## Case 1

### Reflux and anaemia

*JM, aged 48, presented with oesophageal reflux, complaining of heartburn. There were no alarm features, she drank little alcohol and was a non-smoker. OTC antacids gave temporary relief. She was taking no other medication. Examination of her abdomen revealed no abnormality and she was not overweight.*

Persistent reflux symptoms should trigger at least an FBC. If she has iron deficiency anaemia and is no longer menstruating then she does have an alarm symptom.

*JM was anaemic with Hb 10.4, low MCV and ferritin. She was postmenopausal, had no dietary problems and no hint of bleeding. Gastroscopy revealed a small hiatus hernia. Colonoscopy was normal. H.pylori was negative.*

Endoscopic assessment is only necessary for confirmed iron deficiency anaemia demonstrated by low Hb, low serum ferritin and red cell microcytosis or hypochromia in the absence of chronic disease or haemoglobinopathies. Blood loss from the bowel is the most common cause of iron deficiency anaemia in men and postmenopausal women. Iron deficiency may be due to inadequate diet, increased demand, poor absorption, or bleeding. Absorption of iron may be affected by gastrectomy and coeliac disease. Benign causes of bleeding include peptic ulceration and angiodysplasia. However, possible malignancy in the colon or stomach may be a concern.

*JM's investigations did not reveal a cause of her iron deficiency anaemia and the question arose as to whether her small bowel should be investigated.*

Small bowel tumours are rare but arteriovenous malformations may be present with sufficient blood loss to cause anaemia. Small bowel examination is generally only indicated if anaemia becomes transfusion dependent.

*JM was subsequently kept symptom free by taking regular lansoprazole in full dosage. Stepping down her medication to the maintenance dose was attempted but symptoms returned. A course of iron tablets resolved her anaemia and this has not recurred although her haemoglobin remains close to the lower limit of normal.*