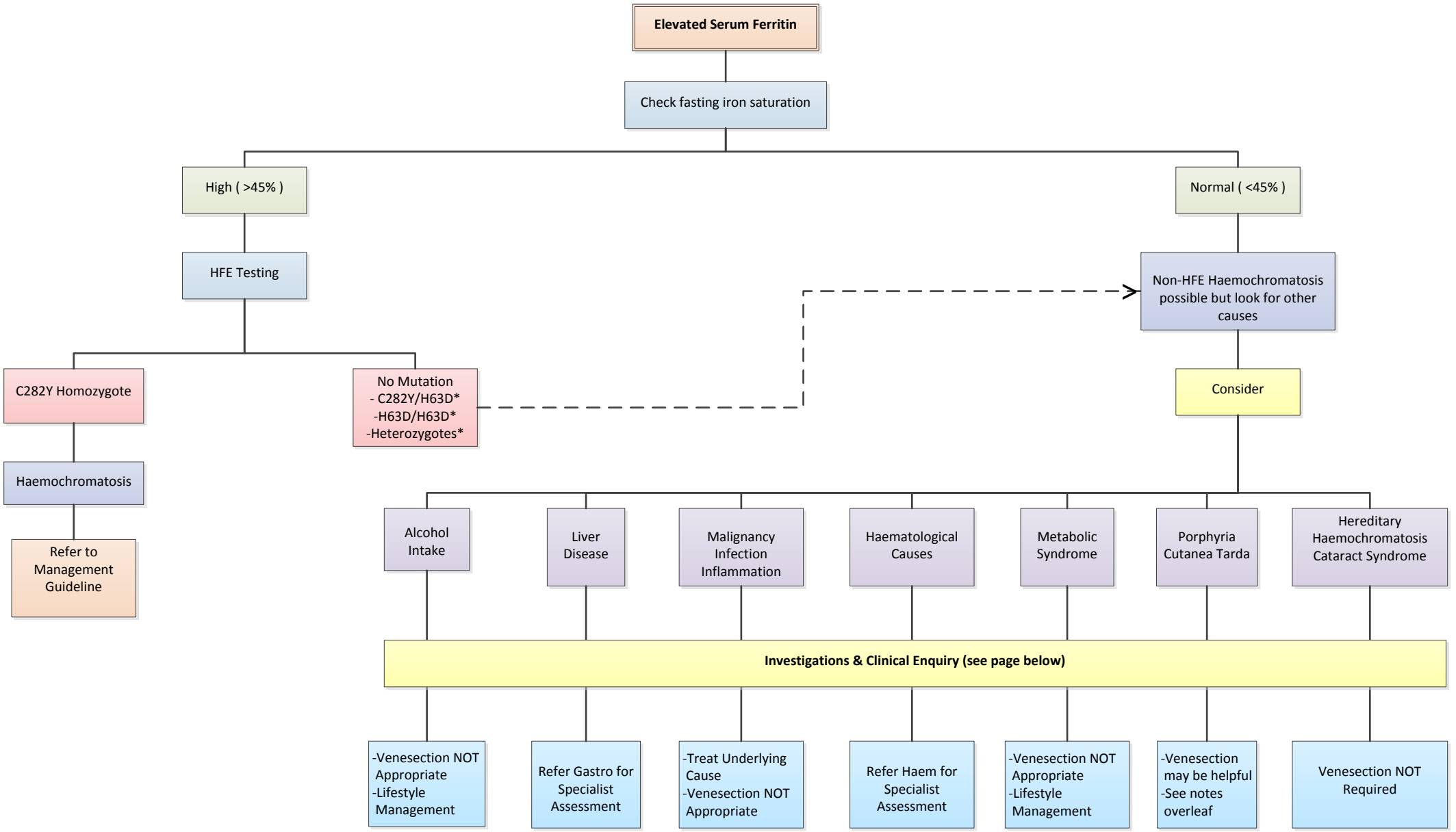

*Can have Hyperferritaemia but don't develop sufficient iron deposition for clinical disease in absence of additional risk factors. Screen for other causes, consider referral if ferritin >1000+/- deranged LFTs.

HYPERFERRITINAEMIA

Elevated ferritin levels are common. Most will not have iron overload

Many varied conditions can result in elevated ferritins. In the absence of C282Y/C282Y homozygosity the following investigations are recommended:

- Weight/BMI measurement
- Blood pressure
- Triglycerides
- Cholesterol
- HbA1C
- Liver ultrasound
- LFTs
- Viral hepatitis screen
- Liver autoantibody screen including immunoglobulins
- Ceruloplasmin
- FBC
- CRP

Clinical enquiry should include:

- Presence of cataracts and family history of early onset cataracts. Consider Hereditary Hyperferritinaemia Cataract Syndrome. Affected individuals do not require venesection.
- Skin blistering, hyperpigmentation, hypertrichosis. Consider Porphyria Cutanea Tarda (genetic and acquired causes). Referral to dermatology for diagnostic biopsy. Patients with confirmed diagnosis should be screened for haemochromatosis and hepatitis C. Individuals with positive HFE or HCV screens should be referred to gastroenterology. Venesection may be useful and can help skin condition.
- History of previous regular blood transfusions. Consider transfusional iron overload. Note FBC may now be normal if underlying primary reason for transfusions now treated.

Most cases of hyperferritinaemia are likely related to metabolic syndrome.

If after assessment and management of lifestyle factors ferritin remains elevated this should be monitored on a yearly basis. If the ferritin remains >1000 for >12 months patients should be referred to gastroenterology so consideration can be given to the need for further investigation/imaging.