The Labile Side of Iron Supplementation in CKD

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ABSTRACT

The practice of intravenous iron supplementation has grown as nephrologists have gradually moved away from the liberal use of erythropoiesis-stimulating agents as the main treatment for the anemia of CKD. This approach, together with the introduction of large-dose iron preparations, raises the future specter of inadvertent iatrogenic iron toxicity. Concerns have been raised in original studies and reviews about cardiac complications and severe infections that result from long-term intravenous iron supplementation. Regarding the iron preparations specifically, even though all the currently available preparations appear to be relatively safe in the short term, little is known regarding their long-term safety. In this review we summarize current knowledge of iron metabolism with an emphasis on the sources and potentially harmful effects of labile iron, highlight the approaches to identifying labile iron in pharmaceutical preparations and body fluids and its potential toxic role as a pathogenic factor in the complications of CKD, and propose methods for its early detection in at-risk patients.


The anemia of CKD is routinely treated with erythropoiesis-stimulating agents (ESAs) and iron supplements, mostly via the intravenous route. In the last decade, several randomized controlled trials consistently indicated adverse cardiovascular outcomes with hemoglobin levels targeted above 13 g/dl. Therefore, current KDIGO guidelines for CKD recommend hemoglobin levels of 10 (or possibly less) to 11.5 g/dl. As a result of the renewed doubt regarding the long-term safety of ESAs, as well as the recently instituted 'bundling' of dialysis services to include both ESAs and intravenous iron (IVI), nephrologists have gradually moved away from the liberal use of ESA in CKD anemia toward more IVI supplementation. This policy, together with the introduction of large-dose iron preparations, has raised the future specter of potential inadvertent iatrogenic iron toxicity. Although in the short term, all currently available iron preparations appear to be safe, little is known regarding the long-term safety of repeated IVI. The purpose of this review is to summarize current knowledge of iron biology, with an emphasis on the metal's potentially harmful effects, highlight the role of iron toxicity as a pathogenic factor in the complications of CKD and propose methods for its early detection in at-risk patients. The role of iron in kidney injury will not be addressed and the reader is referred to an excellent comprehensive review of this subject.

IRON BIOLOGY

The classic perception of iron in the biomedical field has been of a Janus-faced or double-edged sword element essential for life but life-threatening if not properly controlled. Thus, inherent to cell and system is the maintenance of a pool of iron available for biosynthetic purposes. In body fluids such a pool is associated with plasma transferrin (TF) molecules that safely carry the metal and supply it to cells 'on demand', i.e., as per the level of expression of cell TF receptors. In cells, most of the iron is stably associated with proteins or cofactors, but their manufacture or degradation also involve labile forms of the metal that are both redox-active and ligand-exchangeable. This poses a constant demand on cells to prevent labile Fe2+/Fe3+ from promiscuous generation of toxically reactive O species (ROS) from reactive O intermediates (ROI, such as superoxide and hydrogen peroxide), that normally represent up to 1% of O2 consumed by the respiratory chain (Figure 1). To cope with such natural imperfections, mammalian cells rely on two complementary defense strategies: (1) control of labile cell iron (LCI) levels by coordinating iron uptake versus utilization and/or storage, and (2) control of ROS formation by eliminating ROIs with superoxide dismutases and various peroxidases, as well as by antioxidant molecules. However, whenever...
those protective measures fail or become insufficient, as in siderosis or inflammatory crisis, cell oxidative damage ensues, often leading to necrotic cell death or to more complex death paths such as ferroptosis or oxytosis, if rescuable by iron chelators or antioxidants, respectively. \(^{14,15}\) Pathologic scenarios develop in the two main types of siderosis: systemic siderosis (inherited or iatrogenic), whereby cells are overwhelmed by excessive ingress of non-physiologic forms of plasma iron and in regional siderosis (inherited or acquired) where damage results from maldistribution of the metal within cell compartments. \(^{16,17}\)

**Tissue Iron Accumulation and Siderotic Damage**

The identification of tissue iron overload (siderosis) in experimental and clinical settings has largely relied on the detection of iron agglomerates by histochemical stains \(^{18}\) or magnetic resonance imaging (MRI). \(^{19}\) Although often perceived as deleterious, the mere presence of iron agglomerates in cells is not to be tacitly taken as indicating siderotic damage, insofar as the metal is chemically shielded within ferritin shells. \(^{11}\) The etiopathology of siderotic damage is most likely associated with ROS formation catalyzed by LCI. \(^{14}\) This relies largely on the fact that permeant iron chelators can confer direct protection from ROS-mediated oxidations by demonstrably complexing LCI and thereby rendering it non-labile. \(^{2}\) LCI can also be reduced by overexpression of ferritin molecules. \(^{20}\) These two features, redox activity and susceptibility to specific iron chelators, define LCI \(^{19}\) (also called labile iron pool, LIP) which is a physiologic component that is maintained homeostatically by most cell types. \(^{21–23}\) The emerging issue is in which conditions does LCI attain levels that implicate it in siderotic damage or, conversely, in iron deprivation, which can also be deleterious. \(^{21}\) A related issue is how do different cell types cope when exposed to non-physiologic iron forms that appear in plasma of patients with systemic iron overload or with iatrogenic iron forms that are delivered parenterally as iron supplements?

**Labile Cell Iron**

LCI was hypothesized as a transitory pool of labile iron that is at the crossroads of cell metabolism. \(^{21}\) Experimentally, it was demonstrated in living cells with the aid of fluorescent probes that either sense labile iron per se or monitor its propensity to generate ROS when prompted by pro-oxidants but curbed by membrane permeant chelators. LCI is maintained in metabolically active cells at submicromolar level, representing 1%–2% of the total cell iron content. \(^{21}\) Those homeostatic levels reflect a balance between metal uptake and utilization versus the iron-absorptive capacity of cell ferritin, but also the cell metal ligand composition and the redox activity of the cell compartment in question. As mentioned above, the link between labile iron and biologic damage has largely leaned on the demonstrable ability of permeant iron chelators to protect or ameliorate cell functions affected by siderosis and, thereby, rescue cells from entrance into a death path. \(^{24–26}\) That has provided a rationale for treating siderotic disorders of systemic or regional character with chelators, while taking into consideration that the benefits expected from regional iron detoxification by chelation need to be balanced.
against the possible systemic depletion of an essential metal.

**Labile Plasma Iron**

Unlike LCI, plasma normally has spare Tf iron binding capacity for effectively binding incoming labile iron (from absorption by the gut or recycling by the reticuloendothelial system (RES)) and thereby rendering it non-labile, i.e., non-redox-active and non-transferable to potential iron acceptors (e.g., citrate, nucleotides) and even to some chelators in pharmacologic use. Physiologically, after being taken up by cells via Tf receptor-mediated endocytosis, Tf will release the iron chelates, leading to erroneous assessment of iron overload and of chelation efficacy. Last, but not least, the association of NTBI forms with plasma albumin might not only blunt the detection of NTBI but also affect its source of tissue siderosis.3,5 A typical misusage of the term NTBI is found with PIPs that generate in plasma mM concentrations of NTBI. However, unlike the NTBI detected in systemic siderosis, iatrogenic NTBI derived from most PIP formulations is ‘mostly’ non-toxic, ‘safely’ acquired and processed by the RES macrophages.24,25

Thus, while the introduction of the term NTBI was a landmark in understanding the pathophysiology of systemic iron overload, its potential toxic effects can neither be reliably estimated just from concentration. For example, in chronic diabetes, persistent plasma NTBI is detectable (even at TSAT as low as approximately 50%), but in the absence of overt tissue iron overload.32 In chelated patients, some NTBI assays do not necessarily distinguish between genuine NTBI and iron chelates, leading to erroneous assessment of iron overload and of chelation efficacy. Last, but not least, the association of NTBI forms with plasma albumin might not only blunt the detection of NTBI but also affect its source of tissue siderosis. These harmful effects of NTBI have been linked to impaired neutrophil and T-cell function, thereby promoting bacterial growth both in vivo and in vitro, at least in short term (2–3 day) studies.4,5 In addition there is evidence from the pre-ESA period for impaired neutrophil function in dialysis patients with iron overload and, subsequently, for abnormal T-cell function in mice iron-overloaded by intraperitoneal injection of iron dextran. In the latter experiments, the mice failed to mount a Th1-mediated protective response to C. albicans infection, but were rescued with the iron chelator deferoxamine.4,5

**IRON IN THE PATHOGENESIS OF CKD COMPLICATIONS**

On a backdrop of CKD, a condition of underlying oxidative stress, there is clear scope for excess iron-associated adverse outcomes via ROS-induced damage which could contribute to endothelial dysfunction, inflammation, and immune dysfunction.18,39 Also, iron is required for bacterial growth and part of the human antibacterial armamentarium relies on iron mobilization from plasma into sanctuaries associated with the RES. However, iron-laden RES cells become vulnerable to intracellular pathogens.40 Antibacterial host defenses also depend on iron-catalyzed formation of ROS, which is critical for normal phagocytic function. Conversely, excess iron has been linked to impaired neutrophil and T-cell function, thereby promoting bacterial growth both in vivo and in vitro, at least in short term (2–3 day) studies.4,5 In addition there is evidence from the pre-ESA period for impaired neutrophil function in dialysis patients with iron overload and, subsequently, for abnormal T-cell function in mice iron-overloaded by intraperitoneal injection of iron dextran. In the latter experiments, the mice failed to mount a Th1-mediated protective response to C. albicans infection, but were rescued with the iron chelator deferoxamine.4,5
Against this theoretical background, observational studies linking amounts of administered iron to adverse outcomes in CKD have steadily increased in recent years, but with inconsistent results. Because the link between administered iron and outcomes has been comprehensively reviewed in a recent JASN article,43 we briefly summarize earlier data, address in more detail studies that have appeared since that publication and offer our own views on the subject.

As reported, observational studies have shown a weak association between amounts of iron administered and increased mortality or cardiovascular events,44–52 incidence of bacterial infection53,54 and a somewhat stronger association between ferritin levels and carotid-intimal thickness.55

Recently two Japanese studies and an international one have provided support for an association between iron dosage and all-cause mortality in ESRD.47,48 In the Japanese study a highly significant association was observed between rising serum ferritin (>100 versus <100 ng/ml) and mortality.48 These intriguing results are difficult to interpret in light of ferritin levels that would be considered frank iron deficiency in the Western world. Nevertheless, mortality in Japanese ESRD and other patient groups is persistently lower than in Western countries. Although tempting to invoke a contribution of minimalist IVI protocols to this phenomenon, Japanese and Western populations differ in many other respects, besides IVI protocols, including prolonged genetic isolation, different dietary intake, and body habitus. Therefore, we reserve judgement on this issue.

In the recently published Dialysis Outcomes and Practice Patterns Study, involving 32,435 patients from 32 countries, IVI doses >300 mg monthly, as compared with lower doses, were associated with higher all-cause, cardiovascular, and infectious mortality, as well as hospitalization. Moreover, this association was seen not only when hemoglobin was >12 g/dl, as observed previously,1,3,4 but even within the guideline-recommended range of 10–12 g/dl, although not with values <10 g/dl.49 These studies were performed on prevalent dialysis populations and, despite multiple adjustments for confounding, using sophisticated contemporary statistical techniques, could still suffer from undetected residual confounding and be subject to survivor bias. The only study to date on incident hemodialysis patients, also just published, showed that administration of ≤1050 mg IVI in 3 months or 2100 mg in 6 months was not associated with all-cause, cardiovascular, or infection-related mortality. However, non-statistically significant findings suggested the possibility of infection-related mortality with receipt of >1050 mg in 3 months or >2100 mg in 6 months.50

Only two randomized controlled trials (RCTs) have addressed the association between iron dosage and infection and then only as a secondary end point. In the Dialysis Patients’ Response to IVI with Elevated Ferritin (DRIVE) study,56 patients who were randomized to iron gluconate had a similar incidence of bacterial infections as the placebo group, both at the end of the 6-week study period and after a further 6-week observation period (DRIVE II).57 However, this trial was too short and the sample size insufficient for assessing the likelihood of infrequent events or medium-term safety. Similar results were seen in the second RCT, which used iron dextran.58

Iron dosing method and polymer composition may also contribute to infection risk. Bolus dosing has been associated with a higher infection risk than maintenance dosing53 and iron sucrose with a greater risk than dextran or gluconate.54 In this regard, newer preparations, such as ferric carboxymaltose and the recently FDA-approved ferric citrate (oral preparation),59 have yet to be assessed. Oral ferric citrate is of particular interest because it is marketed as a phosphate binder, but some iron is also absorbed. As shown in a recently published study, patients receiving ferric citrate not only had good phosphate control, but also their requirements for IVI were reduced compared with placebo controls. In addition, the favorable safety data obtained from the 56-week follow-up period are reassuring.60 The potential benefit of orally delivered iron is that absorption may be regulated more physiologically, if hepcidin-induced resistance to iron absorption is sufficiently countered. Conversely, we cannot exclude unregulated absorption and longer-term safety issues, including generation of ROS and its adverse consequences.

The discrepant results elucidated above may be explained by different follow-up times, variable underlying comorbidities, inflammatory status (as reflected, at least in part, by varying serum ferritin levels) and oxidative stress. Other biomarkers, such as hepcidin, also suffer from this limitation of reflecting inflammation as well as iron overload.61 Taken together, the epidemiologic evidence for iron-associated adverse effects in CKD is, at best, unconvincing, most probably due to the many confounding factors involved. Nevertheless, some experts believe that indiscriminate use of IVI to achieve guideline-recommended hemoglobin targets in ESA hyporesponsive patients is likely to be detrimental.62,63

LPI, Tissue Iron Deposition, Oxidative Stress, and Damage in CKD

The generation of LPI in ESRD patients supplemented with parenteral PPs has been proposed in various studies that dealt with the appearance of oxidized plasma components64–74 and demonstrated by direct measurements of LPI.35,75

Both ours35 and other groups75,76 have reported LPI detection in approximately 10% of hemodialysis patients receiving IVI, but, by 48 h after administration, LPI was apparently no longer detectable. Although several abnormalities detected during or shortly after iron administration have been reported, they are apparently also of transient nature. However, the critical and still outstanding question is whether relatively short but repetitive exposures to LPI will over time pose the risk of oxidative tissue damage caused either by cumulative LPI infiltration into cells or via plasma oxidation products.68,77,78

Several studies have reported high tissue iron levels in CKD detected either
maximum  

vitro model of leukocyte  

esis in CKD was reported. Using an  

for direct IVI involvement in atherogen-

1) through enhanced NADPH-oxidase  

cular cell adhesion molecule-1 (VCAM-

haten the expression of intracellular cell  

accelerate early atherogenesis by upregu-

lating iron-mediated tissue damage. In  

IVI also has been implicated in the prop-

gation of renal tissue damage in animal  

models of CKD. Moreover, in a very  

JASN paper, the  

r o s i sa na p o l i p o r e i t a t i o n (Ed e -  

iron preparation exacerbated atheroscle-

ration of iron deposition as hemosiderin, it gives no information re-

With adequate long-term follow-up. The study should be sufficiently powered to  

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small doses of iron sucrose (EudraCT  

Number: 2013-002267-25).

Potential Contamination of  

travenous Iron Formulations with  

Labile Iron

Most IVI formulations in clinical use are  

nanoparticles comprised of a polyiron  

oxide/hydroxide core coated with carbo-

hydrate (Table 1). It is generally accepted  

that these formulations, prepared as PIPs,  

supply metabolic iron to circulating Tf  

by a mechanism that recapitulates physi-

ologic iron recycling via erythropoietin-

osis (Figure 2A). With few exceptions, PIPs  

are regarded as ‘relatively’ free of labile  

iron and stable in circulation until endocytosed and processed by macro-

phages by mechanisms that are only partly

Table 1. Selected properties of polymeric iron preparations

<table>
<thead>
<tr>
<th>Iron Preparation</th>
<th>LMW Iron Dextran (INFeD® USA; Cosmofer® Europe)</th>
<th>HMW Iron Dextran (Dexferrium®)</th>
<th>Iron Sucrose (Venofer®)</th>
<th>Sodium Ferric Gluconate (Ferlecit®)</th>
<th>Ferumoxytol (Feraheme®)</th>
<th>Ferric Carboxymaltose (Ferinject®)</th>
<th>Iron Isomaltoside 1000 (Monofer®)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for LI release</td>
<td>++</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
<td>±</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>Maximum approved dose</td>
<td>100 mg IV push</td>
<td>100 mg IV push</td>
<td>100–200 mg IV push</td>
<td>125 mg IV over 2–5 min</td>
<td>510 mg IV over 1 min</td>
<td>750 mg IV push/infusion over 15 min</td>
<td>100–200 mg IV bolus or 1000 mg</td>
</tr>
</tbody>
</table>

LI, labile iron; LMW, low molecular weight; HMW, high molecular weight.

*Not available in the United States.

disease and infection. Clearly, as succinctly stated in a recent editorial, the ground  

is set for multi-center RCTs on both CKD dialysis and non-dialysis patients, compar-

ing different iron-dosing regimens, with adequate long-term follow-up. The study  

should be sufficiently powered to avoid imbalances in the type of anemia, degree  

of inflammation, dialysis modality where appropriate, and available iron  

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Red blood cells (RBCs) (left) and of PIPs (right). Left. Macrophages phagocyte aged RBCs (see number 1 enclosed in a circle), into a phago-

some that after acquisition of hydrolytic enzymes from fusion processes (see number 2 enclosed in a circle) disrupt the cell and proteolyse Hb leading to release of the heme moi-

ety (H) and its transfer across the cytosol via hrg1 (see number 3 enclosed in a circle) to  

the endoplasmic reticulum, where heme oxygenase 1 (hox1) (see number 4 enclosed in a circle) cleaves heme and releases biliverdin (BLVD), Fe(II) and CO. The Fe(II) can be exported  

from the cells into the plasma via ferroportin1 (FFPN1) (see number 5 enclosed in a circle) where it can be incorporated into transferrin or stored as ferritin (see number 1 enclosed in a circle) that eventually can enter the lysosomal pathway of degradation (see number 7 enclosed in a circle) and release Fe(II) into the LCI pool. Right. Same as for RBCs, except  

that the hydrolytically processed PIP Fe(II) is released into the cytosol. Hb, hemoglobin.
understood (Figure 2B). However, an impending issue is the possible contamination of the newer IVI formulations designed for intensive iron supplementation, ferric carboxymaltose, ferumoxytol and iron isomaltoside, with labile iron and the subsequent generation of LPI following massive intravenous administration of these polymers. This is of particular importance for quality control of the formulations themselves, as well as for their fate in plasma of patients with CKD and other chronic inflammatory diseases.

With the wider and more intense application of chemically diverse IVI supplements, it would seem prudent to obtain more information about the safety of the various products in terms of: (1) propensity to generate labile iron under different storage conditions and (2) possible adverse reactions related to transient rises in LPI as a function of delivery rates and dosage. The latter is especially relevant for patients with high plasma levels of (1) pro-oxidants, e.g., chronic patients with diabetes; (2) hepcidin due to an inflammatory state or mutations affecting its expression; or (3) low ferroportin activity, induced either directly by elevated hepcidin levels or, independently of hepcidin, via toll-like receptors 2 and 6 signaling.

These phenomena, in turn, could cause excessive splenic or hepatic retention of PIPs as such or as elevated ferritin but also perhaps as potentially toxic levels of LCI. The recent introduction of methods to measure the LPI potentially contained in IVI preparations will allow the systematic testing of our hypothesis that LPI could be formed in highly oxidized plasma or plasma with little antioxidant capacity and/or high redox-active groups (e.g., advanced-glycation end products) as found in patients with CKD.

CONCLUSIONS AND FUTURE DIRECTIONS

Iron-induced cell damage or death, resulting from the intrinsic inflammatory nature of CKD and, possibly, exacerbated by repeated infusions of IVI in our patients remains a relatively unexplored field. The recent upsurge in the use of IVI following reports incriminating excessive ESA dosing as being associated with increased mortality, behooves nephrologists to take heed of the potential for replacing ESA toxicity with iron toxicity. This potential is highlighted by the intermittent detection of labile iron in both CKD patients’ plasma and currently available IVI preparations. In addition, the recent promotion of preparations containing up to 500 mg of iron per dose, although by the nature of their structure thought to be safe, further enhances the risk of iatrogenic iron toxicity. Given this combination of factors, we propose the following two-pronged strategy: (1) multi-center, international RCTs comparing different iron-dosing regimens in both CKD and ESRD patients, with adequate long-term follow-up; (2) the systematic monitoring of LPI during and post administration, which could serve as a promising biomarker of impending iron toxicity.

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REFERENCES


Lability of Iron Supplementation in CKD


59. Auyuxia (ferric citrate) tablets. 2015. 11-1-2015
84. Macdougall IC: Evolution of iv iron compounds over the last century. J Ren Care 35 [Suppl 2]: 8–13, 2009

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