The Investigation and Management of Iron Deficiency Anaemia: An audit

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Background

- IDA occurs in 2-5% of men and postmenopausal women in the developed world. [1]
- 4-13% of gastroenterology clinic referrals arise from a diagnosis of IDA made in primary care.[1]
- Blood loss from the gastrointestinal tract is the commonest cause of IDA in men and postmenopausal women. [1]
- 1% of patients with IDA will have a renal tract maligancy.[1]
- The pretest probability of coeliac disease in those with IDA alone is ~5%.[1]
- IDA is suggested by a serum Hb concentration below the appropriate reference range in combination with a serum ferritin of <15µg/dl (in the absence of inflammatory disease). [1]

Guidelines for the Investigation & Management of IDA[1]

Upper and Lower GI investigation:

- Should be considered in all male and post-menopausal females in whom IDA has been confirmed unless there is a history of significant non-GI blood loss.
- Unless the upper GI endoscopy reveals carcinoma or coeliac disease, examination of the lower GI tract is required. Oesophagitis, erosions, peptic ulceration should not at this stage be accepted as cause of IDA.
- FOB is of no benefit being insensitive and nonspecific.

Urine Dipstick:

- Recommended in all patients.
- US of renal tract if haematuria found on dipstick.

Coeliac Serology:

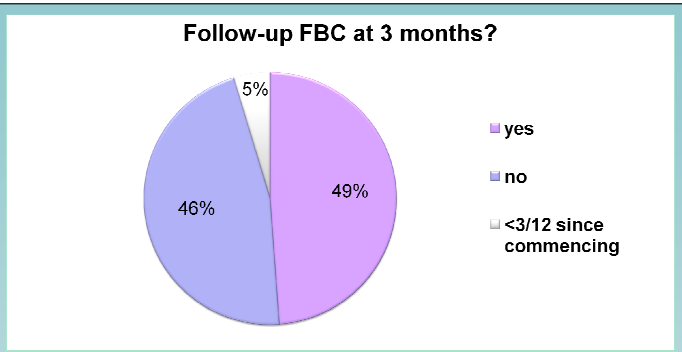
- Coeliac serology should be undertaken at presentation.
- Duodenal biopsy specimens should be taken at OGD if serology not documented.

Investigation of Pre-menopausal women:

- All pre-menopausal women should be screened for coeliac disease.
- GI investigation is recommended for asymptomatic premenopausal women with IDA aged ≥50 years.2
- OGD indicated if IDA with associated upper GI complaints.
- Colonic investigation indicated if presence of colonic symptoms, strong family history or poor response to iron supplementation.

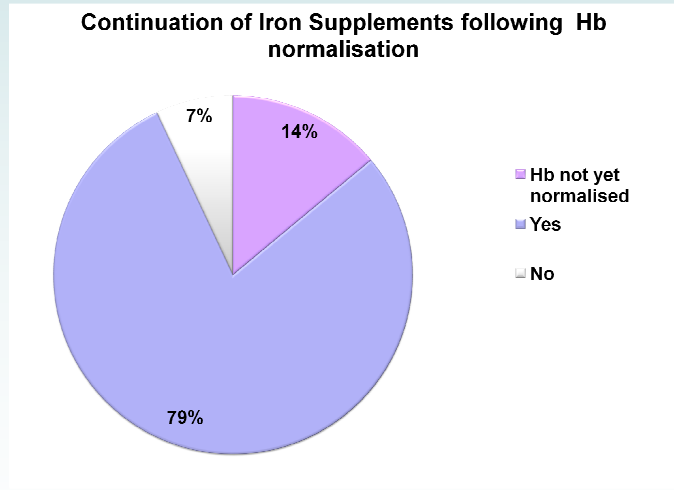
Management

- Iron supplementation is vital to correct anaemia and replenish stores.
- FBC, ferritin checked at 3 weeks to assess response.
- Oral iron should be continued for 3 months after the Hb has been normalised.



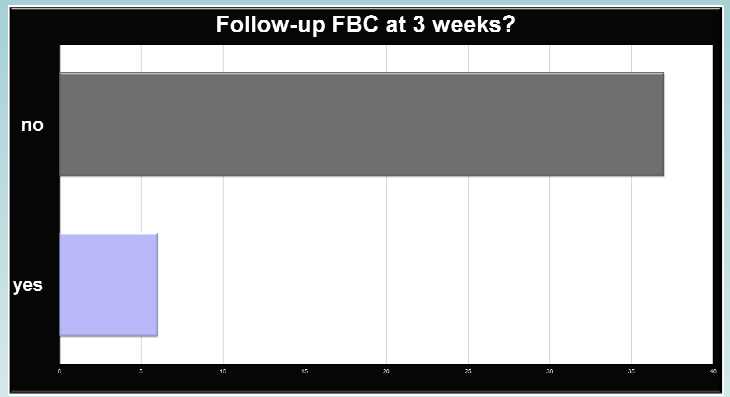
Results

- 62.7% of patients (9.3% male, 25.5% postmenopausal) diagnosed with IDA, failed to receive further serological/radiological/invasive investigations.
- 4.6% of patients diagnosed with IDA had coeliac serology results recorded.
- In 25.6% of patients IDA had been further investigated with a lower and/or upper GI tract scope



Intervention

- The findings of this audit were communicated to the General Practitioners of The Cork Road Clinic, MPHC.
- A summary of the guidelines with respect to the appropriate investigation of IDA was distributed to the General Practitioners, Trainees and medical students of The Cork Road Clinic, MPHC.



Conclusion

- This audit has identified in particular a hesitancy among general practitioners to refer cases of IDA for necessary upper and/or lower GI tract investigations. The failure to promptly investigate IDA can potentially stunt the early diagnosis of gastric and intestinal malignancy.
- It is hoped that with the educational interventions outlined above an increased awareness among practitioners in this regard may arise.
- An improvement in the appropriate investigation of IDA will be sought in the re-audit phase of this research.
- Although the continuation of Iron supplementation for 3 months once Hb had normalised was commendable, the proportion of patients with a documented FBC at 3 months was found to be lacking.
- It is anticipated that with the educational interventions outlines above that there will be an improvement in practices in this regard.

References

1. Andrew F Goddard, Martin W James, Alistair S McIntyre, Brian B Scott. Guidelines for the management of iron deficiency anaemia. GUT. 2011;60: 1309-1316
2. NHS National Institute for Health and Clinical Excellence. Referral Guidelines for Suspected Cancer. Clinical Guidance 27, 2005.