The NHS in Newcastle, North Tyneside and Northumberland

Asymptomatic Iron Deficiency Anaemia (IDA) Referral Form

Before sending this form, please read 'General Principles' and flow charts overleaf

Name of patient:
DOB:
NHS no:
Address:

Post code:
Telephone number:

Practice:
Practice Address:

Referring doctor:
Referral date:

Preferred Hospital:

Newcastle Hospitals
Fax 0191 282 5551

RVI □
Freeman □

Northumbria Hospitals
Fax 0191 293 2571

Hexham □
North Tyneside □
Wansbeck □
AI □
BI □

Results: *(Note: incomplete forms will be returned)*

Hb :
U&Es/eGFR:
MCV:
tTG (Coeliac serology): Y / N

(<120 men, <110 women. Iron deficiency with NO anaemia may need to be investigated, see General Principles)

Ferritin:
Urine dip: Y / N

Alarm symptoms *(Please circle. If answer is "Yes" to any of these, consider referral under 2 week rule using separate appropriate form as per NICE guidance*)*

*Abdominal/rectal mass: Y / N
*Weight loss & Abdo pain: Y / N
*Altered bowel habit >60 yrs: Y / N
*IDA > 60 years: Y / N
*IDA < 50 yrs with rectal bleeding Y / N
*Dysphagia

Fitness for colonoscopy (*see general principles)*

This patient is fit for colonoscopy Yes / No
This patient will be able to take bowel prep at home Yes / No
This patient is able to give informed consent Yes / No

Other significant medical problems *(tick if yes, please give details)*

Cardiac conditions □ ……
Respiratory Conditions □ ……...

Diabetes □ Insulin □ Tablets □ Diet controlled □

Anticoagulants □ Warfarin / NOAC (……) Indication: ……...

Antiplatelets □ Clopidogrel / Prasugrel Ticagrelor / Cangrelor Indication: ……

If patient is on anticoagulants / antiplatelets, can it be stopped safely? Yes □ No □ NA □
(Follow local guidelines for stopping. If answer is "no", patient may need clinic review)

Patient suitable for direct to test ☐

Require OPD appointment *(rather than direct to test)* ☐
Reason for OPA over a nurse pre-assessment. ……

Medication printout attached ☐

Iron deficiency anaemia: General Principles. Based on *BSG 2011 guidelines* *(Gut 2011;60:1309-1316)* and *NICE guideline - Suspected cancer: recognition and referral* *(23 June 2015)*

- **IDA must be proven** on haematological and biochemical tests and urine must be dipped. Check coeliac serology. Patients with low ferritin, do not require any more tests to confirm iron deficiency. In renal disease or inflammatory conditions ferritin <50, confirms iron deficiency.

- For **premenopausal women** gastroscopy should be considered if upper GI symptoms present. **Colonoscopy is not indicated** in the absence of bowel symptoms or strong family history of colorectal cancer (1° relative <45 years or 2 affected 1° relatives). Gynaecology causes should be considered.

- **Iron deficiency without anaemia** should only be investigated in post-menopausal women and men over 50 years as yield is low.

- Patients with **microcytosis but normal ferritin** need screening for haemaglobinopathy and referral to haematology if normal (?sideroblastic anaemia).

- If patient has IDA with **Hb <8.0**, consider giving 2 weeks of iron treatment. Please advise the patient to **stop oral iron 10 days prior** to colonoscopy.

- Please ensure that the patients had **eGFR** checked within the last month, to avoid further delay awaiting this results during pre-assessment, especially they have CKD, frail, or on drugs like ACEI, diuretics, NSAIDs or NOAC etc.

- Direct to test patients will be offered OGD and colonoscopy after a nurse pre-assessment.

- Consider OPD appointment if patient is/has:
    - frail and elderly
    - cognitive impairment or learning disabilities
    - significant co-morbidities
    - concerns about direct to test route
    - recurrent iron deficiency anaemia (to avoid multiple repeat investigations)
    - ferritin >50 with anaemia or has anaemia of chronic disease
    - frail and a serious diagnosis will not alter further management. Explore patient preferences first and consider treating with iron +/- PPI without tests. Reasonable to refer these patients in Gastroenterology OPD, if GP is unsure or patient wants a second opinion.

Aspirin and Antiplatelets

Patients on low dose aspirin may continue on treatment.

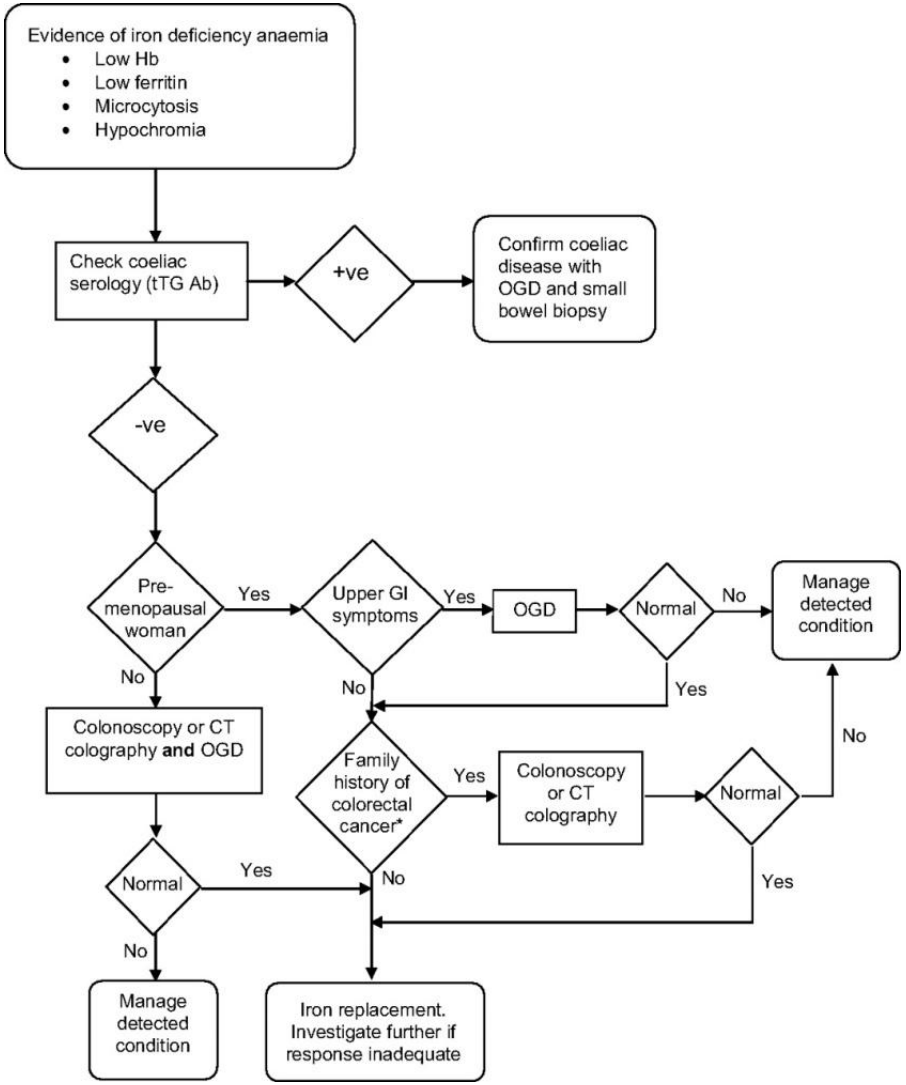
High risk antiplatelet patients *are those, who are on antiplatelets* **(Clopidogrel / Prasugrel / Ticagrelor)** *because of coronary [first 12 months] or carotid artery/other vascular stents or recent stroke.* They will be picked up during pre-assessment clinic and discussion will include a repeat procedure for polypectomy at a later date, off antiplatelets if polyps are detected with cardiology/vascular/stroke team input.

Low risk antiplatelet patients are patients who are on Clopidogrel because they can't tolerate aspirin. Clopidogrel is to be **stopped 7 days** prior to investigation.

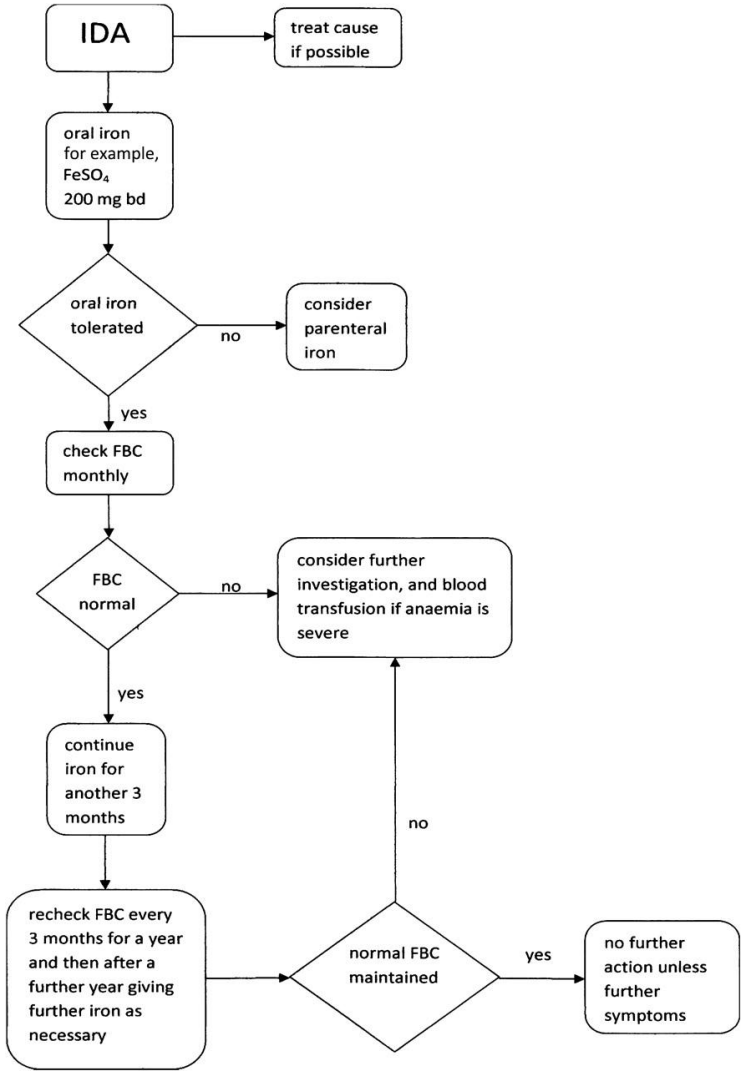
NOAC (Newer Oral Anticoagulants)

Patients on the NOACs (Rivaroxaban etc.) **need to come off them** before even low risk procedures such as OGD with biopsies as there are no reversal agents available for these. Time of stopping depends on the eGFR *(see guidance for stopping NOAC - page 4).*

Abbreviated flow chart of the investigation of iron deficiency anaemia



Abbreviated flow chart of the treatment of iron deficiency anaemia



***Source**: Guidelines for the management of iron deficiency anaemia. Gut 2011;60:1309-1316*

Guidelines for the management of patients on P2Y12 receptor antagonist antiplatelet agents or warfarin or direct oral anticoagulants (DOAC) undergoing endoscopic procedures are set out in the recent BSG guidance. *Endoscopy in patients on antiplatelet or anticoagulant therapy, including direct oral anticoagulants: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guidelines. Gut 2016;65:374–389.* See link below http://www.bsg.org.uk/images/stories/docs/clinical/guidelines/endoscopy/bsg_esge_anticoag_16.pdf (accessed 03/05/2016)

If patient has high risk condition or moderate/high risk of thrombosis making it unsafe to stop NOACs without bridging Low Molecular Weight Heparin, do not refer them for direct to test. Follow the appropriate local guidelines (Newcastle or Northumbria) on stopping NOACs.

These guidelines make recommendations for the investigation of iron deficiency anaemia. The interventions should be offered to all people who are likely to benefit, irrespective of race, disability, gender, age, sexual orientation or religion. Information should be provided to patients in an accessible format and consideration should be given to mobility and communication issues, and being aware of sensitive and cultural issues.

Membership of the Iron Deficiency Anaemia Working Group
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