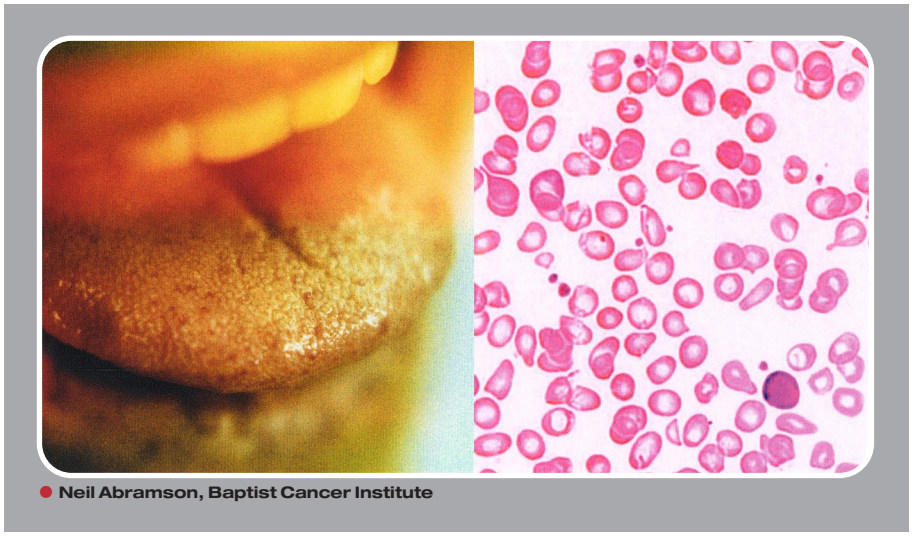
bloodwork
IMAGES IN HEMATOLOGY

# Persistent iron deficiency



Neil Abramson, Baptist Cancer Institute

A 38-year-old man was seen by his physician for tiredness. He indicated that his stools were dark but that he occasionally took iron. The stool hemoccult affirmed the presence of blood. Laboratory work revealed a moderate anemia and mild reticulocytosis. The peripheral blood smear showed microcytosis and hypochromia.

The physician instructed the patient to take iron more frequently and to make a return visit. Two weeks later, there was no change in the hemoglobin. A referral was made for endoscopy. The gastroenterologist examined the patient and observed a few telangiectasias on the tips of the fingers and chest and numerous telangiectasias on the face and tongue (see photograph). When asked about the family history, the patient reported that his father and a few paternal aunts and uncles also had gastrointestinal bleeding. In addition, he noted that his teenaged daughter had telangiectasias. The gastroenterologist performed the endoscopic examination and found rare telangiectasias scattered throughout the upper gastrointestinal tract.

In this case, persistent iron deficiency was caused by continued gastrointestinal bleeding from hemorrhagic hereditary telangiectasia (HHT). This is an autosomal dominant disease with predominant mucocutaneous and visceral telangiectasia. HHT can be easily diagnosed when telangiectasias are found in combination with a family history of telangiectasias or bleeding. These vessel abnormalities can also be present in the lung and liver. Treatment options are limited except for local cauterization of acute bleeding sites and the use of vasopressin. More definitive therapy to prevent bleeding is limited but may include a trial of estrogen/progesterone hormones or anti-angiogenesis factors. Long-term iron therapy is usually needed for the anemia.