

Iron Deficiency Anaemia

Iron Deficiency Anaemia (IDA) is a significant public health problem in Australia. It is estimated to occur in 2-5% of adult men and postmenopausal women. Gastrointestinal (GI) blood loss from colonic cancer or gastric cancer, and malabsorption in coeliac disease are the most important causes that need to be investigated and referred to a gastroenterologist as delayed diagnosis may result in chronic morbidity.

Symptoms

- Extreme fatigue or weakness
- Pale skin
- Chest pain, palpitations or shortness of breath
- Headache, dizziness or lightheadedness
- Glossitis and angular stomatitis
- Brittle nails

Diagnosis

Iron deficiency should always be looked for if there is anaemia, low MCV or low MCH on a blood count. However, iron deficiency is never a final diagnosis in itself and a cause should always be sought. Common causes include excessive blood loss, inadequate iron intake or inadequate iron absorption from the gut.

Initial Investigations

- Full Blood Count to look at Hemoglobin, MCV, MCH
- Coeliac Serology, Thyroid Function Tests
- Iron Studies: Serum ferritin is the most powerful test for iron deficiency

When to Refer

Red Flags for Urgent Gastroenterologist Referral

- Overt GI bleeding
- Dysphagia
- Persistent heart burn
- Persistent abdominal pain
- Anorexia
- Weight loss
- Change in bowel habit
- Rectal pain

Premenopausal females <50yrs

- Screen for coeliac disease and refer for endoscopy if positive
- Refer for endoscopic investigation if there are red flags, focal symptoms of GI disease, a strong family history of colorectal cancer or persistent IDA after correction of potential causative factors

Postmenopausal females and male patients

- Refer to gastroenterologist for upper and lower GI endoscopy once IDA diagnosis confirmed Iron deficiency in the absence of anaemia
- Refer for endoscopic investigation if aged >50yrs

Differentials

- **Thalassemia**
- **Anaemia of chronic disease**
- **Sideroblastic Anaemia**

First-Line Treatment

Iron supplementation to correct anaemia and replenish body stores is the mainstay of treatment. Blood transfusion should be reserved for patients with or at risk of cardiovascular instability due to the degree of their anaemia.

Follow-up & Monitoring

- In clinically stable patients without significant ongoing blood loss, monitor initial response to iron by repeating Hb at 3 – 4 weeks. Hb should rise 20 g/L.
- If Hb has risen as expected, recheck Hb & iron studies at 2 – 3 months. Hb should be normal. If on oral iron, ensure continued compliance to replete stores (e.g. 3 to 6 months after Hb normal).
- Once iron stores are replenished (confirm with ferritin) & assuming no significant ongoing blood losses, iron therapy can be stopped & iron status monitored



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Dr Raghu Gill is an Interventional Endoscopist with extensive experience in the endoscopic diagnosis and management of diseases of the gastrointestinal tract. Dr Gill has recently started consulting in Burwood and offers immediate appointments for your patients. All privately insured patients are covered by a strictly 'no gap' policy for the procedure and the anaesthetist.

Contact

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