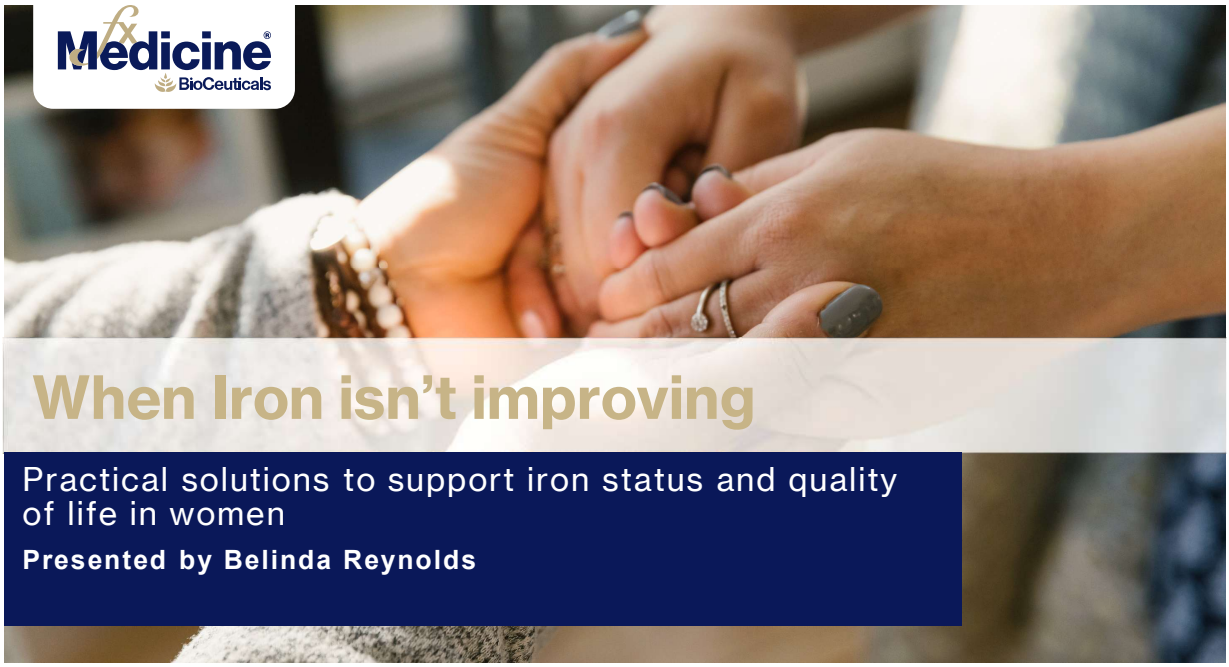
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When Iron isn't improving
Practical solutions to support iron status and quality of life in women
Presented by Belinda Reynolds

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PRESENTER
Belinda Reynolds
Dietitian
Medicine
BioCeuticals

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Learning objectives

- **Recognise** the barriers to successful iron repletion in women with persistent low iron status.
- **Compare** iron supplementation approaches based on bioavailability and tolerability.
- **Translate** emerging research on iron regulation and supporting nutrients into practical patient recommendations.

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Agenda



Prevalence



Influencing factors
- Gut health
- Stress
- Sports
- Infection, inflammation and “nutritional immunity”
- Antibiotics



How to increase iron levels



Essential co-factors and diet



Case study



Summary and Practice points

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Prevalence

5

Iron deficiency is common, and under-recognised

34.8% of young Australian women 18–39 yrs have serum ferritin <30 µg/L[1]



40% of Australian women aged 14–50 yrs have inadequate dietary iron intake[2]



21% of women in an Australian community screen had received an IV iron infusion in the past 2 yrs[1]



(1) MacLean et al., 2024 (2) Passarelli et al.,2024

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Iron deficiency symptoms

- Fatigue
- Pale skin
- Shortness of breath
- Frequent infections
- Headache
- Dizziness or lightheadedness
- Cold hands and feet
- Inflamed/sore tongue
- Brittle nails
- Fast heartbeat
- Unusual cravings for non-nutritive substances, such as ice, dirt or starch
- Poor appetite, especially in infants and children with iron deficiency anemia

CLINICAL PEARL

Low iron may also impact certain neurotransmitters, resulting in mood and sleep disturbances.

Investigating iron status should be considered in children where sleep challenges and/or fussy eating are present.

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Iron deficiency is common, and under-recognised

IT'S RARELY JUST "*LOW IRON*"

- Women with low iron were more than twice as likely to experience frequent heavy menstrual bleeding.
- Each pregnancy can cost a woman roughly half her iron stores – 1,400 mg lost through gestation, labour and breastfeeding.
- Malabsorption, restrictive/vegetarian diets and chronic inflammation compound the picture.



Wilson et al., 2025; Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; MacLean et al., 2024;

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Iron deficiency - pathophysiology

Category	Examples
Loss	Heavy menstrual bleeding, childbirth, breastfeeding, gastrointestinal blood loss.
Intake	Low- energy diets, vegetarian or vegan diets, restrictive eating.
Absorption	Coeliac disease, Inflammatory bowel disease (IBD), *Helicobacter pylori* (*H. pylori*), hypochlorhydria, acid suppression, bariatric surgery.
Demand or sequestration	Pregnancy, endurance exercise, infection and chronic inflammation.

Wilson et al., 2024; Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; MacLean et al., 2025;

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Perimenopause is a blind spot in iron screening

- Perimenopausal anovulatory cycles frequently cause heavier and more erratic bleeding than a woman's baseline.
- A thrombosis/haematology clinical review real case: a 47-year-old woman whose cycles shifted from a stable pattern to 21–32 day cycles, with clots 2–3 cm in diameter and overnight flooding, presented with a ferritin of 7 µg/L and haemoglobin of 105 g/L.
- Perimenopause symptoms (fatigue, brain fog, mood changes, poor concentration) directly overlap with iron deficiency anaemia symptoms.
- 20% of women experience excessive menstrual blood loss, accounting for 40 of every 1,000 medical consultations annually.

Ghandi et al., 2022; Jones & Sung, 2025; Cutts & Fennessy, 2025



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Pregnancy triples iron demand, and raises the stakes

- Pregnancy requires a total of 1,000–1,200 mg of iron, with demand peaking in the third trimester as blood volume expands and the foetus grows.
- **11–18% of Australian pregnancies are affected by iron deficiency anaemia.**
- Untreated deficiency is linked to preterm birth, low birth weight, postpartum haemorrhage and impaired fetal neurodevelopment.
- Ferrous bisglycinate is linked to 40% fewer combined GI complaints than ferrous fumarate/sulphate in pregnancy, when nausea and reflux are already common.



Frayne & Pinchon, 2019; Smith-Wade et al., 2020; Moyle, 2025; Milman & Bergholt, 2024

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Iron absorption, regulation and utilisation

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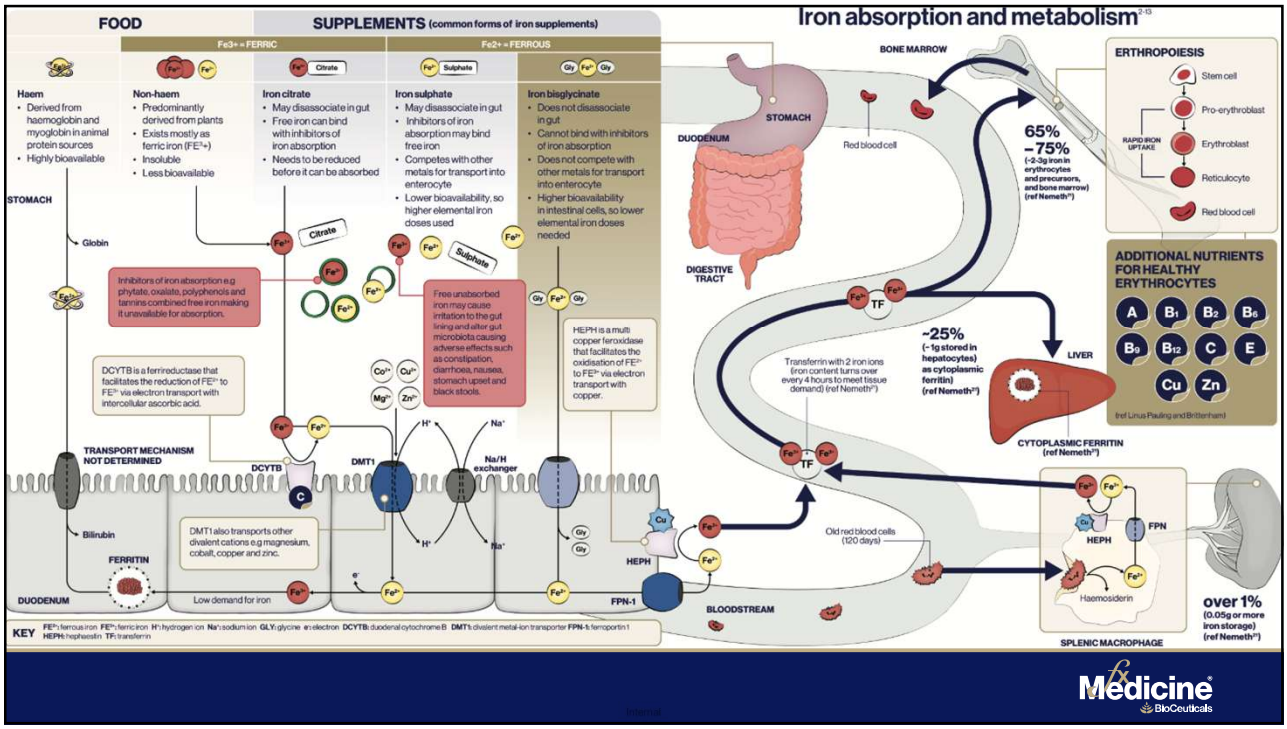

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Influencing factors

Gut Health

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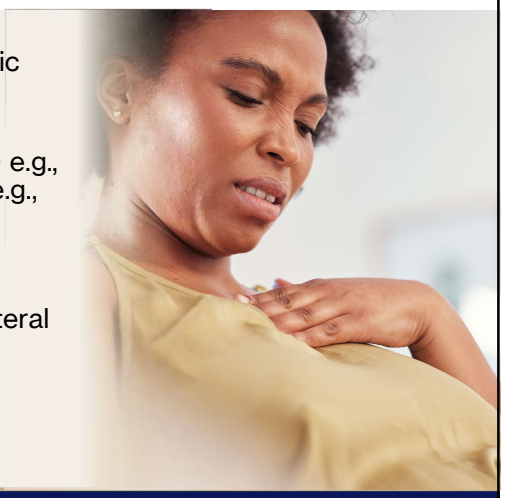
Gastric acid: A critical determinant in iron absorption

- Gastric acid and hypochlorhydria: low pH of normal gastric acid is required to solubilise ferric iron and enable its reduction to the bioavailable ferrous form.
- Impact of acid suppression Proton Pump Inhibitors (PPIs) e.g., omeprazole and Histamine-2(H-2) receptor antagonists e.g., cimetidine and antacids inhibit gastric acid production.
- By elevating stomach pH, these medications prevent iron solubilisation and disrupt proton-coupled Divalent Metal Transporter 1 (DMT1) transport, significantly reducing enteral iron absorption.
- A vegan diet is associated with a significant reduction in dietary acid load.



Ebea-Ugwuanyi et al., 2024; Pantopoulos et al., 2024; Müller et al., 2021

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Clinical causes of hypochlorhydria

- ***H. pylori* infection**: causes chronic atrophic gastritis and elevates gastric pH, directly decreasing iron absorption and elevating serum hepcidin levels.
- **Autoimmune atrophic gastritis**: causes gastric parietal cell destruction and achlorhydria/hypochlorhydria, impacting both iron and B12 absorption.
- **Gastric and bariatric surgery**: gastrectomy, gastric bypass, or duodenal resection reduce gastric acid exposure and bypass the primary site of iron absorption.
- **Coeliac disease**: Immune-mediated duodenal villous atrophy damages the enterocyte brush border and downregulates or disrupts essential transport proteins (DMT1 and ferroportin-1). Iron deficiency anemia (IDA) is present in up to 50% of coeliac patients at diagnosis.
- **Ultrastructural damage and gluten sensitivity**: Even in the absence of total villous atrophy (or in non-coeliac gluten sensitivity), microvilli alterations and disrupted glycocalyx can cause persistent iron malabsorption.
- **IBD and Small Intestinal Bacterial Overgrowth (SIBO)**: severely impair iron uptake through combined mucosal destruction and cytokine-driven hepcidin upregulation.

Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021

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Influencing factors

Chronic stress

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Chronic stress can raise hepcidin, and block absorption

- Hepcidin behaves as an acute-phase-type protein; it responds to inflammatory signalling (Interleukin 6), not just iron status.
- Psychological and physiological stress activates inflammatory pathways that can drive this same hepcidin response.
- Hepcidin also fluctuates across the menstrual cycle alongside oxidative stress markers.
- A patient under sustained stress may absorb iron less efficiently even on an otherwise appropriate regimen.

CLINICAL PEARL

The gut–brain axis links stress physiology to gut motility, barrier function and microbial balance. Supporting gut health is a logical adjunct when stress is a contributing factor to a patient's iron picture (alongside addressing the stress itself).

Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; Pantopoulos et al., 2024; Prentice et al., 2019; Kasahara et al., 2024

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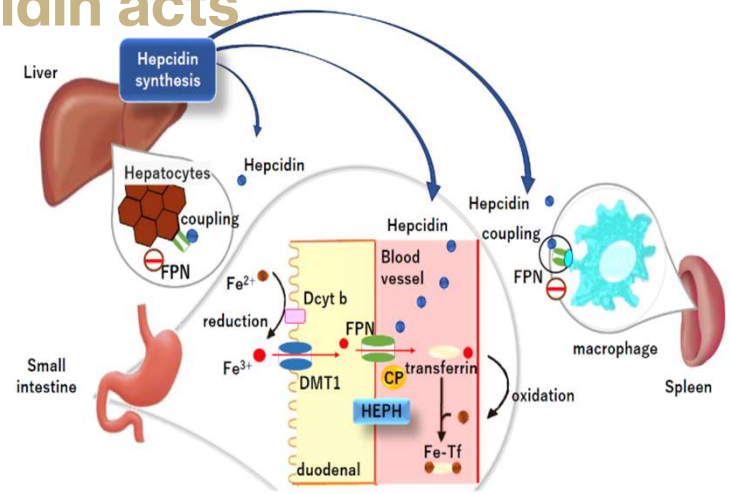
Regulation of iron metabolism when hepcidin acts



Takahashi et al., 2025

CLINICAL PEARL

This mechanism explains why increasing standard daily oral iron doses during periods of high hepcidin or inflammation is counterproductive. It simply accumulates unabsorbed iron in the intestinal lumen, causing mucosal irritation without increasing systemic supply.

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Influencing factors

Sports

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Iron deficiency in sports

- Intense and endurance exercise can deplete functional iron stores by up to **70%** compared to the general population.
- Iron loss during exercise occurs via:-
  - **Foot-strike heamolysis** (impact-induced red blood cell destruction)
  - **Sweat loss** (up to 22.5 µg/L)
  - **Heamaturia** (running-induced bladder mucosal trauma)
  - **Gastrointestinal ischemia/microbleeding**
  - **Poor dietary intake**
- Strenuous exercise triggers an acute inflammatory release of **IL-6**, which upregulates the liver hormone **hepcidin**.



Kardasis et al., 2023

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Iron deficiency in sports

- **Iron deficiency non-anaemia (IDNA)** is far more common in female athletes (15–35%) than male athletes (5–11%). Reduced oestrogen levels result in higher hepcidin activity and reduced gastrointestinal iron uptake.
- **Sports anaemia (Pseudoanaemia)**: Aerobic training expands total plasma volume faster than red cell mass, creating a dilutional decrease in hemoglobin concentrations that can mimic anaemia.



Kardasis et al., 2023

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Iron deficiency in sports

Positive diagnosis of IDNA or IDA in adult athletes

Iron treatment

Dietary counselling
Refer athlete to a dietician and recommend consuming iron rich diet.

Note: High-intensity athletes like endurance athletes may need up to 70% more iron intake daily than the recommended dosage. Guidance based on continued clinical and laboratory evidence.

Oral iron therapy
- Oral iron recommended in the morning on an empty stomach.
- Counsel iron therapy with vitamin C supplement.
- Suggest avoiding intake of coffee, tea and calcium one hour before and after taking the iron therapy.

IV iron therapy
Indicated when oral therapy is not tolerated, when a quick iron repletion is desired, or for symptomatic or severe IDA (<7g/dL of Hb).

Blood transfusion
Indicated for severe IDA (<7g/dL or Hb).

Kardasis et al., 2023

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Influencing factors

Infection and inflammation

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Infection, inflammation and "nutritional immunity"

- This is a host-defence mechanism ("nutritional immunity"): iron is deliberately withheld from circulation to limit pathogen access.
- It explains why ferritin can look "normal" or high in an unwell or chronically inflamed patient, despite functional iron deficiency.
- Antibiotic use and recurrent illness are common, under-discussed contributors to a patient's "*iron won't budge*" picture.

CLINICAL PEARL

For clients with recurrent infections or antibiotic courses interrupting iron progress, supporting immune resilience and the gut microbiome disrupted by antibiotics can be a relevant adjunct discussion.

Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; Pantopoulos et al., 2024; Prentice et al., 2019; Shen et al., 2017

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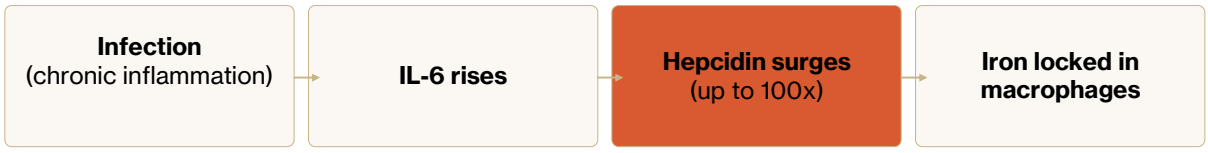
Infection, inflammation and "nutritional immunity"



Ganz, 2003

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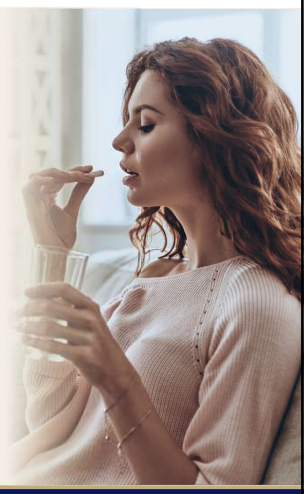
Supporting during recovery from infection and antibiotic treatment

- The GIT houses 70-80% of the body's immune cells.
- Antibiotics reduce microbial diversity and weaken immune defenses.
- The use of antibiotics, illness and infection drive systemic inflammation, alter the gut microbiome, and deplete short-chain fatty acids (SCFAs).
- This bidirectional cycle heightens infection susceptibility while contributing to gastrointestinal symptoms.



Mullish et al. 2024, Karamantziani et al. 2024, Piskin et al. 2022, and Prentice et al. 2019

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Supporting during recovery from infection and antibiotic treatment

- **Strain-specific probiotics** help maintain microbial balance, preserve SCFA production, reinforce gut barrier integrity, and modulate immune pathways during antibiotic therapy.
- Clinical outcomes are strictly strain- and dose-specific and cannot be generalised across species.
- Meta-analytic data show that multi-species formulations offer superior protection against antibiotic-associated GI side effects compared to single-species products.

	Species/ strain	Daily dose and population	Strain-specific outcomes, compared to placebo
URTI occurrence reduction	*B. animalis* subsp. *lactis* BI-04	2 billion CFU; 150 days; 465 healthy, physically active Australian adults	***Reduced the overall risk of acute URTI episodes by 27%** over a 5-month winter season (p=0.02). There was also a trend toward a first-cold delay by approximately three weeks.[1]
Support during antibiotic intake	*B. bifidum* Rosell®-71	3 billion CFU; 6 weeks; 581 healthy university students under academic stress	*Significantly **increased the proportion of healthy days** (p=0.05). Only 24% reported at least one cold/flu day, compared to 37% in placebo group (p≤0.05).[10] *Lowered self-reported stress and **reduced diarrhoea, loose stools and bowel urgency**, including during antibiotic use.[11]
	L. rhamnosus Rosell®-11 & *L. helveticus* Rosell®-52 (Lacidofil®)	4 billion CFU twice daily; 14 days; 146 healthy adults; antibiotics for initial 7 days	Significantly **reduced the duration of diarrhoea-like bowel movements by a full day** (p=0.037) in a post hoc analysis.[12]
Microbiome support	*B. animalis* subsp. *lactis* Howaru® HN019	65 million to 5 billion CFU; 4 weeks; 80 healthy elderly adults	At 1–5 billion CFU, HN019 **significantly increased beneficial gut microbiome** bifidobacteria and lactobacilli, while reducing enterobacteria.[13]
Bowel regularity		1.8 billion to 17.2 billion CFU; 14 days; 88 adults	Significantly **decreased whole gut transit time** (WGTT) by up to 33%, and **reduced functional GI symptom frequency**, including irregular bowel movements and flatulence.[14]

West et al. , 2014; Evans et al. , 2016; Ferguson & Taylor, 2022. IMAGE from Bioceutical Flyer

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How can we increase iron levels

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GI side effects are the real barrier to iron repletion

- Up to 50% of patients become non-adherent to oral iron, largely driven by GI intolerance.
- 12% constipation, 11% nausea, 8% diarrhoea with standard ferrous salts, plus flatulence, cramping and dark stools.

CLINICAL APPLICATION
Dosage: 24mg iron bisglycinate Ferrochel™ on alternate days as a single dose.

CLINICAL PEARL
Tolerability isn't a side issue; it IS the efficacy issue. A supplement that isn't taken cannot correct iron status, however "potent" its elemental dose.



Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; Pantopoulos et al., 2024; Tolkien et al., 2015

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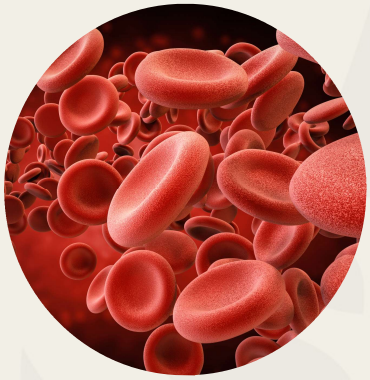
Why iron glycinate behaves differently in the gut

- **Standard iron salts:** Ferrous sulfate, fumarate and polymaltose rely on the DMT1 transporter, the same route saturated by dietary non-haem iron and disrupted by unabsorbed free iron irritating the mucosa.
- **Iron glycinate (bisglycinate)**: Iron is chelated to two glycine molecules, forming a stable, neutral complex absorbed intact via the peptide transporter PepT1, in addition to DMT1.
- A dual absorption pathway that bypasses competition at the DMT1 site, improving uptake while reducing the free ionic iron left to irritate the gut lining.



Ebea-Ugwuanyi et al., 2024; Bumrungpert et al., 2022; Milman & Bergholt, 2024

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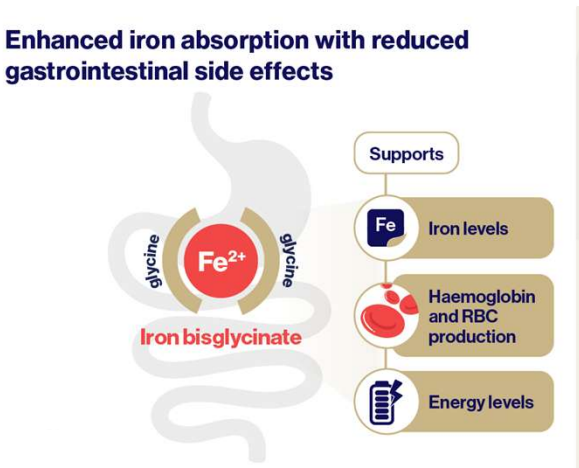
Iron glycinate greater bioavailability

- **Iron glycinate has 1.5-2 x greater bioavailability** per mg elemental iron vs ferrous sulfate.
- A randomised crossover trial in non-anaemic women found significantly higher relative bioavailability for iron glycinate vs ferrous sulfate.
- **40% lower total combined GI complaints** on ferrous bisglycinate vs fumarate/sulphate in pregnancy.



Ebea-Ugwuanyi et al., 2024; Bumrungpert et al., 2022; Milman & Bergholt, 2024

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Lower elemental dose, equivalent, or better, efficacy

	Ferrous sulfate / fumarate	Iron polymaltose	Iron glycinate (Ferrochel™)
Typical elemental dose	60-105 mg/day	100 mg/day	24-25 mg/day
Absorption pathway	DMT-1 only	Passive, pH-dependent	DMT-1 + PepT1 (dual)
Relative bioavailability	Low (<10-20%); easily blocked by phytates, polyphenols and calcium	Lower/slower absorption kinetics than ferrous salts; less affected by food	2- to 4- fold higher bioavailability; protected from dietary inhibitors
GI tolerability	Poor tolerability (12% constipation, 11% nausea, 8% diarrhoea, up to 50% non-adherence)	Better tolerated than ferrous sulfate, but high faecal iron load remains	40-60% reduction in GI side effects, lowest rate of dark stools

Milman & Bergholt, 2024; Tolkien et al., 2015; Lo et al., 2023, Frayne and Pinchon, 2019; Patopoulos, 2024, Bumrungpert et al., 2022, Fischer et al., 2023, Ones Health 2026 (bioavailability synthesis)

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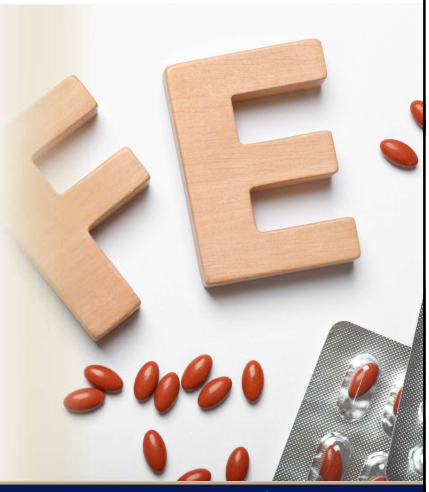
Lack of an “iron deficiency” claim

- Listed products are limited to TGA-permitted indications and wording.
- A product can contain iron and be positioned for ‘blood health’ or ‘energy support’ without carrying a therapeutic claim to treat iron deficiency or iron-deficiency anaemia.
- Absence of an ‘iron deficiency’ claim is a regulatory/labeling issue, not necessarily evidence of inferior efficacy.
- Diagnosis and treatment of iron deficiency remain clinical responsibilities; product use should be guided by symptoms, iron studies and response to therapy.



TGA 2026

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Hepcidin is the body's iron "gatekeeper"

What raises hepcidin:

- A dose of oral iron itself (dose-independent - 100 mg and 200 mg rise similarly).
- Infection, illness and chronic inflammation (via IL-6).
- Psychological and physiological stress.
- Twice-daily / split dosing more than once-daily dosing.

The clinical consequence

A large daily dose taken when hepcidin is already elevated from yesterday's dose is largely wasted, poorly absorbed, and often just adding to GI load and unabsorbed iron reaching the colon. This is the biological rationale behind reconsidering daily high-dose regimens, not just tolerability.

Oral iron dose taken → **Hepcidin rises within hours** → **Ferroportin blocked in gut lining** → **Absorption falls for ~24 hours**

Ebea-Ugwuanyi et al., 2024; Montoro-Huguet et al., 2021; Pantopoulos et al., 2024; Prentice et al., 2019; Anderson & Frazer, 2017

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The case for alternate-day dosing

- +34% higher cumulative total iron absorption with alternate-day vs consecutive-day dosing (p=0.001).
- 33% higher rate of GI side effects with daily vs alternate-day supplementation.

CLINICAL PEARL

Clients who tolerate iron but plateau on daily dosing, or who experience cumulative GI symptoms, alternate-day dosing (of the same total tablets) may improve both absorption per dose and adherence

CLINICAL APPLICATION

Dosage: 24-48 mg iron bisglycinate Ferrochel™ on alternate days as a single dose.

Stoffel et al. 2017, 2020

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What about IV infusion?

- As a one-off or occasional correction, IV iron is well-established and safe.
- For people who genuinely can't absorb or tolerate oral iron, it's often the right clinical choice.
- **Where it gets more complicated is repeated, ongoing use over the long term:**
  - Ferric carboxymaltose (FCM), one of the most commonly used formulations, causes hypophosphatemia in roughly 40–70% of patients, and it can persist for weeks to months. With repeated dosing, this can progress to genuine osteomalacia (bone pain, muscle weakness, fractures from softened bone).
  - It doesn't fix the underlying cause.
  - Iron overload is a risk with repeated dosing if ferritin and transferrin saturation aren't monitored between rounds as it can accumulate.
  - Hypersensitivity/anaphylaxis risk exists with any IV iron, though modern formulations have made this much rarer than older ones like iron dextran.

Martens & Wolf, 2023; Nataatmadja & Francis, 2019

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Gut health as the foundation for nutrient absorption

- A healthy, undamaged intestinal lining supports optimal uptake of iron, vitamin B12, folate and other micronutrients at the point of absorption.
- Both constipation and loose stools/diarrhoea can impair nutrient contact time and absorption efficiency.

CLINICAL PEARL

In a client with ongoing GI symptoms, dysbiosis, or a history of poor tolerance to iron supplements, supporting overall gut health and normalising bowel habits with a general daily probiotic that features *Bacillus coagulans* Unique IS-2, shown to relieve abdominal pain and discomfort, can be a reasonable adjunct alongside a well-tolerated, well-absorbed iron strategy.

Montoro-Huguet et al. 2021; Pantopoulos 2024; Zhang et al. 2022

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Can probiotics help ease stress and anxiety and lower hepcidin?

- Mullish et al. (2024) reported that 8 weeks of Lab4 probiotic supplementation in females with medically diagnosed IBS was associated with reductions in Hospital Anxiety and Depression Scale (HADS) scores related to mild anxiety (31.4%) and low mood (32.1%), suggesting a potential role in supporting mood balance in this population.
- The study also reported changes in the composition of specific gut microbiota species in participants receiving the Lab4 blend compared to placebo.

Table 1: Randomised, double-blind, placebo-controlled studies of Lab4 blend in medically diagnosed IBS.

	Williams et al. 2009[7]	Mullish et al. 2024[8]
Participants	n = 52 adults with IBS	n = 56 female adults with IBS
Potency	Lab4 25 billion CFU	Lab4 25 billion CFU
Dose	1 capsule per day, or placebo	1 capsule per day, or placebo
Duration	8 weeks	8 weeks
OUTCOMES: Lab4 blend, at 25 billion CFU, significantly improved symptoms of medically diagnosed IBS		
Abdominal bloating	↑ Significant improvement from 4 weeks#	↑ Significant improvement from 4 weeks*
Abdominal pain	↑ Significant improvement from 4 weeks#	↑ Significant improvement from 4 weeks*
Bowel regularity satisfaction/ dissatisfaction	↑ Significantly improved satisfaction from 6 weeks*	↑ Significant improvement in dissatisfaction from 4 weeks#
Quality of life	↑ Significant benefits at week 8*	↑ Significant benefits from 4 weeks#
Mild anxiety and mood		↑ Significant improvements at week 8*

WIlliams et al., 2009 ; Mullish et al., 2024; IMAGE: Bioceutical flyer

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Vitamin B12 and folate: essential co-factors for red blood cell production

- Erythroblasts require folate and vitamin B12 to proliferate and differentiate during red blood cell production.
- Deficiency impairs DNA synthesis (purine/thymidylate pathways), causing erythroblast apoptosis and ineffective erythropoiesis.
- The result can be macrocytic/megaloblastic changes; a different mechanism to, but easily overlapping with, iron deficiency.
- Vitamin B12 also supports cellular energy metabolism, compounding the fatigue picture when low alongside iron.

CLINICAL PEARL

A client who is "not improving" on iron alone may have a co-existing vitamin B12 or folate insufficiency masking or compounding the picture, particularly relevant in restrictive diets, malabsorption, or after prolonged GIT symptoms.

Behringer et al. 2025; Skavinska et al. 2025 and Montoro-Huguet et al. 2021

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Vitamin A deficiency can silently blunt the response to iron therapy

- Vitamin A deficiency impairs the release of iron from hepatic stores and reduces circulating transferrin, meaning iron can be "stuck" in storage even when levels look adequate.
- Low vitamin A status is associated with subclinical low-grade inflammation and elevated IL-6 levels, which triggers the production of hepcidin.
- In vitamin A–and-iron-deficient children, vitamin A supplementation alone raised haemoglobin and mobilised stored iron, likely mediated through increased erythropoietin, even without changing total body iron.
- A 2024 study in adolescent girls found that low baseline vitamin A status predicted a blunted haemoglobin response to standard iron-folic acid supplementation — i.e., vitamin A status can be a genuine reason iron treatment underperforms.

Andersen et al., 2023; Dantham et al., 2024

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Dietary strategies to enhance iron absorption

- **Pair iron with vitamin C -** Ascorbic acid reduces non-haem iron to a more absorbable form, pair iron-rich meals with citrus, capsicum or berries.
- **Combine haem/non-haem -** Small amounts of haem iron (meat, poultry, fish) enhance absorption of non-haem iron (lentils, quinoa, pepitas) eaten in the same meal.
- **Separate inhibitors -** Tea, coffee, and calcium/dairy taken with meals can reduce non-haem iron absorption by up to 60–90% , space these 1–2 hours apart.
- **Address phytate load** - Soaking, sprouting and fermenting legumes and wholegrains reduces phytate binding of non-haem iron.

CLINICAL PEARL

Food-first sets the foundation; but for many women with ongoing losses (menstrual, pregnancy) or malabsorption, diet alone won't close the gap. This is where supplementation strategy matters.

Piskin et al. 2022; Montoro-Huguet et al. 2021

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Dietary strategies to enhance iron absorption

- **Support intestinal and microbiome health** – a variety of prebiotic and fibre-rich foods support intestinal microbial diversity and short chain fatty acid production
- **Partially hydrolysed guar gum (PHGG)** - preliminary research suggests that PHGG may indirectly support iron absorption by promoting intestinal health and microbial fermentation, lowering colonic pH and potentially increasing colonic ferroportin expression

CLINICAL PEARL

Prebiotic fibres contribute to microbiome health, reduce intestinal pH and support healthy bowel movements.

Better intestinal health can also minimise inflammation that can compromise iron uptake.

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Case study

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Case study: perimenopause and persistent iron deficiency



Lorella

AGE:	WEIGHT:	HEIGHT:
46	68 kg	165cm

Assessment
Ferritin 8 µg/L, Hb 108 g/L; heavy, erratic cycles (21–34 days) with clots and overnight flooding.
Fatigue, brain fog, low mood and poor concentration.
Non-adherent to prior ferrous sulfate due to GI upset and constipation; low-normal B12; 56gr protein per day; intermittent fasting.

This case has been de-identified – patient name and case detail changed where necessary to protect the patient's identity.

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Case study: perimenopause and persistent iron deficiency



Lorella

AGE:	WEIGHT:	HEIGHT:
46	68 kg	165cm

Treatment approach

Iron bisglycinate Ferrochel™ 24 mg elemental includes vitamin C 200 mg, active Vitamin B6 (24.4 mg), B9 (125mcg) and B12 (250 mcg). Dosage – 2 tablets, alternate-day dosing.
Daily probiotic with strains *Lactobacillus acidophilus* (CUL 21), *Lactobacillus acidophilus* (CUL 60), *Bifidobacterium animalis ssp. lactis* (CUL 34), *Bifidobacterium bifidum* (CUL 20). Dosage – 1 capsule/day.
Sunfibre® partially hydrolysed guar gum (PHGG) with berry juice powder, acacia gum and green tea extract. Dosage – 2 level scoops mix with water

GP prescribed tranexamic acid to reduce heavy menstrual flow at night.

Dietary recommendations: introduced breakfast, increased haem and non-haem iron, Vitamin C and A foods, reduced alcohol intake, caffeine/dairy spaced away from iron doses, 80 g protein/day).

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Case study: perimenopause and persistent iron deficiency



Lorella

AGE:	WEIGHT:	HEIGHT:
46	68 kg	165cm

Outcome – 3 month review

Ferritin 34 µg/L, Hb 126 g/L.
B12 normal range.

Energy, concentration and mood markedly improved; energy to train; no overnight flooding- unintentional weight loss of 2 kg and feeling lighter.

No GI side effects reported; adherence >90%.

This case has been de-identified – patient name and case detail changed where necessary to protect the patient's identity.

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Summary

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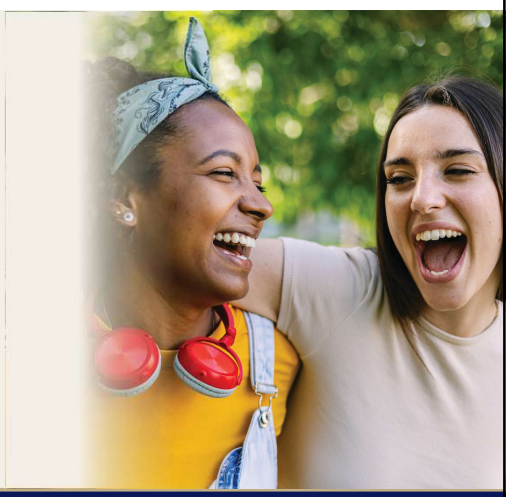
Key clinical takeaways

- ✓ Iron deficiency in women is common, under-screened, and often multi-factorial; don't stop at "eat more red meat."
- ✓ GI tolerability drives real-world efficacy; a supplement not taken cannot correct iron status.
- ✓ Iron glycinate offers an evidence-supported, dual-pathway alternative with lower effective doses and fewer GI complaints.
- ✓ Hepcidin biology supports reconsidering daily high-dose regimens, alternate-day dosing may suit select patients.
- ✓ Stress, illness and inflammation all raise hepcidin; look beyond the ferritin number.
- ✓ Vitamin B12, folate and gut health are part of the full picture, not an afterthought.



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Further education



ACCESS NOW



ACCESS NOW

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Thank you

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Q&A

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MORE QUESTIONS?

1300 650 455

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FOOTER (OPTIONAL)

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