Iron deficiency anaemia in pregnancy



Iron deficiency anaemia (IDA) affects 1 in 4 women of childbearing age in the UK. Negative effects can include an increased risk of postpartum depression, postpartum haemorrhage, low birth weight and pre-term birth.

Testing for IDA is recommended at booking and at 28 weeks. If other risk factors are present an additional test should be taken at 20-24 weeks.

Individual risk factors can include a previous history of anaemia, multiparity >3, less than one year since the last pregnancy, multiple pregnancy, teenage pregnancy, and medical conditions that affect absorption of iron, or inflammatory disorders.





Haemoglobin Thresholds





1st Trimester

A Hb less than 110 g/L indicates anaemia. Consider serum ferritin and haemoglobinopathy screen.

2nd/3rd Trimester

A Hb less than 105 g/L indicates anaemia. Consider serum ferritin and haemoglobinopathy screen.



Postpartum

A Hb less than 100 g/L indicates anaemia. Consider serum ferritin.

Advice for everyone

Discuss healthy eating and factors that can affect iron absorption at booking.

Include a conversation about signs and symptoms of anaemia to encourage reporting, so that further blood tests can be done if they occur.

Signs and symptoms to be aware of include, fatigue, dizziness, irritability, pallor, breathlessness, weakness, palpitations, hair loss, feeling cold, pica - particularly soil or ice.

If symptoms are severe consider referral to secondary care.







Prevention of iron deficiency anaemia



Eat more

Meat and chicken (well cooked, avoid liver in pregnancy) Dark green vegetables (wash well) Beans, lentils, chickpeas Oily fish (salmon, sardines, mackerel, limit to two portions per week) Nuts, seeds and dried fruit





Have less

Tea and coffee - avoid one hour before and after meals. These drinks contain tannins which reduce iron absorption

Iron supplementation

Routine supplementation is not recommended. However, when indicated it can help optimise red cell mass, reducing the symptoms of IDA and minimising the risk of needing a blood transfusion.

Vitamin C may increase absorption of oral iron.



IV iron may be indicated from the second trimester onwards if unable to tolerate oral iron, if oral iron is ineffective, if symptoms are severe or if anaemia is detected at 34 weeks or more.



Oral iron is recommended as the first line treatment for IDA. Ideally take on an empty stomach. Haemoglobin should be checked after 2 to 4 weeks to assess efficacy. Upon reaching a satisfactory haemoglobin, continue iron for 3 months or until 6 weeks postpartum.



Care in labour

The mode and timing of delivery is not affected by anaemia. However, anaemia in pregnancy may increase the risk of a postpartum haemorrhage therefore birthing in a hospital setting is recommended.

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If anaemia is present active management of the third stage is recommended to minimise blood

Cell salvage can be considered if significant blood loss is anticipated at caesarean section.



Royal College of Obstetricians and Gynaecologists (2015) Greentop Guideline 47: Blood Transfusion in Obstetrics <u>https://www.rcog.org.uk/media/sdqcorsf/gtg-47.pdf</u>

NICE (2021) Antenatal Care Guideline NG201 https://www.nice.org.uk/guidance/ng201

Pavord S, Daru J, Prasannan N, Robinson S, Stanworth S, Girling J (2019) UK Guidelines on the management of iron deficiency anaemia in pregnancy. British Journal of Haematology https://onlinelibrary.wiley.com/doi/full/10.1111/bjh.16221



