E2 LANGUAGE

Practice test

READING SUB-TEST – TEXT BOOKLET: PART A

CANDIDATE NUMBER:

LAST NAME:

FIRST NAME:

OTHER NAMES:

PROFESSION:

VENUE:

TEST DATE:

Passport Photo

CANDIDATE SIGNATURE _____

Sedation: Iron deficiencies

Text A

Iron deficiency and iron deficiency anaemia are common. The serum ferritin level is the most useful indicator of iron deficiency, but interpretation can be complex. Identifying the cause of iron deficiency is crucial. Oral iron supplements are effective first-line treatment. Intravenous iron infusions, if required, are safe, effective and practical.

Key Points

- Measurement of the serum ferritin level is the most useful diagnostic assay for detecting iron deficiency, but interpretation may be difficult in patients with comorbidities.
- Identifying the cause of iron deficiency is crucial; referral to a gastroenterologist is often required.
- Faecal occult blood testing is not recommended in the evaluation of iron deficiency; a negative result does not impact on the diagnostic evaluation.
- Oral iron is an effective first-line treatment, and simple strategies can facilitate patient tolerance.
- For patients who cannot tolerate oral therapy or require more rapid correction of iron deficiency, intravenous iron infusions are safe, effective and practical, given the short infusion times of available formulations.
- Intramuscular iron is no longer recommended for patients of any age.

Text B

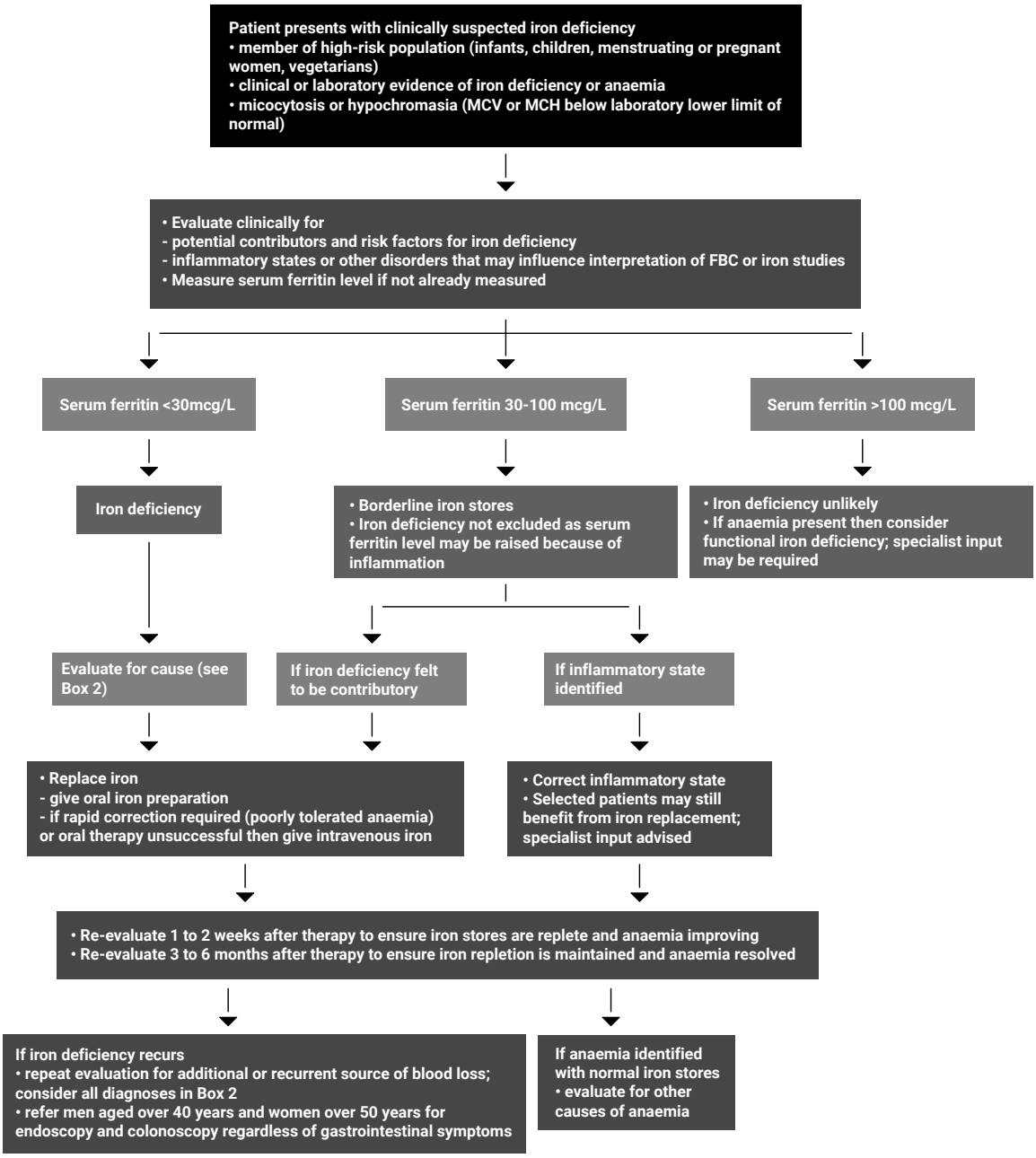
Treatment of infants and children

Although iron deficiency in children cannot be corrected solely by dietary change, dietary advice should be given to parents and carers. Cows' milk is low in iron compared with breast milk and infant formula, and enteropathy caused by hypersensitivity to cows' milk protein can lead to occult gastrointestinal blood loss. Excess cows' milk intake (in lieu of iron-rich solid foods) is the most common cause of iron deficiency in young children. Other risk factors for dietary iron deficiency include late introduction of or insufficient iron-rich foods, prolonged exclusive breastfeeding and early introduction of cows' milk.

Adult doses of iron can be toxic to children, and paediatric-specific protocols on iron supplementation should be followed. The usual paediatric oral iron dosage is 3 to 6mg/kg elemental iron daily. If oral iron is ineffective or not tolerated then consider other causes of anaemia, referral to a specialist paediatrician and use of IV iron.

Text C

AN ALGORITHM FOR THE IDENTIFICATION AND MANAGEMENT OF ADULTS WITH IRON DEFICIENCY



Text D

INTRAVENOUS PREPARATIONS FOR IRON REPLACEMENT				
Form of Iron	**Presentation**	**Maximum dose per administration**	**Dosing frequency**	**Rate of administration**
Ferric carboxymaltose	500 mg/10 mL vial or 100 mg/2 mL vial	1000 mg (or 20 mg/kg)	Maximum dose once per week, or 200 mg three times per week	IV injection or infusion 100-200mg: 3 minutes 200-500 mg: 6 minutes 500-1000 mg: 15 minutes
Iron polymaltose	100 mg/2 mL ampoule	2500 mg	Not applicable as entire dose can be delivered in single administration	IV infusion: first 50 mL infused slowly (20 to 40 mL/h); if tolerated then rate can be increased to 120 mL/h*
Iron sucrose	100 mg/5 mL ampoule	100 mg	Maximum three times per week	IV infusion 100 mg over 15 minutes
*Iron polymaltose can also be administered by the intramuscular route. Different maximum doses and dosing frequencies apply.				

END OF PART A
THIS TEXT BOOKLET WILL BE COLLECTED