Original Research Article

Comparative Assessment of Iron Deficiency Anaemia among Chronic Kidney Disease Subjects in Niger Delta Nigeria

ABSTRACT

Iron Deficiency Anaemia which is reduced red blood cells due to iron deficiency had been reported to be a major challenge among Chronic Kidney Disease patients. The cause of anaemia in these patients is multifactorial, ranging from the inability of the kidneys to excrete hepcidin to even the inability of the kidneys to produce erythropoietin. This study aimed at comparatively assessing IDA between CKD and APHS in Niger Delta. A total of 88 subjects were recruited, 55(62.50%) CKDP and 33(37.50%) Control subjects. Samples were collected and analysed for IDA Indicators such as Serum Hepcidin Levels using commercial DRG Hepcidin-25 kit and other Haematological Indices using Automation (Sysmex KX-21N Automated Haematology Analyzer), Leishman Staining Technique and Supravital Staining Technique; Questionnaire was also used to obtain some data, data obtained were analysed using SPSS version 21.The mean values for Serum Hepcidin, Haemoglobin(HB), Packed Cell Volume(PCV), Red Blood Cell count(RBC), Mean Cell Volume(MCV), Mean Cell Haemoglobin(MCH), Mean Cell Haemoglobin Concentration(MCHC), Reticulocyte count(Retics) and Red Cell Distribution Width(RDW) were 52.00ng/ml, 10.00 g/dL, 31.00%, 3.74×10^{2}/L, 78.84fL, 26.58pg, 31.79g/dL, 0.64%, and 14.94% respectively in the CKD patients while that for the APHS were 16.00ng/ml, 14.00g/dL, 42.00%, 4.69×10^{12}/L, 89.37fL, 29.59pg, 33.00g/dL, 1.09% and 13.20% respectively. Statistical T-Test of significance revealed that Serum Hepcidin level was elevated significantly in CKD patients (52.00ng/ml) when compared with APHS(16.00ng/ml) t_{86}= 6.54, $p<0.05$, Haemoglobin value of 10.00g/dL in CKD patients was significantly lower than 14.00g/dL in APHS (t_{86} = -8.49, $p<0.05$), and the values of other haematological indices were lower except RDW that was elevated significantly among CKD patients when compared with the APHS ($p<0.05$) all at significance level of 0.05. The elevated serum hepcidin and RDW level seen in this study may be as a result of diminished renal clearance and inflammatory state of the kidney. The kidney"s inability to make enough erythropoietin may have lead to the low red blood cell count that consequently caused anaemia in subjects studied..The estimation of Serum Hepcidin level in CKD patients in addition to the other Haematological indices will improve the diagnosis, treatment and management of Iron Deficiency Anaemia in these patients.

Keywords: *Iron deficiency. hepcidin, anaemia, chronic kidney disease*

1.0 Introduction

Iron is an essential element required by every aerobic organism largely because of its oxygen carrying capacity in, it is also important for the production of red blood cells. A newly discovered 25- amino acid peptide hormone secreted basically by the liver called Hepcidin is the major controller of systemic iron homeostasis. As important as iron, its excess and reduced states are fatal, so hepcidin helps to maintain a normal level of iron in the circulation for effective erythropoiesis [4,5]. Hepcidin does its function by binding to the iron exporter ferroportin causing its internalization and degradation which results in reduced dietary iron absorption and also reduced iron release from iron storing sites such as the macrophages and liver and this occurs when iron stores are full in a normal condition [18,14]. When hepcidin is secreted in

excess (up- regulated), iron level falls below normal while when secretion is low (down-regulated), it results in iron overload. If these events (high and low secretions of hepcidin) levels are not managed properly, the consequent result is iron deficiency anaemia. This is usually seen in several disease condition, including Chronic Kidney Disease (CKD) [12,10]. In chronic kidney disease patients, hepcidin levels have been reported to be abnormally high due to inability of the kidney to excrete hepcidin and also inflammation. This sudden increase in hepcidin level causes reduction in the amount of iron in the circulation and as such iron deficiency, then iron deficiency anaemia [13,12]. Following the increasing rate of chronic kidney disease, this study is focused on assessing hepcidin level in chronic kidney disease patients in relation to anaemia (iron deficiency anaemia).

2.0 Materials and Methods

2.1 Study Area

The study was carried out in Braitwait Memorial Specialist Hospital, Port Harcourt, Rivers State.

2.2 Study Design

This study was designed as a comparative cross-sectional study. Samples were collected at a single point.

2.3 Study Population

55 chronic kidney disease patients confirmed by their clinician and Laboratory investigation reports documented in their folders, attending Urology clinic in Braithwaite Memorial Specialist Hospital, Port Harcourt and 33 apparently healthy individuals as control who are inhabitants of Rivers State making a total of 88 subjects recruited in this study.

2.4 Eligibility Criteria

Inclusion and Exclusion criteria were stated; for the Inclusion Criteria, adult chronic kidney disease patients who consented were part of the study, adult control subjects whose creatinine and haemoglobin levels are within normal ranges who gave their consent were recruited into the study. And the Exclusion Criteria, children were excluded from the study, adults with acute kidney failure and adults with chronic kidney disease and control subjects who did not consent.

2.5 Ethical Consideration/Informed Consent

Ethical approval was obtained from Rivers State Health Ethics Committee. A written informed consent was obtained from the participants.

2.6 Sampling method

Subjects were selected based on random sampling method where subjects were asked to pick randomly from a set of 0-1 numbers. All subjects who picked "1" where recruited while subjects who picked "0" where not recruited in similar approach explained by Fyneface *et al.* [8,7].

2.7 Sample Collection

A total of ten milliliters (10ml) of venous blood was collected by venipuncture (vacutainer collection), into a plain sample container 5ml was added and the other 5ml was added into an EDTA bottle. The sample in the plain container was allowed to clot, and serum separated by centrifuging at ambient temperature into other sterile plain containers. For hepcidin measurement, the serum obtained were stored at -20^{o}c before analysis. The samples in EDTA containers were analyzed for full blood count.

2.8 Laboratory Methods

Serum Hepcidin level was measured using the Enzyme Linked Immunosorbent Assay (ELISA) method. The other hemaetological indices (Iron Deficiency Anaemia indicators) Haemoglobin, Packed Cell Volume, Red Blood cell Count, MCV, MCH, MCHC and RDW were determined using the automated analyzer. Reticulocyte count was determined using the New Methylene Blue Staining Technique. Peripheral blood film was made and stained with the Leishman stain for the red cell morphology study.

2.9 Data Analysis

Data obtained were analyzed, descriptively (percentage/frequency, mean, standard deviation) and inferential (Independent T-Test and Pearson Correlation) at significance level of 0.05 using the Statistical Package for Social Sciences (SPSS) Version 21.

3.0 Results

Table 1 showed the Mean, Standard Deviation, t and p-values of Serum Hepcidin and Iron Deficiency Anaemia expressed in some Haematological parameters (Heamoglobin (HB), Packed Cell Volume (PCV), Red Blood Cell Count (RBC), Mean Cell Volume (MCV), Mean Cell Haemoglobin (MCH), Mean Cell Haemoglobin Concentration (MCHC), Reticulocyte Count (Retics) and Red Cell Distribution Width (RDW)) of the two groups (CKD and control groups). The t-values and p-values for SH, HB, PCV, RBC, MCV, MCH, MCHC, Retics and RDW were t_{86} = 6.54, -8.49, -8.89, -6.50, -7.55, -5.07, -2.74, -2.80, and 6.28, respectively. The p-values for all the parameters in table were less than 0.05; therefore there were statistically significant

differences between the levels of the various parameters between the two groups of the study population.

Table 1: Mean Comparison of Iron Deficiency Anaemia Indices between CKD Patients and Apparently Healthy Subjects

Variables	Groups	N	Mean±SD	t-value	Df	p- value
Hepcidin(ng/ml)	CKD	55.00	52.00±36.00	6.54	86.00	0.00
	Control	33.00	16.00±13.00			
HB(g/dL)	CKD	55.00	10.00± 3.00	-8.49	86.00	0.00
	Control	33.00	14.00±1.00			
PCV(%)	CKD	55.00	31.00± 8.00	-8.89	86.00	0.00
	Control	33.00	42.00±3.00			
RBC($\times 10^2$/L)	CKD	55.00	3.74±0.93	-6.50	86.00	0.00
	Control	33.00	4.69±0.43			
MCV(pg)	CKD	55.00	78.84±9.31	-7.55	86.00	0.00
	Control	33.00	89.37±3.48			
MCH(fL)	CKD	55.00	26.58±3.99	-5.07	86.00	0.00
	Control	33.00	29.59±1.46			
MCHC(g/dL)	CKD	55.00	31.79± 3.02	-2.74	86.00	0.01
	Control	33.00	33.00±1.01			
Retics(%)	CKD	55.00	0.63±0.77	-2.80	86.00	0.01
	Control	33.00	1.09±0.68			
RDW(%)	CKD	55.00	14.94±1.46	6.28	86.00	0.00
	Control	33.00	13.20± 0.80			

P= 0.05, P ≤ 0.05 = Significant, P > 0.05 = Not Significant

4.0 Discussion

This study aimed at comparatively assessing IDA between CKD and APHS in Niger Delta. Serum Hepcidin was measured in the two groups in this study; there was statistical significance

in elevated Serum Hepcidin level in the CKD participants as compared with the Control participants. This implies that in chronic kidney disease, the impairment of the kidneys prevents proper hepcidin removal resulting in the accumulation of hepcidin in the circulation, also it has been recorded that inflammation induces over production of hepcidin and this is a very common condition among these patients. The elevated Serum Hepcidin level contributed to reduced availability of iron in the circulation of the CKD patients.

This report was in line with many studies by various groups [2,9,3,11,19] with levels of serum hepcidin ranging from 10 folds based on the technique employed, of which many recorded serum hepcidin level as 27.00 – 158.00ng/ml for CKD and normal serum hepcidin to be in the range of 1.00 – 55.00ng/ml, also 1.000 – 130ng/ml [6] and 1.700 – 82.00ng/ml [15] for CKD subjects. In contrast from this study, Peters *et al*.[15] recorded decreased Serum Hepcidin levels among dialyzed patients. Yasuhiro and Masafumi [20]in their study recorded a conflicting results on the cause of the elevated Hepcidin and concluded that the regulation of iron concentration is by many factors not only Hepcidin.

The haematological parameters that were determined to ascertain anaemia (Iron Deficiency Anaemia) in this study were heamoglobin(HB), packed cell volume(PCV), red blood cell count(RBC), mean cell volume(MCV), mean cell haemoglobin(MCH), mean cell haemoglobin concentration(MCHC), reticulocyte count(Retics), red cell distribution width(RDW) and Peripheral Blood Smear. From the results obtained in the present study there were significant reduction in the ranges of these indices in the CKD subjects than in the Control subjects in all the haematological parameters except RDW which was higher in CKD subjects than the Control.

The p-values for all the parameters were less than 0.05; therefore there were statistically significant differences between the levels of the various parameters (HB, PCV, RBC, MCV, MCH, MCHC, Retics and RDW) among the two groups of the study population. The peripheral blood smear morphology pointed to iron deficiency anaemia (microcytic and hypochromic red cells) among the CKD patients compared to the normocytic and normochromic red cells in the Control subjects.

This denotes that anaemia due to lack of iron is prevalent among the Chronic Kidney Disease patients which may be as result of the high Serum Hepcidin recorded among this population and other factors. Anaemia in these patients is a contributing factor to cardiovascular disease, the major cause of death in this condition, many of which are hospitalized and additional cost of

medical care. This study was consistent with that of Shadeda and colleagues [16] in their study on changes in haematological indices in different stages of chronic renal failure (CRF), they also had significantly lower levels of some haematological indices in CRF compared to normal subjects but disagrees in some ways with the studies of Afshan *et al*. [1] and Sneha *et al*.[17] which recorded reduced levels of HB, PCV, RBC, MCH and MCHC, then peripheral blood smear showing normocytic normochromic red cells

Conclusion/Recommendation

This study observed an increase in serum hepcidin and RDW levels in CKD subjects, while other haematological parameters studied were decreased. The increase in serum hepcidin and RDW levels in CKD subjects may be as a result of lack of iron in the body related to blood loss or poor nutrition. It could also be as a result of the diminished renal clearance, or kidney's inability to make enough erythropoietin, thereby causing lack of iron which consequently lead to iron deficiency anaemia in subject studied. It is therefore, recommended that, serum hepcidin measurement should be included among the panel of tests to be carried out in the treatment and management of anaemia (Iron Deficiency Anaemia) in chronic kidney disease patients.

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