BONUS DIGITAL CONTENT

Letters to the Editor

Intravenous Iron Replacement for Iron Deficiency Anemia [FPIN's Clinical Inquiries]

To the Editor: The FPIN by Dr. Mounsey and colleagues emphasizes the lack of mortality benefit for intravenous iron over oral iron.[1] However, there are clinical situations in which intravenous iron is preferred.

The first category is when stress (e.g., chronic heart failure, chronic renal insufficiency) or inflammatory conditions (e.g., autoimmune diseases) have produced increased hepcidin levels which decrease iron absorption in the gut and lack of response to oral iron. The 2022 American College of Cardiology guidelines indicate, "In patients with HFrEF [heart failure with reduced ejection fraction] and iron deficiency with or without anemia, intravenous iron replacement is reasonable to improve functional status and QOL [quality of life]."[2]

The second category is when morbidity is associated with the slow correction of iron stores via the oral route. With oral iron, "3 to 6 months of treatment are required for the repletion of iron stores and the normalization of serum ferritin levels."[3] Intravenous iron is indicated in cases of intolerance or poor effectiveness of the oral route, in active disease, or in patients with more severe anemia (hemoglobin less than 10 g per dL [100 g per L]).[4]

Although intravenous iron administration has risks (mainly allergic reactions), these can be minimized using newer iron compounds such as ferric carboxymaltose, in which adjusted incidence rates for anaphylaxis per 10,000 first administrations were 0.8 cases.[5]

Although there may be lack of mortality benefit, better clinical outcomes would seem to justify the inconvenience and cost of intravenous iron in appropriate situations.

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5. Dave CV, Brittenham GM, Carson JL, et al. Risks for anaphylaxis with intravenous iron formulations: a retrospective cohort study. *Ann Intern Med*. 2022;175(5):656-664. ■

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