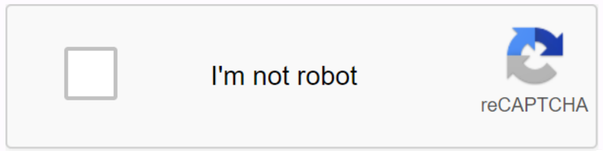

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Sulfato ferroso na gravidez pdf

Promoting Pregnancy Health requires a lot of care in a woman's life. Many of them should be taken just before conception, during pregnancy planning. To prevent malformations in the fetus, doctors recommend the intake of folic acid, a water-soluble vitamin of the B complex, important for the formation of the neural tube of the fetus. Folic acid participates in chromosome bi-partition. It is important, so that what we call neural tube defects, known as DTN, does not occur. It is the only prevention against this problem, explains the gynecologist and head of the Mastology Service of the Federal Hospital of Andaraí, in connection with the Ministry of Health, Luiz Augusto Santana. The neural tube of the fetus begins to close within the first month of gestation. It is the initial nervous system of the fetus, which will form the child's brain and spinal cord. Folic acid deficiency can affect the development of the neural tube, causing conditions such as anencephaly, leading to the death of the child a few days after birth. The gynecologist recalls that prevention should be done in advance. As the woman still does not know how long the pregnancy will happen, recommended is to start taking 3 or 4 months before this planning. And after pregnancy confirmation, prevention should continue. She should keep the medication during the period of embryogenesis, which lasts until the third month of pregnancy, adds Luiz Augusto Santana. Although folic acid is present in several foods, the amount is not sufficient to make this prevention. Ideally, women should start taking it in a medicinal way. We recommend ingesting a 5 milligram per day tablet, guides Luiz Augusto Santana. The drug is provided by the unified health system (SUS), as well as ferrous sulfate, essential for the prevention of anemia during pregnancy. Folic acid does not fatten, prevents anemia, as well as ferrous sulphate and helps the functioning of the vascular system. Green leafy vegetables, chestnuts, whole grains, beans, tomatoes and mushrooms are considered good sources of folic acid. The National Agency for Health Surveillance (Anvisa), in connection with the Ministry of Health, established in 2002 that wheat and maize flour sold in the country should also be enriched with iron and folic acid. Stork Network – Stork Network, launched in 2011 by the federal government, has qualified the care provided to pregnant women in the SUS. The strategy already has $213 million for proposals submitted by states and municipalities. Actions range from strengthening family planning to pregnancy confirmation, through prenatal care, childbirth, postpartum, to the first two years of the child's life. To date, 25 states and 2,731 the process of access to the network has already begun, with the provision of care to 1.58 million pregnant women. R$25 million were also allocated to provide new prenatal exams in 228 municipalities in 13 states. Active People's Advocate – Ministry of Health improves the mechanisms of direct communication with the citizen to improve care and increase the transparency of the SUS. This year, the ministry began distributing the SUS Charter, a new tool that allows users to assess the care and services provided in public hospitals or contracted units. In order to prevent the user from being charged improperly, the letter shall also inform how much sUS has paid for the service and shall request that any fees made be communicated. In addition to the SUS Charter, the user can make the assessment, free of charge, via Health Dial (136). The call can be made from landlines, public or mobile phones, from anywhere in the country. The assessment is also available on the internet, on the health portal. Source: Fabiana Conte/Internal Communication of the Ministry of Health Use of ferrous sulphate during pregnancy: reflections in the light of literature Use of ferrous sulphate during pregnancy: reflections in the light of literature Alba Valéria Sousa CostaI; Leila Maria MadeiraII INurse from the Municipal Maternity of Contagem. Specialist in Obstetrics Nursing, School of Nursing, UFMG. E-mail: albacosta2002@hotmail.com/Alba.costa@bol.com.br/ nursemel@ig.com.br. Rua Santo Antônio do Monte, no 630 aptÂo 303. Bairro Santo Antônio - Belo Horizonte - Minas Gerais ZIP Code: 30.330-220 IIPhD in Nursing. Professor at the SCHOOL of Medical Assistance in UFMG. Member of the Committee for the Coordination of the Specialisation Course in Hospital Healthcare. Sofia Feldman Hospital Nurse Presentation on: 13/12/2004 Approved: 03/05/2007 Summary This is a review literature study on the use of ferrous sulphate during pregnancy, which aimed at: to know the effects of the use of ferrous sulphate daily and weekly during the gestational period and to identify the advantages and disadvantages of the use of ferrous sulphate daily and weekly during the gestational period. Through the literature accessed, it was possible to check whether there are still many uncertainties and controversies regarding treatment and it is important to clarify for the pregnant woman about the undesirable effects of iron use and to monitor treatment to prevent its early abandonment, given the undesirable effects of the drug. Keywords: Complications during pregnancy, Iron Deficiency Anemia, Ferrous Sulphate INTRODUCTION As health professionals in prenatal care we have observed that in general ferrous sulfate supplementation in the second trimester of is not considered a priority. It's not is a routine of tracking and rational use of iron during pregnancy, in which all complaints of pregnant women are assessed, reducing treatment drop-out and waste of medicines, which are common in the public health network, would not be assessed. Another aggravating factor is maternal and neonatal morbidity and mortality, directly related to gestational iron deficiency anaemia, which is completely treatable and preventable. Its prevention and treatment avoids serious consequences during childbirth and puerperia, where blood supplies are no longer sufficient to cope with maternal losses. The lack of motivation of health professionals to treat anaemia with iron salts is often justified by the long duration of treatment and the undesirable effects presented by the pregnant woman, such as: heartburn, nausea, vomiting, diarrhea, constipation and colic occurring in 15% to 20% of patients undergoing daily treatment with oral iron,1 being considered mild and easily remedied with diet and iron salt handling. Another option would be your intake with a small amount of food. These effects contribute to the failure of treatment, becoming a serious public health problem.2,3 In turn, disorders of gastrointestinal motility, common during pregnancy, can also lead to heartburn, nausea, vomiting and constipation, leading to overlaying of symptoms and even preventing the identification of the actual effects of iron during pregnancy. (4) In particular during pregnancy, women's fear of generating large fetuses and difficulties at birth has also been reported as a cause of low-accession treatment.5 Given the haematological changes occurring in the pregnant woman's body, studies and research are being conducted with the aim of proving the need for ferrous sulphate supplementation during pregnancy, thereby preventing anaemia , so common in pregnant women and mainly affecting populations in poor countries. The problem also spreads as an endemic occurrence in rich countries and it is estimated that in Europe, 27 million people have this type of deficit.6 In Brazil, as in other countries, information on the prevalence of anaemia is still limited. Data available from studies conducted in some regions of the country over the past thirty years indicate that the prevalence of iron deficiency anaemia is between 22% and 50%.7 Programs for the prevention of iron deficiency anaemia and, in particular, iron supplementation for pregnant women have been developed in several countries, but most of them have failures in the implementation , monitoring or evaluation.3 ,8 Based on the literature analysis on this subject, in this paper we propose to support the adequacy of the guidelines for women to the effects of iron sais, improving their adherence treatment, and finding more effective ways (lower costs, better coverage and greater adtake) to combat iron deficiency and iron deficiency anemia. Therefore, through the study we intend to: • we know the effects of the use of ferrous sulphate daily and weekly during the gestational period; • identifying the advantages and disadvantages of using ferrous sulphate daily and weekly during the gestational period. The review of the problem presented was made in consultation with the collection of the J. Baeta Vianna Library, the Federal University of Minas Gerais and the computerized databases (Lilas, Medline, Cochrane, among others), using terms relevant to the topic and not limited to the period of publication. FIER DEFICITE ANEMY AND ANEMY DURING Physiological SARCINIA, anemia is present when there is an insufficient amount of hemoglobin to provide oxygen to tissues, which is when the haemoglobin concentration is less than 11 g/dl. The World Health Organisation (WHO) recommends daily use of iron, especially in the second half of pregnancy for non-discriminatory public health programmes for all pregnant women, and the diagnosis is based on two criteria that are haemoglobin (Hb) and the average body volume (MVC). This diagnosis is used because of the low cost and ease of performance and evaluation, and differs from other diseases, in which the diagnosis is generally made when the person has a complaint, followed by clinical investigations.3 In pregnant women with previous nutritional condition compromised, limited deposits are not sufficient to cover this deficiency, leading to microcytic hypochromic anemia.9 In well-fed women, these deposits are sufficient to neutralize the deficiency produced by pregnancy. Food deficiency as a bioavailable iron source has been reported as one of the main causes of iron deficiency anaemia.10.11 The usual Western diet contains little iron, of which generally only 5% to 10% are absorbed. This absorption is between 10% and 30% in the face of increased iron demand, as happens during pregnancy or in organisms with anemia. In addition, foods of animal origin (containing hem iron), as well as vitamin C (ascorbic acid), facilitate the absorption of non-hem iron (contained in foods of plant origin). On the other hand, foods containing calcium, dysphosphonates and antacids make this absorption difficult. Factors such as multiparity, low body mass index (BMI) and alcohol consumption were also reported as factors that interfere with ferritin and serum iron levels during pregnancy. (3) Fischbach12 presents indexes of blood exchange in red blood and as the main elements that should be evaluated for the diagnosis of iron deficiency anemia. MVC (82-98fl): expresses the volume occupied by a single red blood cell and indicates whether the size of red blood cells appears normal (normocytic), < 82µm3 (microcytic) or greater than 100µm3 (macrocytic). This result is the basis of the classification system used to assess anemia. CHCM (31-37g/dl): measures the concentration of hemoglobin in red blood cells, is useful in monitoring treatment for anemia, since the two most accurate haematological determinations (hemoglobin and hematocrit) are used in the calculation of this test. HCM (26-34pg): measured the average weight of hemoglobin by red blood cells and is of diagnostic value in severe anemic patients. The increase in HCM is associated with macrocytic anaemia, and the decrease is associated with microcytic anaemia. Microcytic anemia with iron deficiency is the most common, and its main causes are: food inadequacy, malabsorption, increased iron loss and increased iron needs. Chronic disease and hypochromic-microcytic disease are related to disorders of iron metabolism. The synthesis disorders of porfrine and hem, as well as disorders of the synthesis of globin, are also associated with microcytic anemia. Normocytic anaemia is linked to the appropriate response of the bone marrow (aplastic anaemia, infiltration of malignant cells, myelofibrosis), posthemorrhage and hemolytic, as well as decreased production of erythropoietin (renal and hepatic disease, endocrine deficiencies, malnutrition). Macrocytic anaemia is associated with cobalamin or folic acid deficiency or does not respond to cobalamin or folic acid. When macrocytic anaemia is linked to cobalamin deficiency, the cause of food due to lack of animal products is the trigger. It can also be associated with impaired absorption, intestinal parasites, pancreatic diseases, pregnancy, neoplasms, hyperthyroidism and deficiency of enzymes and proteins of normal serum cobalamin. When macrocytic anaemia is linked to folic acid deficiency, this may be due to decreased intake (vegetables, alcoholism, lactation) or affected absorption (short bowel circuits, steatorea, celiac disease, intrinsic intestinal disease, oral contraceptives) or increased need (pregnancy, lactation, hypothyroidism, overactive hematopoiesis, neoplasia) or impaired use (acid antagonists) or increased loss (hemodialysis). When macrocytic anemia does not respond to cobalamin or folic acid, it may be due to purine synthesis inhibitors, pyrimidine, thymidalate, deoxyribonucleotide, and congenital errors. During pregnancy, they are 900 mg of additional iron, of which about 500 to 600 mg will satisfy the increase in the erythrocytic mass and 300 mg go to the fetus and placenta. Daily maternal needs reach 7 mg in the second half of pregnancy. To meet this need, the body uses several mechanisms, prioritizing the new developing being, placenta and umbilical cord and blood loss at the time of birth and puerperium.13 The maximum additional absorption of iron is obtained when the intake is 30 minutes before the meal. Iron is processed by the cells of the duodenojejunal mucosa, which has a control mechanism, so that its assimilation does not become excessive. This homeostatic resource also works in the opposite direction, increasing the efficiency of absorption in cases of increased deficiency or need.14 Once absorbed by the intestine, iron is transported through the cells of the mucosa into the blood, where it is transported by a protein to the bone marrow to participate in the production of erythrocytes,(15) Ferritin is the readily available form of iron reserve. Based on the theory of intestinal mucosa blockage,6 new treatment regimens have been proposed for intermittent iron deficiency anemia with intervals of three or seven days in order to avoid the effect of iron saturation by intestinal mucosa cells.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published , the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Working Group, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the research evidence published to date is , the research evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Helth Preventive Care Task Force, the evidence published to date is not sufficient to recommend or contraindicate iron supplementation.6 According to the Canadian Task Force on Preventive Helth Care, the research evidence published to date is not sufficient to recommend or contraindicate routine iron supplementation during pregnancy and even questions as to whether a systematic iron supplementation is not sufficient would cause damage. This does not mean that you should not continue to recommend a diet iron-rich for pregnant women, nor should they properly investigate and treat cases of anaemia.17 In addition, in cases where iron supplementation is required, intermittent alternative regimens still require evidence with well-controlled studies so that they are recommended to all pregnant women.3, 8 Barrett et al.17 using radioactive iron isotope in 12 normal pregnant women.3 , 8 Barrett et al.17 using radioactive iron isotope in 12 normal pregnant women.3, 8 Barrett et al.17 using radioactive iron isotope in 12 normal pregnant women.3, 8 Barrett et al.17 using radioactive iron isotope in 12 normal pregnant women. , non-anemic and not using additional iron, found an average absorption of iron of 7%, 36% and 66% in the 12th, 24th and 36weeks of gestation, respectively, demonstrating that the increased demand for iron during pregnancy is met by increased absorption of iron in diets during the same periods. It was observed that, despite increased absorption, there was a gradual decrease in mean haemoglobin, MVC and ferritin levels during the aforementioned gestation weeks. These changes (increased levels of erythropoietin and, consequently, erythrocytes) are after the 20th week of gestation. Given the increase in the production of erythrocytes, which exceeds the average destruction of the life of erythrocytes, which is about 120 days, the production of erythrocytes is reduced in the second half of pregnancy. This justifies the introduction of ferrous sulphate from the 20th week of gestation. The increase in plasma volume is related to the clinical performance of pregnancy and varies greatly from woman to woman. There is a positive correlation between the expansion of plasma volume and the size of pregnancy, i.e. multiple, multiple pregnancies and macrosomal fetuses have a greater increase in plasma volume compared to receiving women, single pregnancies and small fetuses. Losses, even if minimal, of blood, at birth or in the puerperium can cause problems for women who are already anaemy, fetus and newborn. Among the most common effects of iron deficiency anemia, Braden18 emphasizes: - Maternal effects: • reducing the integrity of tissue with the possibility of lesions during childbirth; • prenatal or postnatal infection with delayed healing, fatigue; dizziness; • cardiovascular stress due to low oxygen saturation and pallor of the skin and mucous membranes, as well as shortness over exertion; • decreased resistance to infections, excessive bleeding after birth. This last complication has been reported as one of the leading causes of maternal death, along with hypertension, abortion and infections. There is also a theoretical risk of increased need for transfusion, with concomitant risk of hepatitis B virus and HIV (acquired human immunodeficiency virus). - Fetal and neonatal effects: • miscarriage, wind or young newborn for gestational age (SGA); • intact fetal iron reserves; • fetal disorders due to hypoxia in the last months of pregnancy and labor, when hemoglobin cannot carry enough oxygen to the mother and fetus. Use of ferrous sulphate In a study conducted in Brazil with 193 women of reproductive age, aged 15 to 45 years, who menstruated regularly and with haemoglobin levels ranging from 7.5 g/dL to 11.9 g/dL, the action and treatment with ferrous sulphate (60 mg of elemental iron) administered in daily and weekly doses in a low-income community was compared. After 12 weeks of treatment in which 150 women reached the end of the study, 79 in the weekly schedule and 71 in the daily schedule, the hb averages before treatment were, respectively, 10.52g/dl (SD = 1.13) and 10.72g/dl (SD = 0.92) for the alternative and conventional regimen. After intervention, hb means it reached 11.83g/dl (SD = 0.97) in the weekly regime and at 11.62g/dl (SD = 1.39) in the log. Not statistical significance (p = 0.22) between the differences in averages in the two therapeutic regimens, although the percentage of healing (48.1%) was higher in weekly treatment compared to daily treatment (36.6%). The study concluded that the weekly treatment regimen had the same efficacy as the journal. However, there is no statistical significance of healing between the two alternatives of administration, and the two treatments had the same efficacy. Percentage of anaemia cure, optimal and satisfactory levels of user adhesion, the very low cost (14.3% of conventional) and probably the reduced occurrence of side effects with the administration of iron compounds every seven days are given very promising in terms of the prospects for combating anaemia in women during the reproductive period.2 After revealing these aspects of the therapeutic study, the researchers concluded that the alternative therapeutic regimen is recommended and preferred, compared to classical models disseminated in the routine of health services. Another study 3 with 191 pregnant women, evenly distributed (64, 64, 63) in the respective treatment groups, showed that, after the losses and exclusions that occurred during the research, 150 pregnant women ended. Of these, 48 were treated weekly, 53 twice a week and 49 with daily treatment with a 300 mg drágea of ferrous sulphate equivalent to 60 mg of elemental iron (Fe). This medicine was chosen because it is the most commonly used and recommended form, as well as because it is low cost and well absorbed. It was recommended that the medicine be used at bedtime and/or 30 minutes before one meal. The scheduled duration of treatment was 16 weeks (with an extension of about a week or so). In conclusive terms, three evaluations were highlighted after the end of the study: 1. The weekly treatment regimen is not recommended because of the modesty of its results (27.1% of healing and 41.6% of therapeutic failure). 2. The daily regimen, with 47% cure and only 2.0% of therapeutic failure, would be ideal if it were not for verifying that 28.6% of pregnant women did not show satisfactory support, with a large part giving up treatment due to unwanted side effects. 3. The scheme that used iron twice a week obtained an acceptable percentage of healing (34%), but showed 13.2% of the therapeutic insufficiency, on the ground that no pregnant woman in this group discontinued treatment due to unacceptable side effects. In view of this situation, the author states that the scheme for the use of ferrous sulphate twice a week can be maintained in cases where there is an intolerance to the routine therapeutic plan. Routine. FINALS It is known that women of reproductive age are included in groups at risk of anaemia and that, with a certain frequency, pregnancy begins with insufficient iron reserves, it is important to develop the largest number of studies and researches on anemia in the group of women of childbearing age, so that the available drugs are used in a more rational and critical way.19 In this respect, Viteri et al.6 proposes the use of weekly doses instead of daily doses, assuming that the intestinal mucosa blocks the absorption of iron from the drug when administered repeatedly. Byskirt of the epithelial block barrier, whose cells renew every 80 hours, treatment would be simplified, side effects reduced, cost would be reduced, and there is an expectation of greater efficiency and efficacy in broad coverage interventions.20 However, WHO still expects more effective results of this new approach to schemes to recommend public health 21. Finally, in view of the argument that it would be preferable to treat a false case of anaemia rather than to exclude from true anemic treatment, even because, in addition to curativeness, drug iron supplementation and the recommendation of iron-rich food sources are justified, from an epidemiological and collective health point of view, as primary prevention measures. It is verified that further studies are needed to clarify the real occurrence of low adherence to the use of iron drugs, as well as the training of health professionals who introduce ferrous sulphate as a preventive measure of anaemia in the prenatal routine. In the face of so much uncertainty and controversy about treatment, it is important to clarify the undesirable effects of iron use on pregnant women and to follow the first weeks of introduction of the drug, in order to prevent early abandonment of ferrous sulphate, due to its undesirable effects and which tend to disappear as the body adapts to the drug. 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