IDA
The ORPHAN

(but NOT in BARNSLEY!)

Dr.Atcha. Dr.Kapur. Stacey Ward (Dr.Cutting)

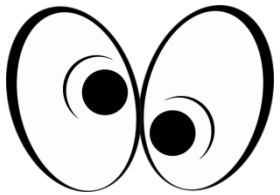
IDA questions – pen and paper

- How Common is IDA in premenopausal women ?
- How Common is IDA in nursing/residential care homes?
- To Diagnose anaemia you need to have - low HB and low ferritin? T/F
- My confidence with DIAGNOSIS of IDA- /10
- My confidence with WHERE TO REFER my IDA patients /10
- My confidence with IRON REPLACEMENT THERAPY /10

Management of IDA – different groups?

- Young women
- Young men
- Elderly
- Special conditions
  - CKD
  - CHF
  - IBD
  - GI surgery
- What is NAID?

The Barnsley IDA Pathway

The need 

2019 – Aug 2021

ENJOY ☺

British Society of Gastroenterology guidelines for the Management of Iron deficiency Anaemia in Adults BMJ- Gut Sept 2021

Highly affective care of IDA patients 4 components

what do you think they were ?

BMJ / GUT article Oct 2021
Highly affective care of IDA patients 4 components

1. Confirmation of IDA
2. Timely access to appropriate investigations
3. Ensure appropriate IRT
4. Strong clinical leadership

in BARNSLEY !!! We fulfil all 4 criteria

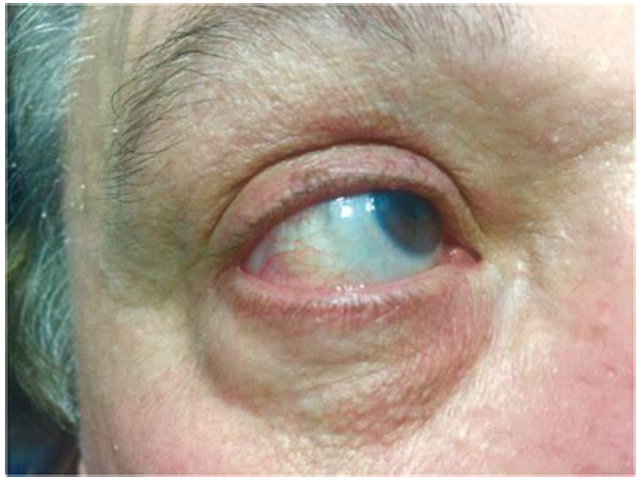
BMJ / GUT article Oct 2021
Highly affective care of IDA patients 4 components

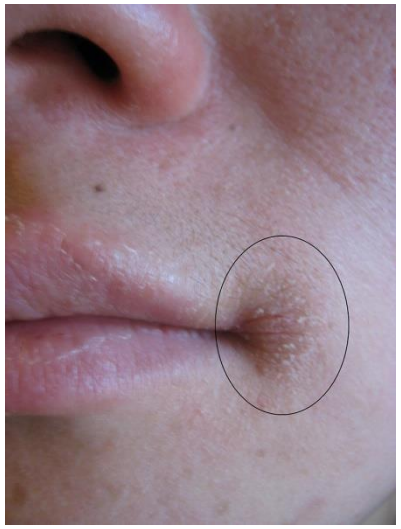
1. **Confirmation of IDA**
2. Timely access to appropriate investigations
3. Ensure appropriate IRT
4. Strong clinical leadership

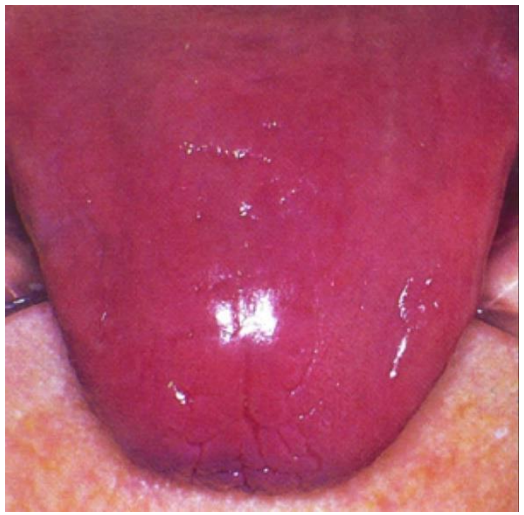
IDA - **Hx** - Examination – Inv

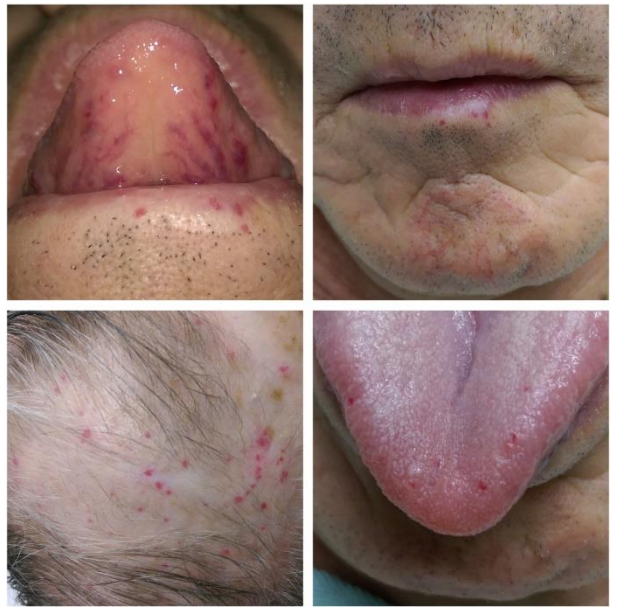
- FHx- GI
- NSAIDS
- PPI
- Chronic conditions
- Donate blood
- Bleeding/bruising
- Restless leg syndrome
- Pagophagia ?

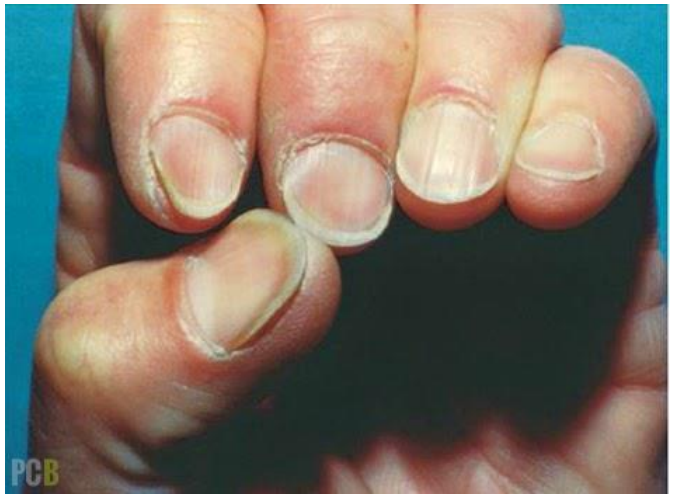
IDA - Hx - Examination – Inv

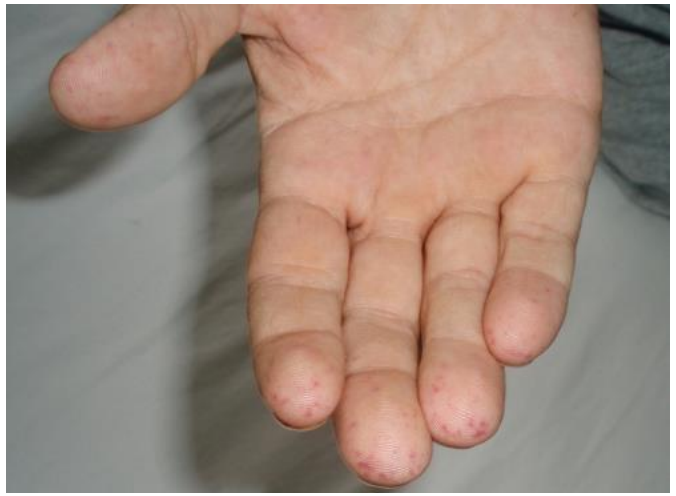












IDA - Hx - **Examination** – Inv

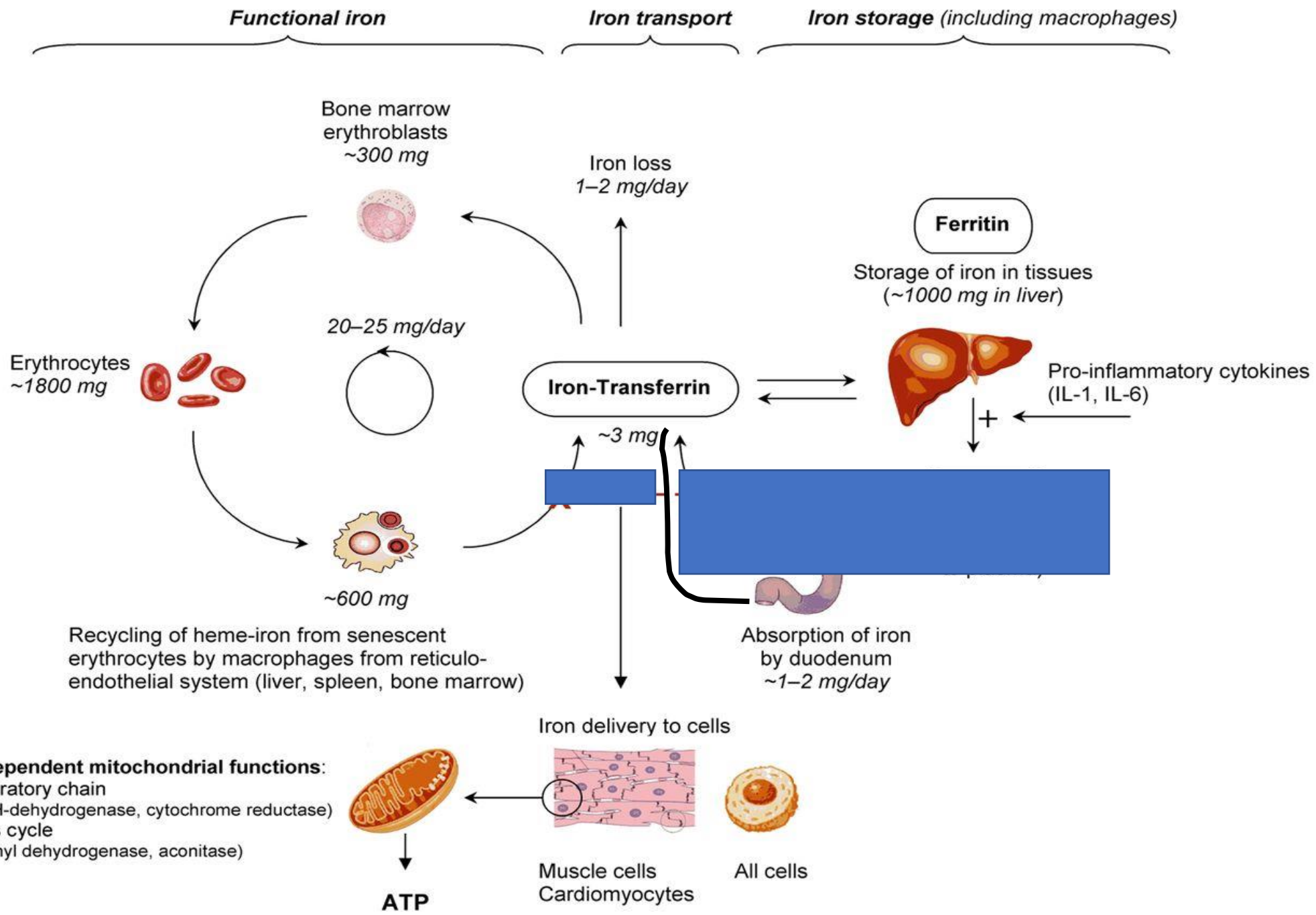
- Angular stomatitis
- Glossitis
- Koilonychia
- Blue sclera
- Telangiectasia !

IDA - Hx - Examination – **Inv**

- FBC
  Hb < 130 < 120 <110 (g/L)
- and what else to diagnose IDA?

- Ferritin
- Transferrin saturation
- CRP

- As GPs nothing else really

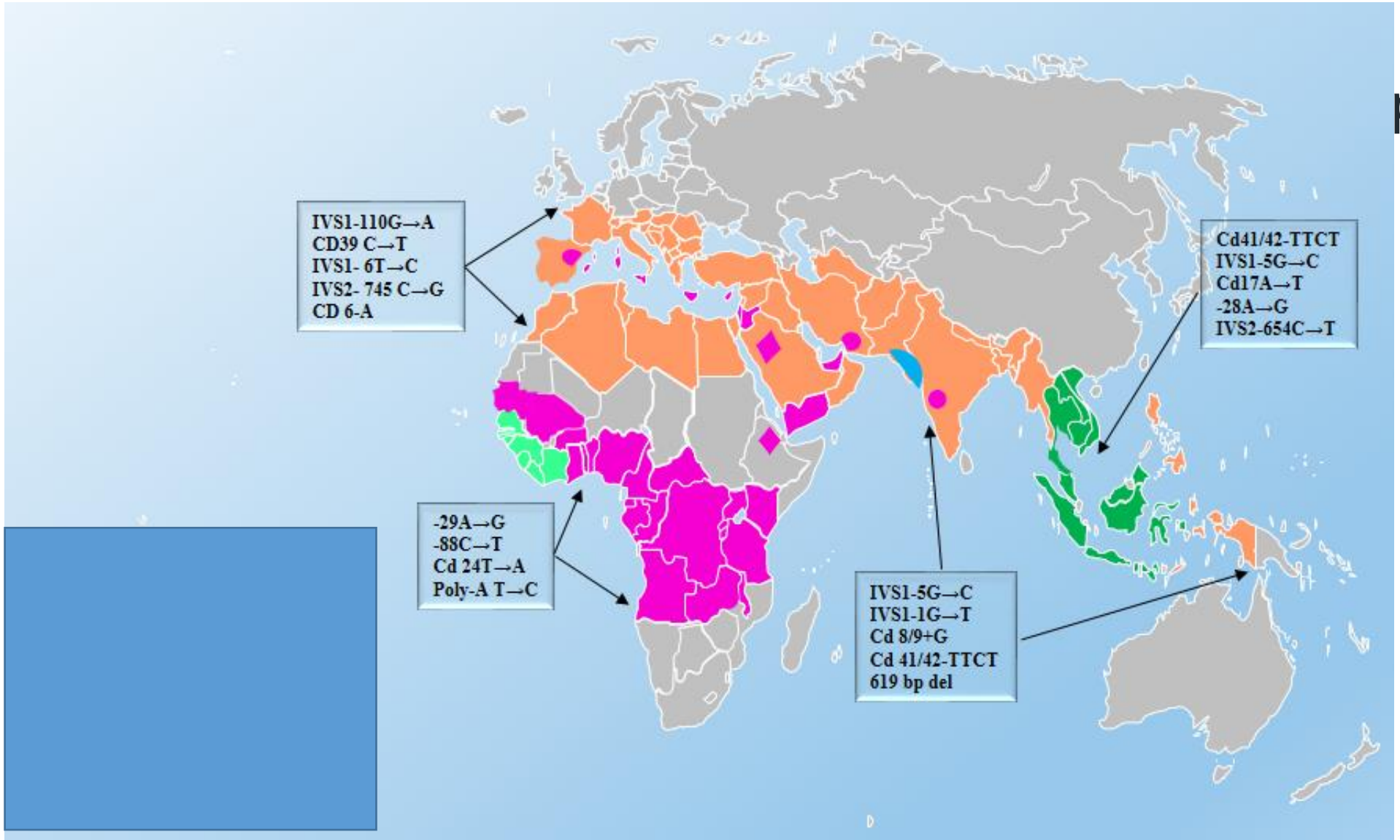

Functional iron
Iron transport
Iron storage (including macrophages)
Bone marrow erythroblasts ~300 mg
Iron loss 1–2 mg/day
Ferritin
Storage of iron in tissues (~1000 mg in liver)
20–25 mg/day
Erythrocytes ~1800 mg
Iron-Transferrin
Pro-inflammatory cytokines (IL-1, IL-6)
~3 mg
~600 mg
Recycling of heme-iron from senescent erythrocytes by macrophages from reticulo-endothelial system (liver, spleen, bone marrow)
Absorption of iron by duodenum ~1–2 mg/day
Iron delivery to cells
Iron-dependent mitochondrial functions:
• Respiratory chain (NADH-dehydrogenase, cytochrome reductase)
• Krebs cycle (succinyl dehydrogenase, aconitase)
ATP
Muscle cells Cardiomyocytes
All cells

IDA confirmation?

- Hb < 130 < 120 <110 (g/L)
- Ferritin < 15 < 30 (ug/L)
- Transferrin < 20%

- Low MCV (falling)
- Low MCH (falling)
- Why? Low/ falling

Low MCV if certain ethnicity !



prus

IDA confirmation- what if

Anaemia of chronic inflammation with IRON deficiency

- Low Hb
- Ferritin 30-100
- **AND** CRP>5
- transferrin < 20 %

Anaemia of chronic inflammation

- Low Hb
- Ferritin >100
- **AND** CRP>5
- transferrin < 20 %

Ferritin> 150- unlikely to be Iron Deficient !!!

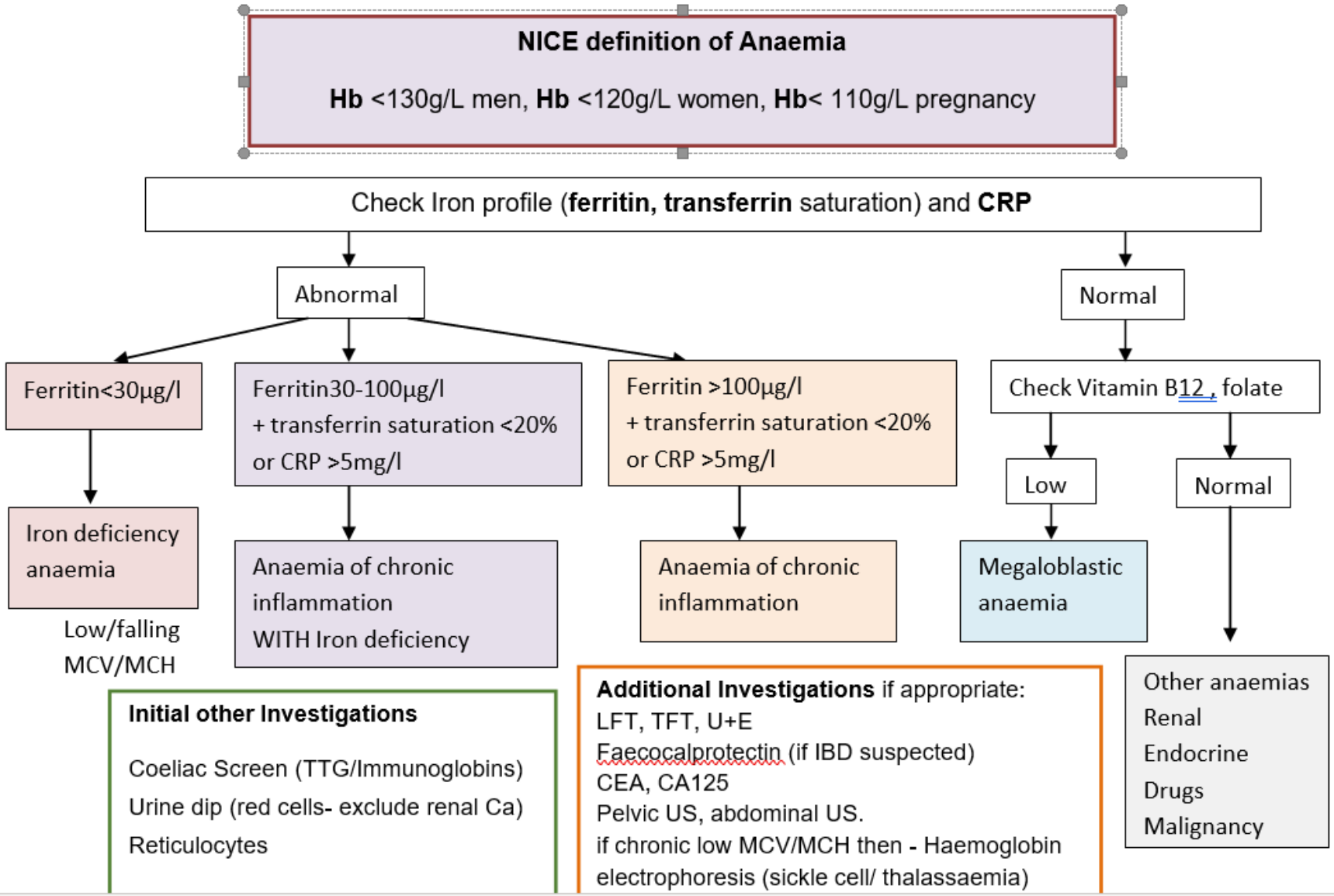
Other initial investigations?

- 1. Hb – Ferritin- transferrin - CRP
- 2. Coeliac screen – 1/20 IDA patients
- 3. Urine dipstick

Q . How reliable is Coeliac serology?

- Coeliac – TTG/ endo-myselial antibody - 2% negative !!! (elderly)
- Urine dipstick – microscopic haematuria
  exclude UTI
  3 dipsticks - persistent blood – refer - Renal Cancer !!!

Adult Iron Deficiency Anaemia (IDA) Pathway



Any questions on Diagnosis of IDA?

- Dr.Kapur

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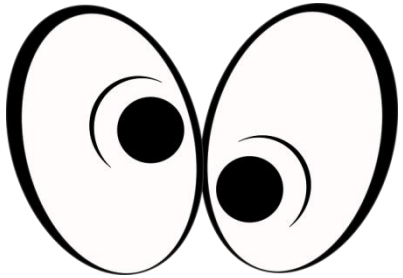
Highly affective care of IDA patients 4 components

1. Confirmation of IDA
2. **Timely access to appropriate investigations**
3. Ensure appropriate IRT
4. Strong clinical leadership

Referrals- where to ?



- Open access Gastroscopy
- Open access Colonoscopy
- Upper GI surgery OPA
- Lower GI surgery OPA
- Gastro clinic OPA
- IDA clinic
- IDA clinic - why gastroscopy AND Colonoscopy???
- 2ww Upper GI
- 2ww Lower GI

Frank blood loss – refer urgent admission

All patients with IDA who are **Coeliac Screen positive** - refer to OPA gastro clinic

Men/ postmenopausal women v Premenopausal women

GI symptoms v No GI symptoms

IDA patients **should not** be referred to open access (non-urgent) endoscopy **clinic**

family hx, travel. {A diagnostic trial of iron treatment should be considered in ALL patients while awaiting investigations (unless colonoscopy imminent) }

Frank blood loss – refer urgent admission

All patients with IDA who are **Coeliac Screen positive** - refer to OPA gastro clinic

men and post-menopausal women-
if IDA and GI symptoms – refer as below

2WW Upper GI- Surgeons if

Weight loss, abdominal pain, dyspepsia, altered bowel habit, reduced appetite, nausea/vomiting, Fhx upper GI cancer

2WW Lower GI surgeons if

abdominal pain, abdominal mass, altered bowel habit, painless rectal bleeding /FIT test +ve, raised faecal calprotectin, blood in stools, Fhx lower GI cancer

Men and post-menopausal women
If IDA and NO GI symptoms
Or Premenopausal women with IDA and upper GI symptoms
Refer to IDA Clinic

- All men and post-menopausal women will havegastroscopy/ D2 biopsies and colonoscopy then 3 months of oral iron
- Premenopausal women will have TTG screen/gastroscopy and D2 biopsies

Then assessment for small bowel capsule

Then review by gastro consultant or haematology

IDA patients **should not** be referred to open access (non-urgent) endoscopy **clinic**

IDA clinic

If men / postmenopausal women with IDA and **NO** GI symptoms Or premenopausal women with Upper GI symptoms

Q15.Why Dual endoscopy – gastroscopy and colonoscopy

- 1/3 IDA have potentially significant GI pathology
  - 1/3 of the 1/3 (1/9) have stomach/ large bowel cancer

- Dual unrelated pathology !

IDA clinic - plus

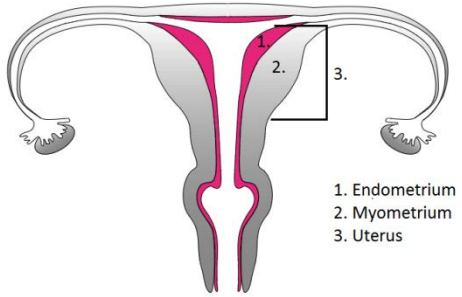
- If endoscopy negative / recurrent IDA / or inadequate response to IRT
- Small bowel capsule inv – mucosal lesions
- Vascular lesions- angioectasia

- CT /MRI ???
- Review with Gastro consultant/ haematology consultant
- Stacey input

Cases- how would you manage them ?

Case Lynn 45 yr old

- SOB on climbing stairs
- Heavy periods
- Hb 7 Ferritin 10 transferrin <20%
- Q. How would you manage Lynn ?
- Referred to AMU pulse 110
- Oral iron and tranexamic acid
- US pelvis
- Gynae



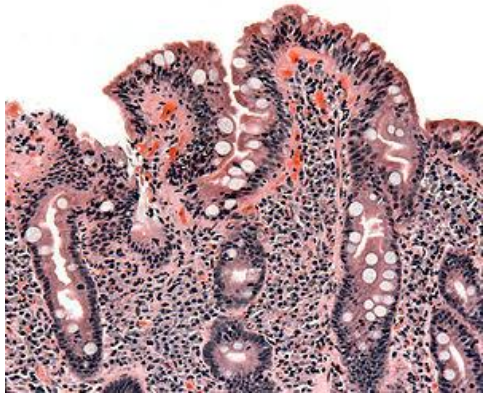
Case – 60 yr old Arnold

- Restless legs syndrome
- Clopidogrel
- No GI symptoms
- Hb 10.8, ferritin 10 Transferrin <20%
- Q. How would you manage Arnold ?
- Coeliac serology / urine dipstick – negative
- ? IDA clinic

36yr old Samantha

- IBS type symptoms
- TATT, 2 kids
- Hb 11 ferritin 20 transferrin < 20%
- Q. How would you manage Samantha ?

- Coeliac screen - anti endomyselial antibody positive –
- OPA Gastro clinic



Gary 36 yr old

- Loin pain, fever , dysuria
- Urine dipstick – wcc, blood
- MSU and antibiotics
- MSU negative

- 3/12 later – same
- Urine dipstick WCC, blood
- MSU negative

- 3/12 later same
- Urine dipstick wcc, blood
- MSU – negative
- FBC , U+E,
- Hb 11 Ferritin 28   Refer 2ww Urology
- Renal Cancer - 2 weeks nephrectomy

50 yr old Masood

- Dyspepsia 6/12 ,weight loss 2.5 stones in 3 months
- Hb low, ferritin, transferrin low
- Q. How would you manage Masood ?

- 2ww upper GI

- Oesophageal Cancer
- Died within 6/12

57yr old Simon

- 6/52 diarrhoea   day and night
- Poor appetite ,weight loss
- Hb 9.0
- Ferritin high
- CRP high

Q. How would you manage Simon ?

- 2ww lower GI
- IBD – Ulcerative Colitis – come back to this later ..

Any questions on Referral of IDA?

- Dr.Kapur

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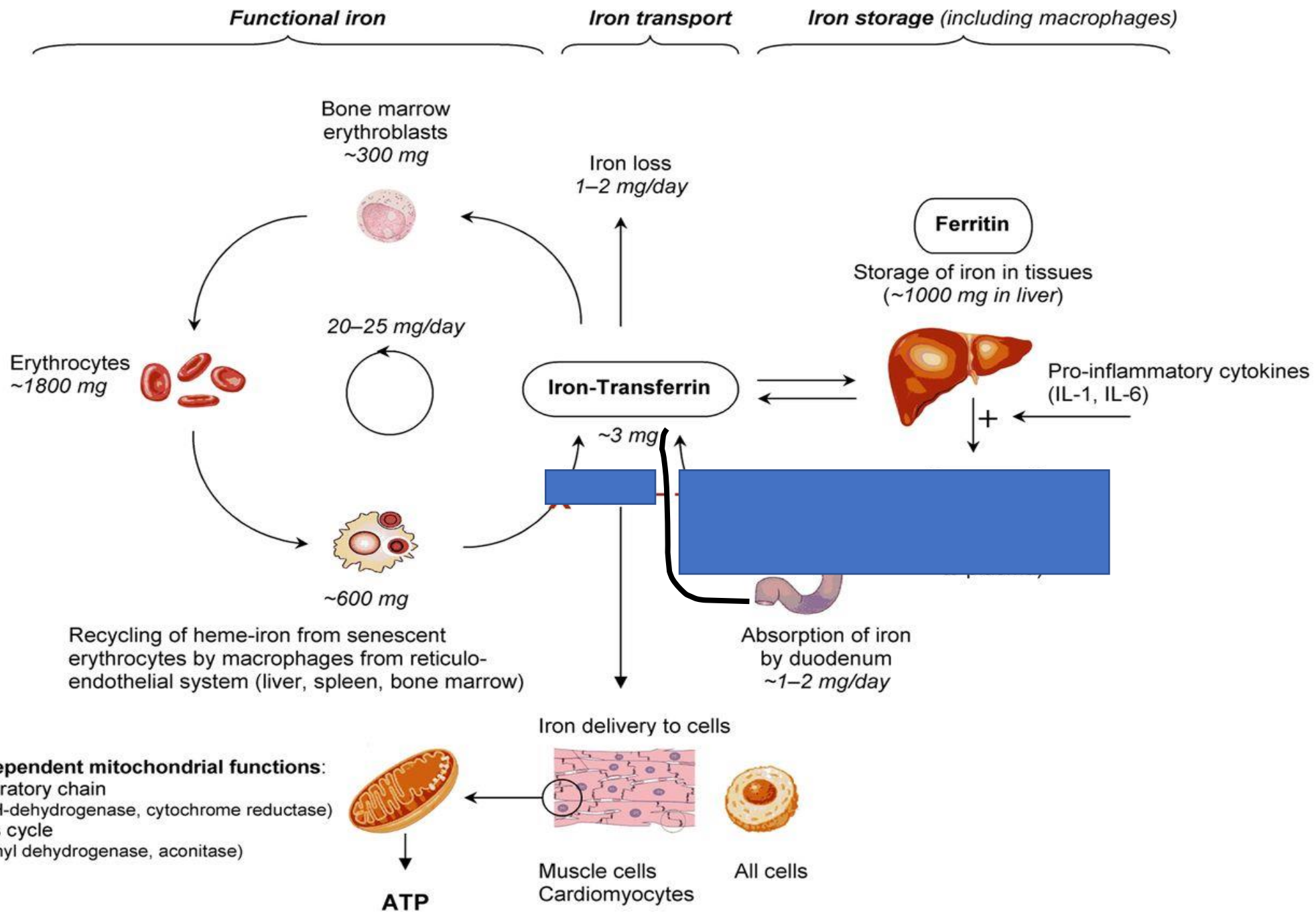
Iron replacement Therapy IRT – aims *

- Restore normal circulating Hb
- Replenish normal body Iron stores
- Improve quality of life
- Improve physiological function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IRT - Iron replacement therapy- 8 questions (paper please)

Q1. Ferrous fumarate (Galfer) and Ferrous sulphate (rarely Sytron) only IRT available for adult IDA in Barnsley primary care ? T/F

Q2. Diagnostic trial of Oral Iron for premenopausal women only? T/F

Q3. Daily recommended oral elemental iron

(50-100 mg) / (100-200 mg) ?

Q4. bd/tds – which regime is most effective?

Q5. Iron tablets are best taken daily ? T/F

Q6. Iron MR tablets are better tolerated and should be tried if necessary ? T/F

Q7. Empty stomach or with food if side effects of oral Iron? T/F

Q8. Iron tabs are best be taken with orange juice as Vitamin C helps with Iron absorption ? T/F

Q9. Oral Iron tablet should be given for 3/12 in total ? T/F

Q10. The Rate of non compliance for IRT is about 25%? T/F

Research on dosing of IRT

- 60 mg od v 60 mg bd
- 200mg alternate day v 100mg od
- 15 mg v 50- 150mg

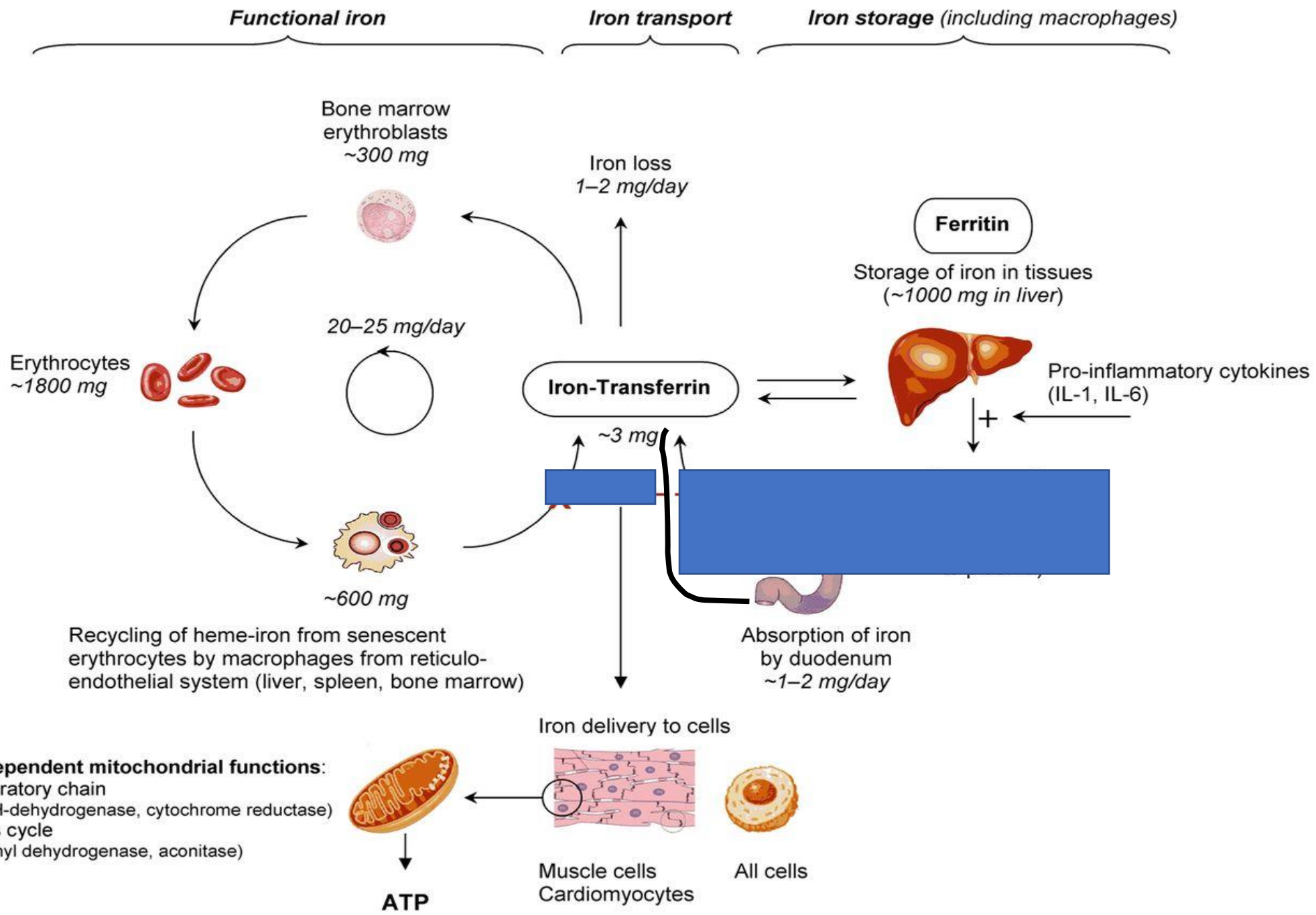
- How can Iron OD/alternate days be as effective as same dose BD/TDS / daily ?

HOW? WHY?

HEPCIDIN!!!

What is it ?

What does it do?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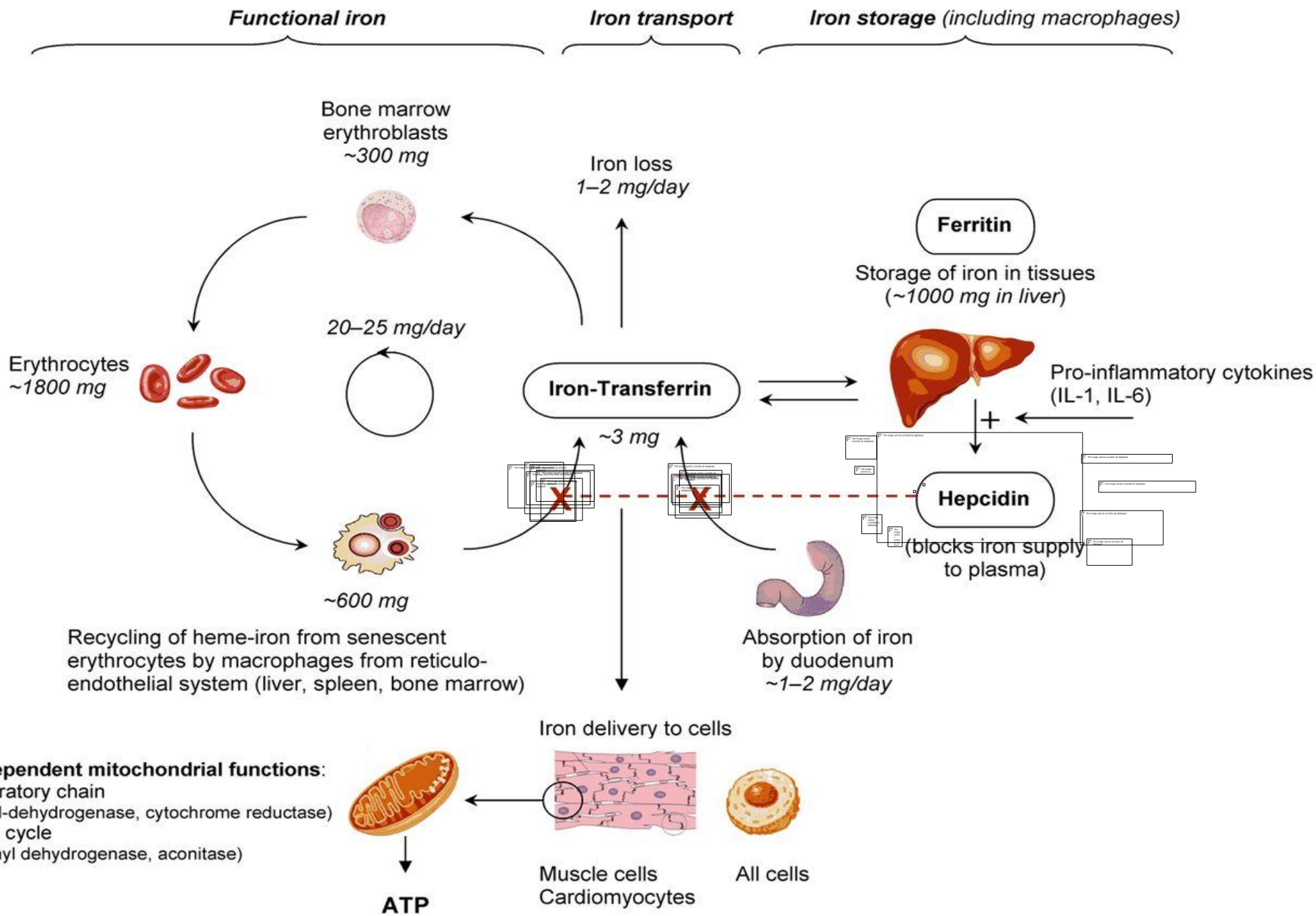
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Pro-inflammatory cytokines
(IL-1, IL-6)
+
Hepcidin
(blocks iron supply
to plasma)
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Recycling of heme-iron from senescent
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by duodenum
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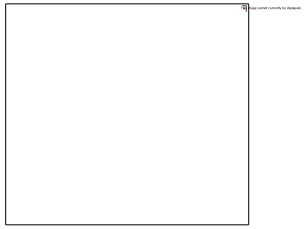
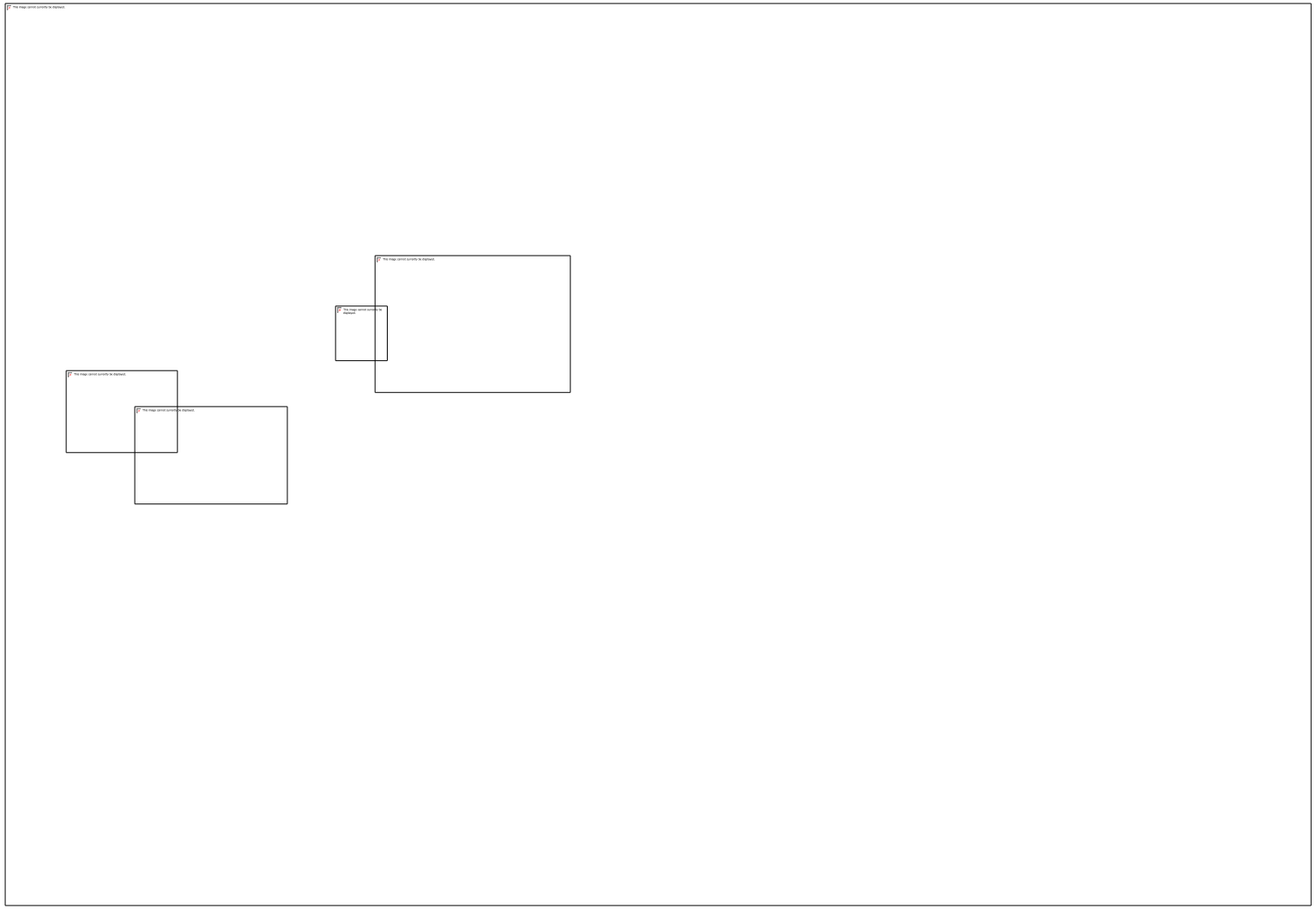
ATP
Muscle cells
Cardiomyocytes
All cells

HEPCIDIN ! 24 hrs





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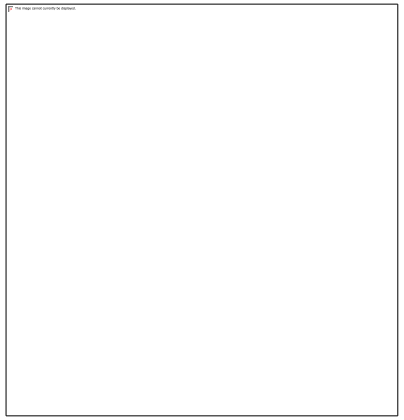
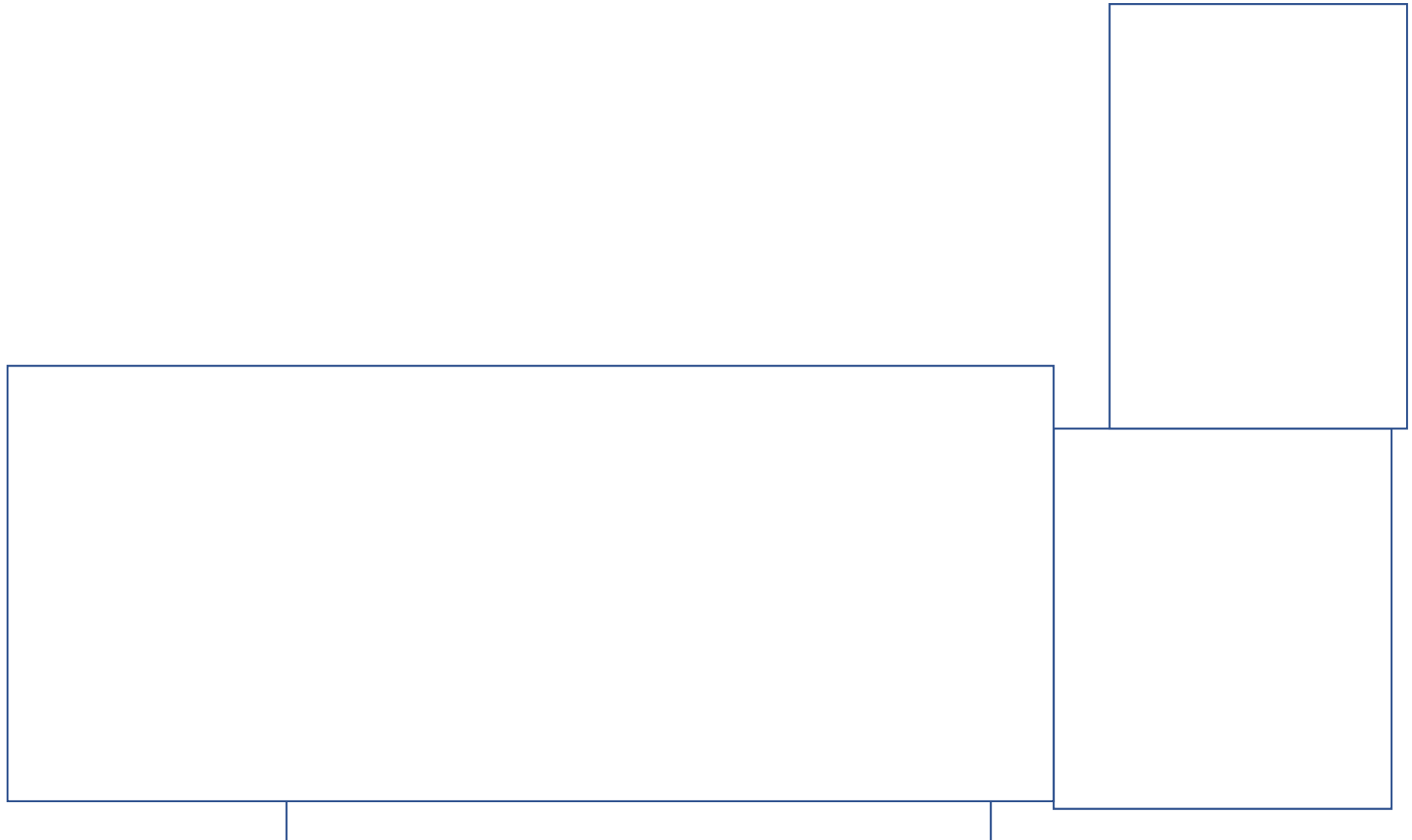




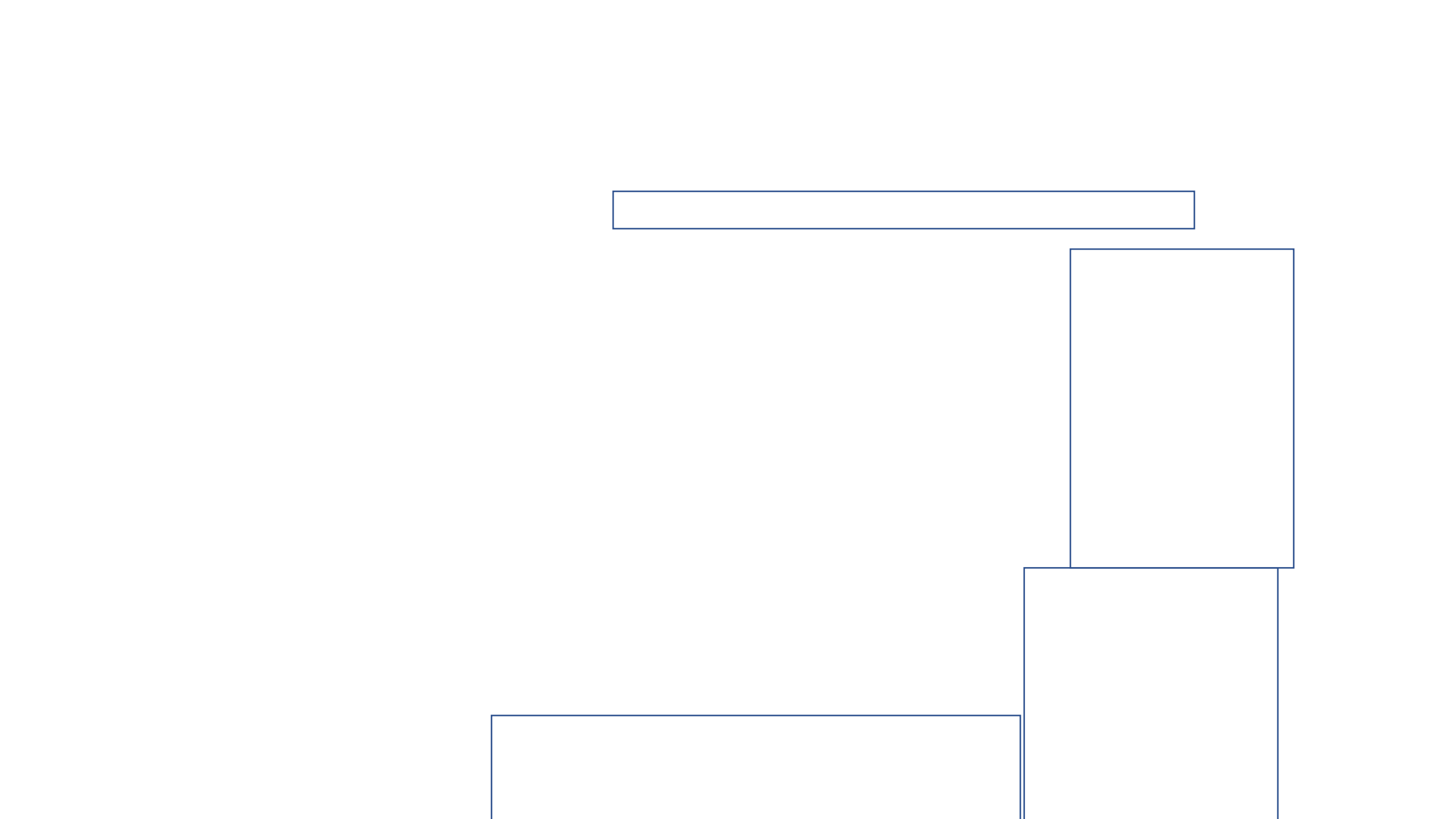
When to check Hb response ?

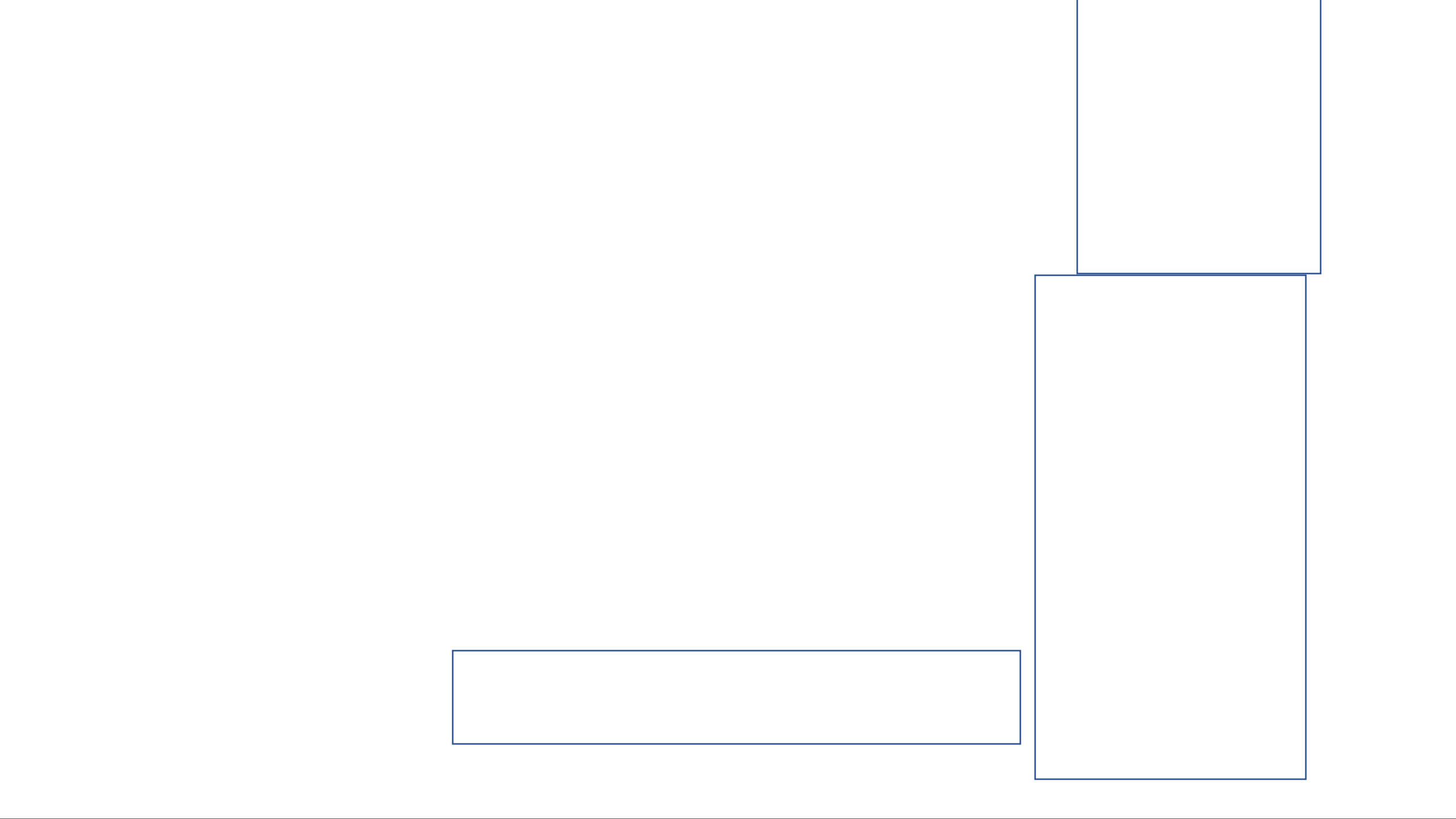
- 2 weeks - ideally
- 4 weeks - practically

- Expectation ?
- How long would you continue IRT?
- normal Hb + 3 MONTHS
- IRT 2-4 weeks with a 10-20g/L rise in Hb is sensitive for diagnosis of IDA !!!

Failure to respond

- Non- compliance !!! What %?
- Malabsorption
- Systemic disease
- Bone marrow pathology
- Haemolysis
- Continued bleeding
- Concurrent deficiency of vit B12 and folate



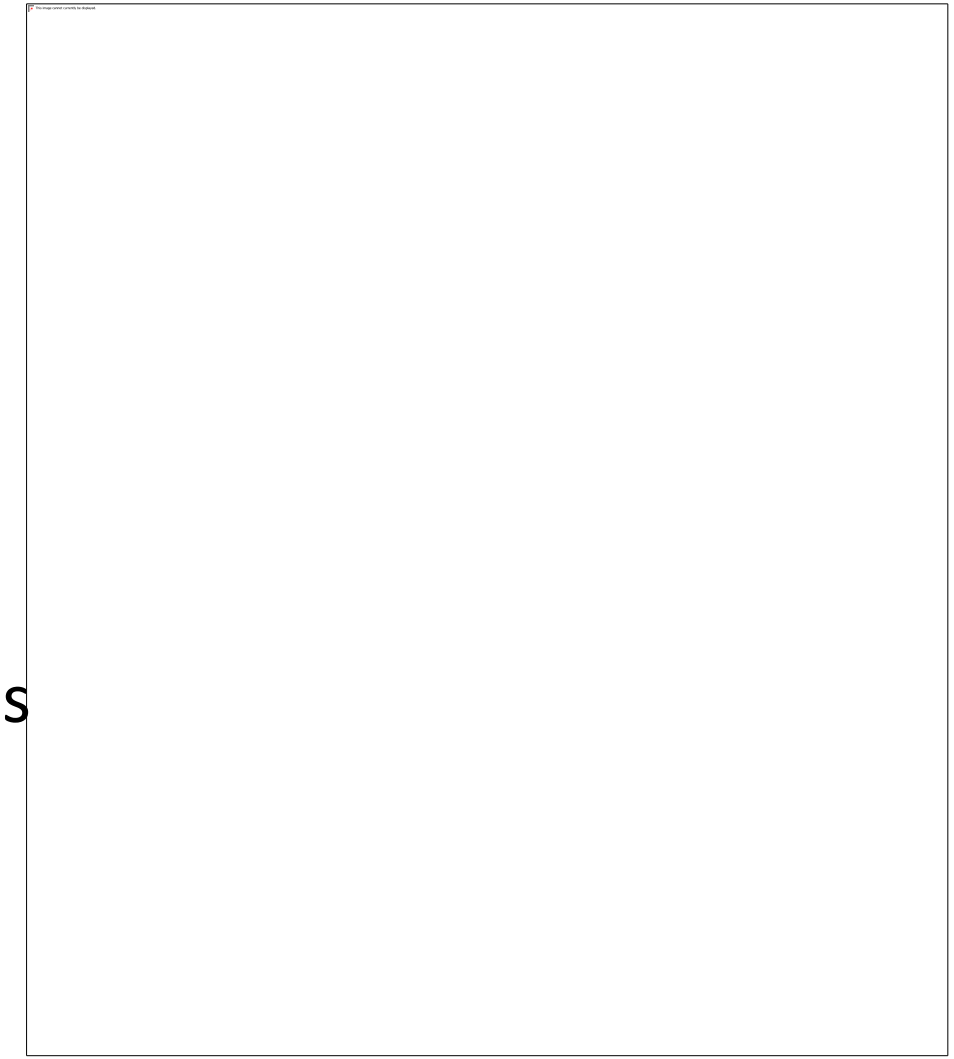


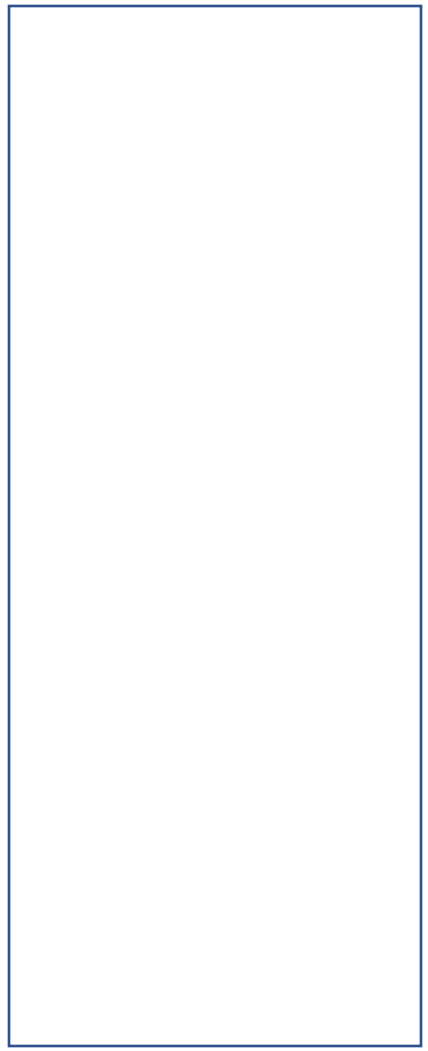
Ferric maltol (Feraccru) 2nd line

- Low iron content
- Slow loading
- Inc compliance

- Dosage 30 mg bd (Dr.Snook)
- Response 6 weeks
- 3 months max to see if Hb improves

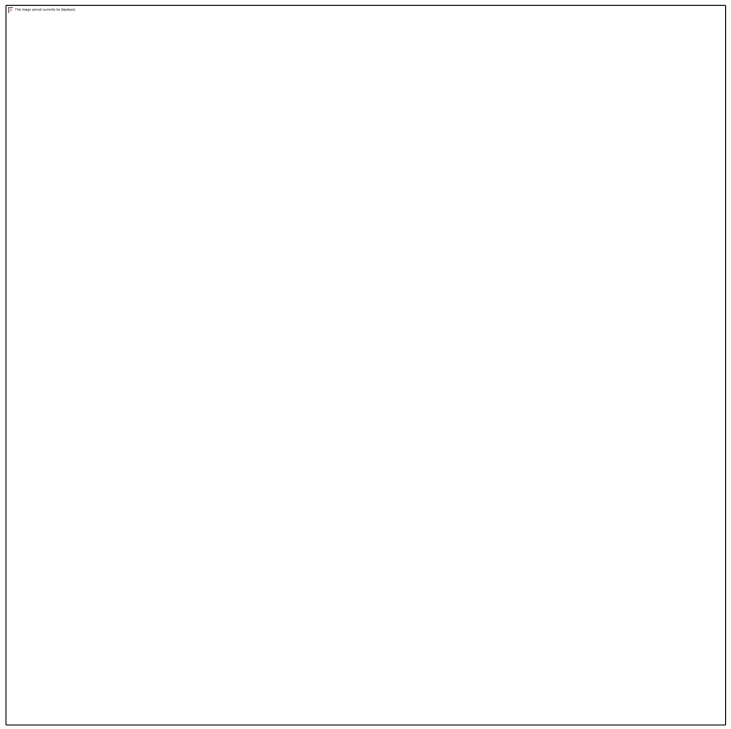
- APC / LMC approved





3rd line - IV Iron

- If oral Fe ineffective/ not tolerated / CI
- **Ferinject**



Patient journey- for Iron infusion

1st

GP

Iron infusion

IDA clinic - vet and prescribe FERINJECT

Referrals that do not meet the criteria, to be resent to GPs with IDA pathway and reason why referral refused

Referral- accepted

PIU – for iron infusion

Appointment for Iron infusion

PIU

Discharge letter to GP
With FERINJECT follow up letter

GP

3/12 check FBC

2nd

GP

Iron infusion

Repeat referral to IDA clinic

PIU

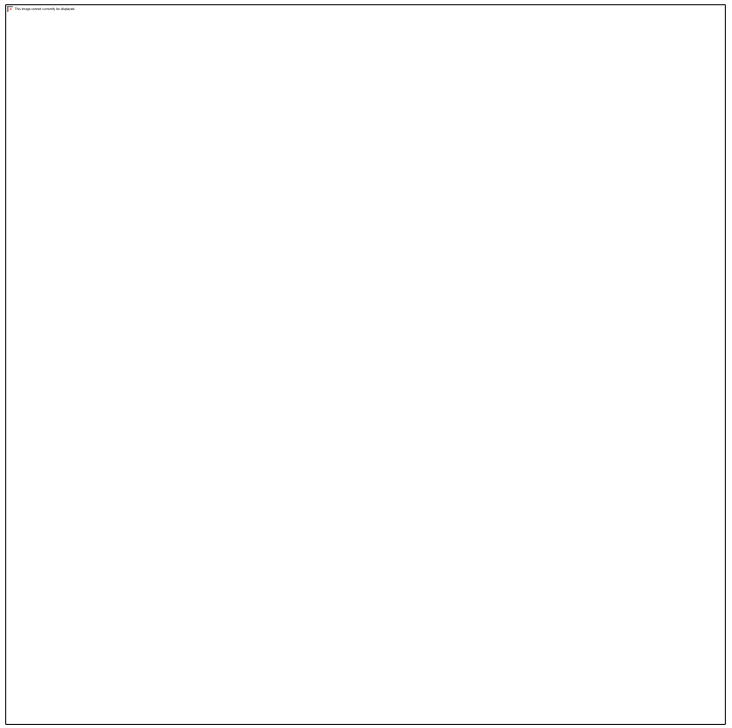
Discharge letter to GP
With FERINJECT follow up letter

GP

3/12 check FBC

Ferinject

- How its given
- What effect it has
- Side effects –Ana/hyper/common/ rare
- IRT – NOT TO TAKE FOR 5 days post infusion
- What follow up needed



- Hypophosphatemia ! = osteomalacia
- Questions- Hospital meds Mx - tel number 01226 432857

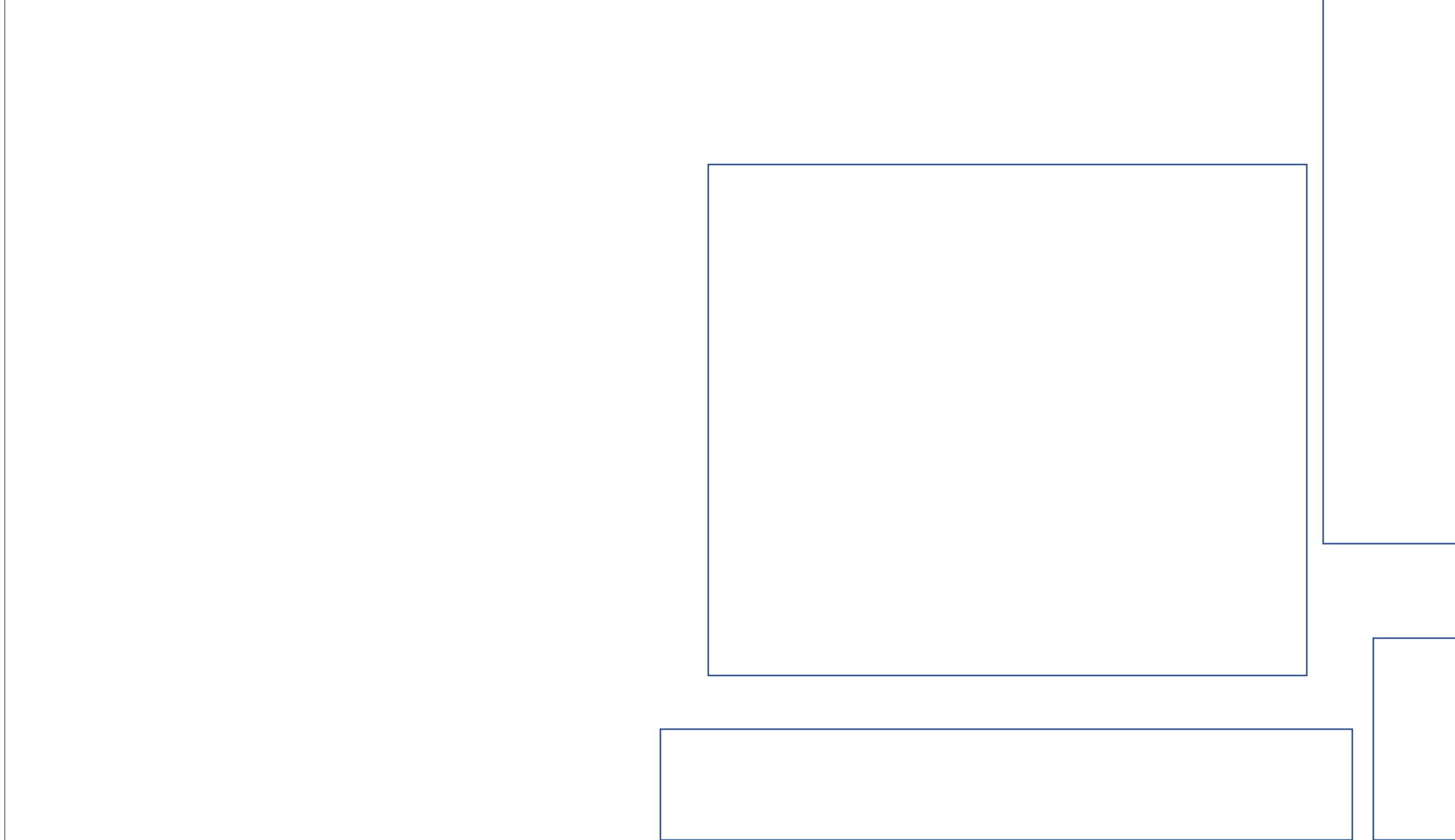
Patient & GP Ferinject leaflets

PIL- Ferinject

- What is Ferinject
- Why do we give it?
- When do we give it?
- Are there any risks?
- When should Ferinject not be given?
- How is the infusion given?
- Follow up?

Follow up

- Hb normalises with IRT (3 months extra IRT- post Hb normalisation)
- Majority of patents will have unexplained IDA
  - -ve BDE
  - No evidence of CD
  - No other symptoms
  - Complete sustained haematological response to IRT
- Periodic FBC measurement – 3/12ly , then 6-12 mthly for 2-3 yrs
- NOT FERRITIN
- HOWEVER IDA recurs in minority 12-25%
- IF chronic unexplained diarrhoea/ wgt loss/ persistent elevated inflammatory markers / persistent- recurrent IDA – rerefer



IRT - Iron replacement therapy- 10 questions

Q1. Ferrous fumarate (Galfer) and Ferrous sulphate (rarely Sytron) only IRT available for adult IDA in Barnsley primary care ? T/F

Q2. Diagnostic trial of Oral Iron for premenopausal women only? T/F

Q3. Daily recommended oral elemental iron

(50-100 mg) / (100-200 mg) ?

Q4. bd/tds – which regime is most effective? Nil

Q5. Iron tablets are best taken daily ? T/F / ??

Q6. Iron MR tablets are better tolerated and should be tried if necessary ? T/F

Q7. Take IRT on an empty stomach or with food if side effects of oral Iron? T/F (70%)

Q8. Iron tabs are best be taken with orange juice as Vitamin C helps with Iron absorption ? T/F

Q9. Oral Iron tablet should be given for 3/12 in total ? T/F

Q10. The Rate of non compliance for IRT is about 25%? T/F

Different groups – any difference in Tx?

- NAID
- Young women
- Young men
- Elderly
- Special conditions
  - CKD
  - CHF
  - IBD
  - GI surgery

Special cases

- Mrs EG 31 – TATT
- Hb 129
- Ferritin 12

- Is she anaemic?
- Would you treat her with Iron tablets ?

Special cases -NAID

Norm		
Normal Hb		
Normal Ferritin		

Special cases -NAID

Norm		**IDA**
Normal Hb		Low Hb
Normal Ferritin		Low ferritin

Special cases -NAID

Non Anaemic Iron Deficiency/ isolated hypoferritinaemia

Norm	**NAID**	**IDA**
Normal Hb	Normal Hb	Low Hb
Normal Ferritin	Low ferritin	Low ferritin

Special cases -NAID

Non Anaemic Iron Deficiency/ isolated hypoferritinaemia

Norm	**NAID**	**IDA**
Normal Hb	Normal Hb	Low Hb
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	>50% premenopausal !!! Men / postmenopausal women	

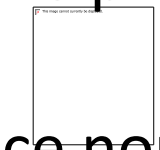
Special cases -NAID

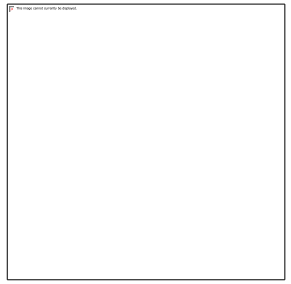
Non Anaemic Iron Deficiency/ isolated hypoferritinaemia

Norm	**NAID**	**IDA**
Normal Hb	Normal Hb	Low Hb
Normal Ferritin	Low ferritin	Low ferritin
	>50% premenopausal !!! Men / postmenopausal women	
	IRT – if symptomatic fatigue, mental quality of life / subjective cognitive function	

Special cases – young women

- Case
- Miss EM – 18 yr old … Tired …..Hb low, ferritin low , transferrin low
- What next?
- Coeliac screen – ve
- Oral Iron 1 st line – nausea
- 2nd line - constipation /abdo pain
- Try alternate day - doesn't help
- Rx Ferric maltol (Ferracru)
- Monitor FBC monthly -- once normal – continue 3 months of IRT
- Check FBC 3/12 ly for a year





Special cases – young women and IDA ?

- Common- 1/10 HEALTHY YOUNG menstruating women
- GI pathology – uncommon
- CD - tests
- IDA clinic - Endoscopy if
  - Non menstruating
  - RED flags / GI symptoms
  - FHx- two 1st degree relatives/ one 1st degree relative <50
  - Recurrent/ persistent IDA

Special case- young men

- Uncommon
- Treat it seriously
- GI pathology yield high
- Coeliac/ malabsorption

Special cases- the Elderly and IDA

- How does Anaemia effect the elderly ?
  - Physical performance
  - Cognitive function
  - Frailty
- How common is Anaemia in the elderly?
- > 50 % of nursing home residents !
- > 20% of 85 yr olds
- > 50% have Vit B12 / folic acid deficiency

Why IDA so common in the elderly?

- Chronic Disease eg CKD/CHF – ferritin v transferrin
  - But still exclude another cause if possible
- Poor diet
- Decreased iron absorption
- Occult blood loss
- Medication eg aspirin and mucosal lesions

Special cases- the Elderly and IDA

- GI pathology yield higher
- CD serology sensitivity is low
- GI malignancy high
- DUAL pathology common

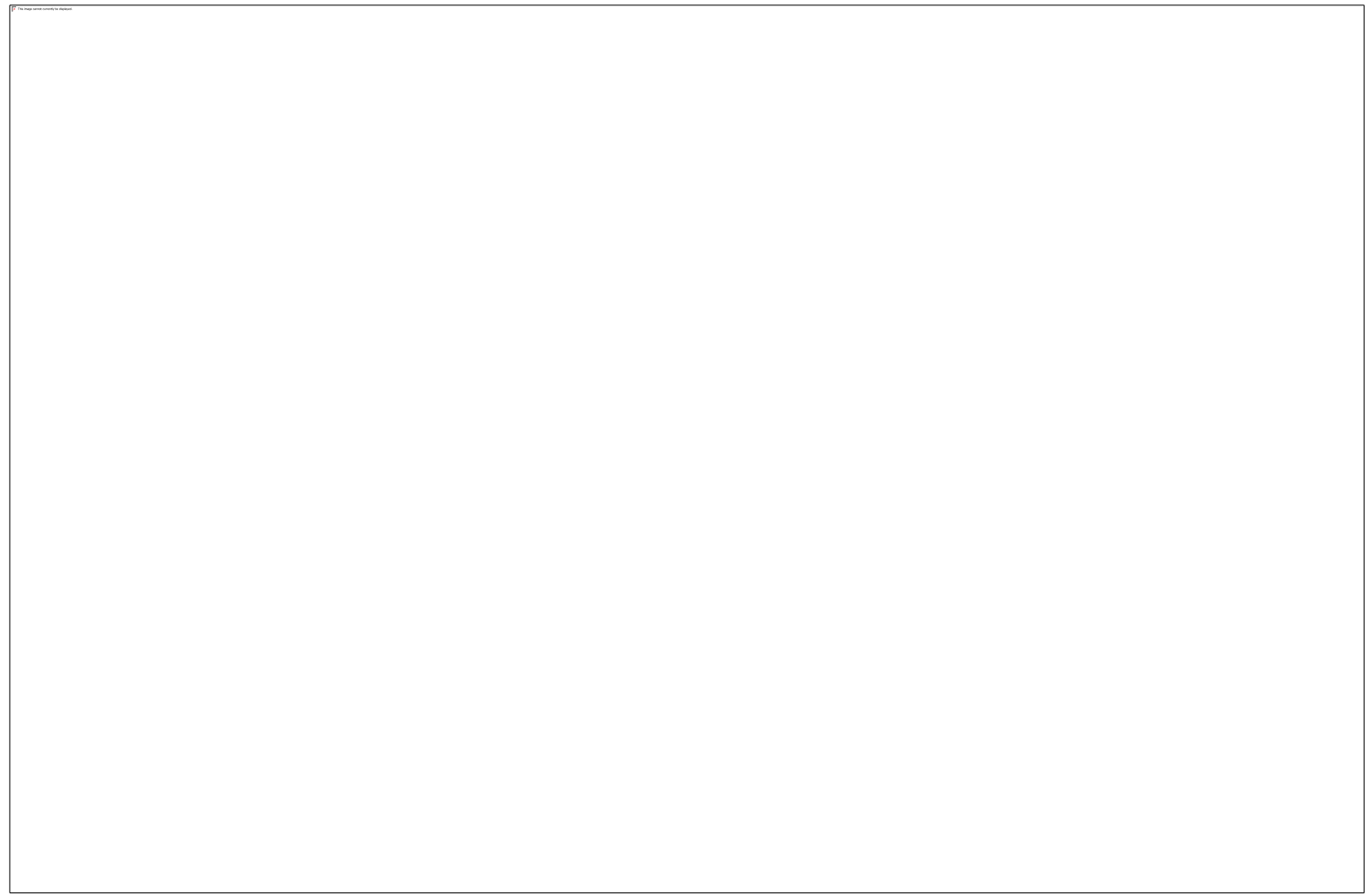
- Thus dual endoscopy and D2 biopsy
- Risks v benefits of inv
- Colonoscopy v CT colonography v colon capsule

Colon Capsule Endoscopy

By Stacey Ward

What Is Colon Capsule Endoscopy?

- **Colon capsule endoscopy (CCE) is a non-invasive technique for diagnostic imaging of the colon.**
- **It does not require air inflation or sedation**
- **allows minimally invasive and painless colonic evaluation**


The maps server currently for displayed.

Indications when to consider colon capsule endoscopy

- When patient refuses colonoscopy and CTC.
- Patient not fit for colonoscopy (cardio/ respiratory medications).
- CTC is contraindicated or inconclusive.
- Low index of suspicion for cancers / polyps.
- Follow up of treatment for IBD.
- Abdominal pain if thought to be appropriate.

(Colon capsule is not a replacement of colonoscopy. Colonoscopy remains the gold standard investigation of the large bowel.)

COLON CAPSULE VERSUS CT COLONOGRAPHY

- **In cases of incomplete colonoscopy, several radiological methods have been traditionally used, but more recent research has shown capsule endoscopy to be fairly accurate and of good exclusion value provided the prep is adequate and transit complete.**

COLON CAPSULE VERSUS CT COLONOGRAPHY

100 Patients with incomplete colonoscopy underwent CTC and CCE.

- CCE detected 24.5% of patients with polyps >6mm
- CTC detected 12.2% of patients with polyps>6mm

This indicating a significant increase in sensitivity for lesions >6mm.

There is a miss rate with CCE dependant on prep and transit and hence choosing the appropriate patient is important

Colon Capsule Endoscopy at BDGH.

- Currently performing up to 2 colon capsule endoscopy procedures per week. (Increased from approx. 20 per year since Covid 19)
- Patient are dated within 2 weeks of referrals.
- Colon Capsule Endoscopy procedures are reviewed and reported within 2 week of the patient having the procedure.
- Dedicated specialist nurse to council patient prior to procedures providing information and support.
- Support patient's through their procedure.

Proposed New Pathway

When to consider colon capsule endoscopy:

- **Colonoscopy cancelled due to uncontrolled Blood pressure.**
- **Colonoscopy cancelled due to Tachycardia/ Bradycardia/ cardiac issues. (Capsule to be done if deemed appropriate and safe by the clinician.)**
- **Colonoscopy abandoned procedure due to difficult colon / patient pain.**
- **Colonoscopy abandoned due to poor prep and colonoscopy not available within 24hours. (Patient to remains fasted and further prep given).**
- **Patients refusing colonoscopy that don't require biopsies (This may help reduce demands on GA list)**

Benefits

- **Improve existing patient pathway.**
- **Reduce the number of patients having to be rebooked for colonoscopy.**
- **Help reduce endoscopy waiting times.**
- **Prevent patient's having to isolate again prior to procedure. Often taking time off work.**
- **Prevent patient having to retake bowel prep.**

Special cases- the Elderly and IDA

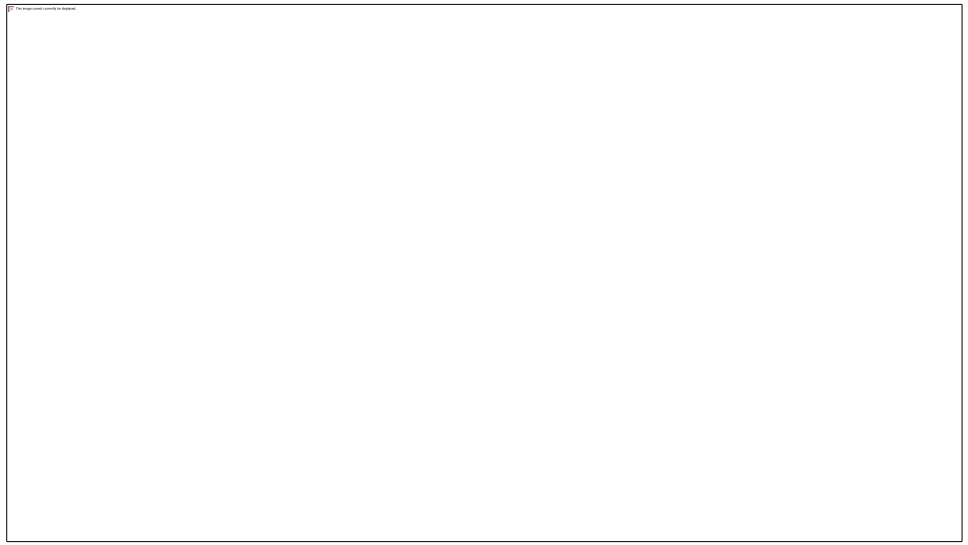
- Some no cause identified - then what?

- Oral iron long term
- if oral iron not tolerated then parentral iron

Special cases- CKD and IDA

- COMPLEX!!!!!
- Anaemia risk if what GFR value?
- GFR< 60ml
- GFR < 30 mls!!!

- Functional AND
- Blood loss from dialysis/ phlebotomy
- Leave to nephrologist ☺



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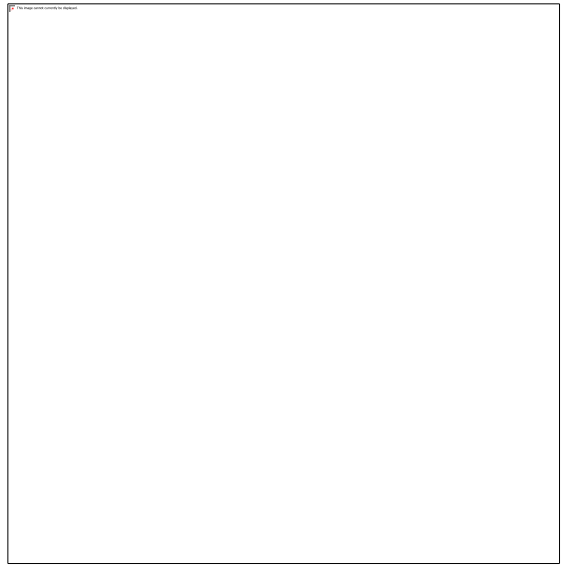
Special cases- CHF and IDA

- 40-70% anaemic – poor function/ poor QOL/ poor prognosis
- Multifactorial – why?
- Malabsorption
- Malnutrition
- GI blood loss
- Chronic inflammation
- Liver - inc hepcidin release



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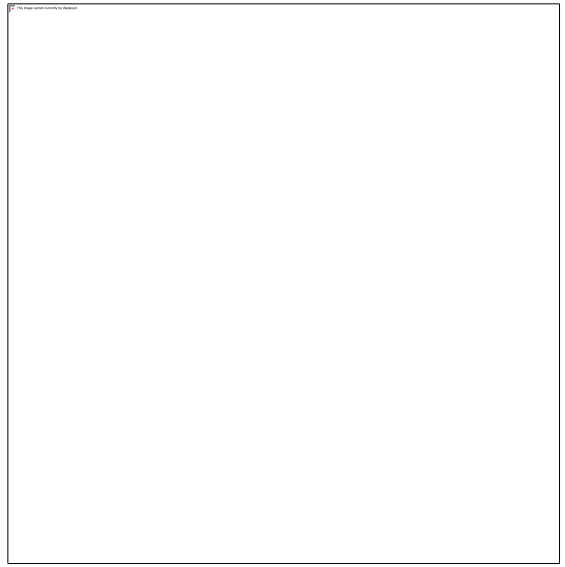
Special cases- CHF and IDA

- IRT in CHF ? How?

- Avoid oral IRT in CHF- why?
  - Poor absorption secondary to gut oedema
  - Inc side effects

- Consider IV IRT sooner rather than later



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Special cases- IBD and IDA

- How many IBD patients IDA?
- 1/3 patients
- Many vit B12 and folate deficient as well
- Marrow suppression- chronic disease
- GI blood loss
- Decreased Iron absorption
  - bowel inflammation
  - systemic inflammation
  - small bowel involvement
  - small bowel surgery

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Special cases- IBD and IDA

- THINK carefully about IRT

- Oral Iron – no more than 100 mg elemental iron / day
- Recheck 3/12 ly even if inflammatory markers normal

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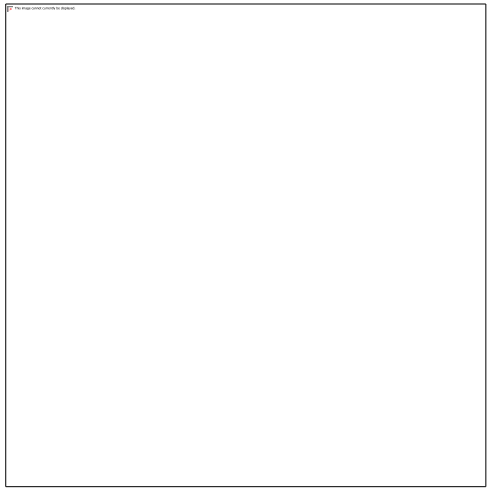
Special cases- GI surgery and IDA

- IDA develop over 10 yrs in some patients

- Partial gastrectomy can predispose to gastric cancer later in life
  - So don’t blame IDA on surgery alone



Where to find this extremely useful Barnsley IDA guidelines ?

BEST website

IDA questions/Answers

- How Common is IDA in premenopausal women ? 1/10
- How Common is IDA in nursing/residential care homes? > 50%
- To Diagnose anaemia you need to have - low HB and low ferritin? T/F/??
- My confidence with DIAGNOSIS of IDA- 8-9/10
- My confidence with WHERE TO REFER my IDA patients 8-9/10
- My confidence with IRON REPLACEMENT THERAPY 8-9/10

Management of IDA – different groups?

- Young women √
- Young men √
- Elderly √
- Special conditions
  - CKD √
  - CHF √
  - IBD √
  - GI surgery √
- What is NAID? √

BMJ / GUT article Oct 2021
Highly affective care of IDA patients 4 components

1. Confirmation of IDA
2. Timely access to appropriate investigations
3. Ensure appropriate IRT
4. **Strong Clinical Leadership**

Barnsley IDA pathway 2019-2021

- Dr.Kapur Gastro Consultant *
- Dr.Cuttings – Haematology Consultant
- Dr.Chan – Haematology Consultant
- Dr.Ghani
- Michelle *
- Stacey – IDA clinic *
- Katherine – Meds Mx *
- Ruth - Meds Mx
- Chris Lawson- meds Mx
- Gillian- Hospital Mx
- Vickey- PIU
- Katherine- GI service manager
- GPs- Dr.Chilikuri, Dr.Birinder, Dr. Ahmed
- + more …….

IDA is NOT and Orphan in Barnsley