

Forenames

Lastname

Hospital No.

D.O.B.

## SDEC IRON DEFICIENCY ANAEMIA (IDA) PATHWAY

### PATHWAY EXCLUSION CRITERIA

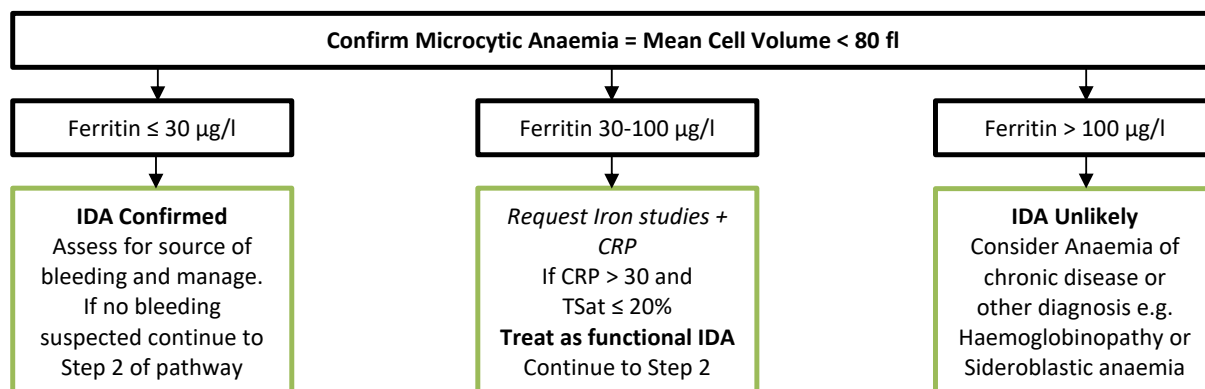
**PATIENTS MUST NOT BE AMBULATED FROM ED WITHOUT REVIEW ON 1B SDEC**

EXCLUDED FROM PATHWAY (Tick reason below) ☐

- |                                                                                   |                                                                |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> If UGIB suspected refer to UGIB pathway                  | <input type="checkbox"/> Macrocytic or Normocytic Anaemia      |
| <input type="checkbox"/> Pregnancy                                                | <input type="checkbox"/> Haematuria suspected as cause of IDA  |
| <input type="checkbox"/> Haemodynamic Instability                                 | <input type="checkbox"/> Menorrhagia suspected as cause of IDA |
| <input type="checkbox"/> Co-existing medical condition preventing Ambulatory Care |                                                                |

### STEP 1: CONFIRM IRON DEFICIENCY ANAEMIA

- ☐ Request FBC, U&E, LFT, Ferritin, B12, Folate and Urinalysis



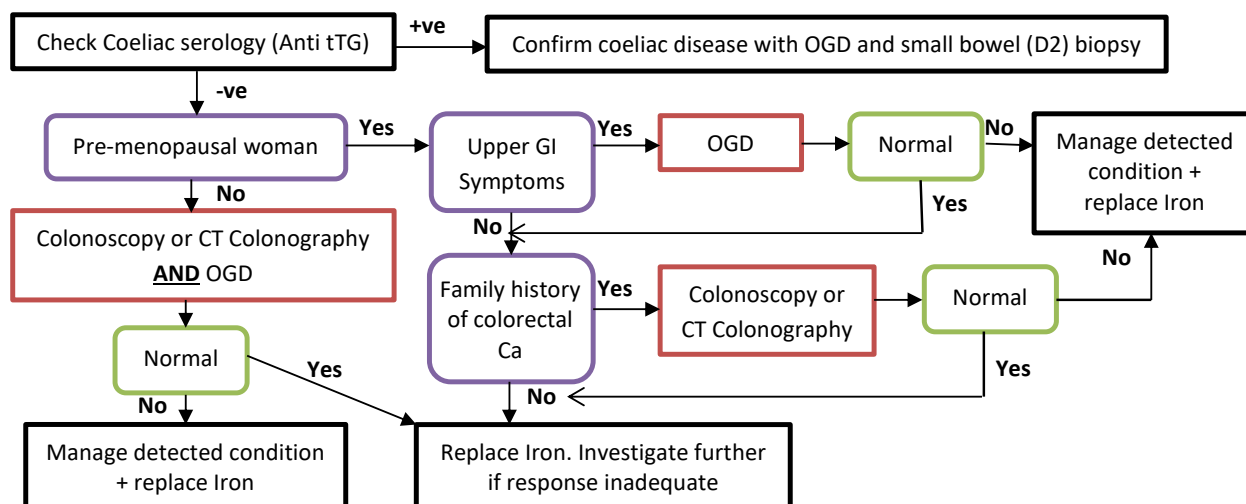
### STEP 2: INVESTIGATION AND REFERRAL FOR IDA

#### Suspected Cancer Referral Criteria:

Male of any age with unexplained iron deficiency anaemia Hb ≤ 120g/L

Female (non-menstruating) or ≥ 50 year of age with unexplained iron deficiency anaemia Hb ≤ 100g/L

If Gastroscopy & Colonoscopy/CT Colonoscopy have been performed within the last 3 years then the patient best managed by their GP who will assess and decide on treatment or onward referral. Otherwise follow flowchart below



#### Guidance for Colonoscopy vs CT Colonography vs CT Contrast without bowel prep

Colonoscopy is the first line investigation and should always be preferred when there are lower GI symptoms. CT Colonography is an acceptable alternative such as in the presence of major comorbidities. It is less invasive, doesn't require sedation and provides limited imaging of other viscera. It may however miss more subtle mucosal pathology such as vascular malformations. CT without bowel prep has a limited place in those with major comorbidities and will only identify relatively gross pathology.

The value of investigating patients where the outcome is unlikely to affect management (major comorbidity and/or limited performance status) should be carefully considered taking into account risks, benefits and alternatives

- ☐ Refer for 2 Week rule pathway Investigations (ensure this is indicated on request on CareFlow)

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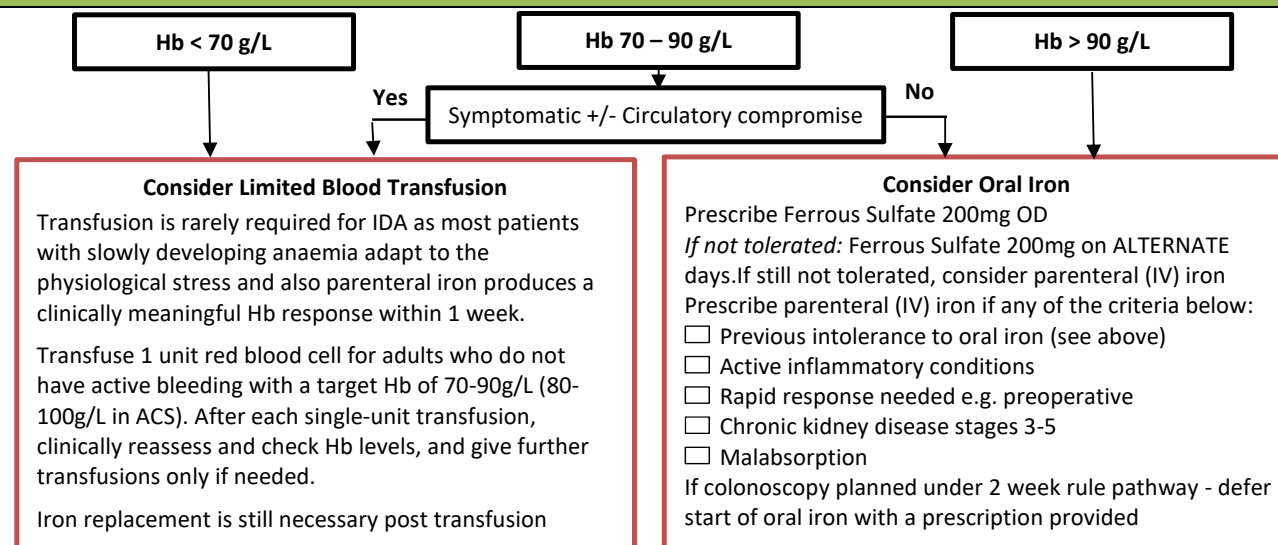
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### STEP 3: TREATMENT OF IDA



### STEP 4: PRESCRIBING FERRIC DERISOMALTOSE "MONOFER" (PARENTERAL (IV) IRON) FOR PATIENTS ≥ 18 YEARS OLD. REFER TO SPC FOR PRESCRIBING INFORMATION. (PRESCRIBE ON EPMA).

TOTAL Dose Required if haemoglobin <100 g/dl				
Weight < 50kg		Weight 50kg to 69kg		Weight ≥70 kg
500mg		1500mg		2000mg
A single Monofer administration should not exceed 20mg/kg				
Weight	Dose 1	Dependent on clinical judgement the second dose administration, particularly if ≤ 200mg, could await follow-up haemoglobin check 4 weeks after the infusion  Patients must be observed for 30 minutes after infusion for risk of hypersensitivity or anaphylactoid reaction using the Monofer® infusion checklist.  Counsel on skin staining and refer to infusion checklist for further monitoring instructions <th>Dose 2 (at least 1 week)</th>		Dose 2 (at least 1 week)
25kg - 49kg	500mg			
50kg	1000mg			500mg
55kg	1100mg			400mg
60kg	1200mg			300mg
65kg	1300mg			200mg
70kg	1400mg			600mg
75kg	1500mg			500mg
80kg	1600mg			400mg
85kg	1700mg			300mg
90kg	1800mg			200mg
95kg	1900mg	100mg		
≥100kg	2000mg			
TOTAL Dose Required if haemoglobin ≥100 g/dl				
Weight < 50kg	Weight 50kg to 69kg	Weight 70kg		Weight ≥75 kg
500mg	1000mg	Dose 1	Dose 2	1500mg
		1400mg	100mg	
Dose of Monofer®	Dilution of 0.9% Sodium Chloride		Administration Time	
≤1000mg	100mL (do not dilute to a concentration less than		15 minutes	
> 1000mg	1mg iron in 1mL)		30 minutes	

### STEP 5: MONITORING & FOLLOW UP

- ☐ It is VITAL that all investigations, referrals and follow up are arranged before discharging the patient home
- ☐ If returning for second Parenteral Iron Infusion document dose and date in discharge letter and give patient a copy
- ☐ Arrange follow up in NSRDS (via CareFlow connect to Inpatient Suspected Cancer Non-Specific Symptoms Team)
- ☐ Complete all information on discharge letter and request GP to repeat FBC after 4 weeks treatment.
  - If improvement in Hb (10 – 20 g/l) - Continue replacement for 2 – 4 months, then re-check Hb
  - If Hb normalised, continue iron replacement for 3 months and check FBC 3 monthly 1 year and 6 monthly 2-3 years
  - If on oral iron and no improvement, consider referral for switch to parenteral iron