Iron Deficiency Camden Pathway

This pathway has been developed from published guidance, in collaboration with local gastroenterologists.

This guidance is to assist GPs in decision making and is not intended to replace clinical judgment.

Clinical Commissioning Group

Differential diagnosis of microcytic anaemia Differential diagnosis of microcytic anaemia

- Iron deficiency anaemia Thalassaemia

- Sideroblastic anaemias
- Anaemia of chronic disease
- Lead poisoning (rare)

associated with ↑ iron and ferritin and ↓ TIBC. Thalassaemia trait is associated with ↓ MCV, MCH and MCHC -often very low for the degree of anaemia)

(Thalassaemia and sideroblastic anaemia

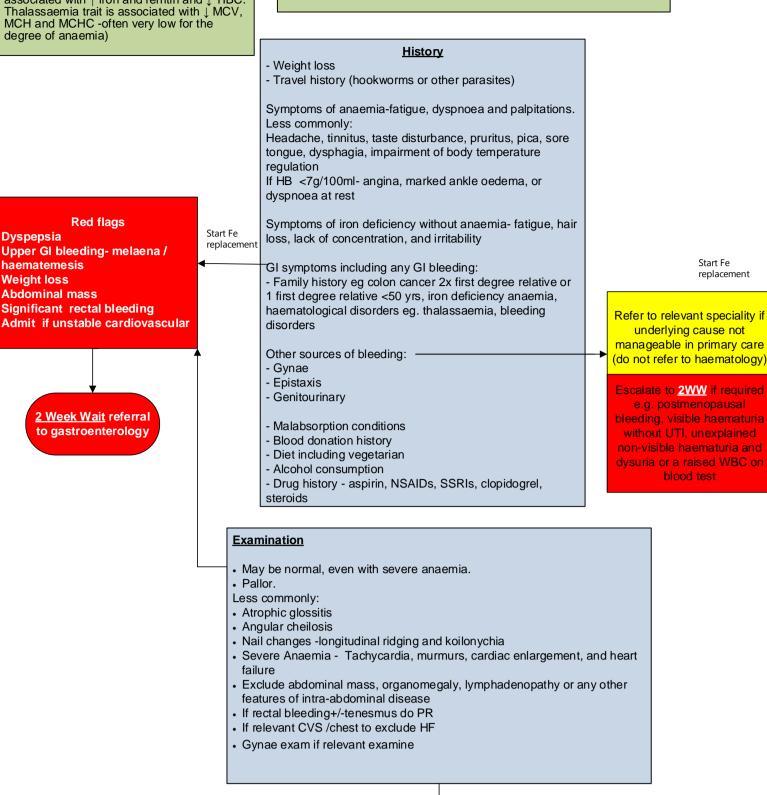
Iron Deficiency

- Low serum ferritin (<15ug/l interpretation difficult if co-existing conditions but is less likely if >50 ug/l)
 Red cell microcytosis (MCV) (<80 fl)

haemoglobinopathy

- Hypochromia (MCH) in the absence of chronic disease or
- RBC), pencil cells and mild thrombocytosis may also be present

• Anisocytosis (variation in size RBC), poikilocytosis (irregular shaped



Is there unexplained anaemia with Hb <11g/L in a man or <10g/L in a postmenopausal woman? replacement No Male with unexplained iron deficiency anaemia (Hb 11-13g/L) or >50yrs with iron deficiency

WHO define anaemia as Hb men<13g/L and women<12g/L, pregnant women

Investigations:

(B12/folate if normocytic anaemia with borderline ferritin, indequate response to Fe supps, dietary deficiency, malabsorption or lack of folate supps in

Consider dipstick urine (1% will have renal tract malignancy) Consider coeliac screen (present in up to 4% - refer gastro if +ve)

FBC if not already done

FOB not recommended

If menorrhagia - clotting/TFT

pregnancy)

<11g/L

Start Fe

2 Week Wait referral

Consider helicobacter pylori testing

Stool examination if relevant travel hx

Haemoglobinopathy screening when appropriate

deficiency (escalate to 2ww if any additional concerns) No

Assess and manage any underlying GI or Gynae symptoms

Female postmenopausal Hb 10-12g/L or with iron

Refer to

gastroenterology

Yes

Start Fe replacement

sufficient to correct fe def anaemia) Treat whilst awaiting investigations or for therapeutic trial in pregnant women, menstruating women

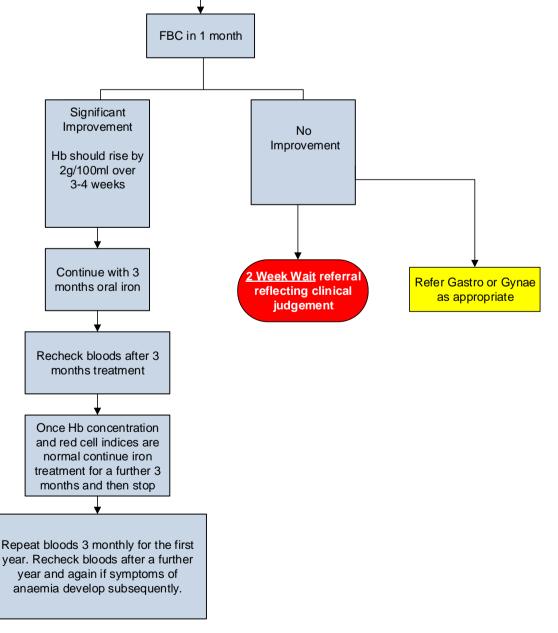
Ferrous fumarate 305mg capsules (100mg elemental

Iron Replacement (dietary changes alone are not

iron/capsule) BD or ferrous fumarate 210mg tablets (68mg elemental iron/tablet) BD to TDS If not tolerated, consider change to alternative iron salt e.g. ferrous sulphate 200mg (65mg elemental iron/ tablet) BD to TDS or reduce frequency Advise patient to take with orange juice If patient still unable to tolerate, refer. GI adverse effects- a common cause of noncompliance, include abdominal pain, constipation or diarrhoea, black stools, nausea and heartburn. Some of which may settle with time. Can minimize by taking

reducing dose frequency or recommending a laxative. Iron absorption may be reduced if high intake phytates eg wholegrain cereals, polyphenols eg tea and coffee, calcium eg dairy products and if on medication raising gastric pH eg antacids/PPIs

with or after food although this may reduce absorption,



Reference

https://cks.nice.org.uk/anaemia-iron-deficiency

Comments & enquiries relating to medication:

Refer to current BNF or SPC for full medicines information

CCCG Medicines Management Team mmt.camdenccg@nhs.net

Clinical Contact for this pathway for queries: Camden.pathways@nhs.net

Pathway created by NCL Approved by Clinical Cabinet Dec 2017 Review due - March 2020