Provincial Adult Iron Deficiency Anemia Primary Care Clinical Pathway

This pathway should be used for **adults with Iron Deficiency Anemia (IDA)**. Use it for guidance on diagnosis and management in patients with clinical suspicion of iron deficiency anemia when: **Male:** Hgb <135 g/L**, Female**: Hgb <120 g/L

This pathway does not provide guidance for anemia in pregnancy **OR** perioperative anemia → Click here Obstetrical screening and treatment algorithm; Peri-operative iron therapy

1. Assess
Symptoms (if not already done):

fatigue, syncope, chest pain, tachycardia, hypotension, restless leg syndrome, pallor

2. Red Flags
- Assessment indicates ongoing GI blood loss

- Active acute bleeding (GI, GU, Epistaxis)
- Underlying CAD with recent instability
- Hgb <60g/L
- Significant symptoms of hemodynamic instability

→ Iron Deficiency Anemia (IDA) Pathway for Colorectal Cancer Diagnosis

→ Refer to RAAPID or Emergency or urgent care facility

No red flags

3a. Diagnosis of iron deficiency:

- ferritin <30ug/L **OR**
- ferritin <100ug/L + TSAT < 0.20 with chronic kidney disease or known inflammatory condition

Consider other types of anemia (including mixed anemias)
See link above for work up details.

3b. Investigate underlying causes: consider blood loss, poor intake, poor absorption

IDA requires management regardless of cause. See link above for details.

4a. Treatment Options

In most cases**, oral iron therapy is first line therapy**. Regimens should be patient-specific and based on tolerability.

- IV Iron therapy should be used when there is:
  - Intolerance of oral therapy
  - Inadequate response to oral iron
  - Malabsorption conditions
  - Urgent Need

See Treatment link above for details for Special populations

TIP: All patients with low ferritin should receive iron supplementation even if Hgb is within normal range

NOTE: Unless contraindicated, patients benefit from oral iron supplementation while waiting for IV iron infusions.

4b. Supplementation

Has patient tried oral iron therapy as well as optimized dietary intake?

Yes →
- Methods tried to improve absorption or tolerance unsuccessful
- Has tried at least 2 formulations of oral iron
- Does Hgb continue to decline?

Yes →

IV Iron Therapy
Consider - indication, medication choice, dose and regimen, and location of infusion.

Ordering IV Iron (see Supplementation link above for details)

→
- Maximum hemoglobin response to IV iron occurs 4-6 weeks after the last dose.
- Consider if ongoing oral supplementation indicated

→ **5. If IDA recurs with no obvious cause - re-investigate and/or refer for further assessment** (see Common Reasons link above or referral guideline tab for details)

No → Oral Iron Optimization

Trial oral iron supplement starting with:
- 100-200 mg of elemental iron daily or every other day. Take with vitamin C; many find night use easiest. Best absorbed on empty stomach (only if tolerated)

→ Perform:
- Ferritin and Hgb after 3 months
- Consider checking *CBC* within 2–4 weeks to monitor for initial response depending on severity of anemia.
- Is there adequate response to oral therapy? See page 2 of Oral Iron Optimization (purple box to the left)

No → Oral Iron Optimization

Yes → Continue iron supplements for at least 3 - 6 months after achieving normal hemoglobin, target normal ferritin