The Treatment of Iron-Deficiency Anemia with Intravenous Iron Dextran

By Sidney Marchasin and Ralph O. Wallerstein

In the therapy of iron-deficiency anemia, iron given orally is safe, effective, inexpensive, and is usually the treatment of choice, but occasionally when a rapid replenishment of iron stores is desired, administration by the parenteral route is indicated. Heath, Strauss and Castle, in 1938, showed that when 16-32 mg. of iron as ferric ammonium citrate is injected subcutaneously or intramuscularly, practically the total amount is utilized for hemoglobin formation.

Two iron compounds, iron ascorbate and colloidal ferric hydroxide, have been given intravenously in doses of 10 mg., but both proved to be unstable and toxic. The introduction of saccharated iron oxide and dextriferron (iron dextrin) about 15 years ago provided improved preparations for intravenous use, for as much as 500 mg. could be injected without causing serious toxic reactions. In 1954, a new compound, iron-dextran complex (Imferon), was found to be effective when given intramuscularly. Most published accounts have dealt with intramuscular administration of this preparation. In one of the few reports on the intravenous use of iron dextran, Callender and Smith described toxic reactions in two patients who had been given 50 mg. parenterally, and suggested further study of its administration by the intravenous route. The present investigation deals with the intravenous use of iron-dextran in very large amounts in 45 patients. Most of the injected iron stayed in the bloodstream for several hours, was well tolerated and eventually utilized. A preliminary report has been published.

Materials and Methods

The subjects consisted of 37 patients with iron-deficiency anemia and eight patients with acute gastrointestinal bleeding. The diagnosis in all cases was supported by the lack of marrow hemosiderin and usually by the characteristic blood picture, low serum iron levels and high total iron-binding capacity. Bone marrow smears were obtained by aspiration; hemosiderin was determined as previously described. Serum iron was determined by the method of Kok and Wild, slightly modified by using 0.2 N hydrochloric acid as diluent, and by boiling the specimen for 5 minutes before adding trichloracetic acid. Using this method, 1:10 in vitro dilutions of Imferon in serum gave serum iron concentrations of 5119 μg./ml., which agreed well with the stated Imferon concentration of 50 mg./ml., and with values obtained in our laboratory of 50.40 μg./ml. when undiluted Imferon was first digested for 20 minutes in 2 ml. chloric acid.

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Supported by grants (2A-5103 and A-2887) from the United States Public Health Service.

Submitted May 20, 1963; accepted for publication Sept. 17, 1963.
All patients were given undiluted iron-dextran intravenously. The compound was administered in a single dose of 2000–3000 mg (6 patients), 1000 mg (18 patients), 100–500 mg (7 patients), and in repeated doses of 250–500 mg, 2–4 times in 2 weeks (6 patients). Iron was given by slow intravenous drip infusion to the first few patients; the remainder received the preparation by injection over a 4–10 minute period. One patient (F. C.), who had continued blood loss from congenital telangiectasis, received a second dose of 3000 mg 2 months after the first injection. Five of the patients had been treated with intramuscularly administered iron-dextran 2–6 months before the intravenous injection. Eight additional patients with severe acute gastrointestinal bleeding received 500–2000 mg of iron-dextran introduced directly into the transfusion bottle. The patients were carefully observed for 48 hours for untoward local or systemic effects and change in vital signs. Frequent serum iron determinations were made in some cases.

The concentration of iron in the urine was determined after the administration of iron-dextran in 3 patients.

RESULTS

No untoward local reactions were observed. Accidental perivascular infiltration in one patient caused only minor, transient discomfort. One patient developed a delayed systemic reaction, characterized by shaking chills and mild abdominal cramps, approximately 8 hours after intravenous injection of 1000 mg of iron-dextran; however, she did not develop fever and had no objective abdominal signs or symptoms; she had a similar reaction when iron-dextran was again given intravenously 1 week later. None of the other patients had any discomfort or change in vital signs.

Serum iron levels usually reached a peak in 10 minutes, then gradually declined from levels as high as 95,000 µg per 100 ml to 100 µg per 100 ml or less in 2 to 4 weeks (fig. 1). Serum samples with an iron content in excess of 12,000 µg per 100 ml appeared brown to the naked eye; concentrations of 6000 µg per 100 ml did not discolor the serum.

Most of the injected iron could be accounted for in the plasma (table 1). For example, in patient F. C., the pretreatment serum iron level was 29 µg./100 ml. Immediately after administration of 3000 mg of iron-dextran, the serum iron level rose to 86,750 µg./100 ml; at 10 minutes it was 95,000 µg./100 ml, at 1 hour 91,000 µg./100 ml, and at 24 hours 78,500 µg. During the first week, the plasma levels decreased in linear fashion at a rate of 525.6 µg./hour. At 5 weeks, the serum iron level had fallen to 40 µg./100 ml. Only 41 µg were excreted in the urine during the first 24 hours. In 2 other patients urinary excretion of iron was less than 100 µg per day for 72 hours. Stainable iron examined in one patient was present in the bone marrow at 12 hours but not at 6 hours.

DISCUSSION

Toxic reactions to intravenously administered iron occur when ionized iron exceeds plasma iron-binding capacity. Normally transferrin, the iron-binding beta-2 globulin, can chelate 8 to 10 mg, or iron. Modern iron preparations for parenteral use owe their lack of toxicity to the complexing of iron with a large, relatively stable colloidal molecule. Iron-dextran is a combination of colloidal ferric hydroxide with dextran of a molecular weight of approximately 355
2000 to 8000. The solution contains 5 per cent iron and has a pH of 6. The complex is a weakly negatively charged molecule, whose stability, in contrast to saccharated iron oxide, does not depend on an absorbed layer of strongly charged irons. Clinically, the stability of iron dextran is demonstrated by the lack of untoward symptoms even when plasma iron levels are extremely high. Despite these levels, iron is not lost in urine and stool in significant amounts, and appears in the marrow only after 6–12 hours. Early plasma levels can account for practically all the injected iron (table 1); it probably is removed slowly by the reticuloendothelial cells.

The indications for the intravenous use of iron-dextran are similar to those for the intramuscular route. Parenteral iron may be given to patients who are (1) unwilling to take iron by the oral route, (2) unable to tolerate it well (e.g., patients with peptic ulcer, regional ileitis or ulcerative colitis), (3) unable to absorb iron well (e.g., in sprue), and (4) to patients who lose relatively large amounts of blood from gastrointestinal lesions that are not amenable to surgical treatment (e.g., congenital telangiectasia, inoperable cancer and blood loss of obscure origin). Occasionally, parenteral iron may be used in patients who fail to respond to oral administration; in these individ-

![Graph showing disappearance rate of serum iron after intravenous administration of iron-dextran.](image)

**Fig. 1.**—Disappearance rate of serum iron after intravenous administration of iron-dextran.
INTRAVENOUS IRON DEXTRAN

Table 1.—Serum Iron Levels after Intravenous Administration of Iron-Dextran

<table>
<thead>
<tr>
<th>Patient</th>
<th>F. C.</th>
<th>S. M.</th>
<th>R. M.</th>
<th>E. C.</th>
<th>V. G.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight in Kg.</td>
<td>57.3</td>
<td>53</td>
<td>54</td>
<td>50</td>
<td>57</td>
</tr>
<tr>
<td>Estimated plasma volume in ml.</td>
<td>2,865</td>
<td>2,650</td>
<td>2,700</td>
<td>2,500</td>
<td>2,850</td>
</tr>
<tr>
<td>Mg. of iron administered</td>
<td>3,000</td>
<td>1,500</td>
<td>1,000</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Predicted peak in µg.</td>
<td>104,700</td>
<td>56,600</td>
<td>37,050</td>
<td>80,000</td>
<td>70,200</td>
</tr>
<tr>
<td>Actual peak in µg.</td>
<td>86,750</td>
<td>48,900</td>
<td>24,250</td>
<td>81,000</td>
<td>54,000</td>
</tr>
<tr>
<td>Per cent of peak value</td>
<td>62.4</td>
<td>87</td>
<td>78</td>
<td>101</td>
<td>77</td>
</tr>
</tbody>
</table>

It is imperative to make a thorough re-evaluation of the diagnosis before proceeding with parenteral therapy. The intravenous route has some advantage over intramuscular injection in (1) bedridden, immobilized patients who have greatly reduced lymph flow and decreased absorption of iron-dextran from the muscle depot, (2) asthenic patients without much muscle mass, (3) patients requiring multiple, relatively large injections of iron who find that intramuscular administration causes discomfort, and (4) patients with severe blood loss from idiopathic thrombocytopenic purpura who may have tissue bleeding after intramuscular injections.

SUMMARY

Iron-dextran, in doses up to 3000 mg., was administered intravenously by single injection to 37 patients with iron deficiency and to 8 additional patients with acute gastrointestinal bleeding. No serious untoward effects were observed. One patient developed chills and mild abdominal cramps 8 hours after injection. Most of the iron could be accounted for in the circulating blood immediately after the injection. Iron was cleared from the plasma slowly for 3 weeks after the administration. Iron-dextran appears to be a safe and well-tolerated intravenous preparation. It is especially useful in the treatment of iron-deficiency in immobilized patients and individuals with small muscle mass.

SUMMARIO IN INTERLINGUA

Dextrano a ferro, in doses de usque a 3.000 mg, esseva administrate per via intravenose in injectiones unic a 37 patientes con carentia de ferro e a 8 patientes additional con acute sanguination gastrointestinal. Nulle serie effectos adverse esseva observate. Un del patientes disveloppava algor e leve grados de crampas abdominal 8 horas post le injection. Le plus grande parte del ferro poteva esser retraciate in le circulation de sanguine immediatemente post le injection. Ferro esseva catabolisate ex le plasma lentemente durante 3 septimanas post le administration. Dextrano a ferro pare esser un salve e ben-tolerate preparato intravenose. Illo es particularmente utile in le tractamento de carentia de ferro in immobilisate patientes e subjectos con minime massas muscular.

ACKNOWLEDGMENT

We are grateful to Miss Joyce Atkinson for performing the iron determinations.
REFERENCES


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