Forenames Mersey and West Lancashire Lastname **Teaching Hospitals** SDEC IRON DEFICIENCY ANAEMIA (IDA) **Hospital No. PATHWAY** D.O.B. **PATHWAY EXCLUSION CRITERIA** PATIENTS MUST NOT BE AMBULATED FROM ED WITHOUT REVIEW ON 1B SDEC EXCLUDED FROM PATHWAY (Tick reason below) ☐ If UGIB suspected refer to UGIB pathway ☐ Macrocytic or Normocytic Anaemia Pregnancy ☐ Haematuria suspected as cause of IDA ☐ Haemodynamic Instability ☐ Menorrhagia suspected as cause of IDA ☐ Co-existing medical condition preventing Ambulatory Care **STEP 1: CONFIRM IRON DEFICIENCY ANAEMIA** ☐ Request FBC, U&E, LFT, Ferritin, B12, Folate and Urinalysis Confirm Microcytic Anaemia = Mean Cell Volume < 80 fl Ferritin ≤ 30 μg/l Ferritin 30-100 µg/l Ferritin > 100 μg/l **IDA Confirmed** Request Iron studies + **IDA Unlikely** Assess for source of CRP Consider Anaemia of If CRP > 30 and bleeding and manage. chronic disease or If no bleeding TSat ≤ 20% other diagnosis e.g. suspected continue to Treat as functional IDA Haemoglobinopathy or Step 2 of pathway Continue to Step 2 Sideroblastic anaemia 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 Check Coeliac serology (Anti tTG) Confirm coeliac disease with OGD and small bowel (D2) biopsy Yes Yes Manage detected OGD Normal Pre-menopausal woman Upper GI condition + Symptoms , No Yes replace Iron No 🛊 Colonoscopy or CT Colonography AND OGD Family history Yes Colonoscopy or Normal of colorectal CT Colonography Ca Normal Yes Yes No ← No 🕹 Manage detected condition Replace Iron. Investigate further + replace Iron if response inadequate 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 sedationand 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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SDEC IRON DEFICIENCY ANAEMIA (IDA) PATHWAY

STEP 3: TREATMENT OF IDA Hb < 70 g/L Hb > 90 g/L Yes Symptomatic +/- Circulatory compromise No

Consider Limited Blood Transfusion

Transfusion is rarely required for IDA as most patients with slowly developing anaemia adapt to the physiological stress and also parenteral iron produces a clinically meaningful Hb response within 1 week.

Transfuse 1 unit red blood cell for adults who do not have active bleeding with a target Hb of 70-90g/L (80-100g/L in ACS). After each single-unit transfusion, clinically reassess and check Hb levels, and give further transfusions only if needed.

Iron replacement is still necessary post transfusion

Consider Oral Iron

Prescribe Ferrous Sulfate 200mg OD If not tolerated: Ferrous Sulfate 200mg on ALTERNATE days. If still not tolerated, consider parenteral (IV) iron Prescribe parenteral (IV) iron if any of the criteria below:

- ☐ Previous intolerance to oral iron (see above)
- ☐ Active inflammatory conditions
- ☐ Rapid response needed e.g. preoperative
- ☐ Chronic kidney disease stages 3-5
- ☐ Malabsorption

If colonoscopy planned under 2 week rule pathway - defer start of oral iron with a prescription provided

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

TEXTILO GEST RELETATION OF GEOGRAPHIC TRANSPORT (TRESORDE GIVE TRANS)								
		TOTAL	Dose Required if	haemoglobin <1	00 g/dl			
Weight < 50kg			Weight 50kg to 69kg		1	Weight ≥70 kg		
500mg				1500mg			2000mg	
A single Monofer administration should not exceed 20mg/kg								
Weight		Dose 1				Dose	2 (at least 1 week)	
25kg - 49kg	!	500mg	Denendent on	clinical judger	nent the	a .		
50kg	1	L000mg	•	, ,	stration, particularly if		500mg	
55kg	1	L100mg		could await	_	400mg		
60kg	1	L200mg		check 4 weeks		300mg		
65kg	1	L300mg	infusion	meen i meene		200mg		
70kg	1	L400mg					600mg	
75kg	1	L500mg		atients must be observed for 30 mir			500mg	
80kg	1	L600mg	after infusion fo	•		400mg		
85kg	1	L700mg	anaphylactoid reaction using the Monofer infusion checklist. Counsel on skin staining and refer to infusion				300mg	
90kg	1	L800mg					200mg	
95kg	1	L900mg				1	100mg	
≥100kg	2	2000mg	checklist for furt	checklist for further monitoring instructions				
TOTAL Dose Required if haemoglobin ≥100 g/dl								
Weight < 50kg	Weight < 50kg Weigh		50kg to 69kg Weigl		ht 70kg		Weight ≥75 kg	
500mg		1	000mg	Dose 1		Dose 2	1500mg	
				1400mg		100mg	<u> </u>	
Dose of Monofer® Dilution o			f 0.9% Sodium Chloride		Administration Time			
≤1000mg	000mg 100mL (do not dilute to a concentration less t					15 minutes		
> 1000mg	1mg iron in 1mL)					30 minutes		

STEP 5: MONITORING & FOLLOW UP

- $\ \square$ 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