

## Guidelines

# Diagnosis of chronic anaemia in gastrointestinal disorders: A guideline by the Italian Association of Hospital Gastroenterologists and Endoscopists (AIGO) and the Italian Society of Paediatric Gastroenterology Hepatology and Nutrition (SIGENP)



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## ABSTRACT

Anaemia is a common pathologic condition, present in almost 5% of the adult population. Iron deficiency is the most common cause; other mechanisms can be involved, making anaemia a multi-factorial disorder in most cases. Anaemia being a frequent manifestation in the diseases of the gastrointestinal tract, patients are often referred to gastroenterologists. Furthermore, upper and lower endoscopy and enteroscopy are pivotal to the diagnostic roadmap of anaemia. In spite of its relevance in the daily clinical practice, there is a limited number of gastroenterological guidelines dedicated to the diagnosis of anaemia. For this reason, the Italian Association of Hospital Gastroenterologists and Endoscopists and the Italian Society of Paediatric Gastroenterology, Hepatology and Nutrition commissioned a panel of experts to prepare a specific guideline on anaemia and its diagnostic roadmap in the gastroenterological scenario. The panel also discussed about the potential involvement of gastroenterologists and endoscopists in the management of patients with anaemia, with particular attention to the correct use of investigations. The panel

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paid particular attention to practical issues with the aim to support gastroenterologists in their clinical practice when dealing with patients with anaemia.

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## 1. Introduction

Anaemia is a worldwide pathological condition that affects almost 5% of the adult population in the Western countries, iron deficiency (ID) being its most frequent cause [1,2]. The disorders of the gastrointestinal (GI) tract frequently lead to an anaemic status and thus patients are frequently referred to a gastroenterologist [3,4]. GI diseases can induce anaemia through different mechanisms: malabsorption (e.g. coeliac disease, CD) [5], obscure bleeding (e.g. intestinal vascular malformations) [6], chronic inflammation (e.g. inflammatory bowel disease) [7], autoimmune reactions against specific factors (e.g. pernicious anaemia) [8] or, frequently, as a consequence of combined mechanisms. Furthermore, anaemia is a major indication for endoscopy (upper, lower and, in specific cases, enteroscopy) and thus, gastroenterologists should be aware about the differential diagnosis, blood and faecal tests, and diagnostic procedures to use when facing anaemic patients [3]. In spite of its relevance in daily clinical practice, only a few guidelines specifically written for the gastroenterological setting have been published, none of which from the Italian gastroenterological societies [3,9–11].

The present guideline aims to support gastroenterologists in their practice when dealing with patients with anaemia. Apart the necessity to develop a national guideline and differently from the other published guidelines, the proposed one focused on the role of the gastroenterologists and endoscopists in the diagnostic process of patients with anaemia presenting specific sections and including the pediatric and adult settings.

## 2. Methods

In March 2017 the Italian Association of Hospital Gastroenterologists and Endoscopists (AIGO), supported by the Italian Society of Paediatric Gastroenterology, Hepatology and Nutrition (SIGNEP), commissioned a panel of experts, with the aim to prepare a guideline to support specialists in the diagnosis of anaemia related to GI tract diseases. Furthermore, the panel was supported by two members of the Italian Society of Hematology (MDC and IM). The specific tasks carried out by the panel members are reported in the Supplementary File 1 herewith provided.

Key questions were developed following the PICO format [12] and voted. A PubMed/EMBASE search for English-written articles, with no time limits and using appropriate MeSH terms (Supplementary File 1) was performed. Regular conference calls, web-based exchanges and two intermediate meetings were scheduled. The levels of evidence and recommendations were defined for every part of the statement according to the GRADE system [13]. At the end, the panel voted the statements. For clearness, a list of abbreviation is reported in supplementary file 2.

## 3. Classification, diagnosis and clinical biomarkers of anaemia

Anaemia is defined as haemoglobin (Hb) levels <12 g/dl in women and <13 g/dl in men [1]. It is found in one third of the world population and children aged <5 years and women have the highest burden. Half of the cases of anaemia worldwide are due to ID [14]. For practical purposes, anaemia can be classified on the basis

of either the mean cellular volume (MCV), or the underlying pathological mechanism (hypoproliferative, maturation abnormalities, increased destruction of red cells) or the patient's clinical history (acquired or congenital, acute or chronic). In the presence of low MCV (<80 fl), the iron status (serum iron, transferrin, transferrin saturation or total iron capacity and ferritin) is necessary to identify ID anaemia (IDA) [15]. However, a normal MCV level does not exclude the presence of ID, the same way as in chronic inflammatory diseases. Recently, a panel of experts defined ID in chronic inflammatory disorders as "a health-related condition in which iron availability is insufficient to meet the body needs" and the following cut-off values have been proposed for diagnosis: i) serum ferritin <100 mcg/L or transferrin saturation (TSAT) <20%; ii) serum ferritin between 100 mcg/L and 300 mcg/L and TSAT <20% [16]. A high level of MCV (>100 fl) is found in "megaloblastic anaemia", usually due to nutritional deficiency or malabsorption of vitamin B<sub>12</sub> and/or folate [17]. In order to evaluate the underlying pathological mechanism, reticulocyte count, a marker of red blood cell production can direct further investigation. Reticulocytes are usually expressed as percentage of the number of red blood cells or as an absolute number, but the most appropriate parameter is the reticulocyte index (RI): Reticulocyte% × Ht × normal 45%<sup>-1</sup> (for example in case of reticulocyte 2%, Ht 45% the RI is 2) which is corrected for the severity of anaemia. Several novel serological bio-markers are today available to diagnose, classify and evaluate the therapeutic response (Table 1).

### 3.1. Faecal occult blood test

Noteworthy, the use of the stool-based tests is frequently inappropriately used in clinical practice. Thanks to their diagnostic accuracy and non-invasiveness, they are widely carried out in primary care and recommended as first-line screening tools for colorectal cancer (CRC) [18,19]. The most frequently used stool-based CRC screening tests are the guaiac-based faecal occult blood test (gFOBT), and the faecal immunochemical test (FIT). Stool-based tests are a screening tool and, therefore, should be reserved for asymptomatic subjects within the average-risk cohort for CRC screening. The inadequate use of stool-based tests (e.g. outside the age criteria or on subjects with a life expectancy less than 10 years or patients with a family history of CRC who should better undergo direct colonoscopy) increases the number of inappropriate colonoscopies, the amount of costs and overall exposure to potential endoscopic complications [20]. Moreover, stool-based screening tests should not be used in symptomatic subjects such as those reporting anaemia, ID, overt gastrointestinal bleeding, non-bloody diarrhea, abdominal pain or change in bowel habits, as their use postpones the necessary endoscopic investigation, thus leading to diagnostic delays [21,22].

#### 3.1.1. Panel recommendations

- Stool-based tests (FOBT or FIT) should not be carried out on patients with anaemia to investigate its origin (strong recommendation, moderate level of evidence).**

*Vote result: strongly agree 60%, agree 26.7%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 6.7%*

**Table 1**

Serological biomarkers available for diagnosing, classifying and managing anaemia.

Biomarker	Normal range	Clinical utility
Haemoglobin	Adult Male: 13–18 g/dl. Adult Female: 12–16 g/dl.	To diagnose anaemia. To evaluate therapeutic response.
Mean cellular volume, MCV	80–100 fl	To define Normo-/Macro-/Micro-cytic anaemia.
Mean corpuscular haemoglobin, MCH	26–32 pg/cell	To define Normo-/Iper-/Ipo-chromic anemia.
Mean corpuscular haemoglobin concentration, MCHC	32%–36%	To define Normo-/Iper-/Ipo-chromic anemia.
Red blood cell distribution width, RDW	11.8%–15.6%	To evaluate RBC distribution. If increased: suspicion of concomitant presence of different populations of RBC (as in iron and/or folate and/or vitamin B <sub>12</sub> deficiency) or presence of reticulocytes. Index of erythropoietic activity.
Reticulocytes	Absolute values: 25–75 × 10 <sup>9</sup> /l Reticulocytes Index: 0.5%–2.5%	
Ferritin	20–200 mcg/l	It reflects the total amount of iron deposits in the body and is essential to define iron deficiency. Inflammatory protein.
Transferrin	240–360 mg/dl	Main iron transport protein in the bloodstream. Usually increased in iron deficiency anemia, pregnancy, estrogen administration and decreased during iron overload, malnutrition, inflammatory condition Useful to distinguish anaemia due to chronic disorders from iron deficiency anaemia.
Total iron binding capacity, TIBC	240–450 mcg/dl	Indirect measurement of transferrin's capacity of binding iron. Increased in iron deficiency.
Transferrin saturation, TSAT	males: 20%–50% females: 15%–50%	Sideraemia/TIBC × 100 Indirect measurement of transferrin's capacity of binding iron. Usually decrease in iron deficiency and increase in iron overload.
Sideraemia	53–167 mcg/dl	Not indicative of body deposits. If decreased: severe iron deficiency, chronic and/or neoplastic and/or inflammatory diseases. Limited diagnostic value (significant decrease only when the body deposits are almost depleted).
Soluble transferrin receptor	4–7 mg/l	Increased in hyperplastic erythropoiesis and/or iron deficiency. Decreased in hypoplastic erythropoiesis Useful to distinguish iron deficiency anaemia from anaemia caused by chronic or inflammatory diseases.
Hepcidin	Variable values (based on different laboratory methods, nonstandardized normal values are available)	Liver peptide hormone. It regulates iron homeostasis. Acute phase protein. Increased in chronic inflammatory conditions.
Zinc Protoporphyrin	Variable values (based on different laboratory methods, no standardized normal values are available)	
Erythropoietin	2–25 U/l	Hormone stimulating erythropoiesis. Decreased in chronic kidney disease.
Vitamin B12	150–900 pg/ml	Decreased in megaloblastic anaemia.
Folate	2.7–17 ng/ml	Decreased in megaloblastic anaemia.
Haptoglobin	32–205 mg/dl	Protein binding the extra-globular haemoglobin and conveying it to the reticuloendothelial system. Decreased in hemolytic anemia.
Bilirubin	Total: 0.3–1.0 mg/dl Direct: 0.0–0.4 mg/dl Indirect: 0.1–1.0 mg/dl	Increased in hemolytic anaemia (total and indirect).
Lactate dehydrogenase, LDH	135–225 U/l	Intra-cytoplasmatic enzyme. Increased in haemolytic anemia.
Urinary hemoglobin	Absent	Increased in haemolytic anaemia.
Urinary urobilinogen	<0.2 EU/dl	Increased in haemolytic anaemia.

#### 4. Role of endoscopy

##### 4.1. Upper endoscopy

Although invasive, upper endoscopy is widely carried out in the Western countries. Considering the demographic characteristics and clinical history of a patient, it is possible to schedule an adequate strategy and a correct timing for upper endoscopy. IDA in pre-menopausal women is usually attributed to excessive menstrual blood loss (9% to 14% of all women) [23] or to an inadequate dietary intake [24]. In this subset of subjects, if the gynaecological work-up is unremarkable and patients do not respond to iron replacement therapy (IRT), upper endoscopy should firstly be performed to exclude occult blood bleeding from gastric or duodenal GI lesions [25–27]. Significant upper GI tract lesions are present in up to 30% of pre-menopausal women with IDA, as erosive lesions caused by *H. pylori* or NSAID use (55%–68% of cases); upper GI cancers are very rare (0%–3%) [27]. All pre-menopausal women with anaemia should be screened for coeliac disease (CD), which is present in up to 6% of them [25] and duodenal biopsies should be taken.

An increased risk of diagnosing GI cancer within the subsequent two years was observed among men and post-menopausal women with IDA (in 6% of patients older than 50 years and in 9% of women older 65 years) [28]. With these groups of patients, GI sources of bleeding should be excluded, as the first step of the diagnostic flowchart. The current recommendations from the American Family Physicians [29] support upper endoscopy as the first investigation; however, there are no clear guidelines about the correct sequence of the endoscopic investigations [30]. In patients over 50 years, the colonoscopy-first strategy should be preferred [31].

The existence of site-specific symptoms can be a disease predictor, suggesting the route of insertion (upper or lower) [32]. If necessary, upper and lower GI endoscopy can be performed in the same session and the combination of both exams is highly specific to localize any bleeding GI sites that cause anaemia [33,34].

Upper endoscopy can find the cause of digestive bleeding in about 90% of symptomatic cases; its diagnostic yield (DY) drops to 62%–70% in case of asymptomatic patients [32]. Noteworthy, lesions can be missed at the first investigation in about 10% of all upper endoscopies [35]; superficial lesions in hiatal hernia or vascular ectasia of the upper GI tract are often underdiagnosed and

can be difficult to detect. Simultaneous lesions of both the upper and lower gastrointestinal tracts have been found in 9% [36]. An upper GI bleeding source is found in more than one third of the patients with IDA, and most of the lesions are benign [37]. It is important to consider also the existence of non-bleeding sources of IDA, including: CD, gastric surgery, atrophic gastritis, *H. pylori* infection, autoimmune gastritis [37]. For these reasons upper GI endoscopy should include random gastric antral and fund biopsies in addition to duodenal biopsies [38].

It is still unclear whether site-specific symptoms (in the upper and/or lower GI tract) are really predictors of a bleeding lesion at the corresponding site [39,40,41]. Predictors comprise: abdominal symptoms, weight loss ( $\Delta -10\%$  of body weight), and haemoglobin level <10 g/dl with MCV <72 fl. The prevalence of GI cancers in patients with non-ID anaemia is low as compared with patients with IDA (up to 15%) [42]. Although the ferritin cut-off value to be considered in anaemic patients as a predictor of malignancy is not clear, evaluating the GI tract of patients with ferritin levels higher than 100 ng/ml (in the absence of an acute phase response) by endoscopy should not be considered, but the evidence available is still scanty [43,44].

If upper endoscopy is normal and anaemia is not severe without alarm symptoms, oral IRT and a watch-and-wait strategy can be carried out. For patients that do not respond to IRT or with suspected serious illness, a second look by endoscopy may be justified [45].

#### 4.1.1. Panel recommendations

- Upper endoscopy should be performed on pre-menopausal women, in case of failure of the iron replacement therapy (strong recommendation, low level of evidence).*

*Vote result: strongly agree 33.3%, agree 60%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- In case of macroscopically negative upper endoscopy, gastric and duodenal biopsies should be taken in order to exclude coeliac disease and autoimmune gastritis (strong recommendation, low level of evidence).*

*Vote result: strongly agree 53.3%, agree 40%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- Upper endoscopy is often complementary to colonoscopy in the search of a bleeding source. When a source is found in patients aged over 50 years, we suggest avoiding colonoscopy only in the presence of an upper GI cancer (weak recommendation, low level of evidence)*

*Vote result: strongly agree 40%, agree 46.7%, moderately agree 13.3%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

#### 4.2. Lower endoscopy

Blood loss from the GI tract is the most frequent cause of IDA in men and post-menopausal women [46]. Among post-menopausal women and adult men with IDA, upper endoscopy and colonoscopy reveal upper GI lesions in 7%–72%, lower GI lesions in 7%–58%, and lesions affecting both tracts in 0%–29% of the cases. The main colonoscopy findings are: colorectal cancer (0%–34%), adenomas (1%–27%), inflammatory bowel disease (0.4%–10%) and angiodysplasia (0%–7%) [47]. In pre-menopausal women with IDA the DY of endoscopic investigations is up to 95% for upper GI lesions and up to 16% for lower GI lesions. In this group the prevalence of cancer is low (0%–6%) and mostly found in patients aged over 40 years [28]. Based on these findings [48] and the high prevalence of

GI malignancies in adults, the current guidelines recommend that upper and lower GI investigations should be offered to patients aged >50 years [3]. As previously mentioned, the order of the investigations should be guided by the suggestive symptoms (when present), although colonoscopy should be prioritized for patients aged >50 years, because of the high prevalence (roughly 10%) of CRC in this scenario [49].

In pre-menopausal women presenting IDA GI bleedings have been found, mainly, in the upper GI tract while lesions of the lower GI tract have been infrequently described [47]. The guidelines from the British Society of Gastroenterology (BSG) recommend colonoscopy for pre-menopausal <50 years old women with lower abdominal symptoms, a family history for CRC or persistent IDA in spite of IRT [3]. Furthermore, despite the lack of evidence, the BSG guidelines recommend that young men (<50 years old) with IDA should be investigated in the same manner as older men [3]. This recommendation is weakly supported by the few published studies, which have confirmed the infrequent presence of any significant lower GI pathology in young men with IDA [50–52]. A recent study compared colonoscopy findings in young patients (both male and female, aged 40–49 years) to the average-risk of individuals aged 50–54 years undergoing colonoscopy. It concluded that young patients with IDA have a significant lower risk of advanced neoplasia, therefore it would be less likely that they were to benefit from colonoscopy [52]. Noteworthy, the possible increase in the DY by adding ileoscopy during standard colonoscopy has not been specifically investigated in the setting of anaemia; however, the potential usefulness of ileitis detection in this setting represents a potential indication.

#### 4.2.1. Panel recommendations

- Colonoscopy should be performed on all men and post-menopausal women with IDA (strong recommendation, low quality of evidence).*

*Vote result: strongly agree 66.7%, agree 26.7%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- The visualization of the distal ileum during standard endoscopy should be performed to reveal the presence of ileitis (conditional recommendation, low quality of evidence).*

*Vote result: strongly agree 26.7%, agree 60%, moderately agree 13.3%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- Colonoscopy should be performed on pre-menopausal women with IDA in one or more of the following scenarios: proven absence of a gynaecological cause of IDA, strong family history for CRC, presence of lower abdominal symptoms, failure to respond to IRT (strong recommendation, low quality of evidence).*

*Vote result: strongly agree 53.3%, agree 46.7%, moderately agree 0%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

#### 4.3. Small-bowel endoscopy

In case of normal findings at upper and lower gastrointestinal endoscopy, the small bowel (SB) of anaemic patients, should be deeply investigated [53–57]. A systematic review with meta-analysis, including 24 studies and 1960 patients with IDA, has provided an overall pooled DY of capsule enteroscopy (CE) of 47% (95% CI, 42–52) [58]. In 4 studies (264 patients) focusing on patients with IDA, the DY was 66% (95% CI, 61–72). The most frequently detected lesions were: vascular (31%), inflammatory (18%), and mass/tumor (8%). Noteworthy, a similar finding frequency was for patients less than 50 years of age, underlying the usefulness of CE

for young patients [59]. Furthermore, in case of normal CE results, a watch-and-wait strategy with scheduled clinical re-evaluation is advised by recent guidelines and meta-analyses [53,55–59].

Endoscopic SB exploration is nowadays feasible by means of CE (for diagnostic purposes) and device-assisted enteroscopy (DAE, diagnostic and therapeutic options). A meta-analysis [60] compared the DY of CE vs. double-balloon enteroscopy (DBE) in patients with obscure GI bleeding. The authors pooled the data from 10 studies: the DY was 62% (95% CI, 47–76) for CE and 56% (95% CI, 48–62) for DBE, with an odds ratio for CE compared with DBE of 1.4 (95% CI, 0.9–2.2). A sub-group analysis demonstrated that the DY of a CE-DBE sequential approach was 75% (95% CI, 60–90), with an odds ratio of 1.8 (95% CI, 1–3). Conversely, the DY of DBE after a negative CE was 27% (95% CI, 16–38). Moreover, the CE finding facilitates the decision about the route of insertion and is associated with better long-term outcomes, decreased number of complications and more effective use of endoscopic resources [61].

In a meta-analysis pooling 46 studies and 5796 patients [62], the overall risk of re-bleeding was significantly higher after positive CE compared to negative CE in the Asian studies (OR: 1.8; 95% CI, 1.1–3). The application of a specific therapy after a positive CE index was associated with a lower re-bleeding risk in both the Western (OR 0.4; 95% CI, 0.2–0.9) and Eastern (OR 0.4; 95% CI, 0.2–0.7) populations independently of the bleeding presentation (overt vs. occult).

#### 4.3.1. Panel recommendations

- For patients with anaemia and suspected obscure mid gut bleeding, CE is the first-line diagnostic tool (strong recommendation, low level of evidence).

*Vote result: strongly agree 66.7%, agree 33.3%, moderately agree 0%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- DAE should be performed as the second-line intervention and in case of operative enteroscopy or biopsic sampling (strong recommendation, moderate level of evidence).

*Vote result: strongly agree 60%, agree 33.3%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

## 5. Role of radiologic imaging of the gastrointestinal tract

The studies evaluating the role of imaging techniques in assessing patients with anaemia have focused on computed tomography (CT) and magnetic resonance (MR). Beyond the low invasiveness, the advantages of cross-sectional imaging include the ability to examine the bowel loops throughout, with no superimposition, and the visualization of extra-luminal structures. Imaging can be performed by either enterography technique, requiring ingestion of large volumes of contrast medium, or enteroclysis, with direct administration of enteric fluid by a nasoenteric tube. The majority of studies focused on CT, which features superior temporal and spatial resolution, as compared with MR, and is widely available. Other imaging techniques are not considered; in particular, a specific role of ultrasound is not defined. The barium examination of the SB shows a low DY (3%–17%) [55] in detecting abnormalities in suspected SB bleeding. Some studies have demonstrated that CT enterography (CTE) is potentially useful to detect the source of GI bleeding in patients with overt but not occult bleeding. In absence of overt bleeding, imaging techniques can be considered for selected patients when conventional endoscopy and CE are inconclusive. The majority of CT studies compared the DY of radiology to that of endoscopy (such as CE and DAE) in case of obscure GI bleeding (OGIB). The DY of CE and CTE may be dependent upon

the underlying causes of OGIB, thus CTE should not be considered as a first-line investigation but rather as a complementary examination to CE and it can help to determine the cause of OGIB in selected patients. Compared with cross-sectional imaging, CE is uniformly superior to detect vascular abnormalities, whereas cross-sectional imaging can identify masses and some inflammatory changes missed at CE [63,64].

A single prospective study comparing CE and CTE in IDA has been published [65]. CE demonstrated to be superior to SB enteroclysis (DY 57% vs. 12%) and CTE (DY 78% vs. 22%) for patients with unexplained IDA and negative results at routine endoscopy [65]. However, the combination of the two techniques reached diagnosis in 37 out of 45 patients (82%). Other studies have reported significantly lower results in the subset of OGIB with a DY for CTE ranging from 10%–15% [66,67] to 30% [68]. A few other small-scale studies (with case series including patients with both overt and obscure bleeding) have failed to demonstrate any significant difference between CE and CTE even if the DY of CE showed superior [64,69,70]. With regard to OGIB, DAE has a higher DY than DAE; however, a complementary role of CE, CTE and DAE has been suggested in a recent retrospective study [68] which demonstrated that the DY for DAE could be increased after obtaining a previous examination with CE or CTE, in order to assess the better enteroscopic approach.

MR enterography (MRE) is a non-invasive imaging technique with a known role in monitoring the disease activity and complications of Crohn's disease (CrD). The usefulness of MRE extends to the investigation of patients with symptoms related to the jejunoleal tract, including suspected midgut bleeding. In this setting, MRE is both alternative and complementary to CE with a prominent role when obstructive symptoms are present and in case of young age because of the prevalence of SB tumors and CrD in young patients with IDA. Moreover, the absence of ionizing radiation represents the major strength of MRE, along with rapid image acquisition and high-contrast resolution. Oral and intravenous contrast agents enable the detection of intestinal wall abnormalities. Nevertheless, some limitation in diagnostic accuracy has been measured due to the sub-optimal distension of the proximal intestinal tract. The data from the literature is limited in terms of adequate inter-comparison of SB imaging techniques. MR role has been explored in prospective and retrospective studies in which the enrolment criteria consisted in IDA and/or GI symptoms suggestive of SB disease [71,72]. In those studies, MRE and CE showed comparable DY as to suspected mid-gut bleeding; however, a warning rose about a tendency towards limited radiologic accuracy in the proximal SB tract [72]. The head-to-head comparison of MRE and CE DY, using DBE and expert panel consensus as the reference standard, was accomplished by designing a prospective study including 38 OGIB patients [73]: CE and MRE resulted in 61% (95% CI, 36–81) and 21% (95% CI, 7–46) sensitivity and 85% (95% CI, 61–96) and 100% (95% CI, 9–100) specificity vs. the reference standard, respectively. The performance of CE strengthened its role as the first-choice option in suspected mid-gut bleeding cases and outlined the alternative and complementary usefulness of MRE in this context.

#### 5.1. Panel recommendation

- For patients with anaemia, cross-sectional imaging, such as MR and CT, is not indicated as a first-line investigation (strong recommendation, moderate level of evidence).

*Vote result: strongly agree 40%, agree 53.3%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- With IDA and suspected OGIB, CTE and MRE may be complementary to CE (and DAE) for selected patients with non-diagnostic CE,

contraindication to CE and/or suspected SB tumor (strong recommendation, moderate level of evidence).

**Vote result:** strongly agree 53.3%, agree 46.7%, moderately agree 0%, moderately disagree 0%, disagree 0%, strongly disagree 0%

- MRE represents a valuable diagnostic tool for IDA patients under high clinical suspicion of SB neoplasia (strong recommendation, low level of evidence).

**Vote result:** strongly agree 26.7%, agree 73.3%, moderately agree 0%, moderately disagree 0%, disagree 0%, strongly disagree 0%

## 6. Specific factors

### 6.1. *Helicobacter pylori*

*H. pylori* infection is a chronic disease that may cause IDA through different mechanisms, including blood loss, iron malabsorption, and iron consumption [74]. Occult blood loss may occur from infection-induced ulcerative or erosive lesions in the gastro-duodenal mucosa. *H. pylori*-associated chronic active gastritis, particularly when pangastritis or atrophy develops, causes some alterations of the gastric function, including decreased secretion of both gastric and ascorbic acids, which are essential to the intestinal absorption of dietary iron. Moreover, it has been observed that *H. pylori* induces hepcidin expression in the gastric mucosa [75]. The increased serum hepcidin levels in *H. pylori*-infected IDA patients decrease after successful *H. pylori* eradication [76]. Finally, iron sequestration and utilization by *H. pylori* itself have been reported [77].

A recent meta-analysis of cross-sectional studies overall found that *H. pylori*-infected patients are at increased risk of both IDA (OR 1.72; 95% CI, 1.2–2.4) and ID (OR 1.33; 95% CI, 1.1–1.5) as compared to those with no infection. A sub-group analysis of 4 studies on adults showed an OR of 1.7 (95% CI, 1–2.8) for IDA in *H. pylori* infected patients [78].

Four meta-analyses compared Hb level modifications (Standardized Mean Difference; SMD) at 1–3 months following *H. pylori* eradication therapy plus iron supplementation as compared to iron supplementation alone, and showed conflicting results [78–81]. A meta-analysis (16 trials: 13 paediatric and 3 on adults, involving 956 patients) found a significant difference between the two groups (SMD: 1.48 g/dl; 95% CI, 1–2). When taking into account the 3 studies including adults, we computed that the SMD of haemoglobin increases was 5.83 g/dl in 103 patients receiving *H. pylori* treatment and iron as compared to 3.8 g/dl in the 82 patients treated with iron alone (SMD: 2 g/dl; 95% CI, 1.5–2.5;  $P=0.05$ ) [79]. Another meta-analysis (8 trials: 6 paediatric and 2 on adults; 450 patients) found that the overall increase of haemoglobin levels was significantly higher in *H. pylori* eradicated patients (SMD: 1.29 g/dl; 95% CI, 0.6–2,  $P=0.0002$ ) [80]. However, the sub-group analysis of the studies on adults failed to find a significant difference (SMD: 1.5 g/dl; 95% CI, 0.8–2.2,  $P=0.51$ ; 128 patients). A meta-analysis of 4 high-quality paediatric studies found that the increases in haemoglobin levels did not significantly differ between patients receiving iron and eradication therapy and those on only IRT (SMD: 4.06 g/dl; 95% CI, 2.6–10.7;  $P=0.23$ ) [81]. Similarly, a more recent meta-analysis (7 studies: 6 paediatric and 1 on adults; 515 patients) has found that the haemoglobin increase did not significantly differ in the whole analysis (SMD: 0.36 g/dl; 95% CI, 7–0.78;  $P=1$ ), as well as in the single study on adults [78]. It should be noted that all the trials on adults were confined to Asia, the quality of the studies was judged low, a significant heterogeneity among the studies emerged, and there was evidence of publication bias.

Three uncontrolled interventional studies assessed the long-term effect of *H. pylori* eradication without IRT in adult IDA patients with unexplained iron refractoriness or dependency. In an Italian study [82] on 30 patients, 18 (75%) and 22 (91.7%) out of 24 *H. pylori*-cured patients achieved IDA recovery at 6 and 12 months, respectively, at per protocol (PP) analysis, whilst no modifications occurred in the 3 patients who failed eradication. Of note, as many as 24 (80%) of these patients had pangastritis [9]. Another study performed in Israel showed IDA regression 4–69 months following bacterial eradication in 11 (78.6%) out of 14 male patients with *H. pylori* alone, as well as in further 2 (25%) out of 8 of patients with both *H. pylori* and autoimmune gastritis [83]. Finally, in a Spanish study on 84 patients (M/F: 10/74), recovery from IDA at 6 months was achieved in 80% of males, 71.4% of post-menopausal women, and 23.3% of pre-menopausal women at PP analysis [84].

#### 6.1.1. Panel recommendations

- *H. pylori* infection needs testing in adult patients with IDA (strong recommendation, high level of evidence).

**Vote result:** strongly agree 33.3%, agree 53.3%, moderately agree 13.3%, moderately disagree 0%, disagree 0%, strongly disagree 0%

- Bacterial eradication may improve and accelerate IDA recovery when associated with oral iron supplementation (conditional recommendation, low level of evidence).

**Vote result:** strongly agree 13.3%, agree 53.3%, moderately agree 26.7%, moderately disagree 6.7%, disagree 0%, strongly disagree 0%

- *H. pylori* eradication is a therapeutic option for patients with otherwise unexplained IDA (strong recommendation, low level of evidence).

**Vote result:** strongly agree 13.3%, agree 60%, moderately agree 26.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%

### 6.2. Coeliac disease

Anaemia is one of the most common presentations of CD, found in 12%–69% of adult patients, and may be the only presenting symptom [85–92]. Anaemia is mainly due to ID (80% of cases) [86,87] as a consequence of iron malabsorption [93]. On the other hand, contrasting data on the prevalence of CD in patients with anaemia have been reported. A systematic review [94] evaluated 12 studies and assessed the prevalence of CD among patients with anaemia (especially IDA) [40,92,95–104]. These authors reported a CD frequency in IDA patients with gastrointestinal symptoms ranging from 10.3% to 15% [95,99,100]. Four studies assessed the prevalence of CD in asymptomatic IDA patients by serology and CD prevalence ranged from 2.3% to 5.0% [92,97,101,102]. Other three studies assessed the prevalence of CD by duodenal histology in asymptomatic IDA patients and found values ranging from 2.9% to 6% [40,96,104]. A systematic review [105] examined 13 studies and concluded that CD is demonstrable in 1.8% to 14.6% of IDA patients [25,37,106–112]. CD frequency is higher among patients who have not responded to oral IRT compared to responsive ones [106]. Furthermore, several studies have reported that 73%–100% of IDA patients diagnosed with CD were adult pre-menopausal women. The higher iron demand in adult pre-menopausal women, as a result of menstrual loss, associated to a condition of chronic iron malabsorption attributable to CD, probably explains this higher prevalence of CD. However, such studies on CD and anaemia were heterogeneous in design, as some included only patients with IDA whereas other studies included both folate and iron-deficiency

patients, and used different methods to diagnose CD, often in selected referral populations.

In CD serological screening, the presence of IgA-anti-transglutaminase (anti-tTG IgA) or IgG-anti-deamidated gliadin peptides (anti-DGP IgG) is considered with high suspicion of CD [113]. Other guidelines suggest anti-tTG IgA testing as the only exam [114], as its accuracy is considered sufficiently high, with sensitivity and specificity of about 95%. However, as IgA deficiency occurs in 2%–3% of patients with CD [115], the measurement of IgA levels should be recommended, when only IgA-based CD serology is performed. In any case, intestinal biopsy and duodenal histology evaluation are essential for the diagnosis of adult CD and cannot be replaced by serology. Furthermore, the prevalence of sero-negative CD could be much higher than commonly considered (with estimation between 6% and 22% of all diagnosed cases) [116]. Consequently, intestinal biopsies have been suggested for individuals with anaemia of unknown origin, irrespective of whether they have had serology for CD. However, HLA DQ2/DQ8 testing should be performed on the sero-negative patients who show a high clinical suspicion of CD diagnosis, due to its high negative predictive value [117].

Noteworthy, iron malabsorption is not the only cause of anaemia in CD. In some patients, nutritional fiber/calcium deficiency may also contribute to ID in CD [118,119] as well as genetic factors [120]. Furthermore, other pathological mechanisms leading to anaemia in CD patients are folate and/or vitamin B12 malabsorption and deficiency. In affected individuals, low plasma folate and vitamin B12 deficiency were observed in 10%–81% and 5%–41% respectively [121–125].

Finally, persistent anaemia in CD patients on a gluten free diet needs to be carefully investigated. In this context, physicians must consider other concomitant causes of anaemia in such patients (*i.e.* blood loss, inflammation, nutritional deficiencies, folate and vitamin B<sub>12</sub> malabsorption and deficiency), development of refractory CD [126,127], concomitant *H. pylori* infection [78] or and iron-refractory iron deficiency anaemia (IRIDA, an autosomal recessive sideropenic anaemia) [128].

#### 6.2.1. Panel recommendations

- All patients with anaemia must be serologically tested for CD (strong recommendation, high level of evidence).

*Vote result: strongly agree 86.7%, agree 6.7%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- As the prevalence of sero-negative CD could be high, intestinal biopsies have been suggested for individuals with anaemia of unknown origin, irrespective of whether they have had serology for CD (conditional recommendation, moderate level of evidence).

*Vote result: strongly agree 26.7%, agree 46.7%, moderately agree 20%, moderately disagree 6.7%, disagree 0%, strongly disagree 0%*

#### 6.3. Inflammatory bowel disease

Anaemia is the most common extra-intestinal manifestation of IBD [129], with blood loss, malabsorption, dietary restrictions, SB insufficiency being the main mechanisms [9]. Chronic disease anaemia and ID often co-exist in IBD, but the latter is prevalent [130,131].

The prevalence of anaemia in IBD is varied and depends on the studied population (in/out-patient settings) and the applied criteria. A recent meta-analysis of 6 European series has showed a cumulative prevalence of 24% (95% CI, 18–31); IDA was present in 57% of cases. Among the variables, CrD and active inflamma-

tion were the strongest risk factors [130]. The Norwegian IBSEN inception cohort (756 patients prospectively assessed at 1, 5, 10 years) showed that the relative risk (RR) for anaemia was 2.9 (95% CI, 1.9–4.2) and 1.7 (95% CI, 1.1–2.4) for CrD and ulcerative colitis (UC), respectively. The prevalence of anaemia faded with the time and extent of observation; unfortunately, the data on iron status to define the type of anaemia were unavailable [132]. Furthermore, a recent retrospective study from the USA (on administrative data) on 5104 CrD and 6249 UC cases has showed that up to one third of IBD patients present with anaemia (32.4% and 27.6% of the CrD and UC cases, respectively) and most of them have IDA [131].

The guidelines to avail recommend iron therapy to all patients with IBD and IDA, with the aim of normalizing Hb levels [9]. From 2011 to date, 5 meta-analyses [133–137], a systematic review [138] comparing intravenous (i.v.) vs. oral IRT, and a meta-analysis comparing different i.v. iron formulations [137] for patients with IDA and IBD, have been published. The first meta-analysis by Lee *et al.* [133], which included three RCTs involving 333 patients, has showed a superiority of i.v.-administered IRT compared with oral IRT; however a high number of patients discontinued oral therapy for GI side effects (OR 6.2; 95% CI, 2.2–17); 5 out of 203 patients stopped i.v. therapy for severe side effects (rash, thrombocytopenia, thrombophlebitis, edema). Except for one meta-analysis [135], all the other studies [134,136,137] confirmed an advantage of i.v. IRT over oral IRT, with a relevant number of discontinuations during oral therapy for GI symptoms, whereas in the case of i.v. therapy the side effects were rare but clinically severe. Furthermore, a network meta-analysis [137] comparing i.v. and oral therapy and the efficacy of different i.v. iron formulations (iron carboxymaltose, iron isomaltoside, iron sucrose) found that iron carboxymaltose was superior to oral therapy (OR = 1.9; 95% CI, 1.1–3.2), without differences in safety of the different i.v. iron formulations. Interestingly, a recent study [139] has showed a shift of gut microbiota toward an unsafer composition in patients administrated with oral IRT, although the clinical implication of this finding is not yet fully understood.

#### 6.3.1. Panel recommendations

- The prevalence of anaemia in IBD patients is high, thus, the presence of IBD in patients with anaemia should be carefully screened (conditional recommendation, low level of evidence).

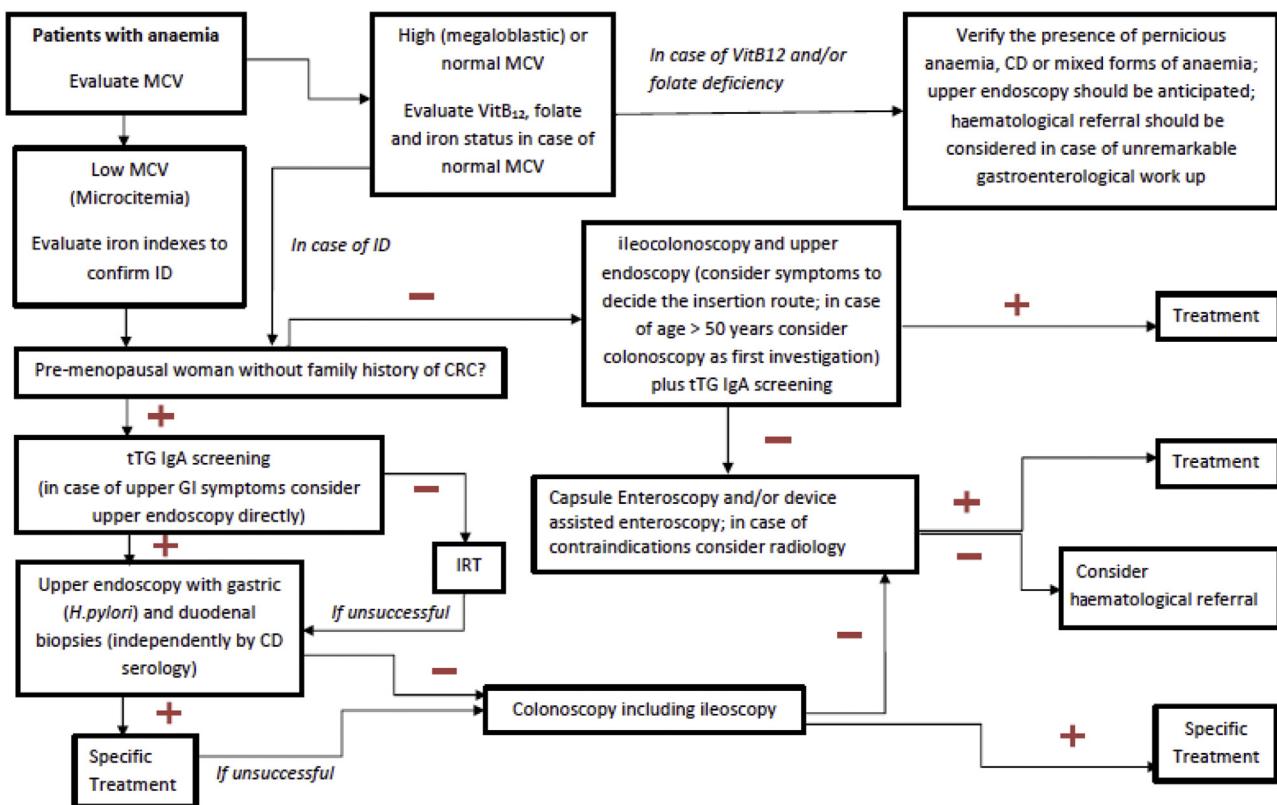
*Vote result: strongly agree 53.3%, agree 13.3%, moderately agree 33.3%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- IRT is recommended for IDA and it is effective to use both the i.v. and oral routes. However, the i.v. route should be preferred (strong recommendation, high level of evidence).

*Vote result: strongly agree 53.3%, agree 40%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

#### 7. Approach to patients with non-iron deficiency anaemia

Non-ID anaemia is infrequent and principally derives from vitamin B<sub>12</sub> and/or folate deficiency. The most frequent cause of megaloblastic anaemia is autoimmune atrophic gastritis (pernicious anemia) and thus patients with macrocytic anaemia are referred to the gastroenterologist. The diagnostic work-up includes the detection of anti-parietal cell antibodies (APCA), assessment of vitamin B<sub>12</sub> serological levels and upper endoscopy. APCA can be found in more than 85% of patients, whilst isolate intrinsic factor antibodies presence occurs in less than 1% of patients [140]. Also pepsinogen I levels can be useful in the flowchart [141]. At upper endoscopy, multiple biopsies in antrum, gastric body, fundus and duodenum should be taken, in order to perform a complete



**Fig. 1.** Diagnostic gastroenterological flowchart for adult patients with anaemia.

assessment of the potential causes of megaloblastic anaemia. Typically, autoimmune atrophic gastritis, with or without intestinal metaplasia, is confined in the mucosa of the gastric body and fundus, sparing the antrum. It represents a precancerous condition for both neuroendocrine tumors and gastric cancer, thus deserving endoscopic-histologic follow up every 3–4 years [142,143].

In general, the absorption of Vitamin B12 requires the normal function of the stomach, pancreas and small intestine [144]. Other causes of its deficiency are manifold: dietary low intake (as in strict vegan diet), gastrectomy, pancreatic abnormalities (chronic pancreatitis, pancreatectomy), SB disease (ileal disease, CD or CrD) terminal ileal resection or bypass, bacterial overgrowth, fish tapeworm i.e. *Diphyllobothrium latum*) [145]. Among the malabsorption causes of B<sub>12</sub> vitamin deficiency the most frequent one is pernicious anaemia [144]. In pernicious anaemia, Vitamin B12 deficiency is treated with intramuscular injection of hydroxocobalamin 1 mg three times a week for two weeks and then three-monthly for life to prevent neurological consequences related to chronic vitamin B<sub>12</sub> deficiency [146]. Patients with an unremarkable gastroenterological work-up should be referred to the haematologist to ruled out myelofibrosis and other haematological causes (inherited disorders, transcobalamin II deficiency, intrinsic factor deficiency, cubilin deficiency, etc.) [145].

### 7.1. Panel recommendations

- Patients with megaloblastic anaemia should investigated for autoimmune atrophic gastritis. When pernicious anaemia is diagnosed, long-life intramuscular supplementation of vitamin B12 is needed, as well as a scheduled endoscopic surveillance (strong recommendation, high level of evidence)

*Vote result: strongly agree 86.7%, agree 6.7%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

**Table 2**  
Haemoglobin cut-off values for the definition of anaemia in children.

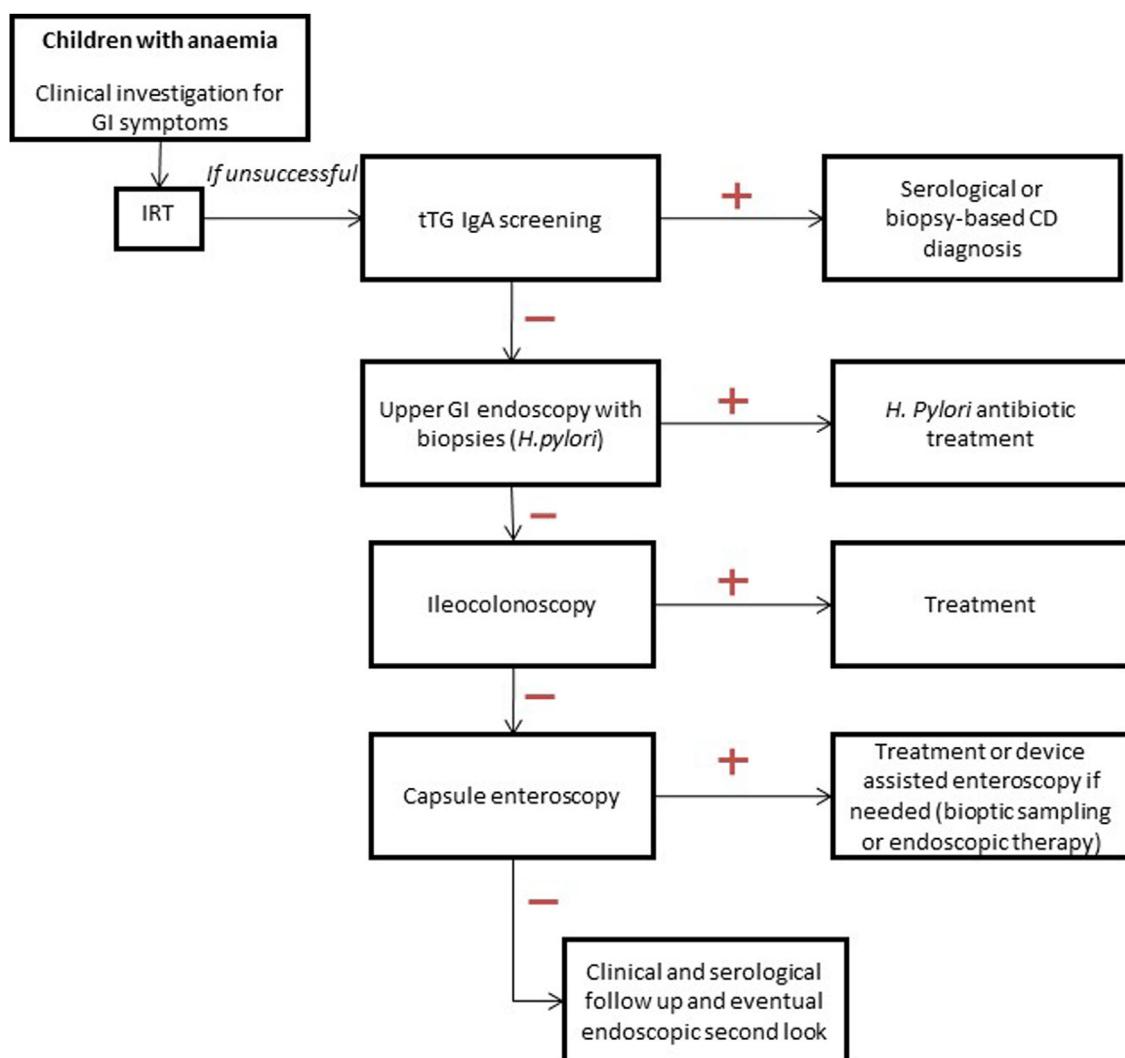
Age	Hemoglobin cut-off value (g/dl)
0–1 weeks	13.5
2 months	9
4–24 months	10.5
2–5 years	11
5–11 years	11.5
12–14 years	12

- Patients with megaloblastic anaemia without pernicious anaemia should be referred to the haematologist for further diagnostic work-up (strong recommendation, low level of evidence)

*Vote result: strongly agree 60%, agree 33.3%, moderately agree 6.7%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

### 8. Approach to anaemic patients during childhood

Anaemia is a diagnostic challenge during childhood as well: a systematic review has showed that IDA is a frequent condition among pre-school children all over the world [147] with a prevalence of 9.6% (95% CI, 7.2–12.0). The normal values of Hb during childhood are reported in Table 2 [148]. Although GI diseases are well-known causes of refractory anaemia in children, the real prevalence is unclear because of the lack of systematic reviews and manuscripts investigating this specific issue. Evidence is available about the role of *H. pylori*, peptic diseases and IDA: a meta-analysis published in 2016 [78] has showed an important association (OR 2.2; 95% CI, 1.4–3.4) by analyzing four paediatric studies [149–152]. Following this meta-analysis, a population-based study was published [153], confirming the association between *H. pylori* and IDA (OR 1.7; 95% CI, 1.2–2.3). Two paediatric studies [154,155] evaluated the prevalence of CD in children with IDA, showing a 21.3% and



**Fig. 2.** Diagnostic gastroenterological flowchart for pediatric patients with anaemia.

8.4% prevalence, respectively, and demonstrated the need for CD screening in children with IDA. Although IDA is a common complication of IBD, this issue has never been investigated as the possible alarm symptom. In a large meta-analysis, IDA was described in 24% of adults with IBD [130]. Furthermore, three studies [156–158] suggested a high prevalence of IDA at diagnosis (74%, 30% and 61% respectively).

Other GI conditions to be possibly associated with chronic anaemia in children were only anecdotally reported. IDA can be caused by: gastric diseases, such as autoimmune gastritis [159,160] and collagenous gastritis [161,162], occult gastrointestinal bleeding due to post-surgical conditions (e.g. post anastomotic ulcerations) [163,164], vascular malformations [165,166] or blue rubber bleb nevus syndrome (BRBNS) [167,168]. Endoscopy is routinely performed to assess chronic refractory anaemia, but the evidence regarding children is scarce. Two studies [169,170] addressing the role of upper gastrointestinal endoscopy, showed a DY of 84% and 43%, respectively, in a small cohort of children with IDA. Lower GI endoscopy was not studied in that scenario.

OGIB and IDA are the most frequent clinical indications in children who underwent CE [171,172]. The DY of CE in this setting ranged from a 37% [173] to 53% [172], up to a 64% [174]. As to imaging, a study investigated the DY of MR in children with OGIB [175]: MR was performed on 13 children with a DY of 77%. Two studies on DAE in children have been published with OGIB being

the indication in 28% and 16%, respectively, of the cases considered, with a DY of 50% and 62%, respectively.

#### 8.1. Panel recommendations

- *Upper GI endoscopy should be considered for chronic refractory anaemia of unknown etiology in children (weak recommendation, low level of evidence).*

*Vote result: strongly agree 46.2%, agree 73.3%, moderately agree 46.2%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- *Lower GI endoscopy should be considered towards the diagnosis of chronic refractory anaemia (conditional recommendation, low level of evidence).*

*Vote result: strongly agree 46.2%, agree 23.1%, moderately agree 30.8%, moderately disagree 0%, disagree 0%, strongly disagree 0%*

- *In case of operative endoscopy CE and DAE should be performed on children with persistent anaemia and in case of inconclusive upper and lower endoscopy (conditional recommendation, low level of evidence).*

**Vote result:** strongly agree 38.5%, agree 30.8%, moderately agree 30.8%, moderately disagree 0%, disagree 0%, strongly disagree 0%

- DAE can be indicated in the diagnostic and therapeutic approaches to chronic refractory anaemia after or together with CE findings (conditional recommendation, low level of evidence).

**Vote result:** strongly agree 23.1%, agree 46.2%, moderately agree 30.8%, moderately disagree 0%, disagree 0%, strongly disagree 0%

## 9. Final recommendations

Anaemia always poses a diagnostic challenge as numerous are the GI diseases leading to a decrease in Hb levels. A correct diagnostic approach is essential to improve a patient's prognosis and to establish correct therapeutic and follow-up processes. In view of the importance of anaemia in the clinical routine, the current lack of studies investigating this issue is bemusing. Figs. 1 and 2 provide the diagnostic roadmaps to handle adults and children with anaemia.

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## Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <https://doi.org/10.1016/j.dld.2019.01.022>.

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