Primary Care
Women's Health Society

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TOP TIPS

For Managing Iron Deficiency and Iron Deficiency Anaemia

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Top Tips For Managing Iron Deficiency and Iron Deficiency Anaemia

1.

Recommended **daily intake of iron** for women in their reproductive years is 18mg each day (median is 12mg) to combat loss due to menstruation.

2.

Medications

- Drug interactions can affect iron levels, for example, calcium tablets have a short-term effect on iron absorption. Consider discontinuing or suggest separate timing when possible.
- Prolonged use of medications that reduce gastric acid levels, such as proton pump inhibitors, can lead to iron deficiency (ID).

3.

Following commencement of **oral iron therapy**, a further full blood count and serum ferritin level should be undertaken 3–4 weeks later to assess response to treatment.

4.

Most common reason for an **inadequate response** is non-compliance but ongoing loss and inadequate iron absorption due to an inflammatory or malabsorption condition such as coeliac disease may be responsible. Haemoglobin should rise by 20g/L every 3–4 weeks.

5.

To **maximise absorption**, iron tablets should be taken on an empty stomach. Tannins and milk should be avoided but fruit juice containing ascorbic acid taken in conjunction with iron supplements increases their absorption.

6.

Side effects of oral iron therapy include nausea, vomiting, constipation, dark stools, and abdominal discomfort because of free radical-mediated mucosal luminal damage.

7.

Once haemoglobin and serum ferritin levels are normal, treatment should be continued for a further three months. If haemoglobin levels fall below normal, reinvestigation should be considered along with re-provision of iron supplementation.

8.

Parenteral iron

- Parenteral iron is generally reserved for use when oral therapy is unsuccessful, or if there is continuing blood loss, or in malabsorption.
- Side effects of parenteral iron include hypotension, malaise, nausea, vomiting, arthralgia, and abdominal pain. Side effects are more common with iron dextran and less commonly associated with the administration of iron sucrose and iron carboxymaltose.

9.

Serum ferritin is the most reliable indicator of ID, **in the absence of inflammation or chronic disease**. Serum ferritin levels below 15 ng/mL (33.7 pmol/L) are consistent with a diagnosis of iron deficiency.

10.

When **acute or chronic inflammation,** hepatocellular damage and some malignancies are present transferrin saturation is a more useful investigation for assessing ID. A transferrin saturation of less than 16% is indicative of insufficient iron supply for erythropoiesis.