TREATMENT OF IRON DEFICIENCY ANAEMIA

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TREATMENT

PROPHYLACTIC

CURATIVE

PROPHYLACTIC TREATMENT

- 1. Avoidance of frequency of child births
  2. Supplementary iron therapy
  3. Dietary prescription
  4. Adequate treatment of associated conditions
  5. Monitoring of Hb regularly

CURATIVE

ANAEMIA IS A SIGN NOT A DISEASE SO AN ACURATE DIAGNOSIS SHOULD BE MADE

1. Hospitalization
2. General treatment
3. Specific therapy

When to hospitalize?

- Ideal to admit when Hb < 9gm %
  → is co But due to high prevalance in INDIA
  <7.5gm% nsidered
  →associated obstetrical medical complications
  even with moderate degree of anaemia

General treatment

- → Diet : balanced diet rich in proteins iron and vitamins
  →Improve appetite: Acid pepsin preparation thrice daily after meals
  →INFECTIONS : specific antibiotic therapy
  → Treatment of associated disorders

SPECIFIC THERAPY

- AIM : To raise the Hb level near to normal as possible thereafter to restore IRON reserve.....

Choice of therapy depends on

- 1.severity
  2. period of gestation
  3. associated complicating factors

IRON THERAPY

- ORAL ROUTE

→best absorbed in ferrous form

PREPERATIONS AVAILABLE

→Ferrous sulphate

→ Ferrous fumarate

→ Ferrous succinate

Ferrous sulphate is most commonly used

FERSOLATE TABLET contains 200mg ferrous sulphate (60mg elemental Fe and traces of copper and manganese)

- TID with or after meals
  max. dose can be 6 tabs per a day stepped up gradual in 3 to 4 days and continued till the blood picture becomes normal
  → maintenance dose is 1 tab a day for atleast 100 days following delivery to replenish the store

DRAWBACKS

- 1.Intolerance
  2.Unpredictable absorption rate
  3. With the therapeutic dose serum iron may be restored but there is difficulty in replenishing iron store

What should we observe?

- Response of therapy
  Rate of improvement
  If fails causes of failure

Contraindications of oral therapy

1. Intolerance to the oral iron
2. advanced pregnancy with severe anaemia

PARENTERAL THERAPY

- IT CAN BE
  →INTRAVENOUS
  →INTRA MUSCULAR
  indications of parenteral therapy
  1. contraindicated oral therapy
  2. patient not co operative to take oral iron
  3. advanced pregnancy cases seen for first time with severe anaemia

INTRAVENOUS ROUTE

- TOTAL DOSE INFUSION
  Iron dextran or Iron sucrose
  ADVANTAGES:
  1.Eliminate repeated painful i.m injections
  2.Treatment completed in a day and patient cn be discharged
  3. less cost
  LIMITATIONS:
  1.Unsuitable if at least 4 weeks time not available
  2.previous history of reactions

Estimation of the total requirement

- →$0.3 \times W(100\text{-}Hb\%)$ for iron dextran
  w=patients weight in pounds
  →PROCEDURE: required amount of iron is mixed with 500ml of 0.9% saline
  →DRIP RATE= 10 drops/minute for first 20min there after increased to 40drops/min

INTRAMUSCULAR THERAPY

- IRON DEXTRAN
  IRON-SORBITAL-CITRICACID IN DEXTRIN
  are the compounds can be used and contains 50mg elemental iron per ml ORAL IRON SHOULD BE SUSPENDED AT LEAST 24hrs PRIOR TO THERAPY TO AVOID REACTION
  →DRAWBACKS:
  1.PAINFUL
  2.STAINING OF SKIN
  3. ABSCESS FORMATION

BLOOD TRANSFUSION

- INDICATIONS:
  1.correct anaemia due to blood loss and PPH
  2. severe anaemia and termed pregnancy before the patient goes into labour
  3.Refractory anaemia
  4.Associated infections

Fresh properly typed grouped and cross matched packed cells are used

→80-100ml at a time with gap of >24hrs

MANAGEMENT DURING LABOUR

- FIRST STAGE:
  1.patient should br comfortable on bed
  2.oxygen inhalation
  3.strict asepsis
  SECOND STAGE:
  1.asepsis should be maintained
  2.prophylactic low forceps or vacuum delivery
  3.i.v methergin 0.2mg following the delivery of anterior shoulder
  THIRD STAGE OF LABOUR:
  1.replenish the blood lost by transfusion
  2.postpartum cardiac overload should be avoided

PUERPERIUM

- 1.prophylactic antibiotics
  2.antianaemic therapy should be continued till replenish the store

- THANK U