



Iron-Deficiency Anemia Work-Up

- Evaluate for blood loss.
- Evaluate for dietary deficiencies.
- Labwork classically shows:
 - ↓ Hgb
 - MCV < 80
 - Ferritin < 30
 - ↑ TIBC
- Consider checking a lead level in children <6 years. See [lead screening guideline](#).

Causes of Iron-Deficiency Anemia

- Decreased dietary intake.
- Severe/ongoing blood loss (especially GI or uterine).
- In toddlers: excess milk intake. (Recommended daily milk intake is <16 ounces.)
- History of gastric bypass.
- Malabsorption syndromes.
- Coexisting inflammatory state that interferes with iron homeostasis (example: rheumatoid arthritis or lupus).

Diagnosis of iron-deficiency has been established.

Patient meets criteria for iron infusion, and patient or parent has agreed to infusion.

Provider places order "Refer to Infusion – Internal." Include patient's phone number.

Provider places future orders using "AMB IV Iron" or "PED Pediatric Iron Infusion" Power Plans.

- Provider updates Problem List with Iron-Deficiency Anemia.
- In the comments, provider states the plan (iron infusion with date ordered) and includes goal hemoglobin after infusions.

Infusion clinic nurse schedules patient for infusion. Case Managers write Letter of Medical Necessity. Village clinic arranges travel.

- Infusion(s) given per orders.
- All patients should have a follow-up hemoglobin level checked one month after infusion.
- If not at goal hemoglobin, patient should return to Bethel outpatient clinic for further evaluation.

See [Anemia in Pregnancy](#) guideline for indications in pregnancy.

Indications for Iron Infusion

If patient is hemodynamically unstable due to anemia, consider transfusion regardless of hemoglobin level. Ensure iron studies have been sent prior to transfusion.

- Hemoglobin between 5 and 7 in a hemodynamically stable, asymptomatic patient:
 - Patients <18 years: iron infusion likely indicated. Consult pediatric hematologist.
 - Patients ≥18 years: consider iron infusion alone vs transfusion followed by iron infusion based on clinical judgment.
- Hemoglobin between 7 and 8 with failure of oral iron therapy. Failure is defined as:
 - Minimal improvement in hemoglobin level despite at least two months of compliance with oral iron (in children 6 mg/kg/day; in adults ferrous sulfate 325 mg PO daily with ascorbic acid 500 mg PO daily)
 - Intractable GI side effects
 - Non-compliance after at least three attempts at oral iron therapy.
- Other patients may receive iron infusion if recommended by a hematologist.

Note: Patients <2 should have a hematology consult prior to beginning an infusion. The Infusion Center does not generally treat children <2, so they are generally admitted to Inpatient Pediatrics for iron infusions.

Iron Replacement Dose Calculation

$$\text{Total Iron Replacement Dose (in mg)} = 0.6 \times \text{weight} \times \left[100 - \left(\frac{\text{actual hemoglobin}}{\text{desired hemoglobin}} \right) \times 100 \right]$$

For pediatric patients:

- Using iron sucrose, this dose should be given in aliquots of 5-7 mg/kg until the full replacement dose has been given. Max dose is 100 mg for initial dose and 300 mg for repeat doses.
- Per Pediatric Hematology, may give children two iron sucrose doses 24 hours apart and then repeat in 1-2 weeks. Giving more frequent dosing or more than two daily doses in a row results in decreased absorption and increased side effects in children.

For adult patients:

- Dose is typically iron sucrose 300 mg IV daily x3 doses.

Side Effects/Reactions

Efficacy and safety have been evaluated in adults and children older than two years. Consult pediatric hematologist for children younger than two years.

Specific reactions (rare):

- Hypersensitivity, including anaphylaxis and angioedema. Stop infusion immediately and treat as anaphylaxis.
- Hypotension (related to high total doses or rapid infusions). Stop infusion and treat with IVF, as appropriate.
- Infection: avoid administering if active systemic infection.
- For IV infiltrates, place cold pack.

Resources

- Consult Peds Wards On Duty by Tiger Connect.
- A pediatric hematologist can be reached for further questions at Alaska Pediatric Oncology at (907) 929-3773.
- ANMC Adult Hematology Oncology can be reached at (907) 729-1180.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Approved by Clinical Guideline Committee 8/23/23.

Click [here](#) to see the supplemental resources for this guideline.

If comments about this guideline, please contact Leslie_Hermann@ykhc.org