RECOGNIZE AND TREAT IRON DEFICIENCY ANEMIA IN PREGNANT WOMEN

JULIANNA SCHANTZ-DUNN, MD, MPH, AND ROBERT L. BARBIERI, MD (EDITORIAL; DECEMBER 2017)

Consider thalassemia traits in patients with iron deficiency

The editorial is an excellent review of iron deficiency as an associated finding with adverse health and pregnancy outcomes. However, one genetic issue appears to have escaped comment. In Florida, our African American patients have a commonly found association with microcytic anemia at least as often as iron deficiency: a variety of α- and ß-thalassemia traits that may occur individually or together. Other racial groups, including Mediterranean and Asian patients, also may carry both the α- and ß-thalassemia traits.

Your recommendation to routinely screen for ferritin deficit is laudable as a general health care practice. If the screening result is normal, however, consider thalassemia carrier states as a secondary explanation as well as a genetic issue requiring partner testing. Aggressive iron loading of a nondeficient anemic patient can risk excess absorption, storage, and ultimate organ compromise in later life if continued indefinitely.

Richard P. Perkins, MD
Fort Myers, Florida

Patient education is key to managing iron deficiency

Forty years ago, my professors expounded on how some people could not absorb iron and that the answer was intravenous iron infusion. After writing a few prescriptions, however, I found that I no longer had patients with absorptive problems once I learned to carefully, and with visual aids, explain the iron story and

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meticulously monitor compliance. I have been through the "slow Fe" and the "prenatal vitamins have iron" nonsense. Ferrous sulfate is about as good as anything. I have explained the theory of vitamin C–assist and found that telling people to avoid taking iron with meals is folly.

I suggest that the iron story is complete. Rather than wasting money on further research, we should spend funds on teaching young physicians to educate patients and monitor compliance. In recent years, I have found that a daily text message to the patient frequently is very helpful.

Robert W. Jackson, MD
Washougal, Washington

Dr. Barbieri responds

I thank Drs. Perkins and Jackson for their helpful recommendations for the management of iron deficiency anemia. I agree with Dr. Perkins that screening for thalassemia is an important part of preconception and prenatal care. In the editorial's table on page 10 discussing the differential diagnosis of anemia, we mentioned the importance of hemoglobin electrophoresis and measurement of vitamin B12 and folate levels to identify cases of anemia caused by thalassemia or vitamin deficiency. I agree with Dr. Jackson that oral iron supplementation along with patient education can resolve most cases of iron deficiency in early and mid-pregnancy. However, in the last few weeks of pregnancy there may not be sufficient time for oral iron supplementation to be effective in resolving iron deficiency anemia. In this situation and in patients at high risk for malabsorption, including women with prior gastric bypass, intravenous iron might be the best approach to resolving the anemia.

STOP USING CODEINE, OXYCODONE, HYDROCODONE, TRAMADOL, AND ASPIRIN IN WOMEN WHO ARE BREASTFEEDING

ROBERT L. BARBIERI, MD (EDITORIAL; OCTOBER 2017)

An either/or choice is not a good strategy for pain

I found Dr. Barbieri's editorial on postpartum opioid use and breastfeeding interesting, but one key issue was not addressed: Following this guidance means that new mothers have to choose between breastfeeding and pain control. You may explain to a patient with 2-day cesarean delivery pain, "If you take pain medicine while breastfeeding, it can adversely affect the baby. So we will give you acetaminophen." While some moms will deal with it, others will stop breastfeeding. With the increasing pressure to advocate for breastfeeding, this strategy is likely not realistic.

R. Lee Toler, DO
Bolivia, North Carolina

My pain management protocol

While presently in an office-based setting, back in my inpatient practice

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days I would order oxycodone plus acetaminophen for 1 to 2 days postoperative cesarean delivery, and only 1 day after normal spontaneous delivery if the patient had a large perineal repair or multiparous involution pain. Otherwise, it was ibuprofen 800 mg, then 400 to 600 mg on discharge home.

Gabrielle Long, CNM
Mohegan Lake, New York

Respect women's postsurgical pain management needs

There is a real disrespect for pain control for women, such as after a cesarean delivery. I would like to see any male have major surgery through a large muscle like the uterus and not need significant pain control options!

Anne V. Hale, MD
El Paso, Texas

Dr. Barbieri responds

I agree with Ms. Long that most postpartum patients, including many who have had a cesarean delivery, can achieve adequate pain control with the use of parenteral and oral nonsteroidal anti-inflammatory drugs (NSAIDs) and oral acetaminophen. Drs. Toler and Hale are concerned that postpartum pain control might be suboptimal if opioids are underprescribed. However, in many developed countries obstetricians do not use opioid pain medicine for postpartum pain management, relying on NSAIDs and acetaminophen. Given the success of this approach, I think we can significantly reduce the use of opioids by postpartum women in the United States by optimizing our use of nonopioid medications.