



Universitatea de Stat de Medicină și Farmacie
„Nicolae Testemitanu,, din Republica Moldova

Bazele culturii informatiei

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de Medicină și Farmacie „Nicolae Testemitanu,,



Medicina bazată pe dovezi

- Acesta este un domeniu de cunoaștere, care include rezultatele cercetării de încredere, experiența clinică a medicului și interesele pacientului.
- metode de medicina bazată pe dovezi + set de reguli de cercetare și analiză ulterioară, care asigură fiabilitatea rezultatelor.

Aplicarea medicinei bazată pe dovezi necesită timp, competență și experiență, fiind necesară parcurgerea mai multor etape:

- transformarea problemei medicale în întrebare clinică,
- căutarea evidențelor relevante pentru răspunsul la întrebarea respectivă,
- evaluarea validității (conformitatea cu adevărul), a impactului (mărimea efectului) și a relevanței (utilitatea) metodei,
- integrarea evidențelor medicale relevante în practică,
- evaluarea eficienței și eficacității acestora în teren.

Actualmente există o serie de facilități care permit aplicarea metodologiei medicale bazată pe evidențe, între care se pot menționa:

- existența sistemelor informatice de asistare a deciziei medicale,
- realizarea sintezelor informatice și a meta-analizelor,
- apariția a numeroase publicații științifice de practică a medicinei bazată pe dovezi (Evidence-Medicina bazată pe dovezi Based Medicine, Evidence-Based Healthcare & Public Health etc.),
- dezvoltarea informaticii medicale, crearea de strategii de educație medicală continuă.

Logistica medicinei bazată pe dovezi este structurată pe trei nivele:

Nivelul organizatoric. În anul 1979 Archie Cochrane critica societatea medicală pentru lipsa unei modalități prin care să se pună la dispoziția medicilor rezultatele cercetărilor recente, lipsa cărora poate conduce la aplicarea cu întârziere a acestora în practica medicală. Au luat naștere în acest sens, o serie de organizații :

Colaborarea Cochrane are scopul de a crea și de a aduce la zi sinteze sistematice cu ultimele actualități din diverse domenii medicale.

Această organizație este constituită dintr-un grup metodologic care creează metodologii și îndrumă organizația în îmbunătățirea validității și preciziei sintezelor sistematice, precum și o rețea internațională de centre naționale care promovează obiectivele colaborării la nivele naționale.

Colaborarea AGREE este o organizație internațională care se ocupă cu implementarea ghidurilor de practică medicală

Nivelul tehnologic și financiar este asigurat din granturi de cercetare, cheltuielile fiind necesare pentru crearea și menținerea la zi a evidențelor primare și secundare, implementarea și administrarea bazelor de date, accesul la bazele de date, instruirea personalului etc.

Resursele umane sunt reprezentate de ***specialiști în domeniu*** care au rolul de a elabora evidențele medicale; ***informaticienii*** care se ocupă de suportul informatic pentru crearea și managementul evidențelor, respectiv pentru decizia medicală asistată pe calculator; persoane cu rol în dezvoltarea de politici sanitare (normative și legislative);

medicii practicieni, care integrează evidențele valide în practica curentă, alături de experiența individuală.

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- aneurysm
- anemia in children
- anesthesia
- anemia in pregnancy
- anemia workup
- anemia adult
- anemia treatment
- anemia of chronic kidney disease

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Search Results for "anemia"

Topic Outline

☒ All Topics☐ Adult☐ Pediatric☐ Patient☐ Graphics

- Approach to the adult patient with anemia
- Approach to the child with anemia
- Anemia in the older adult
- Causes and diagnosis of iron deficiency anemia in the adult
- Treatment of the adult with iron deficiency anemia
- Anemia of chronic disease (anemia of [chronic] inflammation)
- Anemias due to decreased red cell production
- Approach to the diagnosis of hemolytic anemia in the adult
- Anemia in children due to decreased red blood cell production
- Autoimmune hemolytic anemia in children
- Overview of hemolytic anemias in children
- Palliative care: Overview of fatigue, weakness, and asthenia
- Overview of care of the adult kidney transplant recipient
- Role of erythropoiesis-stimulating agents in the treatment of anemia in patients with cancer
- Hematologic consequences of malignancy: Anemia and bleeding
- Aplastic anemia: Pathogenesis; clinical manifestations; and diagnosis
- Erythropoietin for the anemia of chronic kidney disease among predialysis and peritoneal dialysis patients
- Routine comprehensive care for children with sickle cell disease
- Hematopoietic cell transplantation in aplastic anemia
- Anemia of prematurity
- Clinical aspects, diagnosis, and treatment of the sideroblastic anemias
- Acute chest syndrome in adults with sickle cell disease

Search Results for "anemia"

All Topics

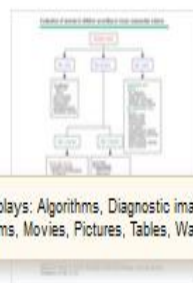
Adult

Pediatric

Patient

Graphics

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Evaluation of anemia in children according to mean co...



Blood smear in sideroblastic anemia



Bone marrow biopsy in aplastic anemia



Approach to the child with unconjugated hyperbilirubi...



Approach to the child with unconjugated hyperbilirubi...



Identification of iron deficiency anemia in rheumatoid arthritis



Anemia of chronic disease - bone marrow iron stain



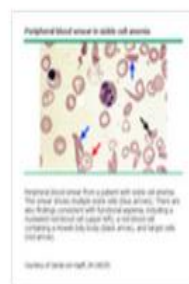
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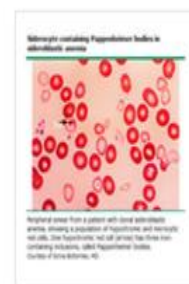
Micronodular cirrhosis in sideroblastic anemia



Peripheral smear in Heinz body hemolytic anemia showi...



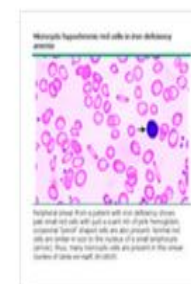
Peripheral blood smear in sickle cell anemia



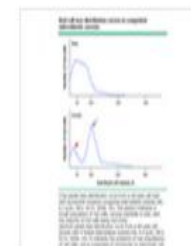
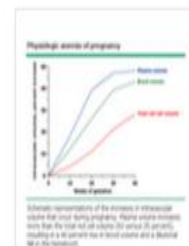
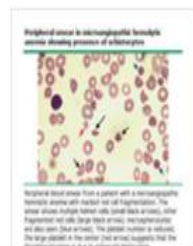
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Iron overload in the liver in sideroblastic anemia



Microcytic hypochromic red cells in iron deficiency anemia

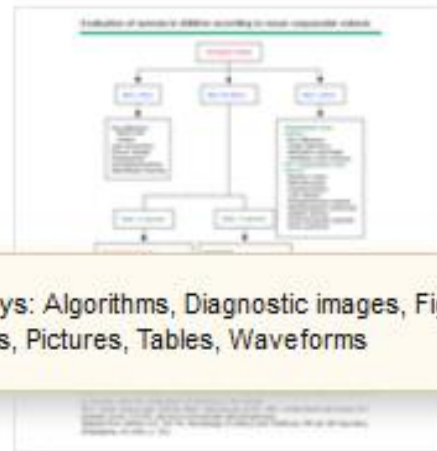


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Search Results for "anemia"

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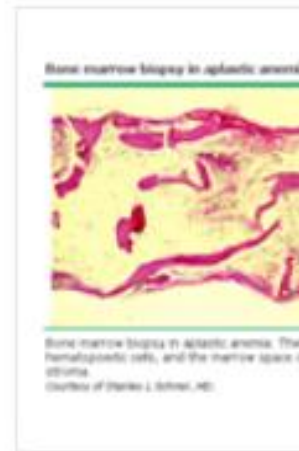
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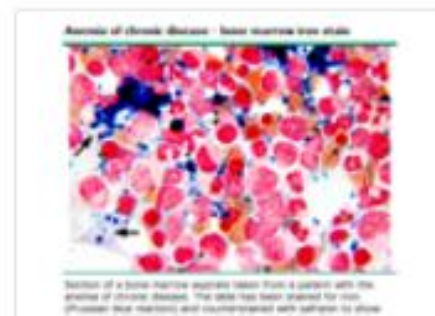
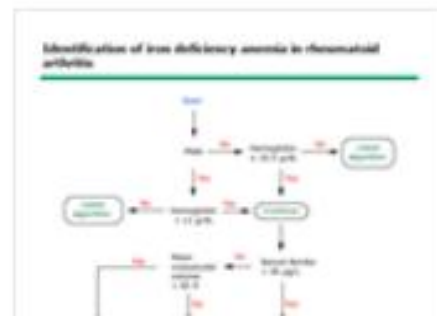
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All search results | Prioritize adult topics | Prioritize pediatric topics | Prioritize patient topics

- **Treatment of hypertension in children and adolescents**
- New-onset hypertension in children and adolescents
- Management of hypertension in children and adolescents
- Approach to the child with hypertension
- Idiopathic intracranial hypertension (pseudotumor cerebri): Prognosis and treatment
- Acute management, imaging, and prognosis of urinary tract infections in children
- Symptomatic management of nephrotic syndrome in children
- Overview of the management of chronic kidney disease in children
- Management of coarctation of the aorta
- Approach to hypertensive emergencies and urgencies in children
- Comorbidities and complications of type 2 diabetes mellitus in children and adolescents
- Management of patent ductus arteriosus
- Congenital rubella syndrome: Management, outcome, and prevention
- Management of the child at-risk for atherosclerosis
- Childhood lead poisoning: Management
- Traumatic hyphema: Clinical features and management
- Evaluation and management of edema in children
- Management of urea cycle disorders
- Treatment of Gaucher disease
- Acute asthma exacerbations in children: Outpatient management
- Intracranial subdural hematoma in children: Clinical features, evaluation, and management
- Clinical features, diagnosis, and treatment of neonatal encephalopathy

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său.

Topic Outline

INTRODUCTION

DEFINITIONS

RATIONALE FOR INTERVENTION

NONPHARMACOLOGIC THERAPY

- Weight reduction
- Exercise
 - Sports participation
- Diet
 - Salt reduction
- Potassium intake and the DASH diet
 - Avoidance of excess alcohol
 - Other CVD risk factors

PHARMACOLOGIC THERAPY

- Whom to treat
- Antihypertensive drugs
 - Thiazide diuretics

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dorite din conținut.

• Beta-blockers

• Calcium channel blockers

• Diuretics

• ACE inhibitors

• Angiotensin receptor blockers

• Vasodilators

• Combination therapy

INFORMATION FOR PATIENTS

SUMMARY AND RECOMMENDATIONS

GRAPHICS

FIGURES

- BP change and salt intake

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relevanței informațiilor obținute .

Treatment of the adult with iron deficiency anemia

TOPIC OUTLINE

SUMMARY & RECOMMENDATIONS

INTRODUCTION

MANAGEMENT OVERVIEW

- Public health aspects
- Diagnostic issues
- Treatment issues

ORAL IRON THERAPY

- General principles
- Choice of preparation
- Dosing in older adults
- Expected response
- Side effects
- Duration of treatment
- Failure to respond to oral iron therapy
- Pregnancy

PARENTERAL IRON THERAPY

- Indications
 - Excessive continuing blood loss
 - Inflammatory bowel disease
 - Chronic kidney disease
 - Use in cancer patients
- Available preparations
 - Iron dextran
 - Total dose infusion
 - Test dose
 - Ferric gluconate complex

Treatment of the adult with iron deficiency anemia

Author
Stanley L Schrier, MD
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Section Editor
William C Mentzer, MD

Deputy Editor
Stephen A Landaw, MD, PhD

Disclosures

All topics are updated as new evidence becomes available and our [peer review process](#) is complete.
Literature review current through: Oct 2013. | **This topic last updated:** okt 24, 2013.

INTRODUCTION — The management of adults with anemia due to iron deficiency, including the relevant diagnostic and therapeutic issues as well as the choice of iron preparation, will be discussed here.

The causes and diagnosis of iron deficiency are discussed separately, as is the treatment of iron deficiency in infants and young children and adolescents. (See "[Causes and diagnosis of iron deficiency anemia in the adult](#)" and "[Iron deficiency in infants and young children: Treatment](#)" and "[Iron requirements and iron deficiency in adolescents](#)".)

The uses of iron preparations for the treatment of functional iron deficiency in patients with chronic kidney disease as well as malignancy being treated with erythropoietin are specialized subjects and are presented separately. (See "[Iron balance in non-dialysis, peritoneal dialysis, and home hemodialysis patients](#)" and "[Use of iron preparation in hemodialysis patients](#)" and "[Diagnosis of iron deficiency in chronic kidney disease](#)" and "[Role of erythropoiesis-stimulating agents in the treatment of anemia in patient with cancer](#)", section on 'Iron monitoring and supplementation'.)

MANAGEMENT OVERVIEW — The usual presenting symptoms in adults, as seen in current practice, are primarily due to anemia, and include weakness, headache, irritability, and varying degrees of fatigue and exercise intolerance. However, many patients are asymptomatic and may recognize that they had fatigue, weakness, exercise intolerance, pagophagia (ice craving, a form of pica), or restless legs syndrome only after successful treatment with iron. (See "[Causes and diagnosis of iron deficiency anemia in the adult](#)", section on 'Clinical manifestations'.)

Public health aspects — More than a quarter of the world's population is anemic, and about one-half of this burden is a result of iron deficiency anemia, being most prevalent among preschool children and women. The prevention and treatment of iron deficiency is obviously a major public health goal, especially in low- and middle-income countries, although the various aspects of this issue are complex and beyond the scope of this review [1]. (See "[Iron deficiency in infants and young children: Screening](#)".)

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mia

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anemia due to iron deficiency, including the relevant diagnostic and therapeutic issues as well as the choice of iron

discussed separately, as is the treatment of iron deficiency in infants and young children and adolescents. (See ["Causes"](#) and ["Iron deficiency in infants and young children: Treatment"](#) and ["Iron requirements and iron deficiency in](#)

functional iron deficiency in patients with chronic kidney disease as well as malignancy being treated with erythropoietin
ely. (See ["Iron balance in non-dialysis, peritoneal dialysis, and home hemodialysis patients"](#) and ["Use of iron preparations
ciency in chronic kidney disease"](#) and ["Role of erythropoiesis-stimulating agents in the treatment of anemia in patients
mentation".](#))

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se intolerance. However, many patients are asymptomatic and may recognize that they had fatigue, weakness, exercise

Căutarea în
cadrul temei

Treatment of the adult with iron deficiency anemia

- Duration of treatment
- Failure to respond to oral iron therapy
- Pregnancy

PARENTERAL IRON THERAPY

- Indications
 - Excessive continuing blood loss
 - Inflammatory bowel disease
 - Chronic kidney disease
 - Use in cancer patients
- Available preparations
 - Iron dextran
 - Total dose infusion
 - Test dose
 - Ferric gluconate complex
 - Test dose
 - Iron sucrose
 - Test dose
 - Ferumoxytol
 - Ferric carboxymaltose
 - Iron isomaltoside
 - Intramuscular iron
- Prevention and treatment of adverse drug events
 - Overview
 - Risk of infection
 - Need for premedication
- Calculation of the dose
 - Correction of anemia
 - Repletion of iron stores

Treatment of the adult with iron deficiency anemia

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Disclosures

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Literature review current through: Oct 2013. | This topic last updated: OCT 24, 2013.

INTRODUCTION — The management of adults with **anemia** due to iron deficiency (ID) and the use of iron preparation, will be discussed here.

The causes and diagnosis of iron deficiency are discussed separately, as is the treatment of iron deficiency in infants and children. (See ["Diagnosis of iron deficiency anemia in the adult"](#) and ["Iron deficiency in infants and young children: Treatment and iron requirements and iron deficiency in adolescents"](#).)

The uses of iron preparations for the treatment of functional iron deficiency in patients with chronic kidney disease as well as malignancy being treated with erythropoietin are specialized subjects and are presented separately. (See ["Iron balance in non-dialysis, peritoneal dialysis, and home hemodialysis patients"](#) and ["Use of iron preparations in hemodialysis patients"](#) and ["Diagnosis of iron deficiency in chronic kidney disease"](#) and ["Role of erythropoiesis-stimulating agents in the management of iron deficiency anemia with cancer"](#), section on 'Iron monitoring and supplementation'.)

MANAGEMENT OVERVIEW — The usual presenting symptoms in adults, as seen in current practice, are primarily irritability, and varying degrees of fatigue and exercise intolerance. However, many patients are asymptomatic and may have symptoms of iron deficiency such as pica, restless legs syndrome, or pagophagia (ice craving, a form of pica), or restless legs syndrome only after successful treatment with iron. (See ["Diagnosis of iron deficiency anemia in the adult"](#), section on 'Clinical manifestations'.)

Public health aspects — More than a quarter of the world's population is **anemic**, and about one-half of this burden is a result of iron deficiency **anemia**, being most prevalent among preschool children and women. The prevention and treatment of iron deficiency is obviously a major public health goal, especially in low- and middle-income countries, although the various aspects of this issue are complex and beyond the scope of this review [1]. (See ["Iron deficiency in infants and young children: Screening,](#)

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Treatment of the adult with iron deficiency anemia

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INTRODUCTION — The management of adult with anemia due to iron deficiency, including the relevant diagnostic and therapeutic issues as well as the choice of iron preparation, will be discussed here.

The causes and diagnosis of iron deficiency are discussed separately, as is the treatment of iron deficiency in infants and young children. (See "and diagnosis of iron deficiency anemia in the adult" and "Iron deficiency in infants and young children: Treatment" and "adolescents".)

The uses of iron preparations for the treatment of functional iron deficiency in patients with chronic kidney disease as well as in patients on peritoneal dialysis, and home hemodialysis are specialized subjects and are presented separately. (See "Iron balance in hemodialysis patients" and "Diagnosis of iron deficiency in chronic kidney disease" and "Use of erythropoiesis-stimulating agents in the treatment of anemia in patients with cancer", section on 'Iron monitoring and supplementation'.)

MANAGEMENT OVERVIEW — The usual presenting symptoms in iron deficiency anemia include fatigue, weakness, headache, irritability, and varying degrees of fatigue and exercise intolerance. Hematologic manifestations include microcytosis, hypochromia, and reticulocytosis. (See "anemia in the adult", section on 'Clinical manifestations'.)

Public health aspects — More than a quarter of the world's population is affected by iron deficiency anemia, being most prevalent among preschool children and women. The prevention and treatment of iron deficiency is obviously a major public health goal, especially in low- and middle-income countries, although the various aspects of this issue are complex and beyond the scope of this review [1]. (See "Iron deficiency in infants and young children: Screening, diagnosis, and treatment" and "Diagnosis of iron deficiency in infants and young children: Treatment".)

Data ultimei actualizări a temei

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Topic Feedback

Treatment of the adult with iron deficiency anemia

NONANEMIC SUBJECTS

INFORMATION FOR PATIENTS

SUMMARY AND
RECOMMENDATIONS

- Indications for treatment
- Initial treatment
- Resistant or relapsed disease

REFERENCES

GRAPHICS [View All](#)

TABLES

- Iron bioavailability
- Failure to respond to iron
- Drug ratings in pregnancy
- IV iron preparations
- Parenteral iron dose

RELATED TOPICS

[Allergic reactions to vaccines](#)[Anemia of chronic disease](#) ([anemia of \[chronic\] inflammation](#))[Causes and diagnosis of iron deficiency anemia in the adult](#)[Clinical manifestations of hereditary hemochromatosis](#)[Diagnosis of iron deficiency in chronic kidney disease](#)[Hereditary hemorrhagic telangiectasia \(Osler-Weber-Rendu syndrome\)](#)

Prevention and treatment of adverse drug events — The following sections should be **required reading** for all clinicians contemplating the use of an intravenous iron preparation.

Overview — Each of the available formulations of IV iron has been associated with reports of life-threatening adverse drug events (ADEs) [39,60,61]. While the Food and Drug Administration's Adverse Event Reporting System (AERS) has been employed for comparing such rates [39,62], it is not possible to draw valid conclusions about comparative risks from the AERS database and other voluntarily submitted reports [60,63].

There exist only a small number of randomized, prospective trials comparing the relative safety of the various intravenous iron preparations [64]: three have shown relatively equal safety for low molecular weight [iron dextran](#) and [iron sucrose](#) [61,65,66]; one has shown relatively equal safety for iron sucrose and [ferric gluconate](#) complex [67]; while one, in abstract form, has shown comparable safety for low molecular weight [iron dextran](#) preparations and [ferric gluconate](#) complex [68].

Patients with a history of drug allergy, and personnel trained in the use of emergency equipment and personnel trained in the use of emergency equipment. However, while we have seen such anaphylactic reactions with low molecular weight iron dextran preparations [59],

- Systemic effects of IV iron include anaphylaxis. Anaphylaxis is a life-threatening reaction that can occur with any IV iron preparation. The benefit is obtained from the use of non-iron-containing intravenous fluids.
- A flare of arthritis in patients with inflammatory arthritis, such as rheumatoid arthritis, commonly occurs. This can usually be abated by the use of 125 mg of intravenous [methylprednisolone](#) immediately before the iron infusion and 1 mg/kg per day of oral [prednisone](#) for four days thereafter. The cause of these reactions is unknown as tryptase levels, a marker of mast cell degranulation, have been normal following these reactions. (See "[Allergic reactions to vaccines](#)", section on '[Dextran](#)' and "[Perioperative anaphylaxis: Evaluation and prevention of recurrent reactions](#)", section on '[Colloids](#)'.)
- Approximately 0.5 to 1 percent of patients may complain of arthralgias, myalgias, or flushing **without** associated hypotension, tachypnea, tachycardia, wheezing, stridor, or periorbital edema [30,59]. After symptoms abate, rechallenge is appropriate and symptoms rarely recur. The empiric use of steroids prior to rechallenge may be beneficial, but is untested. In the rare patient who reacts in this manner twice, the IV formulation should be changed. No intervention for these complaints is necessary. Specifically, the use of antihistamines for prevention or treatment is inappropriate. (See '[Need for premedication](#)' below.)

Risk of infection — Bacteria and other infectious agents require iron as a growth factor, and patients with hereditary hemochromatosis and iron overload are known to be

Tabelele și graficele pot fi vizualizate prin deschiderea lor de la text făcând clic pe link-urile din paranteze, precum și grafice în conținutul subiectelor.

Vizualizarea tabelelor și a graficelor

Radiation biodosimetry

Dose (Gy)	Vomiting (%)	Time to vomiting (hours)	ALC day 1 (/microL)	Lymphocyte fall rate constant (k)*	Lymphocyte dicentrics (per 1000)
0	0	-	2450	-	1-2
1	19	-	2160	0.126	88
2	35	4.6	1900	0.252	234
3	54	2.6	1680	0.378	439
4	72	1.7	1480	0.504	703
5	86	1.3	1310	0.63	1000
6	94	1.0	1150	0.756	
7	98	0.8	1010	0.881	
8	99	0.7	890	1.01	
9	100	0.6	790	1.13	
10	100	0.5	700	1.26	

Gy: absorbed whole body dose in Grey units; ALC: absolute lymphocyte count per microL.

* The lymphocyte fall rate constant is derived from a semilogarithmic plot of the absolute lymphocyte count (ALC) versus time in days, in the form of $2450 \times e(-kt)$. The time (in days) for the ALC to fall to one-half of its original value [half-time, $T(1/2)$] can be obtained from the following equation: $T(1/2) = 0.693/k$.

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Treatment of the adult with iron deficiency anemia

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Sistemul oferă și alte subiecte care sunt aproape de rezultatele căutării, dar nu pot conține cuvinte din interogarea de căutare

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Initial treatment

- Because of ease of treatment, we recommend that patients with uncomplicated iron deficiency anemia be treated with oral iron rather than an intravenous (IV) iron formulation ([Grade 1B](#)).

An appropriate daily dose for the treatment of iron deficiency in adults is in the range of 150 to 200 mg/day of elemental iron. While there is insufficient information to select one oral iron preparation over another, one 325 mg tablet of [ferrous sulfate](#) (iron content 65 mg) taken three times per day contains this amount of iron. (See '[Oral iron therapy](#)' above.)

- For patients who have a history of intolerance to oral iron therapy, published evidence supports a larger and earlier role for intravenous iron. Intramuscular iron preparations should not be used for this purpose. (See '[General principles](#)' above and '[Intramuscular iron](#)' above.)
 - High molecular weight [iron dextran](#) preparations are associated with a considerably higher incidence of adverse events than are the low molecular weight preparations, and should not be employed. Otherwise, there is insufficient evidence for the superiority of one parenteral iron preparation over another (ie, [iron sucrose](#), [ferric gluconate](#) complex, low molecular weight iron [dextran](#); [ferumoxytol](#)) ([table 4](#)). (See '[Available preparations](#)' above and '[Prevention and treatment of adverse drug events](#)' above.)
 - Clinicians contemplating the use of intravenous iron preparations should be fully conversant with requirements for a test dose, rates of infusion, maximum allowed doses, and the need, if any, for premedication. The use of antihistamines for premedication or treatment of infusional side effects is to be avoided. (See '[Prevention and treatment of adverse drug events](#)' above.)

The choice of the intravenous iron depends upon whether the treatment goal is to restore hemoglobin levels to normal or to restore both hemoglobin levels and

parenteral iron therapy, the cause for this failure should be determined and appropriate action undertaken. The table below lists the causes of failure when this occurs ([table 2](#)). (See '[Failure to respond to oral iron therapy](#)' above.)

Following successful treatment) is most often due to persistence or relapse of the initial inciting cause (eg, recurrent bleeding) and should be treated appropriately.

Dacă faceți clic pe numele medicamentului, primiți acces la baza de UpToDate despre medicamente actualizată în cu detalii despre preparate.

Dextran: Drug information



TOPIC OUTLINE

Brand Names: U.S.
Pharmacologic Category
Dosing: Adult
Dosing: Pediatric
Dosing: Geriatric
Dosing: Renal Impairment
Dosing: Hepatic Impairment
Dosage Forms: U.S.
Generic Equivalent Available: U.S.
Administration
Compatibility
Use
Medication Safety Issues
Adverse Reactions Significant
Contraindications
Warnings/Precautions
Metabolism/Transport Effects
Drug Interactions
Pregnancy Risk Factor
Pregnancy Implications
Lactation
Breast-Feeding Considerations
Pricing: U.S. (Medi-Span®)
Monitoring Parameters
International Brand Names
Mechanism of Action

Dextran: Drug information Lexicomp®

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(For additional information [see "Dextran: Pediatric drug information"](#))

For abbreviations and symbols that may be used in Lexicomp ([show table](#))

Brand Names: U.S. LMD in D5W; LMD in NaCl

Pharmacologic Category Plasma Volume Expander, Colloid

Dosing: Adult

Volume expansion/shock: I.V.: *Dextran 40*: Infuse 500-1000 mL (~10 mL/kg) as rapidly as possible (maximum: 20 mL/kg/day for first 24 hours; 10 mL/kg/day thereafter); therapy should not be continued beyond 5 days

Pump prime: *Dextran 40*: Varies with the volume of the pump oxygenator; generally, the solution is added in a dose of 10-20 mL/kg (or 1-2 g/kg); usual maximum total dose: 20 mL/kg (or 2 g/kg)

Postoperative prophylaxis of venous thrombosis/pulmonary embolism (Dextran 40): Begin during surgical procedure and give 500-1000 mL (~10 mL/kg); an additional 50 g (500 mL) should be administered every 2-3 days during the period of risk (up to 2 weeks postoperatively); usual maximum infusion rate for nonemergency use: 4 mL/minute

Dosing: Pediatric

(For additional information [see "Dextran: Pediatric drug information"](#))

Treatment of shock or impending shock (when blood or blood products are not available): I.V.: *Dextran 40*: Infuse 10 mL/kg as rapidly as possible (maximum: 20 mL/kg/day for the first 24 hours; 10 mL/kg/day thereafter); therapy should not be continued beyond 5 days

Dosing: Geriatric Refer to adult dosing.

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