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PANCREATIC EXOCRINE INSUFFICIENCY THE NEW UEG/HAPANEU GUIDELINES

Iron deficiency (ID) and anemia of chronic diseases (ACD) are the most common causes of anemia in inflammatory bowel disease (IBD), and frequently coexist. In these circumstances, detection of ID may be difficult as inflammation influences the parameters of iron metabolism. The prevalence of iron deficiency anemia (IDA) ranges between 36% and 76% in this population of patients. Anemia may impair physical condition, quality of life (QOL), and cognitive function, negatively affecting almost every aspect of daily life. Furthermore, it may be one of the causes of death in IBD. Consequently, iron replacement therapy should be initiated as soon as ID or IDA is detected, together with the treatment of underlying inflammation. Oral iron therapy is a simple and cheap treatment, but often is poorly tolerated and may worsen the intestinal damage. Moreover, in inflammatory states, duodenal iron absorption is blocked by a cytokine-mediated mechanism. Consequently, intravenous iron therapy is preferred in the presence of severe anemia, intolerance or lack of response to oral iron, and moderately to severely active disease. Recently, new intravenous iron compounds (iron carboxymaltose, iron isomaltoside 1000, ferumoxytol) have become available. Iron carboxymaltose has been shown to be safe and effective in IBD patients with IDA. Furthermore, it allows for rapid administration of high single doses, saving time and costs. If proven to be efficacious and well tolerated, it may become the standard therapy in the near future.

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