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Iron Overload in an Infant With Rh-Isoimmunization

A late preterm (gestational age-36 wk) baby girl weighing 2.1 kg was born to a 30-year-old, G4A2L1 mother delivered through cesarean section. Mother had Rh-ve blood group, had a living child with Rh+ve blood group in G1 pregnancy; and G2 and G3 were aborted in first trimester. She did not receive anti-D prophylaxis during initial three pregnancies. In the current pregnancy (G4), fetal hydrops fetalis was detected in 24-week antenatal scan, indirect coombs test (ICT) was 1:256 titre positive. She was managed with five intra uterine transfusions (IUT) between 25-34 weeks of pregnancy. Baby had received phototherapy and exchange transfusion for severe hyper-bilirubinemia during first postnatal week.

At one-month of age, baby presented with moderate anemia (hemoglobin - 8.3 gm/dL), without icterus and organomegaly. She was afebrile, active, and with appropriate weight gain. Her blood group was O positive (due to multiple IUTs). Her reticulocyte count was 3.5%, mean corpuscular volume MCV- 74 fL, negative direct Coombs test (DCT) and microcytic normo-chromic red blood cells (absence of hemolysis) found in peripheral smear. She had hyperferritinemia (755, 655 ng/mL) with raised serum iron (138,129 g/dL) and transferrin saturation (76.7%, 56.6%) with low TIBC (180,228 mcg/dL) on day 29 and 63 of age, respectively. On follow up at age of 3 month and 6 month, she had only raised hyperferritinemia (322, 225 ng/mL), with normal hemoglobin (12 g/dL) at 6 month. Baby was managed conservatively with routine supplementation of vitamin D, without any iron chelation therapy.

This neonate presented with asymptomatic anemia and was found to have iron overload. The presence of hyperferritinemia in our case was similar to previous case studies following multiple IUTs [1-3]. The possible differential diagnosis could be common causes of anemia or either existing hemolysis due to Rh-isoimmunization, or suppression of erythropoiesis due to iron overload, or excessive nadir of physiological anemia of infancy [2].

The burden of Rh-isoimmunization is more prevalent in developing countries like India. It causes hydrops fetalis and increases neonatal morbidity [4]. IUT is the management option for severe fetal anemia, guided by antenatal middle cerebral artery Doppler. Currently, the facility for IUT is available only in few referral tertiary care centers of India, and the infants are subsequently followed by pediatricians. We suggest that pedia-tricians should be cautious in prescribing iron supplementation to such infant, who have received multiple intrauterine transfusions.

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