

Intravenous iron therapy in a rural hospital

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Dear Editor,
We would like to share our ideas on the publication, 'Intravenous iron therapy in a rural hospital: A retrospective chart review'.¹ Kattini et al. concluded that '*we recommend iron maltoside for efficient intravenous iron replacement in non-pregnant patients and single or multiple doses of 200 mg iron sucrose during pregnancy*'.¹ In our setting in rural Asia, anaemia is common and iron supplementation is routinely used for the management of the problem. However, intravenous iron therapy is rarely used. In our area, anaemia in pregnancy is complex. The anaemia might be due to iron deficiency disorder or inherited haemoglobin disorder (such as thalassaemia).^{2,3} In some cases, both iron deficiency disorder or inherited haemoglobin disorder cause anaemia. In these cases, the iron therapy is very hard since the patient usually has a trend of developing haemochromatosis due to inherited haemoglobin disorder.

The oral iron supplementary is more preferable, and it is easier to monitor the pregnant patient than using intravenous therapy. In addition, it is necessary to rule out co-existence between iron deficiency anaemia and inherited haemoglobin disorder before starting iron therapy.

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RESPONSE

The purpose of our study was to identify the clinical options for

providing intravenous iron therapy when indicated. Participants were

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predominantly preoperative patients or women near the end of their pregnancy, patients for whom the limited time frame prompted a consideration of intravenous therapy.

The profile of anaemia was beyond the scope of our study, but we will respond to the authors' clinically relevant comments. In our setting, microcytic anaemia likely reflects iron deficiency anaemia (IDA). The prevalence of IDA in Indigenous women of child-bearing age in Canada has been documented as high as 23%.^{1,2} Other causes of microcytic anaemia: chronic disease, thalassaemia, and sideroblastic anaemia can be ruled out with the measurement of serum ferritin, iron concentration, transferrin saturation and iron-binding capacity. Deciding on who

requires iron replacement therapy will always be an individualised clinical decision and will be context and patient dependent.

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