Heart failure secondary to iron overload is the main cause of death in patients with \(\beta\)-thalassemia major. Combination therapy with deferoxamine and deferiprone has been shown to be more effective than either drug used alone in patients with \(\beta\)-thalassemia major and symptomatic cardiomyopathy. Although monitoring the response to chelation therapy is usually carried out by indirect measurement of the serum ferritin level or by direct determination of tissue iron content in biopsy specimens, magnetic resonance imaging (MRI) seems to be useful for noninvasive qualitative and quantitative assessment of iron deposition.

We present a case in which the efficacy of double chelation therapy in a patient with \(\beta\)-thalassemia major and heart failure was demonstrated by MRI.

**Key words:** Magnetic resonance imaging. \(\beta\)-Thalassemia major. Deferoxamine. Deferiprone.

**INTRODUCTION**

Cardiomyopathy secondary to iron deposition in thalassemia major is the main cause of death in patients with this condition.\(^1\),\(^2\) Early identification of the tissue iron deposits is important, particularly in the cardiac tissues, so that chelating therapy can be initiated while the process is still reversible. Magnetic resonance imaging (MRI) is a useful technique for this purpose, since it can detect and quantitatively estimate the amount of iron deposited in various organs.\(^3\),\(^4\) Recent studies have shown that combined deferoxamine and deferiprone treatment is effective when heart failure develops despite standard chelating therapy with deferoxamine.

**CASE STUDY**

A 22-year-old male with homozygous betathalassemia (beta/delta beta) under treatment with transfusion support every 3 weeks and subcutaneous deferoxamine since the age of 14 was hospitalized for symptoms of progressive dyspnea and edema of the lower limbs. Transthoracic echocardiography showed biventricular dilated cardiomyopathy with severely affected left ventricular systolic function and an
ejection fraction (EF) of 20%. Serum ferritin at the time of hospital admission was 1645 ng/mL and the analyses showed liver function alterations (GOT, 84 U/L; GPT, 110 U/L; alkaline phosphatase, 467 U/L; LDH, 687 U/L; and gamma-GPT 36 U/L).

Magnetic resonance imaging was performed to visualize the cardiac hemochromatosis. The gradient echo sequences (FLASH, TR/TE 700/11, flip angle 30°) showed an overall decrease in the myocardial signal that was more pronounced in the posterior and lateral segments, and a notably decreased liver signal (Figure 1A). The functional sequences confirmed volume increases in both ventricles with severely depressed biventricular function (left-ventricular end-diastolic volume [LVEDV] and left ventricular end-systolic volume [LVESV] of 130 and 87 mL/m², respectively, with an EF of 32%) (Figure 2A and B).

Symptomatic treatment was established with diuretics, captopril, and digoxin, and the standard chelating treatment with deferoxamine was changed to combined
Deferiprone is a molecule 5 times smaller and more lipophilic than deferoxamine, allowing better intracellular penetration. Once it is bound to iron, it becomes a more hydrophilic complex that is easily transported out of the cell and eliminated. Deferiprone has been shown to be more effective than deferoxamine, particularly for the elimination of myocardial iron. Moreover, combined therapy (deferiprone + deferoxamine) results in greater chelating activity and therefore, better results than deferoxamine alone, with good tolerance and no reports of major side effects.

Thus, MRI is a useful diagnostic imaging method for early detection of cardiac hemochromatosis, provides the possibility to establish prophylactic chelating therapy, and allows monitoring of the treatment response once cardiac dysfunction has occurred. A combined treatment regimen with deferoxamine and deferiprone should be assessed in cases in which intravenous treatment with deferoxamine alone is not effective.

REFERENCES