Management of Iron Deficiency Anaemia in Pregnancy

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Policy on a Page: Key Messages

Aim:

To provide support for clinical decision making in the context of iron deficiency anaemia during pregnancy.

Summary of key changes (for revised documents only)

- Enhanced risk assessment and screening recommendations.
- Updated diagnosis and treatment thresholds for iron deficiency.
- Changed first-line oral iron to Ferrous Fumarate 210 mg once daily.
- Clarified referral criteria and indications for IV iron.
- Expanded Ferinject consent, monitoring and safety requirements.
- Updated labour and birth management guidance.

Key Requirements:

- Screen for anaemia at booking and 28 weeks, with additional screening for multiple pregnancies.
- Diagnose and treat iron deficiency promptly using haemoglobin and ferritin results.
- Provide dietary advice and commence oral iron as first-line treatment.
- Repeat FBC after 2 weeks to assess treatment response.
- Escalate to IV iron when anaemia is severe, oral iron is not tolerated, or response is inadequate.
- Investigate alternative causes of anaemia if haemoglobin does not improve.
- Optimise intrapartum care and minimise the need for blood transfusion.

Target Audience:

To provide support for clinical decision making in the context of iron deficiency anaemia during pregnancy.

Training:

Staff are expected to access appropriate training where provided.

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1. Introduction/Overview

Anaemia is defined as haemoglobin (Hb) value less than 2 standard deviations below the mean value for a healthy matched population.
The definition of anaemia in pregnancy is Hb levels of:

- <110g/l in the first trimester
- <105 g/l in the second and third trimesters
- <100 g/l in the postpartum period.

(British Committee for Standards in Haematology 2011)

Anaemia is the commonest medical disorder in pregnancy. Pregnancy causes 2-3-fold increase requirement of iron and 10–20-fold increase in requirement in folate. Due to low absorption levels (increasing throughout pregnancy), a typical diet will only provide 1.5mg-5mg of iron while daily iron requirements may reach between 0.8-10mg/day.

Iron deficiency is the commonest cause of anaemia in pregnancy (50% of all cases of anaemia in pregnancy worldwide). It causes maternal morbidity by increased susceptibility to infections, poor work capacity and performance and disturbances of postpartum cognition and emotions. It is associated with poor fetal iron stores, developmental disorders and has possible links with autism and schizophrenia in the child's later life. Low iron levels increase the risk of low birth weight, preterm birth and postpartum haemorrhage (FIGO Committee on Childbirth and Postpartum Haemorrhage, 2025; British Society for Haematology, 2019).

Where iron supplementation is not effective alternative causes of anaemia should be considered including: B12 or folate deficiency, thalassemia, inflammatory disorders, haemolysis and blood loss.

2. Scope

This policy applies to all members of staff working within maternity, gynaecology and the early pregnancy assessment unit.

3. Statement/Background

If you have difficulty understanding any part of this guideline- including due to learning, sensory, or communication needs- please speak with your Line Manager or contact the authors of this guideline for support or clarification.

Staff must take a proactive approach to identifying and meeting the accessibility and communication needs of people with disabilities and/or language barriers, including offering information in alternative formats, arranging interpretation or communication support as required, and not relying solely on individuals to request adjustments.

The term "woman/ women" will be used throughout this document however, it is recognised that this refers to all pregnant, birthing and postnatal people regardless of gender identification.

This guideline supports the requirements of the Welsh Language Standards. Individuals will be offered the opportunity to communicate in Welsh, and reasonable steps will be taken to ensure that Welsh language needs are identified and accommodated where required.

4. Aim

To provide support for clinical decision making in the context of iron deficiency anaemia during pregnancy.

5. Main Body

Clinical Features of Iron Deficiency Anaemia

- Anaemia in pregnancy is often asymptomatic and may be diagnosed on routine screening.

- Women may present with tiredness, dizziness, fainting, irritability, poor concentration, headaches, shortness of breath and lethargy and in these circumstances, haemoglobin should be tested.

- Storage iron is depleted before a fall in Hb and as iron is an essential element in all cells, symptoms of iron deficiency may occur even without anaemia: These include fatigue, irritability, poor concentration and hair loss.
- Signs of anaemia **can** occur in the absence of a low Hb. In this instance it would be diagnosed by a full blood count with a reduced MCV (Mean Cell Volume) and MCHC (Mean Corpuscular haemoglobin Concentration).

Antenatal Screening

- Full blood count should be assessed at booking and at 28 weeks.
- Pregnant women should be assessed for their risk of having or developing iron deficiency, and for their risk of any anaemia or blood loss causing significant harm. At booking the *'Risk Assessment Tool for Women at Booking in ABUHB'* as per Appendix 1 should be used to determine anaemia risk.
- Multiple pregnancies confer a higher risk of iron deficiency and so these women should be screened with a Full Blood Count (FBC) at booking, 20 weeks and 28 weeks.
- Some pregnant women are at higher risk of iron deficiency and should be treated empirically with oral iron:
    - Previous anaemia
    - Multiparity >=3
    - Twin or higher order multiple pregnancy
    - Interpregnancy interval <1 year
    - Women with poor dietary habits
    - Women following a vegetarian or vegan diet
    - Pregnancy teenager

    - Recent history of clinically significant bleeding/ bleeding disorder
    - Inflammatory bowel disease
    - Jehovah's Witness
- Some women are at increased risk should anaemia occur and should have ferritin levels tested even in the absence of a low haemoglobin so that they can be optimally managed before anaemia occurs:
    - Jehovah witnesses
    - Women at increased risk of obstetric bleeding
    - Women with complex blood compatibilities

- With an intrapartum blood loss of more than 10%, haemoglobin level should be checked within 6-48 hours.

Diagnosis

- Iron deficiency anaemia presents with low Hb (as defined below), reduced MCV (normal range 80- 100 fL) and MCHC (normal range 27.0- 33.0 pg).
    - 1st and 3rd trimesters <110g/L
    - 2nd trimester <105g/L
    - Postnatal <100g/L
- Serum ferritin is the most useful and easily available parameter for assessing iron deficiency. They are a measure of longer-term iron levels and are not influenced by recent ingestion of iron. Levels below 15 µ/l are diagnostic of established iron deficiency. A level below 30 µ/l in pregnancy should prompt treatment because pregnancy can falsely elevate the reading (note ferritin can also be raised in inflammatory/ infective conditions).
- With normal ferritin levels and symptoms or other haematological evidence of anaemia, it can be helpful to check transferrin

saturations, with a level of <20% being diagnostic for iron deficiency.

- Women with a normal Hb but a low MCV should have their ferritin checked and if ferritin is <30µ/l, oral iron should be commenced.
- Serum ferritin should be routinely checked first with patients with haemoglobinopathy.
- All women diagnosed with iron deficiency in pregnancy should receive the patient information leaflet (PIL) as per Appendix 6.

Treatment

**Please refer to Appendix 2 for Iron Deficiency Anaemia in Pregnancy Flow Chart*

Dietary Advice

- All women should be counselled regarding diet in pregnancy including detail of iron rich foods sources and factors that might inhibit or promote iron absorption.
- Foods rich in iron include red meat, fish, poultry, pulses/legumes, green vegetables, nuts and seeds. Many breads and breakfast cereals are also fortified with iron.

Factors Influencing the Absorption of Iron

Factors that **inhibit** iron absorption	Factors that **enhance** iron absorption
Foods rich in calcium	Haem iron
Tannins in tea	Ferrous iron
Phytates in cereals	Ascorbic Acid Retinol and carotenes

Table 1 Factors Influencing Iron Absorption

- Dietary changes alone are insufficient to correct iron deficiency.
- A trial of oral iron should be considered as the first line for anaemia, providing haemoglobinopathy has been excluded.
- **First line treatment is Ferrous Fumerate 210 mg once daily.**
- 40-80mg of elemental iron is the maximum amount that can be absorbed daily. The absorption of iron in the GI tract causes further inhibition of iron absorption for 24-48 hours. Therefore, giving iron more frequently or at greater dose only increases side effects and does not improve anaemia.
- There is increasing support suggesting no significant difference in iron level increases between daily and alternate day administration, with reduced gastrointestinal side effects noted with alternate day administration which can be considered.

Dose and Elemental Iron Content

Preparation	Dose per tablet	Elemental iron
Ferrous Fumarate	210mg	68mg
Ferrous Gluconate	300mg	35mg
Ferrous Sulphate	200mg	65mg
Pregaday		100mg

Table 2 Dose and Elemental Iron Content

- Women should be counselled how to take oral iron supplements correctly. To maximise absorption iron should be taken in the morning, on an empty stomach, 1 hour before (or 2 hours after) meals, calcium, PPI's, antacids, thyroxine, hot drinks, soy or eggs. It is also advised to take with any of the absorption enhancing factors included above (such as vitamin C in orange juice).

Side Effects

- Side effects of oral iron administration include nausea, vomiting, stomach cramps, loose, dark or black stools, dark tooth staining.
- For women who experience side effects, alternate day administration or a preparation with a low elemental iron level (such as ferrous gluconate) should be trialled.

Follow-Up

- A repeat FBC after 2 weeks of oral iron treatment should be taken and an increase in Hb must be demonstrated, otherwise further tests are required, investigating concomitant causes such as folate deficiency or anaemia of chronic disease need to be excluded. Consultant referral is required.
- Once the Hb is in the normal range, replacement should continue for three months and at least 6 weeks postpartum.
- Postnatal women with anaemia should be offered Ferrous Sulphate 200mg once daily for 3 months and be offered a repeat FBC and ferritin to ensure Hb normalises.

Parenteral Iron Therapy

- Parenteral iron should be considered in the following situations:
    - Hb <= 80g/L at any gestation or postnatally (though note a lack of safety data regarding iron infusions in the 1st trimester.)
    - The second trimester onwards and during the third trimester in women with confirmed iron deficiency who fail to respond to oral iron - If the Hb rises less than 10g/L after 2 weeks of treatment or less than 20g/L after 4 weeks.
    - Intolerance or significant side effects encountered with various forms of oral iron.

- Hb <=105g/L at 36 weeks gestation and beyond and planned operative delivery/ increased risk of PPH.

- Ferinject can be given antenatally or postnatally at any maternity day assessment unit with the required infrastructure, or in the Grange University Hospital ward B3 or labour ward.
- The dose of parenteral iron should be calculated on pre-pregnancy weight, aiming for a target Hb of 110g/L.

Ferinject

Indications

- Persistent iron deficiency anaemia following failed treatment/ side effects with oral iron
- Severe perinatal anaemia (Hb ≤80 g/l)
- Hb <105 g/l at >36 weeks' gestation with risk of PPH/ operative birth

Contraindications

- Previous reaction to intravenous iron
- 1st trimester of pregnancy
- Anaemia of alternative cause, i.e., B12 deficiency, Thalassaemia (measure haematinics)
- Cirrhosis or evidence of 'iron' overload, i.e., porphyria cutanea tarda, haemochromatosis

Referral for Ferinject

- Once the decision has been made to administer Ferinject, please discuss with the woman, give patient information leaflet (Appendix 4), explain risks and benefits for verbal consent and obtain written consent from the woman (Appendix 5).

- Please send a referral via Badgernet referrals form – *"Ferinject DAU (Doctor use only) Referral"* (Figure 1)
- Parameters needed are booking weight, height, current Hb and target Hb.
- Ferinject dosing calculation form to be completed in the administering unit.
- Prescriptions for Ferinject (in NaCl 0.9%) to be completed on fluid prescription page and for anti-hypersensitivity medications to be completed on PRN page:
    - IM Adrenaline 1:1000 – 500 mcg (0.5ml) STAT
    - IV hydrocortisone 100-200mg STAT
    - PO Chlorphenamine maleate 4mg TDS
    - INH Salbutamol 1-2 puffs PRN if indicated

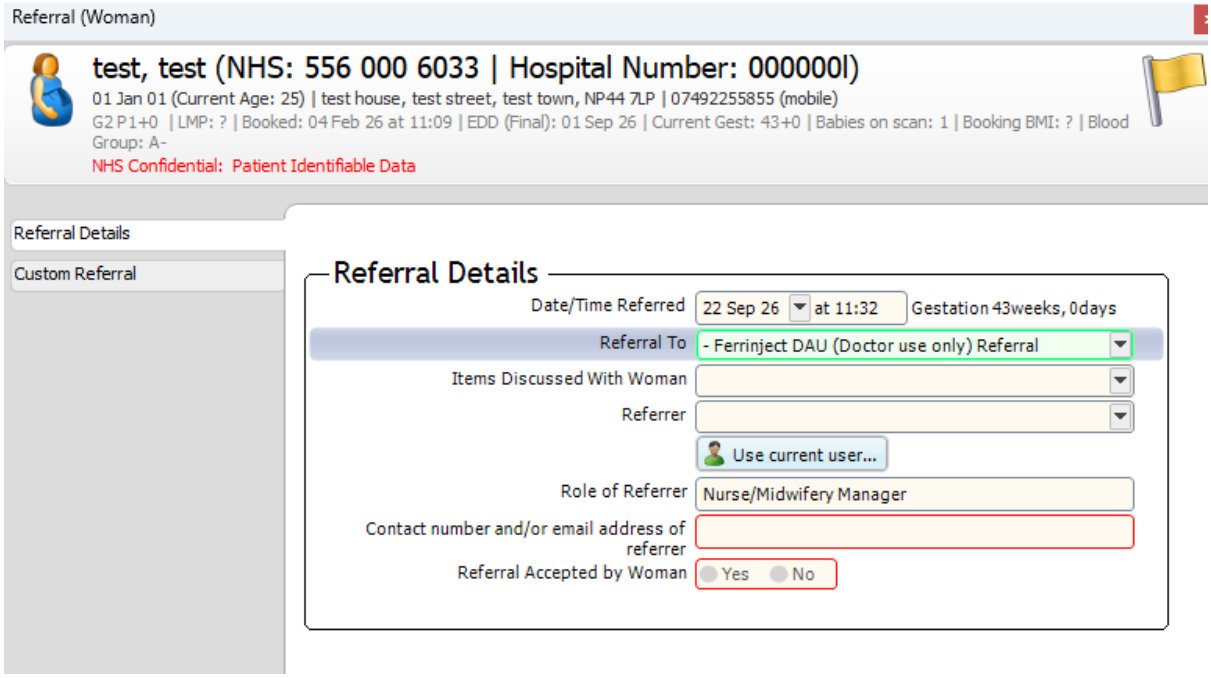


Figure 1 Ferinject Badgernet Referral

On Admission

- Perform and record maternal observations pulse, blood pressure (BP), respiration rate (RR) and fetal heart with pinnard/sonicaid)
- Insert intravenous cannula and flush with NaCl 0.9%

- Max 1000mg per week (patients must return to complete their course)
- Do not dilute to less than 2mg/ml

Observations

- Observations (temperature, respiratory rate, SpO2, blood pressure, pulse rate and fetal heart rate via sonicaid) should be recorded prior to the infusion and at 15 minutes, 30 minutes, and 30 minutes post infusion.

After the infusion

- Ensure patient is monitored for 30 minutes after infusion for signs of delayed hypersensitivity
- No oral iron should be taken following treatment with IV iron for 2 weeks

COMPLICATIONS

- Stop the infusion immediately if:
    - Signs of cannula tissuing/ leakage (skin staining or blebbing (development of blister like bulges in the skin))- call for assistance
    - Hypotension- alert senior staff/ peri-arrest call if significant
    - Signs of hypersensitivity/ anaphylaxis- rash, wheeze, tachycardia, falling BP <90/40 mmHg- call 2222 declaring peri-arrest

Mild Reaction Management

- STOP infusion. DO NOT restart
- Oral (PO) Chlorphenamine if mild reaction
- Intravenous (IV) hydrocortisone if moderate reaction
- Inhaled (INH) Salbutamol if wheeze

- Discuss further management with Registrar / Consultant

Anaphylaxis

- STOP infusion. DO NOT restart. Refer to Resuscitation UK 2021 guideline as per Appendix 3.
- Peri-Arrest call - dial 2222
- Call for senior help (obstetric registrar if in unit without emergency bleeps)
- ABC management
- Give IM adrenaline 1:1,000 - 500mcg (0.5ml) - repeat if necessary

Following Infusion

- Patients should be advised not to take oral iron 24 hours pre infusion and 2 weeks post infusion.

Blood Transfusion

- Blood transfusion should be avoided in non-bleeding women with Hb >80g/L.
- Clinical discretion should be used for patients where there is severe anaemia if close to date of delivery, symptomatic anaemia with features of haemodynamic compromise, acute severe bleeding or risk of further bleeding.

Care in Labour

- Women with a Hb<85g/l are regarded as high risk and should be advised to deliver on the obstetric led unit (Wales Maternity and Neonatal Network, 2022). On admission in labour, IV access should be obtained and bloods taken for FBC and Group & Save (G&S).
- Women with a Hb 85-105 g/l with no symptoms of anaemia require individual assessment and intrapartum care planning in accordance

with the All Wales Midwifery-Led Care Guideline (Pathway B) (Wales Maternity and Neonatal Network, 2022).

- Active management of the third stage of labour is advised.
- Intra-operative Cell Salvage (ICS) is indicated if having a caesarean section.

6. Roles and Responsibilities

It is the responsibility of the maternity, gynaecology and early pregnancy assessment unit teams to ensure that this guideline is adhered to when managing a pregnant woman with iron deficiency anaemia.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and haematology have been consulted with in the development of this policy.

8. Equality Impact Assessment

An equality impact assessment has been carried out and approved as this guideline prioritises care based on standardised assessment and clinical need.

9. Training Requirements

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

10. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Maternal/ neonatal outcomes will be monitored via the local maternity dashboard. Patient experience will be gauged through CIVICA and Listening to People procedures.

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12. Appendices

Appendix 1- Risk Assessment Tool for Women at Booking in ABUHB

RISK ASSESSMENT TOOL FOR WOMEN AT BOOKING IN ABUHB

Risk assessment for Antenatal Iron deficiency (with or without anaemia)

Iron deficiency places a woman at risk of developing anaemia during their pregnancy. Certain factors increase the likelihood that a woman has low iron stores. Identifying women at risk of iron deficiency and treating with oral iron may prevent the development of antenatal anaemia.

Booking assessment

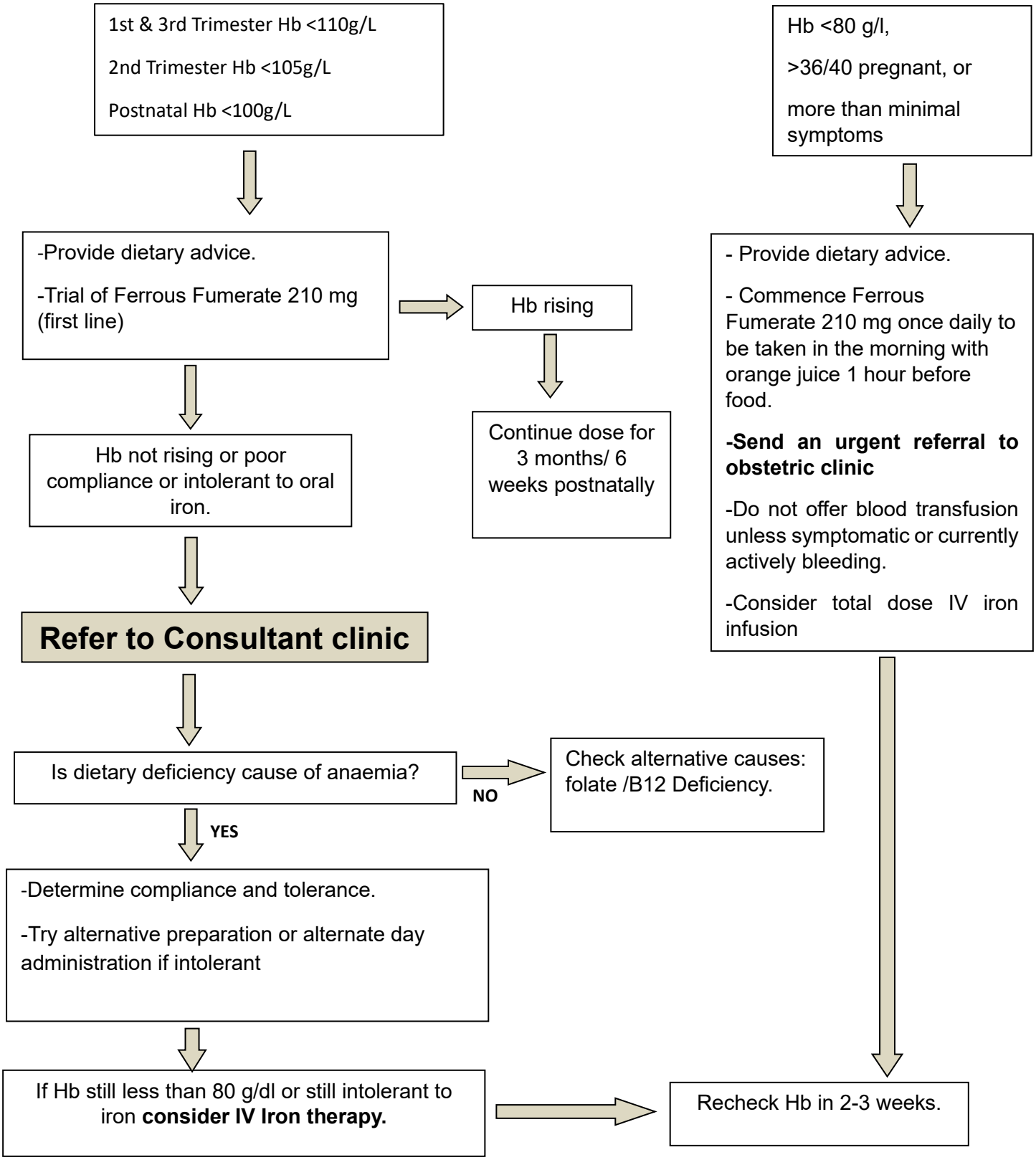
Risk factor	Tick if present
Previous anaemia	
Multiparity >=3	
Twin or higher order multiple pregnancy	
Interpregnancy interval <1 year	
Women with poor dietary habits	
Women following a vegetarian or vegan diet	
Pregnant teenager	
Recent history of clinically significant bleeding/bleeding disorder	
Inflammatory bowel disease	
Jehovah's Witness	
No risk factors identified	

If one or more risk factor is identified:

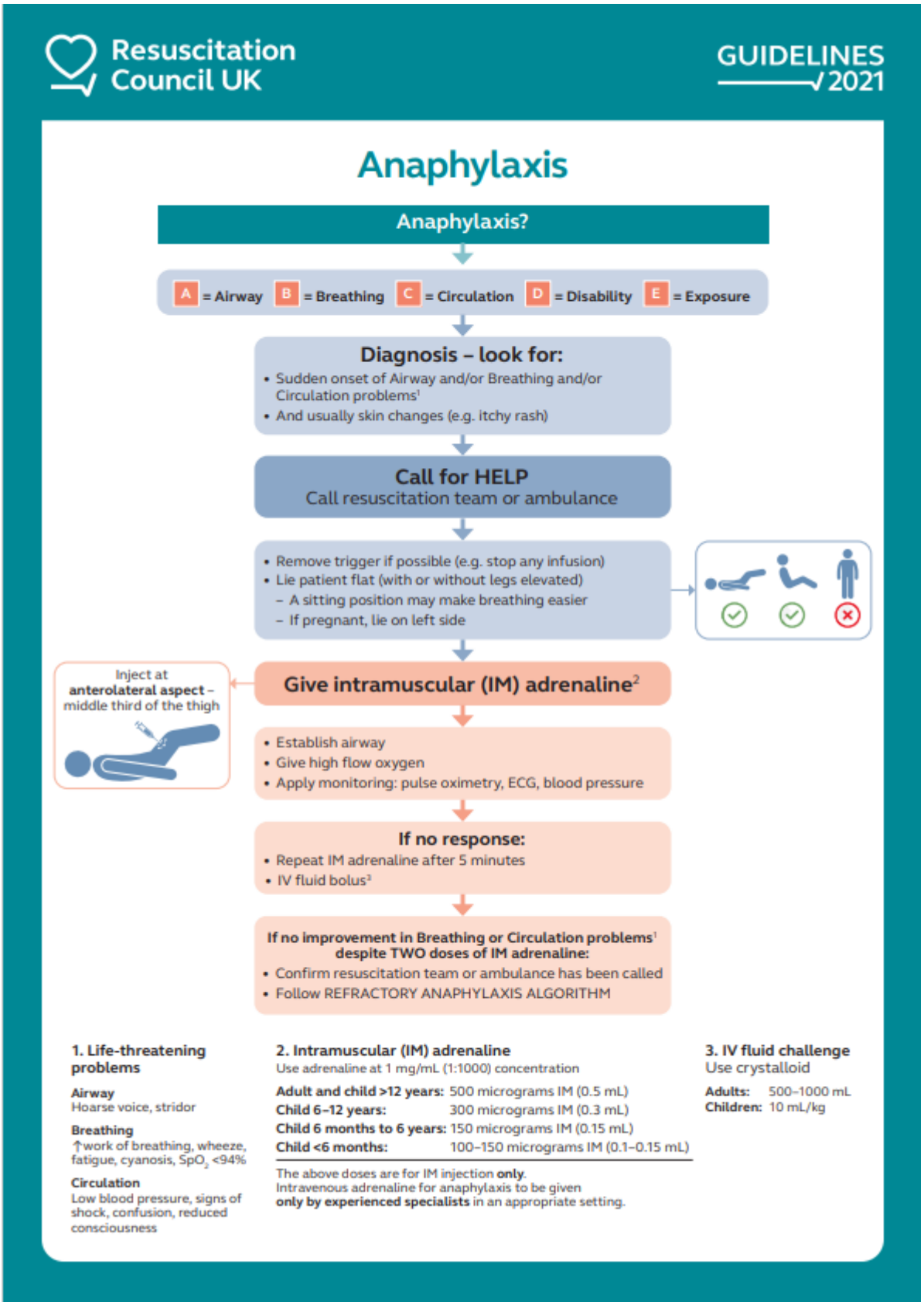
Action	Sign and date when actioned
Start oral iron: Ferrous Fumarate 210mg OD Circle method of administration: WP10 or PGD	
Provide iron deficiency anaemia patient information leaflet	

Signed …… Name…… Date ……

Appendix 2- Anaemia in Pregnancy Flowchart (Check Hb at booking and at 28 weeks)



Appendix 3- Resuscitation UK (2021) Anaphylaxis Algorithm



Resuscitation Council UK

GUIDELINES 2021

Refractory anaphylaxis

No improvement in respiratory or cardiovascular symptoms despite 2 appropriate doses of intramuscular adrenaline

Establish dedicated peripheral IV or IO access

Seek expert[1] help early
Critical care support is essential

Give rapid IV fluid bolus
e.g. 0.9% sodium chloride

&

Start adrenaline infusion
Adrenaline is essential for treating all aspects of anaphylaxis

Give IM* adrenaline every 5 minutes until adrenaline infusion has been started
*IV boluses of adrenaline are not recommended, but may be appropriate in some specialist settings (e.g. peri-operative) while an infusion is set up

Give high flow oxygen
Titrate to SpO_2 94–98%

Monitor HR, BP, pulse oximetry and ECG for cardiac arrhythmia
Take blood sample for mast cell tryptase

Follow local protocol
OR
Peripheral low-dose IV adrenaline infusion:
- 1 mg (1 mL of 1 mg/mL [1:1000]) adrenaline in 100 mL of 0.9% sodium chloride
- Prime and connect with an infusion pump via a dedicated line

DO NOT 'piggy back' on to another infusion line

DO NOT infuse on the same side as a BP cuff as this will interfere with the infusion and risk extravasation

- In both adults and children, start at 0.5–1.0 mL/kg/hour, and **titrate according to clinical response**
- Continuous monitoring and observation is mandatory
- ↑↑ BP is likely to indicate adrenaline overdose

Continue adrenaline infusion and treat ABC symptoms
Titrate according to clinical response

[1]Intravenous adrenaline for anaphylaxis to be given only by experienced specialists in an appropriate setting.

A = Airway

Partial upper airway obstruction/stridor:
Nebulised adrenaline (5mL of 1mg/mL)

Total upper airway obstruction:
Expert help needed, follow difficult airway algorithm

B = Breathing

Oxygenation is more important than intubation

If apnoeic:
- Bag mask ventilation
- Consider tracheal intubation

Severe/persistent bronchospasm:
- Nebulised salbutamol and ipratropium with oxygen
- Consider IV bolus and/or infusion of salbutamol or aminophylline
- Inhalational anaesthesia

C = Circulation

Give further fluid boluses and titrate to response:
Child 10 mL/kg per bolus
Adult 500–1000 mL per bolus
- Use glucose-free crystalloid (e.g. Hartmann's Solution, Plasma-Lyte®)

Large volumes may be required (e.g. 3–5 L in adults)

Place arterial cannula for continuous BP monitoring

Establish central venous access

IF REFRACTORY TO ADRENALINE INFUSION
Consider adding a second vasopressor **in addition** to adrenaline infusion:
- Noradrenaline, vasopressin or metaraminol
- In patients on beta-blockers, consider glucagon

Consider extracorporeal life support

Cardiac arrest – follow ALS ALGORITHM
- Start chest compressions early
- Use IV or IO adrenaline bolus (cardiac arrest protocol)
- Aggressive fluid resuscitation
- Consider prolonged resuscitation/extracorporeal CPR

Appendix 4- Ferinject Patient Information Leaflet



Ferinject is a medicine we use to boost your iron levels. It is given through a drip into the vein. It boosts your body's own production of red blood cells over time, and therefore does not carry some of the *rare* risks associated with a blood transfusion (such as infection).

Certain situations can cause your haemoglobin levels or 'blood count' to drop.

- Increased iron requirement of pregnancy
- Blood loss associated with delivery of your baby or any other causes of blood loss.
- Chronic diseases

A low blood count (anaemia) can have detrimental effects on the health of you and your baby and increase your chances of needing a blood transfusion during or after delivery.

We recommend Ferinject if:

- You are pregnant, blood tests show that you are anaemic *and*
    - you have either not responded to oral iron or have had significant side effects from oral iron.
    - you have insufficient time for the oral iron course (your delivery date is soon).
    - you have decided you do *not* want to have a blood transfusion should you bleed during the delivery of your baby e.g. Jehovah's Witness.

- You have a significant anaemia (low blood count).

Safety

Ferinject is considered safe after the first three months of pregnancy (first trimester), and after you have delivered your baby.
Because only very tiny quantities pass into the breast milk, it is safe to breast feed.

A rare, but permanent complication can be skin staining or discoloration – which happens if some of the drug leaks out of the vein during the

infusion. To reduce this risk, the cannula (plastic straw) put into your vein is first flushed with saline (salt solution) to check it is working well.

Tell the person giving the medicine immediately if you experience any burning, discomfort or swelling at the site of the injection / cannula or in the arm itself.

Other Side Effects

Common (may affect up to 1 in 10 people):

- Headache, dizziness, raised blood pressure, hot flushing, nausea and injection site reactions.
- Transient lowering of blood phosphate levels.
-

Uncommon (may affect up to 1 in 100 people):

- Sensitive skin and numbness, fast heart rate, low blood pressure, difficulty breathing, taste disturbances, vomiting, indigestion, wind, abdominal pains, constipation, hives, redness, rash, aches and pains, fever, fluid accumulation brown discoloration of the skin.
-

Rare (may affect up to 1 in 1000 people):

- Allergic reactions, shivering, feeling unwell, loss of consciousness.

Procedure

We can give Ferinject in most DAUs, on the obstetric wards and delivery suite.
Your midwife will first check your observations (blood pressure, pulse, temperature), and a cannula will be inserted into a vein - usually in your arm or the back of your hand.

Your observations will be checked afterwards and if feeling well, you can go home once the cannula has been removed – 30 minutes after the infusion has finished.

Some people need a further dose if still pregnant – this is usually 1 week after the first.

Cautions and contraindications

You should not receive Ferinject if:

- you have an anaemia caused by other deficiencies (e.g. folate or B12 deficiency)
- you have previously been told you have ‘iron overload’
- you have had a previous allergic reaction to iron
- you have liver cirrhosis or hepatitis

Do not take oral iron tablets after receiving Ferinject

Questions

If you have any questions please contact your midwife, who will be able to arrange discussion with the doctors looking after you.

Appendix 5- Ferinject Consent Form

FERINJECT CONSENT FORM

Your doctor has recommended that you receive a Ferinject infusion because your blood test shows that you are anaemic (lack of iron in the blood). Ferinject is used where you have not responded to iron tablets, or the iron tablets made you feel unwell. You may have one or more infusions depending on your iron levels.

Ferinject (also known as Ferric Carboxymaltose) is an iron preparation that is mixed with sodium chloride and given intravenously. It is given both antenatally and postnatally. As with all medications, there are possible side effects. Common side effects (affecting 1 in 10 people) may include headache, dizziness, feeling hot, high blood pressure and nausea. Uncommon side effects (affecting 1 in 100 people) may include numbness, tingling skin, high heart rate, low blood pressure, vomiting, stomach pain, itching, skin rash and muscle pain. Very rarely someone may experience feeling faint, loss of consciousness, swelling of the face, mouth and throat and difficulty breathing. This is known as anaphylaxis and is thought to affect 1 in 1000 people.

Ferinject can sometimes leak into the surrounding area of your vein, this can cause irritation of the skin and potentially long-lasting brown discolouration at the site of administration. It is very important to let your midwife know if you feel any pain or discomfort during the infusion.

With your consent, a midwife or doctor will insert a cannula into your arm or hand so that you can receive this medication. Your midwife will take your observations and listen to your baby (if you are pregnant) before starting your infusion. The infusion can take anywhere between 6-15mins depending on the dose of Ferinject you have been prescribed. Your midwife will also monitor the cannula site for any signs of complications.

I ……. consent to a Ferinject infusion after reading the information provided above.

Signature ……

Date ……

Clinician Signature …….

Please scan this consent form and upload it to the woman's Badgernet recor

Appendix 6- Anaemia Patient Information Leaflet

Can I help myself?

There are several things you can do to help yourself. These include:

A good balanced diet is essential to make sure you receive enough iron. Foods high in easily absorbed iron are red meat, fish, and poultry. For vegetarians, lentils, fortified cereals and green leafy vegetables eg spinach are all good sources. Vitamin C helps absorption but other foods and drinks may reduce absorption; tea, coffee and calcium containing foods (milk and dairy products). To give you the best chance of absorbing iron, we recommend you try and avoid these at the time of taking iron tablets

Talk to your doctor, or midwife if you think you have any of the symptoms of anaemia listed in this leaflet

Always discuss any alternative medicine, herbal preparation or over the counter treatments for anaemia with a healthcare professional before taking them.



Antenatal anaemia - the facts for expectant mothers

ABUHB

Drs Daniel Helme and Ellie Morgan

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

What is Anaemia in pregnancy?

- Anaemia is either not having enough Haemoglobin (in red blood cells) to take oxygen around the body, or having red blood cells that don't work properly.
- Haemoglobin levels normally drop in pregnancy, below a certain level is defined as anaemia.
- The commonest cause of anaemia is iron deficiency due increased iron requirements of pregnancy
- If you have any of the following risk factors, we recommend a ferritin blood test to check your iron stores
  - Previous anaemia or bleeding history
  - 3 or more children
  - Twin pregnancy
  - Recent pregnancy (within 1 year)
  - Vegetarian or vegan diet
  - If you are less than 18yrs old

Why is it a problem?

Anaemia in pregnancy can cause:

Mother

- Heavy bleeding after delivery
- Need for blood transfusion
- Susceptibility to infection
- Impaired work capacity
- Emotional disturbance

Baby

- Premature delivery
- Low birth-weight
- Developmental problems.

How can it be measured?

A simple blood test can determine whether you are anaemic

What are the signs and symptoms of anaemia?

- Weakness
- Shortness of breath
- Dizziness
- Fast or irregular heartbeat
- Pounding or "whooshing" in your ears
- Headache
- Cold hands or feet
- Pale or yellow skin
- Chest pain
- Poor concentration
- Restless leg syndrome

What treatments are available?

The mainstay of treatment in pregnancy is oral iron tablets.

They should be taken on an empty stomach with a source of vitamin C (orange juice) to improve absorption.

It is very important that if you are prescribed iron tablets but are not able to tolerate them, you inform your midwife or doctor.

If you have a very low blood count or cannot tolerate oral tablets iron can be given in the form of an intravenous infusion (through a drip).