IRON DEFICIENCY ANAEMIA

STACEY WARD

DISEASE BACKGROUND

Iron Deficiency Anaemia (IDA) has a prevalence in 2-5% among adult men and post menopausal women in the developed world and is a common cause of referral to gastroenterologists (4-13% of referrals)

BARNSLEY IDA SERVICE

- **A dedicated nurse led service (under the clinical supervision / support of Dr Kapur Gastro Consultant)**
- **A dedicated streamlined service**
- **Nurse led clinics for new and follow up patients**

HOW TO REFER PATIENTS TO THE IDA SERVICE

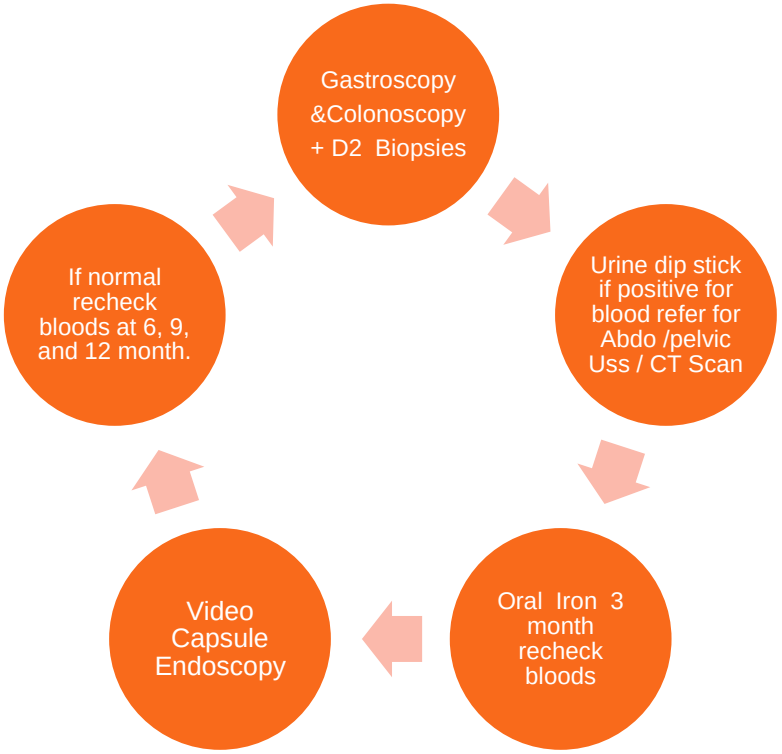
- GP's CAN ACCESS THE SERVICE VIA CHOOSE AND BOOK
- INTERNAL REFERALS (WARD PATIENT'S ETC)
- REFERRALS FROM OTHER SPECIEALITIES. (SURGICAL/ HAEMATOLOGY)

HOW TO DETERMINE IDA

- **Low Hemoglobin** (Normal range women 119-149 / men 132-169)
- **Low Ferritin**(Normal range 22-322). The serum markers of iron deficiency include low ferritin, low transferrin saturation, low serum iron. Serum ferritin is the most powerful test for iron deficiency in the absence of inflammation
- **Microcytosis** (Normal range MCV 82-100)
- **Hypochromia** (Normal MCH 27-32.5)

(Please ensure that these bloods have been carried out prior to referral to the IDA service)

THE PATHWAY


Gastroscopy &Colonoscopy + D2 Biopsies
Urine dip stick if positive for blood refer for Abdo /pelvic Uss / CT Scan
Oral Iron 3 month recheck bloods
Video Capsule Endoscopy
If normal recheck bloods at 6, 9, and 12 month.

THE ROLE OF THE IDA NURSE

- **Assessment of patients referred with IDA. (History of symptoms / medical history)**
- **Organising relevant investigations OGD/Colon/ Abdo/pelvic uss/ capsule endoscopy.**
- **Liaise with the lead consultant to discuss complex/ abnormal out comes.**
- **Patient advocate (supporting/ advising)**
- **Ensuring patient are on relevant oral iron replacement medication**
- **The Iron deficiency anaemia service is NOT a iron infusion service.**
- **Once GI source has been eliminated patients are referred back the referring consultant / physician to manage the anaemia and iron therapy.**

Pathway for Diagnosis and Treatment of Iron Deficiency Anaemia

Consider IV Iron if oral iron is ineffective or cannot be used:

- **Intolerance to oral iron**
- **Active inflammatory conditions**
- **Rapid response needed**
- **Chronic kidney disease stage 3-5**
- **Malabsorption**
- **Patient choice**
- **Iron loss exceeding GI iron absorption capacity.**

Identify patients with IDA

- Low HB
- Low MCV
- Low MCH
- Low ferritin/Iron

Refer to the Iron deficiency anaemia nurse led clinic, for full assessment of IDA symptoms and patient medical history.

Gastroscopy and colonoscopy to be done in all men and all post menopausal women where IDA is confirmed. All patients to be screened for coeliac disease TTG and / or Duodenal Biopsies. (CTC to be considered if patent refuses/will not tolerate colonoscopy.

Urine dipstick/MSU to rule out GU source of anaemia. If blood consider referral to urology. Organise patient to have Abdo/pelvic ultrasound.

If upper or lower GI pathology found at endoscopy please ensure patient is referred to appropriate MDT for discussion and ensure appropriate bloods and scans are arranged.

Patient to be commenced on 3 month course of oral Iron supplements at initial assessment if not already done by GP.

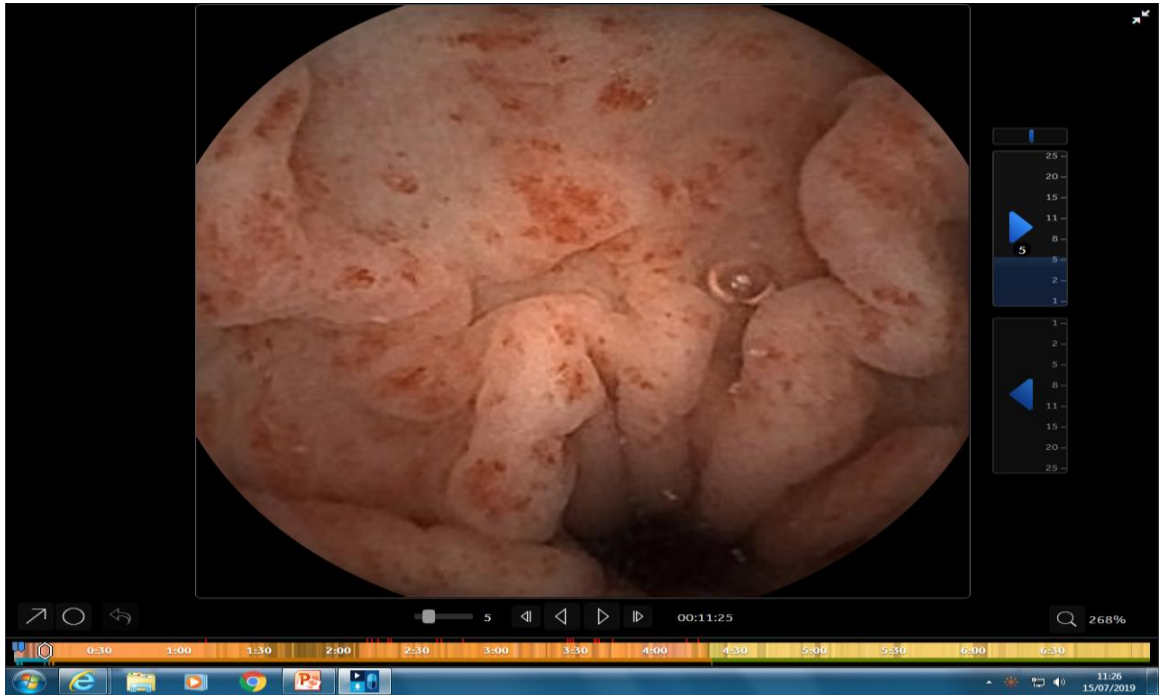
If IDA persists following 3 month course of oral iron, consider small bowel capsule endoscopy. If normal and IDA persist seek gastro consultant advice.

If Gastroscopy /Colonoscopy/D2 Bx normal. Bloods within normal limits following 3 month of oral iron. Discharge bloods to be monitored 3 monthly in primary care. If IDA persists re-refer for SB capsule.

OTHER CAUSES OF IDA

- **Diet (** Certain types of food preferences or intolerances may lead to a diet that does not contain sufficient iron-rich foods.)
- **Medications (**A comprehensive list of all medicines being taken is vital. Many people will mention over the counter, homeopathic and/or herbal remedies alongside any medications that are regularly prescribed by a clinician. There can be contraindications and a comprehensive list will allow identification of any type of medicine that might cause gastrointestinal bleeding (bleeding from the stomach and intestines), such as ibuprofen or aspirin**)**
- **Menstrual Pattern**
- **Pregnancy and lactation**
- **Family History**
- **Blood donation**
- **Travel**
- **Renal Causes (**Just 1% of people diagnosed with IDA will have renal tract malignancy. This may present as obvious or occult haematuria (Goddard et al., 2011).**)**
- **Haematology Causes (**Thalassaemia**)**

IDENTIFIED PATHOLOGY



CASE STUDY

73 year old female presented Iron deficiency anaemia.

No GI symptoms noted on clinical assessment.

Treated with blood transfusion and iron infusions.

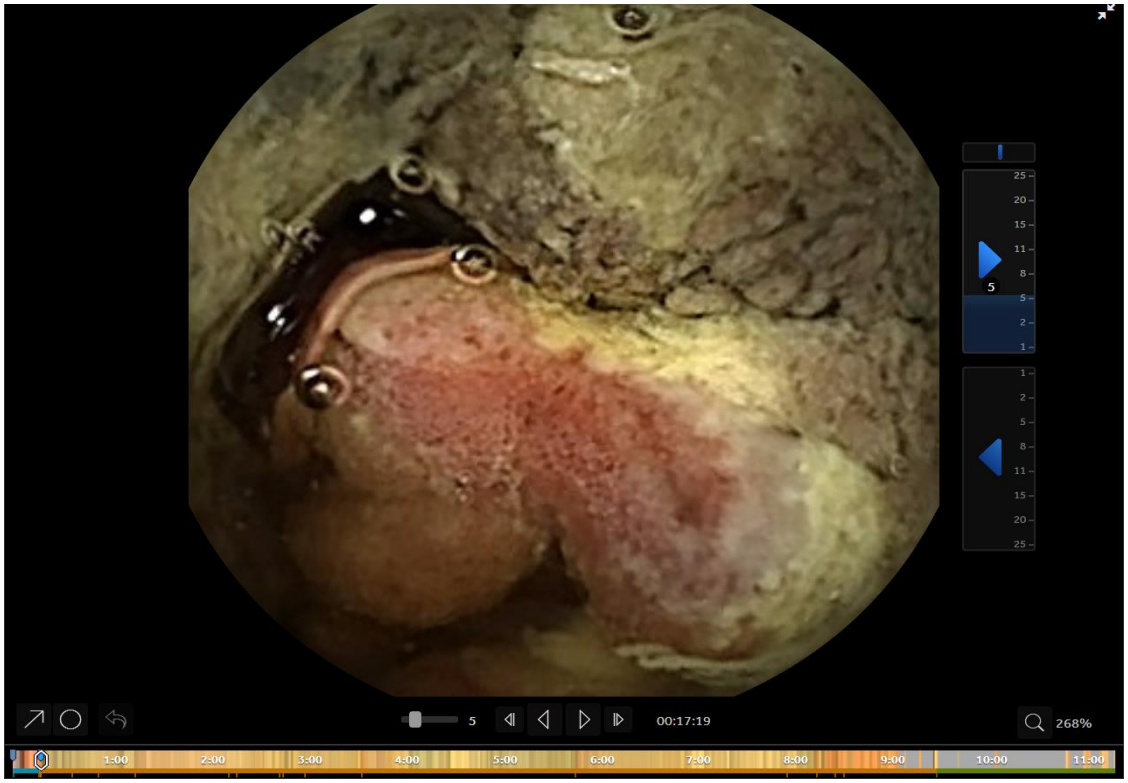
Patient booked for OGD and Colonoscopy.

GAVE noted on OGD. APC applied to areas.

Patient managed with regular OGD +/ - APC. Every 3 month under GA.

Managed with iron / blood transfusions as required.

IDENTIFIED PATHOLOGY



CASE STUDY

71 year old female presented in the Iron deficiency anaemia nurse led clinic. Undergone recent OGD and colonoscopy to investigate IDA. These investigations did not highlight any gross abnormalities noted. There were colonic polyps identified, these were removed and reported as adenoma low grade dysplasia. Gastroscopy was unremarkable.

On clinical assessment the patient was fit and well and did not describe any GI symptoms.

A small bowel Capsule endoscopy was requested.

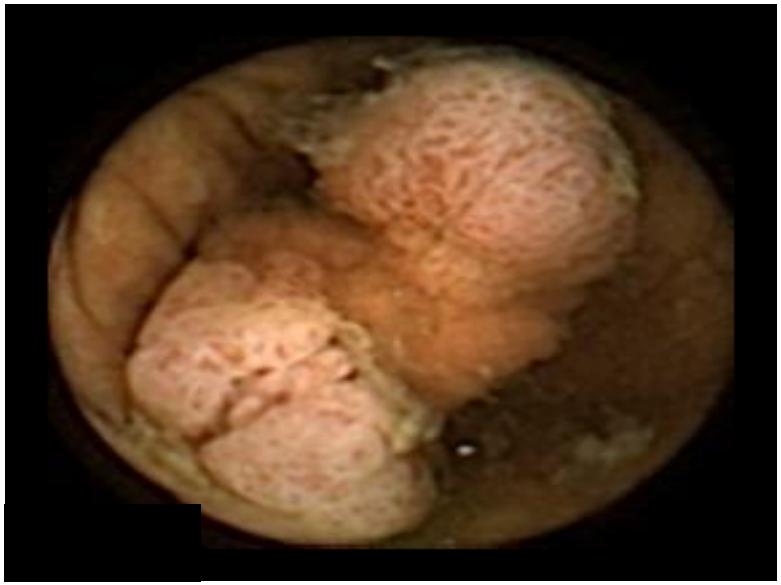
There was a lesion noted in the proximal small bowel. A CT scan was requested and the patient was booked for a OGD / Enteroscopy to obtain histology.

This was reported as carcinoma of the small bowel.

Patient was booked or laparotomy and resection of the tumour.

Surgery was successful, patient recovered well following surgery.

IDENTIFIED PATHOLOGY



CASE STUDY

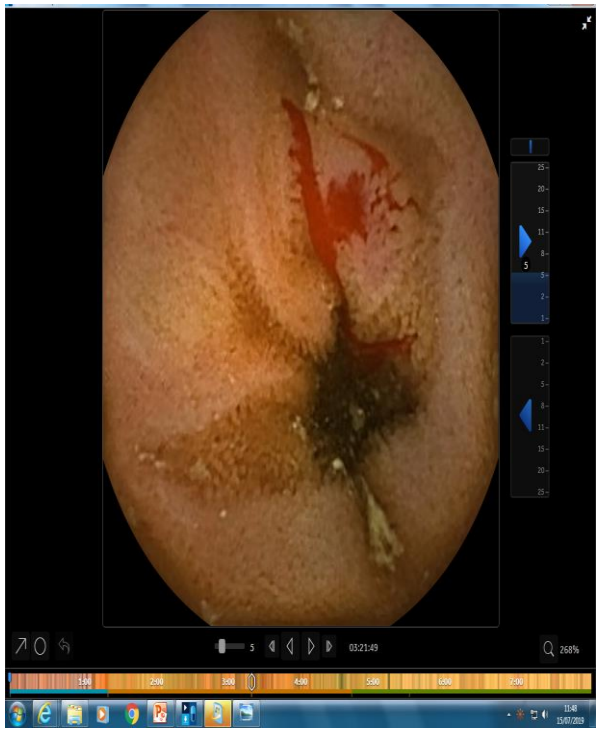
54 year old male presented through the iron deficiency anaemia clinic.

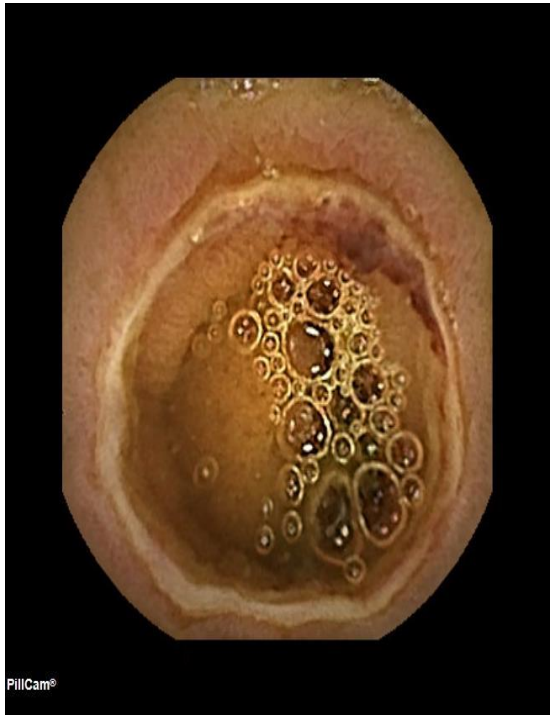
On clinical assessment denied any lower GI symptoms.

Patient booked as per protocol for OGD and colonoscopy to rule out GI source of anaemia.

Sigmoid lesion noted histology taken.

Adenocarcinoma noted on histology patient booked for sigmoidectomy.

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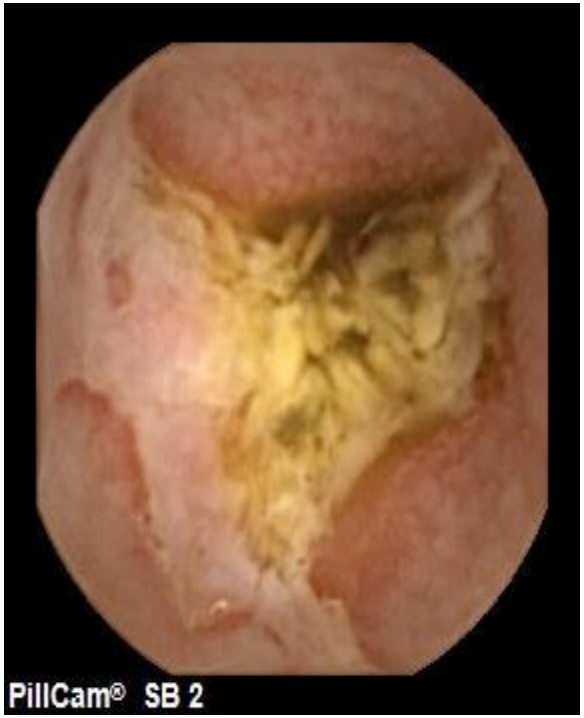
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HOW TO CONTACT THE IDA TEAM

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Thanks!!!
Any question?