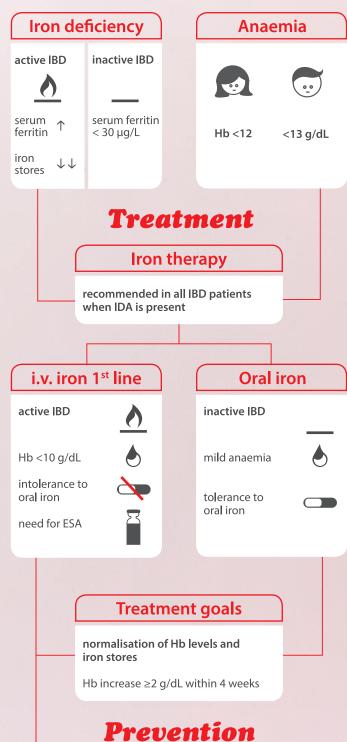
ECCO IRON DEFICIENCY AND ANAEMIA GUIDELINES 2015

Diagnosis and management of iron deficiency and anaemia in inflammatory bowel diseases ¹





Diagnosis



Monitoring and treating for recurrent iron deficiency

retreatment with i.v. iron as soon as:

serum ferritin < 100 μg/L

Hb <12 g/dL

Hb <13 g/dL



goal is to maintain Hb and ferritin in normal range

Diagnosis of anaemia

All patients with IBD should be assessed for the presence of anaemia (women Hb <12 g/dL, men Hb <13 g/dL).

The risk of developing anaemia relates to disease activity, because both blood loss and anaemia of chronic disease are triggered by intestinal inflammation.

Diagnosis of iron deficiency (ID)

Diagnostic criteria for ID depend on the level of inflammation.

In patients without clinical, endoscopic or biochemical evidence of active disease, serum ferritin <30 μ g/L is an appropriate criterion.

Treatment need

Iron supplementation is recommended in all IBD patients when IDA is present.

I.v. iron 1st line

I.v. iron should be considered as first line treatment in patients with

- clinically active IBD
- previous intolerance to oral iron
- a Hb <10 g/dL
- · a need for an ESA

I.v. iron is safe, effective and well-tolerated both in the correction of IDA and maintenance of iron stores in patients with IBD.

Determination of patient's total iron dose need

| Hb (g/dL) | Body weight <70kg | Body weight ≥70kg |
|------------------------------|-------------------|-------------------|
| 10–12 (women) 10–13 (men) | 1000 mg | 1500 mg |
| 7–10 | 1500 mg | 2000 mg |

Oral iron

Oral iron is effective in patients with IBD and may be used in patients

- · with mild anaemia
- whose disease is clinically inactive
- · who have not been previously intolerant to oral iron

Treatment goals

The goal of iron supplementation is to normalise haemoglobin levels and iron stores.

An increase in haemoglobin of at least 2 g/dL within 4 weeks of treatment is an acceptable speed of response.

Prevention of iron deficiency anaemia

IBD patients should be monitored for recurrent ID

- every 3 months for at least a year after correction
- · between 6 and 12 months thereafter
- using a combination of Hb, ferritin, transferrin saturation, and CRP

After successful treatment of IDA with i.v. iron, retreatment with i.v. iron should be initiated as soon as:

- Serum ferritin drops below 100 μg/L or
- Hb <12 g/dL (woman) or <13 g/dL (men)
- Goal of preventive treatment is to maintain Hb and serum ferritin in the normal range

IBD-associated ID and anaemia recur frequently and fast, even after treatment with i.v. iron.

- Recurrence of iron deficiency is lower in patients with higher post-treatment ferritin levels
- Accordingly, it was suggested that i.v. iron replacement might want to target for ferritin levels of up to 400 $\mu g/L$
- The FERGImain study demonstrates that ferric carboxymaltose can prevent recurrence of anaemia in IBD patients.

* Hb 11.0–11.9 g/dL in non-pregnant women, 11.0–12.9 g/dL in men

IDA = iron deficiency anaemia

ESA = erythropoiesis-stimulating agent RLS = restless-leg syndrome CRP = C-reactive protein IBD = inflammatory bowel diseases

Reference:

1. Dignass Axel et al. European Consensus on the diagnosis and management of iron deficiency and anaemia in inflammatory bowel diseases. *Journal of Crohn's and Colitis, 2015, 1-12, doi:10.1093/ecco-jcc/jju009*



