### INTRODUCTION
- Screening of asymptomatic children (6-24 mo) without risk factors is not recommended.
- Risk factors: h/o prematurity, exclusive breastfeeding, low SES, recent immigration to US, cow’s milk intake >16-24oz per day.
- Excessive milk consumption in toddlers and menstrual losses in girls are common causes; in boys and premenarchal girls, IDA suggests GI bleeding until proven otherwise.

http://contemporarypediatrics.modernmedicine.com/contemporary-pediatrics/content/tags/american-academy-pediatrics/iron-deficiency-anemia-toddlers-tee

### INITIAL EVALUATION AND MANAGEMENT BY PRIMARY CARE
- Confirm anemia with CBC + retic: Interpret with age-specific norms.
- For microcytic, hypochromic anemia: 3-5 mg/kg/day elemental Fe, divided BID; consider a stool softener; Hb should markedly improve, even normalize, within 30 days.
- Continue iron for at least 3 months after Hb normalizes to replete storage levels.
- If inadequate response to therapy, send serum ferritin, iron, and TIBC. Investigate compliance.

#### For toddlers/young children:
- Excessive milk intake MUST be addressed.
- Give iron suspension with citrus juice through a straw to maximize absorption and minimize tooth staining.
- If anemia responds, sending iron studies is not necessary.

#### For older children/adolescents:
- Menstrual losses should be assessed.
- Consider stool guaiac at diagnosis.
- Maximum Fe dose: 65mg elemental iron twice daily (325mg FeSO4 tab).
- Resistant IDA may need GI evaluation

### WHEN TO REFER
- If Hb does not improve with dietary and medication compliance.
- If transfusion is needed.
- If menorrhagia raises concern for a bleeding disorder.

### HOW TO REFER
- (413) 794-KIDS
- (413) 794-9338 (Pediatric Hematology at Baystate Regional Cancer Program)

### WHAT TO EXPECT FROM BAYSTATE CHILDREN’S HOSPITAL VISIT
- Investigation for hemoglobinopathy and other causes of anemia.
- Treatment and counseling

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