Background: The diagnosis of iron deficiency anemia (IDA) in the elderly is difficult because of the prevalence of chronic diseases, which can cause anemia with high ferritin levels, even in the presence of iron deficiency. Therefore, we studied the sensitivity and specificity of a serum transferrin receptor assay, which is not affected by chronic diseases, in the diagnosis of IDA in elderly patients.

Methods: We performed a prospective controlled study of 49 consecutive male and female patients older than 80 years who were admitted to an acute geriatric department. Bone marrow aspirate confirmed IDA in all 49 patients. Fourteen additional patients, also older than 80 years, with anemia but without evidence of iron deficiency on results of bone marrow examination, served as a control group. All patients underwent evaluation by means of a detailed medical history and results of complete physical examination, routine blood tests, and specific tests for diagnosis and evaluation of anemia. Examination of bone marrow aspirate was performed for all patients. Levels of transferrin receptor in serum were determined by means of a specific enzyme-linked immunosorbent assay. The transferrin receptor–ferritin index (TR-F index) was defined as the ratio of serum transferrin receptor level to log ferritin level.

Results: Only 8 patients could be diagnosed as having IDA by means of routine blood test results (serum iron, ferritin, and transferrin saturation levels). In contrast, the TR-F index disclosed IDA in 43 of the 49 patients, thus increasing the sensitivity from 16% to 88%.

Conclusions: The diagnosis of IDA in the elderly by means of routine blood tests has a very low sensitivity. The TR-F index is much more sensitive, and when results are positive, the TR-F index can eliminate the need for bone marrow examination.
PATIENTS AND METHODS

SUBJECTS

We studied 106 consecutive patients older than 80 years who were admitted to the Department of Acute Geriatric Medicine, Kaplan Medical Center, Rehovot, Israel, between January 1, 1993, and December 31, 1997, with a diagnosis of anemia (hemoglobin level, <13.0 g/dL in men and <12.0 g/dL in women). Exclusion criteria included acute gastrointestinal tract bleeding, inability or refusal to sign an informed consent, significant vitamin B12 or folic acid deficiency, current iron therapy, known malignancy, and renal or hepatic failure. Sixty-three patients were eligible for the study. All patients underwent a complete medical history and a thorough physical examination on admission, with routine laboratory tests including a complete blood cell count, erythrocyte sedimentation rate, kidney and liver function tests, and serum levels of iron, transferrin, ferritin, vitamin B12, folic acid, C-reactive protein, and TR. Examination of bone marrow aspirate was performed in all patients. All blood samples were drawn before any blood transfusions or iron supplements were given to the patients. All patients agreed to participate in the study by signing an informed consent that was approved by the hospital ethics committee.

DIAGNOSIS OF IDA BY MEANS OF BONE MARROW EXAMINATION

Bone marrow was aspirated from the sternum or iliac crest. The smears were stained using the combined May-Grünwald and Giemsa methods (Orion Diagnostica, Helsinki, Finland), and the iron stores were stained by the Prussian blue method. The presence of less than 10% of normoblasts stained blue was considered evidence for diagnosis of iron deficiency.

DIAGNOSIS OF IDA BY MEANS OF ROUTINE LABORATORY TESTS

Blood cell counts were measured with an automated analyzer (Technicon H 2; Technicon Instruments Corp, Tarrytown, NY). Serum iron level (reference range, 59-138 µg/dL [10.6-28.3 pmol/L] for men and 37-145 µg/dL [6.6-26.0 pmol/L] for women) was measured using an iron FZ assay (Hoffmann-La Roche, Basel, Switzerland) based on a guanidine hydrochloride/Ferrozine reaction. Transferrin level (reference range, 200-400 mg/dL [2.0-4.0 g/L]) was measured with an immunoturbidimetric assay (Boehringer Mannheim, Mannheim, Germany). Transferrin saturation level was calculated with the following equation:

\[
\text{Transferrin saturation} = \frac{\text{Iron}}{(\text{Transferrin} \times 23)} \times 100
\]

where iron level is measured in micromoles per liter and transferrin level in grams per liter (reference value, 20%). The ferritin level (reference range, 24-300 ng/mL [53.9-674.1 pmol/L] for men and 15-307 ng/mL [33.7-689.8 pmol/L] for women) was measured using a chemiluminescence assay (Access Immunoassay System; Beckman Instruments Inc, Chaska, Minn). Iron deficiency was diagnosed by means of routine laboratory test results when serum iron, transferrin saturation, and ferritin levels were all abnormal.

DIAGNOSIS OF IDA BY MEANS OF TR

Serum TR assays were performed using a commercially available kit based on polyclonal antibodies in a sandwich enzyme-linked immunosorbent assay format (Clinigen; R&D Systems, Minneapolis, Minn). According to the assay kit from the manufacturers, the central 95th percentile of the reference distribution of TR concentration is 0.85 to 3.05 mg/L (n=1000). To make the test more specific, we calculated the ratio of TR to log ferritin level (TR-F index). An index value of greater than 1.5 was considered diagnostic of iron deficiency.

CONTROL GROUP

The control group consisted of 14 patients older than 80 years. These patients also underwent investigation for IDA, but the results of their bone marrow aspirate examinations demonstrated that more than 10% of normoblasts contained iron, thus excluding the diagnosis of IDA.

STATISTICAL ANALYSIS

Sensitivity was defined as \(\frac{TP}{(TP+FN)} \times 100\) and specificity as \(\frac{TN}{(TN+FP)} \times 100\), where TP is true positive; FN, false negative; TN, true negative; and FP, false positive. Positive predictive value was defined as \(\frac{TP}{(TP+FP)} \times 100\); negative predictive value, \(\frac{TN}{(TN+FN)} \times 100\). Unless otherwise indicated, data are given as mean±SD.

The reference range, probably due to the concomitant presence of other illnesses. The definitive test for the diagnosis of IDA is the presence of less than 10% of normoblasts stained by Prussian blue in a bone marrow aspiration sample. However, this procedure is invasive, painful, and expensive, and therefore is not performed regularly. Thus, an alternative sensitive and noninvasive test for the diagnosis of IDA in the elderly is needed.

Transferrin receptor (TR) is a transmembrane glycoprotein that is expressed on most cells, especially those that require high iron levels such as immature erythroid cells. It has a major role in the internalization of iron into the cells. Transferrin receptor is susceptible to proteolysis, thus producing soluble serum TR forms. The serum levels of TR reflect the amount of membranous TR, which inversely correlates to iron storage levels. Kohgo et al developed a radioimmunoassay for the measurement of serum TR. They were the first to report that high serum TR levels correlate with iron deficiency. Flow- et al developed an enzyme-linked immunosorbent assay for the detection of TR in patients’ serum samples. Using this assay, Skikne et al also demonstrated that high serum TR levels are specific markers for IDA. Serum TR levels increase in IDA, but not in inflammatory states. The value of serum TR measurement in the diagnosis of IDA in the elderly is not precisely defined, since most previous studies focused on younger popula-
....
The present study clearly demonstrated the important role of the TR-F index in the diagnosis of IDA in elderly patients with anemia. The TR-F index has high specificity (93%) and sensitivity (88%) for the diagnosis of IDA in the elderly compared with the low sensitivity (16%) of the routine laboratory tests now used for the evaluation of IDA.

Iron deficiency anemia is a serious medical problem in the elderly. The high rate of gastrointestinal tract malignancy in these patients makes the study of the gastrointestinal tract obligatory. However, these studies are inconvenient and carry a high risk for complications, especially in elderly patients. Thus, one should not recommend those studies without a clear indication, ie, a definite diagnosis of IDA. Serum iron, transferrin saturation, and ferritin levels often conceal the diagnosis of IDA in elderly patients, mainly because of the coexistence of ACD in many of those patients. The present study confirms these previous observations, demonstrating a very low sensitivity of the routine laboratory tests for the diagnosis of IDA in the elderly (Table 1 and Table 2). The use of routine laboratory tests in our studies did not disclose the diagnosis of IDA in 41 (84%) of 49 patients. This low sensitivity rate for IDA diagnosis is not acceptable. Therefore, bone marrow examination is used for more accurate diagnosis of IDA.

The TR serum levels have been shown to be sensitive markers for IDA. We used the TR-log ferritin ratio, the TR-F index, because it was shown to improve the diagnostic efficiency for IDA compared with serum TR level alone or the TR-ferritin ratio. The TR-F index is an accurate marker for IDA, because it represents the total-body iron stores and the availability of iron for erythropoiesis. To our knowledge, our report is the first study of patients older than 80 years in whom the results of bone marrow examinations and routine blood tests and TR-F index have been compared. In agreement with previous observations in younger groups of patients, we found the TR-F index to be a specific and sensitive test for the diagnosis of IDA in the elderly (Table 2). Our data also support the previous observation of Gimferrer et al, who demonstrated that the TR assay exceeds the diagnostic value of routine laboratory tests for IDA during the early stages of iron depletion.

The routine laboratory tests pointed to the diagnosis of IDA in 8 patients with low mean corpuscular volume and very low levels of serum iron, transferrin saturation, and ferritin. In 35 other patients with higher serum iron levels, the diagnosis could be established only by means of the TR-F index (Table 1). Moreover, in most elderly patients, IDA develops concomitantly with ACD. The most important clinical issue is not to differentiate between these 2 morbidities, but rather to have a good diagnostic tool to identify IDA in the presence of ACD. The routine laboratory tests for IDA are of no value in this situation (Tables 1 and 2). In contrast, the TR-F index findings led to the diagnosis of IDA in 19 patients with high inflammatory variables (C-reactive protein level, >20 mg/dL; erythrocyte sedimentation rate, >50 mm/h), whereas results of routine laboratory tests led to the diagnosis of IDA in only 1 of those 19 patients. Although measurement of TR-F index is about 5 times more expensive than routine laboratory tests, it is less expensive than bone marrow examination, and its diagnostic efficiency is much better than that of the routine laboratory tests for IDA. Thus, it is a cost-effective assay for the diagnosis of IDA.

This study supports the high specificity and sensitivity of the TR-F index in the diagnosis of IDA in elderly patients. It is a simple, noninvasive test. A positive finding on the TR-F index (>1.5) can accurately establish a diagnosis of IDA and may eliminate the need for bone marrow examination. On the other hand, a normal finding on the TR-F index in elderly patients with inflammatory variables does not exclude IDA; thus a bone marrow examination should be considered in those patients.

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Table 2. Specificity, Sensitivity, and Negative and Positive Predictive Values of Routine Laboratory Tests and TR-F Index in the Diagnosis of IDA in the Elderly

<table>
<thead>
<tr>
<th>Routine Laboratory Tests†</th>
<th>TR-F Index</th>
</tr>
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<tbody>
<tr>
<td>Specificity, %‡</td>
<td>100</td>
</tr>
<tr>
<td>Sensitivity, %</td>
<td>16.3</td>
</tr>
<tr>
<td>PPV, %</td>
<td>100</td>
</tr>
<tr>
<td>NPV, %</td>
<td>22.2</td>
</tr>
</tbody>
</table>

*TR-F Index indicates transferrin receptor–ferritin index; IDA, iron deficiency anemia; PPV, positive predictive value; and NPV, negative predictive value.
†Includes serum iron, transferrin saturation, and serum ferritin assays.
‡Bone marrow evaluation was considered the gold standard for definitive diagnosis of IDA.


