article on the above topic along with a very balanced editorial perspective on that paper by Girelli et al. [2]. They demonstrated that referring probable iron deficiency anaemia cases from emergency departments to FTAC for evaluation and intravenous iron administration of Iron Carboxy Maltose (ICM) saves time, money, avoids blood transfusion along with protection from all its attendant infectious and non infectious side effects leading to better clinical outcome of the patients in Spanish health care system.

In Spain prevalence of iron deficiency anaemia was only 1–2.5% increasing to up to 10% in women of child bearing age [3]. However in India this prevalence is very high, up to 53% of women of child bearing age and up to 23% of adult males in recent National Family Health Survey [4]. In addition to anemia Iron deficiency without anaemia must also be present in the population in huge numbers with all its undesirable consequences [5]. Rightly in the editorial accompanying the paper Girelli et al. has written us to be cautious on Intravenous iron administration agreeing simultaneously that this an underutilized mode of iron replacement. Iron deficiency anaemia occurs under vastly different clinical circumstances, some conditions are straight forward some are not so hence just replacing the iron by intravenous route does not end the management of iron deficiency and the mode of iron replacement in countries like ours where infections, haemoglobinopathy, parasitic infestations of gastrointestinal tract are not

uncommon and many other disorders associated with systemic disorders and chronic blood loss due to GI malignancy and drugs also started contributing to this deficiency. In addition large population affected with this condition demands well organised community medicine oriented awareness and oral iron replacement programme. Though this is easier said than done as exemplified our failure to improve the prevalence of Iron deficiency for last 70 years after independence.

In spite of describing Modern Intravenous Iron therapy is safe nine cases of adverse reaction has been described by the authors group in previous years publication and in the present publication 4 cases of complication has been described. Complications described were mild and authors have quoted data from American sources to describe iron infusion is extremely safe and more so when compared to that of PRC transfusion.

However intravenous iron therapy also in our country will not be feasible for most of the patients with iron deficiency in current health care scenario though this mode may be applicable to special subset of patients.

In spite of intravenous replacement of Iron 38% of their patients finally ended up with PRC transfusion meaning there by that assessment of Iron deficiency in such large number of patients requiring transfusion of red cells were not totally correct.

Serious hypophosphatemia has been described with present day intravenous iron therapy as individual case reports [6] and also as case series where around 32% of the patients developed this complication and this complication was more with FCM therapy [7] moreover many of these complications took place quite some time after the infusion was completed making the complication more dangerous as doctors who are not aware and careful about this complication may not be watching for the same and ask the

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patient to come back for a follow up and insists that this is extremely important.

It was found that these complications are much more common in patients with vitamin D deficiency. Vitamin D deficiency as well as iron deficiency are extremely common in India [8] hence my colleagues in this country need to take special care if they are administering IV iron as iron replacement. It may be wise to start vitamin D replacement before starting IV iron. Moreover in my country where on the average 1.7–2 million patients visit any of the large medical college hospitals more than 50% patients will have iron deficiency anaemia and FTAC may not be a good idea as the system will be overwhelmed.

However the concept of fast track special clinics where patients with urgent needs for other disorders could be an extremely good idea and similar concept has been started for some of the overcrowded Thalassemia clinics in India and is regularly applied in other specialised OPDs in big hospitals like AIIMS in New Delhi.

Iron deficiency in blood donors who donate blood regularly and even in first time female blood donors in India is common [9] and has been described world wide. Oral replacement of Iron in this group is useful but is frustrated due to large dropout rates [10].

One interesting idea which comes from reading the paper is the possibility of iron replacement by this route in voluntary blood donors. If iron injection becomes extremely safe then after each donation about 150–200 mg of iron could be given as a side push during the time of blood donation itself, particularly if the donation is taking place in well endowed transfusion medicine centre mitigating the problem of Iron deficiency of blood donation. However there will be logistic problem to carry out such a replacement in busy blood centres.

The paper under discussion [1] put us into a dilemma as traditional and even modern teaching suggests that oral iron therapy is the best form of iron therapy in most of the circumstances [11] but current paper suggests that IV iron infusion is very safe and should be considered more often. The long term effects of large amount of intravenous iron infusion in a population where infections and reasons for iron overload like thalassemia carrier status are common and long term oxidant effect of iron is unknown and poorly studied we should probably be more cautious [11]. Finally we should acknowledge that all intravenous modern iron

preparations are not same in terms of their side effects, some even have black box warning for anaphylaxis [11] and others differ in their prevalence of different complications in different populations [12].

Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflict of interest.

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