INTRODUCTION

Iron overdose has been a problem since last several years, resulting from either the chronic blood transfusion in patients with disorders including sickle cell disease, thalassemia, and myelodysplastic syndromes, or due to the ingestion of excess iron from the drug sources including vitamins and supplements. When left untreated, the iron overload could cause significant adverse effects on multiple organ systems including liver, heart, brain, and endocrine system with the pathophysiology of cardiomyopathy, diabetes, liver dysfunction, and acceleration of various neurodegenerative diseases [1-3].

Therapeutic phlebotomy is also referred to as venesection or bloodletting, and is currently recommended for the treatment...
The safety and efficacy of therapeutic phlebotomy and efficacy studies to prevent or treat diseases repeatedly raised concerns and issued several warnings to the companies marketing OTC chelation products with no proven safety in Parkinson’s, diabetes, cardiovascular conditions, and other health conditions with narrow treatment possibilities. Thus, FDA has insisted companies market OTC chelation agents that are commonly targeting patients with diseases such as autism, Alzheimer’s, Parkinson’s, diabetes, cardiovascular conditions, and other health conditions with narrow treatment possibilities. Thus, FDA has repeatedly raised concerns and issued several warnings to the companies marketing OTC chelation products with no proven safety and efficacy studies to prevent or treat diseases [6]. The present review provides a current update of the iron overload treatment including therapeutic phlebotomy and FDA approved iron-chelating agents such as deferoxamine, deferiprone, and deferasirox for the acute iron poisoning and chronic iron overload. It also summarizes briefly the recent advances in potential new drug development against iron overload.

Iron Overload and Therapeutic Phlebotomy

Therapeutic phlebotomy is currently recommended for treatment of the blood disorders in which red blood cells (RBCs) or serum iron removal manages disease symptoms and complications as in the symptomatic and asymptomatic patients of hereditary hemochromatosis. The two steps of therapeutic phlebotomy includes an initial induction step to induce iron depletion followed by maintenance step to prevent excess iron re-accumulation [10]. In the patients with absolute polycythemia including polycythemia vera and secondary polycythemia, the treatment goals are different. In polycythemia vera, the overall goal is to reduce the RBCs and serum iron together with the beneficial therapeutic reduction of white blood cells and platelets. However, in porphyria cutaneous tarda, the preferred therapy is to remove iron by phlebotomy until the enzyme uroporphyrinogen decarboxylase activity is resumed [11]. Recent study on children with sickle cell anemia, stroke and transfusional iron overload revealed the safety and efficacy of the therapeutic phlebotomy [12].

Toxicity

Assi and Baz have reported some limitations including intolerance or low acceptance of therapeutic phlebotomy in some patients [5]. There were no absolute contraindications reported by these researchers, however the relative contraindications including severe heart disease and anemia were reported. The frequent phlebotomy results in fatigue, dizziness and rarely iron deficiency [5].

Iron Toxicity and Chelation Therapy

Iron toxicity may result in significant morbidity, ultimately leading to mortality around the world. Iron is an essential trace element with high reactivity and iron homeostasis is a complex system, therefore, it is absolutely essential to have the balance for the intestinal iron absorption and release of stored iron. Under normal physiological conditions, iron performs a number of functions including carrying and storing oxygen by binding to hemoglobin or myoglobin, catalyzing the redox reactions, and transporting in the cells through the proteins such as transferrin. The concern with human body lacking any regulated mechanism to excrete iron remains, as it leads to chronic iron overload in patients with blood transfusions to treat wide array of hematological disorders such as sickle cell anemia, thalassemia, aplastic anemia, myelodysplastic and myelofibrosis syndromes. Iron-chelation therapy is intended to combat iron overload, as the chelating agents form a complex with iron and promotes its excretion. The need of the transfusion-dependent patient treatment with iron chelating agents is vital, as the iron overload has pathological effect in heart, liver, brain and endocrine system. Regarding the iron toxicity in brain, the growing body of data supports the view that disruption of the cerebral iron regulation plays an important role in the etiology of neurological disorders including Alzheimer’s disease and Parkinson’s disease [3].

Iron overdose is one of the leading causes of death in both young and adult population. The wide availability of iron as a dietary constituent of multivitamins and supplements provides easy access to both children and adults, thus enhancing the risk for adverse events. The iron-chelation therapy can decrease and in many cases eliminate the morbidity and mortality rates associated with iron toxicity.

Acute Iron Poisoning

Deferoxamine
The treatment approaches of an acute iron toxicity in patients involve optimizing hemodynamic status and providing adequate management care, along with the chelation therapy of deferoxamine [13]. Deferoxamine as the first recommended iron-chelating agent was introduced in the healthcare system but faced significant challenges due to its parenteral use resulting in hypersensitivity and non-compliance. Previous animal studies suggest that deferoxamine is also effective in chelating heavy metals including aluminum, bismuth, and cadmium besides decreasing the absorption of iron [14-17]. The limited literature, however, supports the efficacy of deferoxamine for acute iron toxicity in patients with or without the gastrointestinal decontamination and hemodialysis [18,19]. The earlier human studies on the efficacy of deferoxamine suggested that while it prevents absorption of iron, on the contrary it may exhibit toxicity through a toxic metabolite, ferrioxamine mediated production and absorption [17,20,21]. Currently, deferoxamine is clinically indicated for the acute iron toxicity as an adjunct therapy to the standard measures, including the gastrointestinal decontamination and hemodialysis [19].

**Deferriprone**

Studies related to the efficacy of deferiprone against acute iron intoxication data in the prevention of iron absorption are limited to the experimental animals. The data from some of the previous studies in animals have shown that deferiprone when given immediately after the iron intoxication, produced a significant decrease in the serum iron levels by increasing iron excretion in feces, and thereby, reducing the mortality in the treatment group, especially in the experimental animals that received a follow up dose of deferiprone [22,24]. A combination therapy of deferasirox and deferiprone in rats exhibited chelation of cadmium and iron [14]. So far, no human studies have been reported that address its usage in the short-term acute iron intoxication.

**Chronic Iron Overload**

**Deferoxamine**

*Clinical pharmacology:* FDA approved Deferoxamine (also known as desferrioxamine or desferal) in 1968 for the treatment of chronic iron overload. Deferoxamine has a short half-life of 5-10 minutes and should be administered parenterally [25]. Deferoxamine is a hexadentate hydrophilic chelating agent forming a stable complex with the molecule of iron in 1:1 ratio [26]. It readily chelates iron from liver, from the proteins such as ferritin and hemosiderin, thereby forming a stable complex, thus preventing iron from entering into Haber-Weiss reaction. Deferoxamine, after metabolism by plasma enzymes, is readily soluble in water and excreted from the body via urine and feces [27].

*Clinical use:* Long-term clinical studies support deferoxamine as a chelating agent in chronic iron overload with a reduction in liver iron concentration [28]. Deferoxamine has been shown to improve the survival rate in thalassemia patients by attenuating organ system toxicity [29,30]. The reduction in the mortality and incidence of cardiac complications in transfusion dependent patients with thalassemia has demonstrated the beneficial aspect of deferoxamine [29,31,32]. Deferoxamine is also effective for the reversal of the hepatic iron overload by decreasing the liver iron stores and preventing hepatic fibrosis [33]. In sickle cell anemia, deferoxamine administration has been shown to be effective in decreasing the liver iron level in patients [34,35].

*Toxicity:* The patients administered with deferoxamine should be regularly monitored for kidney function. FDA has issued dose-related warnings that have been reported in post-marketing surveillance, including increase in serum creatinine, renal tubular disorders and acute renal failure. The reported adverse reactions for deferoxamine include hepatic dysfunction, ocular toxicity, auditory toxicity, bone abnormalities, and acute respiratory distress syndrome in different categories of patients treated with deferoxamine [36-39].

**Deferriprone**

*Clinical Pharmacology*

In USA, FDA approved Deferriprone in 2011 as the second-line oral iron-chelating agent for the treatment of patients with blood transfusions-induced iron overload, mainly because of conditions such as thalassemia, when the prior or existing chelation therapy is not adequate [40-42]. It has been clinically observed that there is a significant reduction not only in morbidity but also in mortality with the deferriprone and combination therapy with deferoxamine against iron overload in thalassemia patients [43,44]. Deferiprone is a bidentate hydrophilic chelator and forms a stable complex with the molecule of iron in 3:1 ratio that increases iron excretion and concomitantly decreases iron absorption. It is rapidly absorbed and metabolized by the process of glucuronidation in the liver with relatively short half-life of 47-134 minutes [28,45,46]. A recent meta-analysis study revealed a greater urinary iron excretion in patients with iron overload that were given the combination therapy of deferoxamine and deferriprone when compared with patients receiving either of the two drugs alone [47].

*Clinical use:* FDA has granted an approval of deferriprone treatment to the patients who exhibit iron overload induced by transfusion, due to condition such as thalassemia when current chelation therapy is not sufficient to treat the iron overload. Thalassemia is a serious condition with the risk of developing diabetes, liver disease, heart failure, and arthritis, which can prove fatal. The data from previously conducted trials after prospectively planned analysis revealed that patients did not respond with the deferoxamine therapy, however, treatment of patients with deferriprone revealed it to be a safe and effective chelation therapy as observed with the decrease in serum ferritin levels, thus leading to its approval in the US [17]. Deferiprone in pediatric and adult population of...
patients has shown to decrease serum ferritin concentrations in multiple retrospective and observational studies [48-51].

In the patients with sickle cell disorders, myelodysplastic syndrome and the chronic anemia’s, the deferiprone safety and efficacy against iron overload have not been evaluated and therefore, deferiprone is not approved by FDA for use in any of these conditions. [52].

**Toxicity:** The patients should be regularly monitored for the white blood cell counts. The adverse effects associated with deferiprone includes elevated hepatic enzymes, neutropenia, agranulocytosis, arthralgia, and gastrointestinal side effects [53]. The most serious common side effects are agranulocytosis and neutropenia [54,55]. The common gastrointestinal symptoms include nausea, vomiting, and abdominal pain [2,56]. The deferiprone treatment lead to elevation of liver transaminases and has been suggested to cause progressive liver fibrosis in one trial [57]. The other conditions such as arthritis and arthralgia associated with deferiprone have been commonly found to affect the knees as the large joints [58,59].

**Deferasirox**

**Clinical Pharmacology**

In 2005, deferasirox was approved by the FDA as the oral suspension formulation for the treatment of chronic iron overload due to blood transfusion dependent hemosiderosis and non-transfusion dependent thalassemia in children and adults. Currently, deferasirox is also formulated as a tablet allowing convenient mode of administration for both adult and pediatric patients [60]. Deferasirox is a non-chiral tridentate lipophilic chelator and forms a complex with molecule of iron in the ratio of 2:1. It is a highly specific chelator of iron and does not induce excretion of zinc or copper [61].

The pharmacokinetic profile of deferasirox has been evaluated following a single or the repeated dose regimen in patients with iron overload as well as healthy volunteers, to attain steady state that was reached after 3 days of treatment [62]. In humans, the deferasirox has low tissue distribution with the half-life of 19+/−6.5 hours at 20 and 40 mg/kg body weight [26,63]. The data from in vitro studies have revealed that deferasirox binds to plasma proteins (~ 99%), have strong affinity to serum albumin, and get distributed principally in the plasma [64]. The principal metabolic pathway of deferasirox is through glucuronidation, predominantly by the enzymes including uridine diphosphate glucuronosyltransferase (UGT1) A1 and with a minor extent of metabolism by the enzyme UGT1A3. Cytochrome P450 enzymes has a small contribution in catalyzing the hepatic metabolism of the elimination of deferasirox from the body, with observed major excretion in feces (84%) and minor renal excretion as feces (8%) [65].

**Clinical use:** Deferasirox efficacy has been established in decreasing serum ferritin levels and overall iron overload while demonstrating its efficiency with regard to the liver iron removal [28,66,67]. The excretion of iron as observed by the lowering of the liver iron concentration and serum ferritin, occurred at the higher dose of 20-30 mg/kg day that confirmed its equivalence to deferoxamine in iron overloaded thalassemia patients [28,62,68]. In some patients, the inadequate reduction in liver iron concentration at higher doses may be due to the lack of treatment adherence by patients or an individual variability in drug exposure [22]. Initial data from the animal studies suggest that deferasirox, besides chelating cardiac iron, also possesses the property of gaining access to intracellular iron in a way similar to the other oral chelating agent deferiprone [69,70]. Prior studies have shown the effectiveness of deferasirox in down-regulating the accumulation of cardiac iron in moderate to excessive overload [67,71-73].

**Toxicity:** Deferasirox therapy also requires close monitoring of the patients that could be attained by the measurement of serum transaminases, bilirubin, creatinine clearance, serum creatinine, and bilirubin. The toxicity of deferasirox includes gastrointestinal side effects such as vomiting, nausea, and abdominal pain along with skin rash, rise in creatinine, elevated hepatic enzymes, renal impairment, gastrointestinal hemorrhage, and hepatic failure. Elderly population and patients with health issues such as high-risk myelodysplastic syndromes, low platelet counts, underlying hepatic or renal impairment have more frequency of the above-defined adverse reactions [28,42,62,68,72,79,81].

**Recent Advances in Potential Iron Chelating Agents**

**Deferitazole**

A polyether derivative of desferrithiocin, deferitazole with goal of daily oral administration is currently under non-clinical development for iron overload in patients with transfusion. The inability to draw conclusions from the clinical data led to the termination or withdrawal of its clinical trials. Deferitazole is a tridentate chelator with three dissociation constant, pKₐ: 1.72, 3.78 and 10.70, and forms two different complexes with one and two molecules of iron as deferitazole: Iron in the ratio of 1:1 and 1:2 [82]. The half-life of deferitazole is reported to be 16.2-21.3 h and its acronyms including FBS0701, SSP-004184, and SPD602 are currently in non-clinical drug development [83].

**Clinical use:** Deferitazole is currently in nonclinical drug development phase, with the termination or withdrawal of the clinical trials due to the inability of being able to draw conclusions from the data and evaluation of ongoing non clinical rat studies [84]. The purpose of clinical studies was to evaluate deferitazole for the treatment of transfusion dependent chronic iron overload in patients with hereditary and acquired anemias and thalassemia [85].
Iron-overload in patients with transfusion dependent thalassemia can lead to iron accumulation in heart, leading to iron-overload cardiomyopathy [86]. Previous *in vivo* and *in vitro* studies showed the major pathway for the iron entry is through the L-type calcium channels [87,88].

**Amlodipine**

Amlodipine has shown no serious adverse effects in clinical study with thalassemia major patients, when administered in addition with current chelation therapy to evaluate the reduction in myocardial iron overload when compared to placebo. Fernandes et al. has shown in thalassemia major patients with cardiac siderosis that the amlodipine treatment in combination with existing chelation therapy has reduced the cardiac iron more efficiently when compared with the patients receiving only the chelation therapy [89,90].

**Nifedipine**

Nifedipine has currently completed the phase 1 trial for the evaluation of its potential to increase urinary iron excretion among patients with iron overload. Earlier animal studies showed that nifedipine mobilizes iron from the liver with primary and secondary iron overload and enhances urinary iron excretion [91]. Further studies and clinical trials are needed to re-evaluate the efficacy of nifedipine in treating the iron overload.

**CONCLUSION**

Throughout the world acute iron poisoning poses a significant health problem, which if untreated or with ineffective treatment could result in morbidity and sometimes mortality. Excess iron from the body could be therapeutically removed either by phlebotomy or chelation therapy. Therapeutic phlebotomy is recommended for the patients with excess body iron, tolerance and sufficient hemoglobin. Therapeutic phlebotomy is specially used for the treatment of hereditary hemochromatosis. However, it could become fatal in the patients with transfusional induced iron overload.

The treatment strategies of acute iron poisoning are focused on providing the recommended chelation therapy along with the required supportive care. The classical approach to treat acute iron toxicity involve the use of approved chelating agents along with the adequate patient care while optimizing the hemodynamic status in patients. Deferoxamine was originally recommended for acute iron poisoning, and later was approved for the thalassemia patients with iron overload. The oral treatment of deferoxamine is not possible, due to its poor absorption and short half-life. Deferiprone on the other hand is the oral drug of choice in patients with transfusional induced iron-overload due to thalassemia syndromes, when current chelation therapy is insufficient. In regard with combinational therapy, deferoxamine and deferiprone are recommended for the treatment of iron overload due to thalassemia. Deferasirox is the second oral agent that is recommended for the patients that have intolerance for deferoxamine, deferiprone or combination therapy. Patients with chronic iron overload due to blood transfusions dependent red cell disorders and myelodysplastic syndrome lack the mechanism that could efficiently remove excess iron from the body. Patients requiring transfusions over lifetime also have iron accumulation in multiple organ systems including liver, heart and endocrine system, ultimately leading to organ failure with the enhancement in neurodegenerative disorders in the susceptible patients. Therefore, iron-chelation is a necessary step to prevent organ failure and reduce mortality resulting from an acute or chronic iron poisoning. The oral iron-chelators however, have not been widely studied in humans for an acute iron poisoning and therefore are not approved by FDA for the treatment of acute iron poisoning. The process of iron overload is a chronic and significant socioeconomic and healthcare burden. The parenteral and oral iron-chelating agents including deferoxamine, deferiprone and deferasirox, are recommended and approved by FDA for patients with transfusion dependent red blood cell and other disorders in different case scenarios. The monotherapy is not effective in all patients for a variety of reasons, while the combination therapy may be effective in many situations. There is good prognosis as far as patients with transfusion-induced iron overload are concerned; with well-controlled iron concentration through chelation of iron is concerned. Therefore, patients should avoid OTC chelation therapies with unproven effectiveness and safety that are prominently marketed via Internet or available OTC with claims to reduce the essential or heavy metal concentration in the body.

Few years back, the only chelating agent available was deferoxamine. However, deferoxamine therapy has revealed the undesirable adverse effects along with the issues such as discomfort, pain and hypersensitivity, resulting in its non-compliance. With the emergence of new oral therapies including deferiprone and deferasirox over the last few decades, significant evidence support their use in iron overload. Both oral drugs are effective in reducing the iron overload and its burden; however, several patient characteristics favor one over another. The understanding of iron toxicity together with its consequences on the organ system is an important aspect of employing therapeutic strategies. Iron-chelation therapy is currently proven to be of advantage against the treatment of several conditions including transfusion-dependent thalassemia and hemoglobinopathies, where the management of iron overload is fundamental strategy to reduce both mortality and morbidity.

On the contrary, the adverse drug effects and high costs associated with chelation therapy has its own consequences leading to prevention of optimal dosing and poor adherence to treatment that may result in an inadequate response in the patients.
Therefore, even though the chelation therapy is available, there are instances of poor adherence due to adverse effects or its administration regimen. The potential advances in chelation therapy through research on animal and cell models could make the future human research possible, unlike OTC chelation therapy that is unapproved and unregulated. The continuous efforts are being made to use the extensive knowledge of iron metabolism in humans and the relevant animal models, for the ongoing research in the drug target, drug structure and physicochemical properties, drug absorption and distribution pathways. With the promising advances in drug discovery and development, there is a huge potential of discovering new drugs to satisfy the need of treatment of iron overdose both in children and adults, thus improving the quality of life of the patients with iron-overload.

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