Red cells are produced in the bone marrow (BM) from myeloid progenitor cells, where their production requires a permissive BM micro-environment and adequate substrate (including iron, vitamin B₁₂ and folate) for Hb, protein and DNA synthesis. Erythropoiesis is controlled by erythropoietin (EPO), which is synthesised by peritubular fibroblasts in the renal cortex in response to reduced oxygen tension.

According to the World Health Organization (WHO), anaemia is defined as ‘a condition in which the number of red blood cells or their oxygen-carrying capacity is insufficient to meet physiological needs’. It is the most common disorder globally and one of the conditions that general practitioners most frequently encounter. Anaemia is rarely an isolated disease and is most often a sign of an acquired or inherited disorder.[1]

According to the WHO global database,[2] anaemia is estimated to affect 1.6 billion people. The highest prevalence is found in preschool-age children (47.4%), followed by pregnant females (41.8%), non-pregnant females (30.2%), school-age children (25.4%), and males (12.7%).[2]

When investigating patients with anaemia, two fundamental questions have to be considered: (i) What is the cause of the anaemia?; and (ii) What is the urgency for correcting the anaemia, i.e. is a blood transfusion or other urgent intervention indicated?

Classification
Anaemia may be classified as follows:

Based on red cell characteristics (red cell size, chromia and morphology):

- hypochromic microcytic
- macrocytic normochromic
- normochromic normocytic
- morphology:
  - leuco-erythroblastic
  - micro-/macroangiopathic.

Based on underlying mechanism:

- decreased BM production/output:
  - BM aplasia/infiltrate
- ineffective haematopoiesis, e.g. megaloblastic anaemia (MA), myelodysplastic syndromes (MDSs), HIV
- substrate deficiency
- EPO insufficiency
- peripheral loss/destruction:
  - bleeding
  - sequestration
  - haemolysis.

In this issue of CME, the focus is on anaemia resulting from decreased BM output. Anaemia caused by peripheral loss will be discussed in the next issue.

Diagnostic approach to a patient with suspected anaemia
As anaemia may manifest in a wide range of disorders, a streamlined diagnostic approach is vital (Fig. 1). The approach outlined here is based on the abovementioned classification, clinical scenario and full blood count (FBC) findings.[3]

Patients generally present with symptoms of anaemia, i.e. increased tiredness/fatigue, dyspnoea and decreased effort tolerance. The severity of symptoms depends on the degree of anaemia and rate of Hb decrease. Therefore, at a given Hb level, anaemia from acute blood loss is likely to manifest more severely than anaemia of insidious onset (weeks to months). Symptoms during early childhood should remind one of possible inherited forms of anaemia, e.g. thalassaemia.

History
A detailed history is of paramount importance and often eliminates much of the speculation during investigation. This should include:

- interrogation of the presenting complaint and duration of the problem
- transfusion history
- dietary history, including pica (craving for unusual food items, generally associated with iron deficiency)
- travel history (to endemic malarial or other infectious areas)
- change in bowel habits
- bleeding (e.g. gastrointestinal and genito-urinary)
• drug history (e.g. anticoagulants, antiplatelet agents, renotoxic agents, anticonvulsants)
• chronic disease (e.g. HIV, tuberculosis (TB))
• surgery (e.g. gastrectomy, small-bowel surgery)
• current or recent pregnancy
• family history (particularly in children).

Clinical examination
A wide range of signs and symptoms may be apparent. Systematic examination directs further investigation and may reveal the possible cause.

Skin and mucous membrane:
• pallor is the cardinal clinical sign for anaemia, which should be confirmed by measuring the Hb level
• angular stomatitis
• glossitis in nutritional deficiencies
• koilonychia (spoon-shaped nails) in iron deficiency
• premature greying, which often accompanies MA

• scleral icterus, which indicates possible haemolysis or ineffective erythropoiesis.
• Neuromuscular:
  • muscle weakness
  • headache, lack of concentration, drowsiness, tinnitus
  • paraesthesias, peripheral neuropathy, ataxia and loss of vibration sense, and proprioception in pernicious anaemia.
• Cardiovascular:
  • hyperdynamic circulation with haemic ‘flow’ murmurs
  • cardiac failure.
• Clues for infection, malignancy (e.g. lymphoma, leukaemia, metastatic carcinoma):
  • hepatosplenomegaly
  • lymphadenopathy
  • bleeding manifestations (petechiae, purpura, ecchymosis), BM failure.

Laboratory testing
An FBC, differential and reticulocyte counts together with microscopic blood smear examination should be the starting point of investigations. These confirm the clinical suspicion of anaemia and direct further investigation. Local laboratory/population reference ranges that are age and gender specific should be used. The normal reference ranges for Hb in adults in the Witwatersrand area, Johannesburg, South Africa (SA) are as follows:\[4\]

- male: 13.8 - 17.9 g/dL (anaemia <13 g/dL)
- female: 12.4 - 15.5 g/dL (anaemia <12 g/dL; pregnancy <11 g/dL).  

A reticulocyte count gives an indication of the BM status, i.e. decreased activity v. appropriate response to the anaemia. A reticulocyte production index (RPI) provides a more accurate representation of marrow activity than an isolated reticulocyte count, as it corrects for the degree of anaemia and presence of immature reticulocytes in the peripheral blood. The RPI is calculated as follows:

Fig. 1. Algorithm depicting diagnostic approach to anaemia. (TFT = thyroid function test; LFT = liver function test; MCV = mean cell volume; IVH = intravascular haemolysis; EVH = extravascular haemolysis; FBC = full blood count; Fe = iron.)
Patients may present with one or more of the following: (i) symptoms of anaemia; (ii) infection (due to leucopenia/neutropenia); and (iii) mucocutaneous bleeding (due to thrombocytopenia). The FBC shows a pancytopenia of varying degrees (depending on the severity), reticulocytopenia with a low RPI, and reversal of the normal neutrophil:lymphocyte ratio. The diagnosis is confirmed on microscopic BM examination.

Numerous secondary causes and associations have been identified in AA, but in 60 - 70% of cases the cause remains unknown. It has been proposed that a triggering event, such as a virus or drug, leads to an immune response and to inappropriate expansion of cytotoxic T cells that destroy haematopoietic cells. Causes include viruses (e.g. hepatitis virus, HIV, Epstein-Barr virus, cytomegalovirus); autoimmune disorders (e.g. systemic lupus erythematosus, eosinophilic fasciitis, Sjogren's syndrome); drugs (a wide range, including sulfonamides, anticonvulsants, antimalarials; chemicals (e.g. benzene); and environmental factors (e.g. agricultural pesticides and radiation). The idiopathic variety is the largest group. Paroxysmal nocturnal haemoglobinuria (PNH), caused by expansion of a clone with mutation of the glycosylphosphatidyl-inositol gene, manifests with the clinical triad of haemolytic anaemia, thrombosis and BM failure. PNH clones can be detected on flow cytometry.

Some inherited disorders are characterised by BM hypoplasia/aplasia (affecting one or more haematopoietic cell lines), and are usually accompanied by one or more somatic abnormalities, i.e. part of a clinical syndrome. Inherited BM failure syndromes may be present at birth or develop later in childhood. Of these, the syndromes that affect all three cell lines include Fanconi anaemia, Schwachman-Diamond syndrome and dyskeratosis congenita. Further discussion of these syndromes is beyond the scope of this edition of CME.

Pure red cell aplasia is characterised by an isolated, often severe anaemia with a marked reticulocytopenia. It may be congenital.
Iron deficiency is the most common cause of anaemia, occurring in an estimated 15% of the world’s population. The causes of iron deficiency can be broadly classified as inadequate iron intake (e.g. nutritional deficiency, iron malabsorption) or excessive iron loss (mostly due to bleeding). It is most common in young children and women of childbearing age because of the increased iron demands related to rapid growth and menstrual blood losses/pregnancy, respectively.

Iron deficiency causes a microcytic and/or hypochromic anaemia. Serum iron studies show low serum ferritin and raised transferrin (TF) levels, and low TF percentage saturation. The differential diagnosis for microcytic anaemia includes anaemia of chronic disorder (ACD), thalassaemia trait and sideroblastic anaemia. The frequency of these differential diagnoses depends on the demographics of the population served, with thalassaemia trait being common in patients of Indian or Mediterranean ancestry, and ACD occurring frequently in patients with chronic infection (e.g. HIV or TB), malignancy or autoimmune disorders. ACD is caused by a combination of functional iron deficiency (due to reticuloendothelial iron blockade), and EPO deficiency or resistance, and is characterised on iron studies by raised ferritin and low TF levels with low or normal TF percentage saturation. The anaemia is usually normocytic and normochromic, but can be microcytic in approximately one-third of cases due to long-standing iron restriction at the macrophage level.

Occasionally, the distinction between iron deficiency anaemia (IDA) and ACD can be blurred, as ferritin is an acute-phase protein and may be falsely normal or raised in patients with iron deficiency in the presence of acute inflammation. In this setting, the gold standard for discriminating IDA from ACD is evaluating BM iron stores microscopically. Measuring the soluble TF receptor (STFR) levels and calculating the STFR index (STFR/log ferritin ratio) is also of use in this regard, where a ratio >2 suggests iron deficiency with coexisting ACD. Unfortunately, STFR testing is not universally available in SA laboratories. Of note is that serum iron levels are of minimal use in assessing iron stores, reflecting recent iron intake as opposed to overall iron status. IDA should therefore not be diagnosed solely on the basis of a low serum iron level.

To establish if someone has iron deficiency, one has to include a thorough dietary history, with emphasis on the frequency of red meat consumption, excessive dietary phytates (present in grains and legumes) or tannins (present in tea), which inhibit iron absorption, and pica. In the absence of an obvious nutritional cause, a source of bleeding should be sought (e.g. urogenital, gastrointestinal), particularly in men and postmenopausal women.

Oral iron supplementation is the mainstay of therapy for IDA, but intravenous iron is occasionally necessary when more rapid correction of the Hb level is desired, if iron malabsorption is the main cause for the IDA, or if oral iron is not tolerated. A blood transfusion is indicated for severe, symptomatic anaemia, especially in patients who are bleeding. Treatment of IDA should aim at restoring the Hb to normal, followed by a further 4 - 6 months of therapy to replenish iron stores (Table 2). Iron should ideally be given between meals together with vitamin C to maximise absorption, but it can be administered with food or at reduced doses in patients who experience excessive abdominal side-effects (e.g. abdominal discomfort, nausea or constipation). For patients who are refractory to oral iron therapy, iron malabsorption, ongoing blood loss and non-compliance should be considered.

The treatment of ACD is centred on management of the underlying cause. There may be a role for EPO supplementation, particularly in patients with underlying malignancy and HIV. Intravenous iron may additionally benefit patients with functional iron deficiency. MA is the other major nutritional anaemia caused by vitamin B₁₂ or folate deficiency. As both are required for purine biosynthesis, a deficiency of either nutrient hampers normal DNA synthesis, which results in ineffective haematopoiesis.

Vitamin B₁₂ deficiency is the most frequent cause of MA seen in general practice, the most common cause being pernicious
anaemia. The latter leads to impaired vitamin B₁₂ absorption owing to immune-mediated destruction of the gastric parietal cells and consequent intrinsic factor deficiency. In contrast, dietary deficiency and the postpartum phase most commonly cause folate depletion. Dietary deficiency is currently relatively uncommon in SA owing to mandatory fortification of maize meal and wheat flour. Other causes of vitamin B₁₂ and folate deficiency are summarised in Table 3.

MA is diagnosed by demonstrating low serum levels of vitamin B₁₂ or folate, along with characteristic peripheral blood smear morphology (including macro-ovalocytosis, teardrops, varying numbers of red cell fragments and basophilic stippling, and hypersegmentation (right shift) of neutrophils). Importantly, MA is not universally macrocytic, and cannot be excluded solely owing to the presence of a normal or even a low mean cell volume. When MA is strongly suspected, a trial of vitamin B₁₂ and folate supplementation is advisable, particularly if levels are borderline low.

When vitamin B₁₂ deficiency is diagnosed, further investigation for pernicious anaemia is warranted. Intrinsic-factor antibodies are positive in 50 - 70% of cases. In patients with pernicious anaemia, other organ-specific auto-immune disorders should be excluded (e.g. Addison’s disease and auto-immune thyroiditis). Vitamin B₁₂ deficiency is treated with lifelong parental vitamin B₁₂ replacement therapy, while folate depletion is treated with oral folate supplementation (Table 3). Importantly, folate administration in patients with MA secondary to vitamin B₁₂ deficiency may partially correct the anaemia, but does not address the effects of vitamin B₁₂ deficiency on the central nervous system. Owing to the risk of neurological complications (such as subacute combined degeneration of the spinal cord) in patients with vitamin B₁₂ deficiency, MA should not be presumptively treated with folate alone, as this may accelerate irreversible neurological damage. Although the mainstay of treatment in vitamin B₁₂ deficiency is supplementation with vitamin B₁₂, patients with very severe/life-threatening anaemia may benefit from a blood transfusion. Crucially, these patients should be transfused conservatively and cautiously (no more than 1 or 2 units of blood should be transfused, each unit running over ~2 - 4 hours, followed by 20 mg of intravenous furosemide (Lasix) after each unit), as aggressive transfusion practices are associated with a risk of sudden death in this setting.

Conclusion

There are numerous and varied causes of anaemia. Given the vastness of the topic, a thorough history, physical examination and systematic laboratory investigation are key elements towards determining the cause of the condition.

Table 3. Causes of vitamin B₁₂ and folate deficiencies

<table>
<thead>
<tr>
<th>Vitamin B₁₂ deficiency</th>
<th>Folate deficiency</th>
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<tbody>
<tr>
<td>Dietary deficiency</td>
<td>Dietary deficiency</td>
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<tr>
<td>Ovolactovegetarians</td>
<td>Poor diet (e.g. alcoholics, elderly)</td>
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<td>Malabsorption</td>
<td>Malabsorption</td>
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<tr>
<td>Pernicious anaemia</td>
<td>Inflammatory bowel disease</td>
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<td>Ileal pathology</td>
<td>Coeliac disease</td>
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<tr>
<td>Crohn’s disease/ulcerative colitis</td>
<td>Short-bowel syndrome</td>
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<tr>
<td>Infection, e.g. HIV, TB</td>
<td>Impaired folate metabolism*</td>
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<tr>
<td>Infiltration, e.g. lymphoma surgery</td>
<td>Drugs (e.g. metformin, anticonvulsants, antimalarials)</td>
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<tr>
<td>Gastrectomy, ileal resection</td>
<td>Alcoholism</td>
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<tr>
<td>Diphyllobothrium latum (fish tapeworm)</td>
<td>Hypothyroidism</td>
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<tr>
<td>Blind loop syndrome</td>
<td>Excessive folate demand</td>
</tr>
<tr>
<td>Drugs (e.g. proton pump inhibitors, metformin)</td>
<td>Chronic haemolytic anaemia</td>
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<td></td>
<td>Pregnancy and lactation (particularly if the diet is poor)</td>
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*Serum folate levels may be normal.