

# RECOMMENDATIONS FOR ANAEMIA IN PREGNANCY WITH POTENTIAL SURGERY

- Healthcare workers should be aware that iron deficiency is the most common cause of anaemia in pregnancy and the risk of iron deficiency should be considered in all pregnant women<sup>65</sup>
- Haemoglobin concentration should be routinely measured at booking and at around 28 weeks' gestation or 20 weeks in multiple pregnancy<sup>66</sup>
- Systems must be in place for timely review of blood test results, including monitoring the response to therapy<sup>67</sup>
- Other than pregnancy if no other cause of anaemia is found a diagnostic trial of oral iron should be given without delay, with a repeat FBC in two to three weeks<sup>65</sup>
- Serum ferritin should be measured in women with a known haemoglobinopathy to identify concomitant iron deficiency and exclude iron loading states
- Non-anaemic women at risk of iron deficiency should be identified and either started on prophylactic iron empirically or have serum ferritin checked first<sup>65</sup>
- A serum ferritin level of  $<30\mu\text{g/l}$  in pregnancy is indicative of iron deficiency. Levels higher than this do not rule out iron deficiency or depletion<sup>65</sup>
- All pregnant women should receive dietary advice<sup>65</sup>
- Ferrous iron salts are the current preparation of choice for oral iron supplementation<sup>65</sup>
- Consider alternate day dosing<sup>65</sup>
- A trial of oral iron should be considered as the first line diagnostic test for normocytic or microcytic anaemia in pregnant women with no haemoglobinopathy. Absorption of iron can be promoted by morning dosage, one hour pre-food. Tolerance and efficacy of oral iron can be improved by reducing dosage or frequency, laxatives for constipation, and antacids (rather than proton pump inhibitors) for heartburn
- In women with unknown haemoglobinopathy status, a trial of iron should be offered. However, haemoglobinopathy screening should be undertaken without delay in accordance with the NHS sickle cell and thalassaemia screening programme guideline, but with awareness that iron deficiency can lower the haemoglobin A2 percentage<sup>66</sup>
- IV. iron should be considered from the second trimester onwards for women with confirmed iron deficiency anaemia who are intolerant of, or do not respond to, oral iron<sup>65</sup>
- IV. iron should be considered in women who present after 34 weeks' gestation with confirmed iron deficiency anaemia and a Hb of  $<100\text{g/L}$ <sup>65</sup>. A Cochrane review<sup>69</sup> suggested that it was associated with a greater improvement in haematological indices, that its effects lasted up to three months and that it avoided side effects such as heartburn and constipation. It does however carry the risk of anaphylaxis
- Women with iron deficiency anaemia with a Hb of  $<100\text{g/L}$  should deliver in an obstetrician-led unit<sup>65</sup>
- Consider the use of cell salvage where appropriate intraoperatively
- Women with iron deficiency anaemia should have active management of the third stage of labour<sup>65</sup>
- All women with over 500ml blood loss should have Hb check within 48 hours<sup>65</sup>
- Units need to promote a care pathway (with pharmacy and haematology) that facilitates administration of IV. iron postpartum to women who are previously intolerant of, or do not respond to, oral iron and/or where the severity of symptoms of anaemia requires prompt management<sup>65</sup>
- Obstetric units should have guidelines for the criteria to be used for postnatal red cell transfusion in anaemic women who are not actively bleeding.<sup>65</sup>