Appendix 1 – IRON DEFICIENCY ANAEMIA GUIDANCE

Northern Ireland Transfusion Committee
Iron Deficiency Anaemia Guidance for Preassessment Clinics

Pre-operative anaemia whether mild or severe, is an independent risk factor for postoperative morbidity and mortality

Is the patient anaemic? (Males Hb < 135g/L, Females < 120g/L)
- Yes - Perform Iron Studies
- Evidence of iron deficiency? (Ferritin < 30mcg/L and/or TSAT < 20%)*
- No - TSAT > 20% should not be treated with iron

Is there another known cause for iron deficiency?
- No
- Will proposed surgery treat the cause of iron deficiency?
- Yes
- Is there heavy ongoing blood loss?
- Yes
- Consider treatment with IV Iron preparation of choice
- No
- If date of surgery is close, can it be postponed for 4-6 weeks?***
- Yes
- Can patient take oral iron supplements?****
- Yes
- Commence treatment with oral iron and ascorbic acid
- Adequate improvement in Hb and serum ferritin 3 weeks after starting oral iron?
- Yes
- Continue oral iron and ascorbic acid until surgery
- No
- Check bloods after 2 weeks to monitor response

Commence treatment with oral iron.
If possible, postpone surgery until anaemia has been investigated and treated.
(Refer to British Society of Gastroenterology guidelines for management of iron deficient anaemia)

* Ferritin may be elevated in acute inflammation (e.g. 30-100mcg/L) and can mask iron deficiency

In these cases a TSAT < 20% and a low serum iron identifies iron deficiency

** As per Chief Medical Officer Guidance HSS-MD-22-2012
“Management of the Anaemic Adult Patient Prior to Scheduled Major Surgery”

*** Intravenous iron is indicated for patients with malabsorption states, inflammatory bowel disease, non-compliance with oral iron and intolerance of its side effects

Iron Deficiency Anaemia should always be treated even if surgery is not indicated