

Hb anaemia: T1 <110 T2/T3 <105 Postpartum 48 h <100 g/L Ferritin: <30 µg/L confirms deficiency TSAT: <20% supports deficiency

1 Diagnose

- FBC at booking and 28 weeks
- Ferritin if anaemic or higher-risk
- Equivocal ferritin → add TSAT + CRP
- No empirical iron if haemoglobinopathy unconfirmed
- Trial oral iron may serve as diagnostic test

2 Oral iron — first-line

- Elemental iron 100–200 mg daily
- Empty stomach; avoid tea, coffee, calcium
- Review Hb at 2 weeks — expect ≈10 g/L
- Continue 3 months after Hb normalises
- Intolerance: change form · reduce · alternate-day

3 IV iron — when to escalate

- Indication: intolerance · malabsorption · non-response
- Severe Hb <90 from T2 · late ≥34 weeks
- Confine to T2/T3 unless clearly necessary
- Dose per current SPC (body-weight + Hb)
- Observe ≥30 min after every dose
- Reassess Hb no earlier than 4 weeks
- Phosphate check after FCM if risk factors

4 Postpartum

- Check Hb within 48 h if triggered
- **Hb ≥100**: oral iron · 6-week review
- **Hb 70–99**: oral iron · consider IV iron
- **Hb <70 or bleeding**: transfuse + IV iron
- Caesarean alone is NOT an automatic trigger

5 Transfusion

- Restrictive threshold Hb <70 g/L
- Single-unit reassess in non-bleeding women
- K-negative for women of childbearing age
- CMV-negative for elective pregnancy transfusion
- Do NOT delay urgent transfusion for CMV-negative

Red flags — urgent

- Suspected TTP (ADAMTS13 · PEX)
- Platelets <50 + haemolysis
- Hb fall >20 g/L in 24 h
- Deranged DIC screen
- Anaphylaxis after IV iron
- Heavy vaginal bleeding

Key cautions

- Ferritin is acute-phase
- FCM → symptomatic hypophosphataemia
- No folate alone if B12 may be low
- IV iron does NOT prevent PPD

Emerging — not UK standard

- Routine ferritin at booking + 24–28 wk
- Low-dose / alternate-day oral iron
- Adopt only as audited local policy