Ferric Maltol (Ferracru®) for the treatment of iron deficiency anaemia (IDA)

Traffic light classification- Amber 3

Patient is suitable to start ferric maltol?
- Assessment of cause of IDA
- Intolerant/failed two or more first line oral iron salts including at reduced dosage (see below)

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Start ferric maltol 30mg BD.

Hb decreased →

Repeat FBC and ferritin at 1/12 to assess if Hb and ferritin are improving.

→ Stop ferric maltol and refer to Secondary care for IV iron. For patients with IBD see anaemia in IBD pathway

↓ Hb and ferritin the same or increasing

Continue prescriptions for ferric maltol for a further 8 weeks and repeat bloods.

Normalisation of Hb and ferritin ↙

Stop ferric maltol and recheck haematinics in 3-6 months.

↘ Insufficient rise in Hb and ferritin

Continue treatment for another 3 months.
If no change in Hb and ferritin after 6 month's treatment, consider referral to Secondary care for iv iron.

A guideline for the use of ferric maltol (Feraccru®) in Adults

Ferric maltol (Feraccru®) is licensed to treat iron deficiency anaemia adults.

Anaemia is defined as haemoglobin (Hb) below normal range (120g/L Females, <130g/L Males) with either:

Mean Cell Volume -MCV low <80fl
Ferritin low <20microg/L
Transferrin saturation <20%
Iron <10 micromol/L

Other types of anaemia can be caused by a lack of Vitamin B12 or folate. If iron, ferritin and Transferrin saturation are normal, test for Vitamin B12 and Folate deficiency.

FIRST LINE ORAL IRON TREATMENT:

Ferrous Sulphate 200mg (65mg of elemental iron)
Ferrous Fumarate 210mg (65-70mg of elemental iron)
Ferrous Gluconate 300mg (35mg of elemental iron)

Iron should be prescribed once daily.

Iron preparations should usually be given on an empty stomach as taking with meals can reduce the absorption by 75%. Alternate day dosing may be recommended to reduce side effects along with taking the preparation with food which may reduce the absorption (eg Constipation, diarrhoea, nausea, GI discomfort).

If one of the above preparations is not tolerated, another one from the list with a different salt should be used which may help reduce side effects.

SECOND LINE OPTION IF FIRST LINE NOT TOLERATED

Poor compliance due to adverse effects should be addressed where possible. Offer laxatives for constipation and reassurance for black stools.

An alternative first line oral iron salt should have been trialled (see above).

Intolerance to standard oral iron preparations may persist despite reduction to alternate day dosing, changing to another first line agent or taking with food. Ferric maltol should be considered as an alternative instead of referring to Secondary care for intravenous iron or administering iv iron as an inpatient. Intravenous iron may be preferable if on-going significant bleeding, malabsorption, combination of IDA with significant active inflammation or if the oral route is not available.

Ferric maltol has high bioavailability and is designed to be better tolerated than the standard ferrous salts. Ferric maltol contains 30mg of elemental iron.

There is limited evidence that ferric maltol is any more efficacious than conventional iron preparations, but it has a favourable GI side effect profile.

Ferric maltol is significantly more expensive than conventional ferrous salts. It is however less expensive than parenteral iron and the additional cost of administration of iv iron.

MONITORING
Haemaglobin (Hb) should be checked at least 4 weeks after starting.
Aim for >20g/L rise in Hb over 4 weeks.

Hb levels normalise with iron replacement in most cases of IDA.
Treatment should be stopped after normalisation of Hb levels.
Blood count should be monitored every 6 months up to 2 years.

IDA can recur in a minority of patients. Courses may be repeated as needed.

Failure to respond to oral iron may have many causes including non- compliance, malabsorption, systemic disease, bone marrow pathology, haemolysis, continued bleeding and concurrent deficiency of vitamin B12 or folate.

Ferric maltol exclusion criteria

- Exacerbation of inflammatory bowel disease (IBD)
- Haemochromatosis
- IBD with Hb <95 g/L
- Repeated blood transfusions
- Iron overload symptoms
- Caution in diverticular disease/intestinal stricture.
- Chronic kidney disease
- No previous trial of oral iron salts
- Isolated low ferritin (consider dietary sources of iron)

References

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