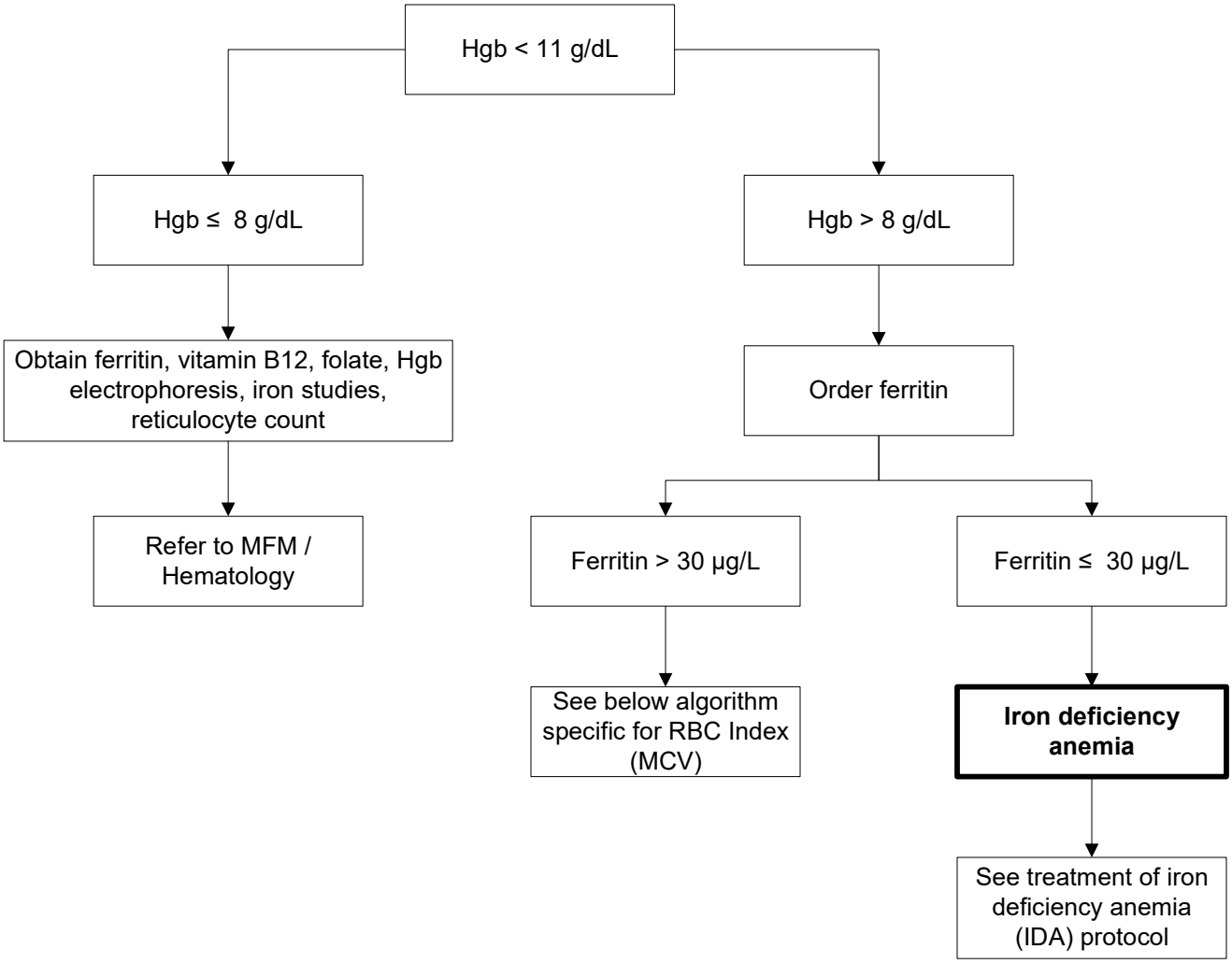
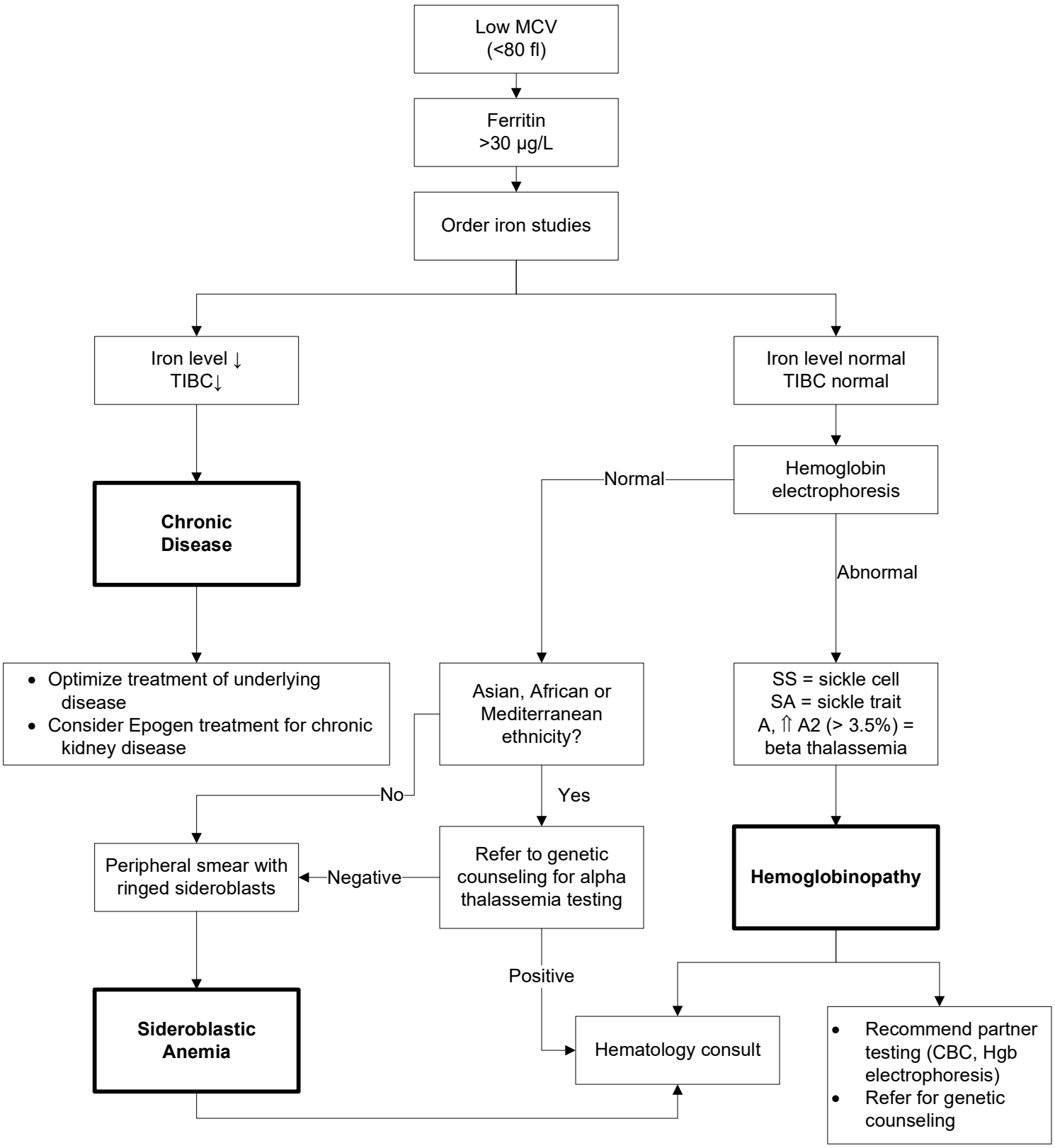
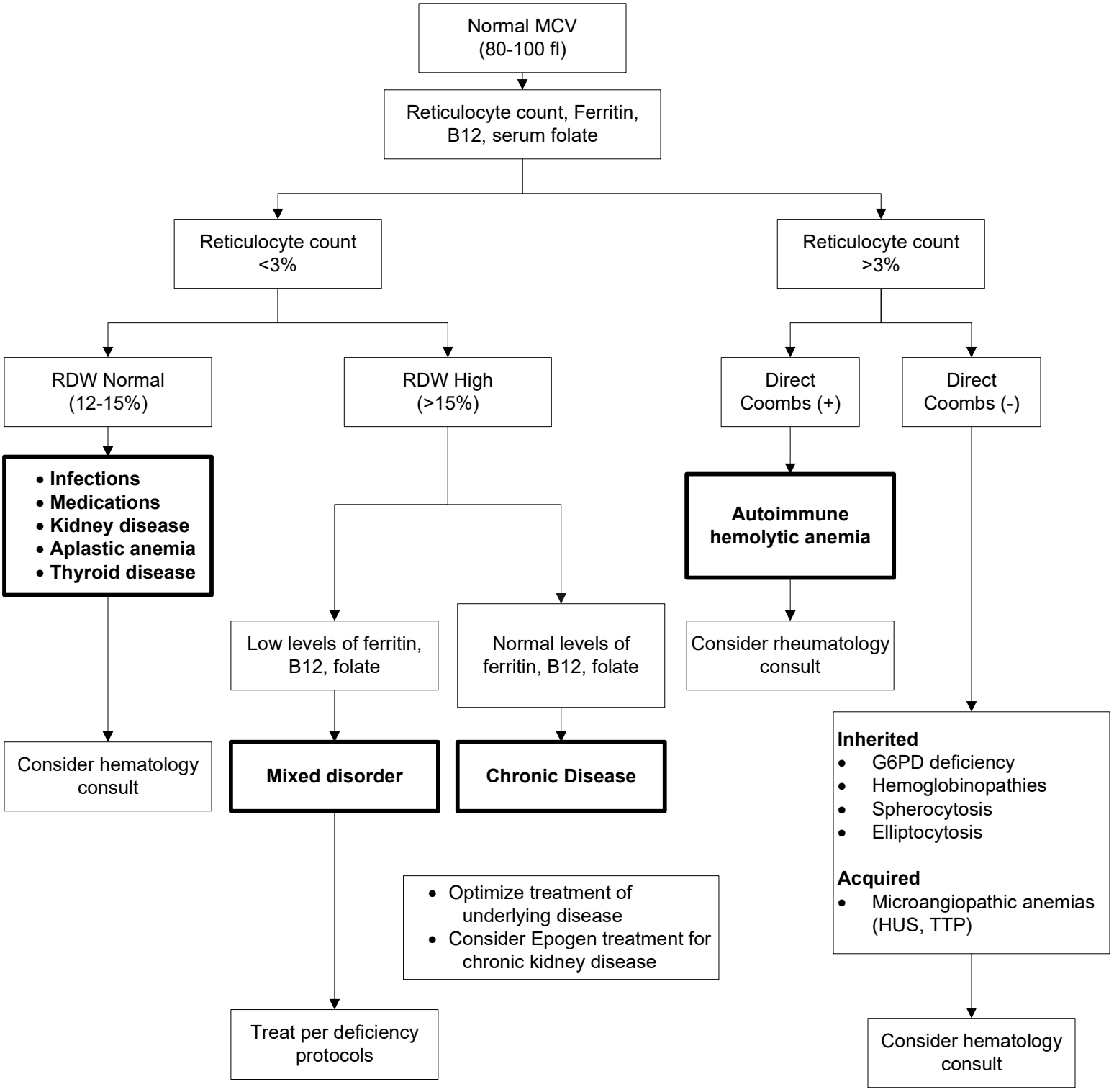
Anemia: Diagnosis



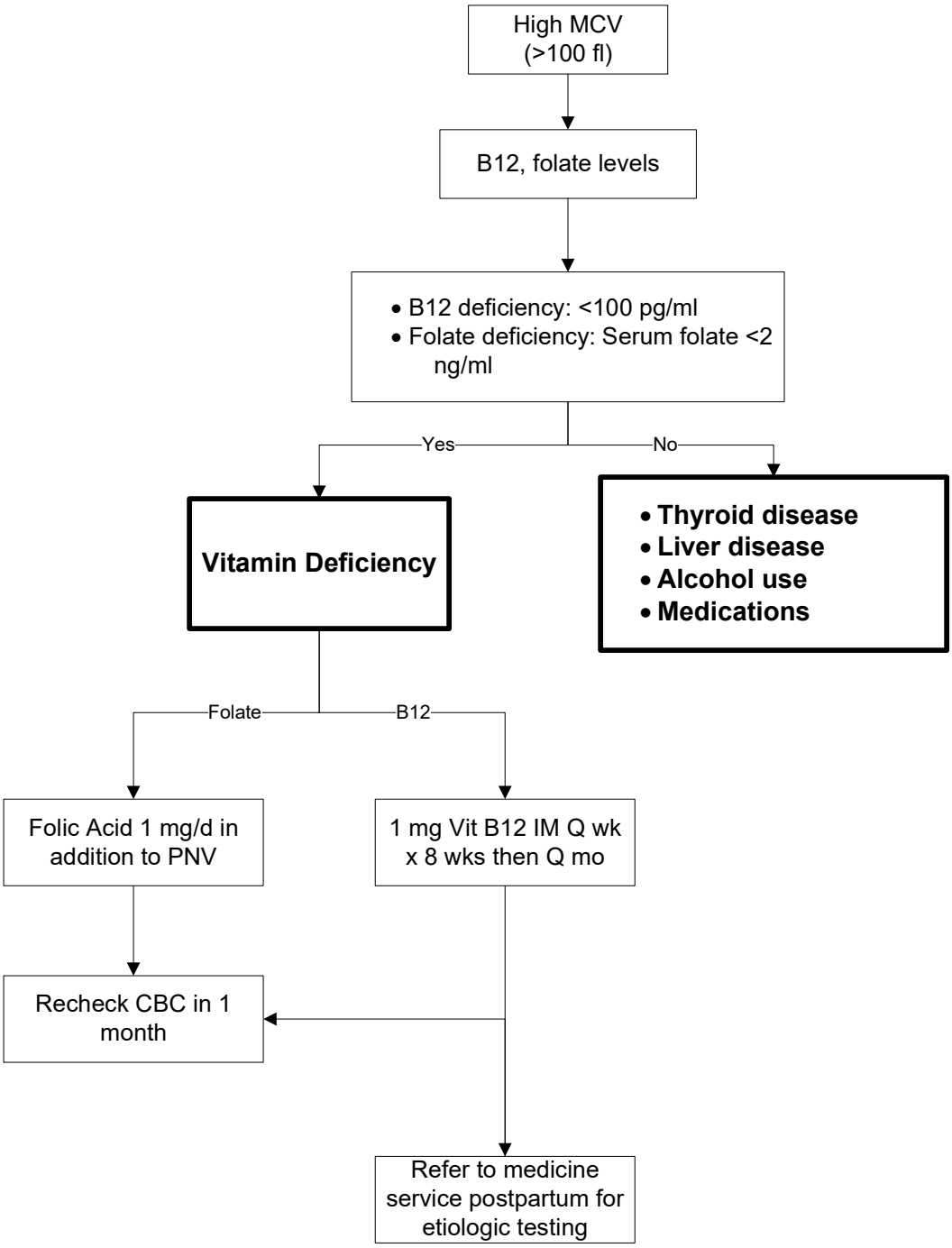
Anemia: Diagnosis (Microcytic)



Anemia: Diagnosis (Normocytic)



Anemia: Diagnosis (Macrocytic)



Anemia References:

- Anemia in Pregnancy. ACOG Practice Bulletin No. 233. American College of Obstetricians and Gynecologists. **Obstet Gynecol** 2021; 138:e55-64.

- Hemoglobinopathies in Pregnancy. ACOG Practice Bulletin No. 78. American College of Obstetricians and Gynecologists. **Obstet Gynecol** 2007; 108:229-37.

- James AH. Iron Deficiency Anemia in Pregnancy. **Obstet Gynecol** 2021; 138(4):663-674.

- Sifakis S, Angelakis E, Vardaki E, Koumantaki Y, Matalliotakis I, Koumantakis E. Erythropoetin in the treatment of iron deficiency anemia during pregnancy" **Gynecol Obstet Invest** 2001; 51; 150-6. rHuEPO combined with parental iron is an effective treatment for moderate and severe anemia during pregnancy, with minimal adverse side effects.

- Braunwald E, Fauci AS, Isselbacher KJ, Kasper DL, Hauser SL, Longo DL, Jameson JL, editors. Ch 107: Megaloblastic anemia IN: Harrison's Online. The McGraw Hill Publishers; 2001-2004. Available from: http://accessmedicine.com/resourceTOC.aspx?resourceID=4. Measurement of the RBC folate level provides useful information because it is not subject to short-term fluctuations in folate intake and is better than serum folate as an index of folate stores.

- Campbell BA. Megaloblastic anemia in pregnancy. **Clin Obstet Gynecol** 1995; 38: 460. If folate deficiency is determined to be the cause of the megaloblastic anemia, then oral replacement is generally sufficient with 1 mg per day.

- Campbell BA. Megaloblastic anemia in pregnancy. **Clin Obstet Gynecol** 1995; 38: 460. If vitamin B12 deficiency is confirmed, parenteral therapy should begin with 1000 ug cyanocobalamin given once a week for 8 weeks followed by monthly injections.

- Means RT et al. Diagnostic Approach to Anemia in Adults, in UptoDate® May, 2022.

NOTIFICATION TO USERS

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur in pregnancy. They should not be interpreted as standard of care but instead represent guidelines for the management of these patients. Variation in practice should be taken into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities. The algorithms remain the intellectual property of the University of North Carolina School of Medicine at Chapel Hill. They cannot be reproduced in whole or part without the expressed permission of the school.