Advice and guidance

Knowledge / guidance reference sheets

Issue 2 – Haematology

Disclaimer

Advice and guidance queries and responses capture a large amount of useful clinical information. The following is a distillation of common areas derived from the large number of responses, however they are not a replacement for the advice you might need for individual cases.

Elevated Ferritin

Increased by history of past transfusions.

Can be raised in infection, inflammation etc. and normal ferritin does not always exclude iron deficiency.

If ferritin is raised and hereditary haemochromatosis is suspected, check iron profile. If iron saturation is raised then refer to Gastroenterology.

Low ferritin

Invariably iron deficiency – not managed by haematology, refer to either gastroenterology or Gynaecology depending of where blood loss is suspected.

Direct access for GPs to Medical day case unit if want to arrange iron infusions for patients intolerant of oral iron.

Mild microcytic anaemia with normal ferritin

Alpha thalassemia trait (African/Indian origin) can cause mild persistent microcytic anaemia. Don't give iron unless iron deficient. Generally, requires no intervention. Partner testing may be required. Counselling in pregnancy only when potential risk of baby with severe Alpha thalassaemia.

Macrocytic/normocytic anaemia

Elderly often have a slowly falling Hb related to a falling eGFR, Anaemia of chronic disease if WBC, platelets and neutrophils are normal.

Macrocytosis without anaemia in the absence of abnormal haematinics / hypothyroid/ alcohol If clinically well only need monitoring.

Raised reticulocyte count + raised bilirubin = haemolysis => refer

Polycythaemia

Haematocrit in women > 0.48 and in men > 0.52 requires investigation if persists > 2/12. Check for obvious COPD, hypoxia or sleep apnoea. Stop smoking for 6-8 weeks and then repeat FBC. Avoid dehydration before reassessment.

Polycythaemia can be due to testosterone replacement, less likely with gel.

WBCs

Benign racial neutropaenia in patients of afro-Caribbean origin. Check blood film, autoimmune screen and viral studies but should have normal Hb and platelets and not be subject to recurrent infections. Review Ferritin, B12 and folate 6-12 monthly.

WBC > 20 persistently without a known cause: arrange blood film and REFER.

Alcohol is toxic to bone marrow and effect lasts months. Can cause neutropaenia.

Eosinophilia. Consider allergic rhinitis, asthma, skin disorders, drug reaction, parasitic and fungal infection, hypoadrenalism, Sarcoid connective tissue disorder and solid tumours. Persistent eosinophilia >1.5 (two tests at least one month apart) with no obvious secondary cause should be referred.

Myeloproliferative disorder –, May present with raised blood count (one or all of blood cells) +/- splenomegaly.

Possible Myelodysplasia – If suspected, need blood film and haematology referral unless very old and frail, not suitable for chemotherapy or supportive care.

Anorexia nervosa can cause neutropaenia and mild pancytopaenia.

Isolated Lymphopenia: not clinically relevant in most cases, consider HIV test if severe.

Platelets

Raised platelet count-check ferritin and treat if iron deficiency. If iron is replaced and platelet remains> 450: -> REFER.

Increased WCC and platelets can follow splenectomy. Alcohol can cause thrombocytopaenia, can take months to recover, remains low in established fibrosis/cirrhosis. Avoid NSAID and aspirin.

Stable thrombocytopaenia. If no bruising or bleeding and other FBC parameters are normal, test 6 monthly and refer if < 100, if Hb low or if WBC low. Check B12, folate, protein electrophoresis, viral screen (Hep B and C, HIV) stool H. Pylori and film (to exclude clumping) Clumping of platelets can lead to false low reading, repeat in citrate bottle (needs to be sent alongside sample in EDTA).

Immunoglobulins

Raised level only indicates bone marrow pathology if monoclonal i.e., paraprotein on electrophoresis. Otherwise, it is polyclonal and reactive and does not need haematology input.

Low levels: always check serum protein electrophoresis and urine for Bence Jones protein, if any of those positive => Refer, if negative could still be non-secretory myeloma (very rare), please discuss, low levels of IgM are common in the elderly

VTE

Recent NICE guidelines do not support long haul flights being a VTE risk factor but in clinical practice it is accepted as 'mild' risk for VTE.

Thrombophilia test is not recommended to check VTE risk re Combined hormonal contraception (avoid if possible if family history of VTE or known thrombophilia).

NOACs are not better than warfarin if compliance is poor.

Splenomegaly

Mild splenomegaly is present in 3% of normal population.

If 'B' symptoms (> 10% weight loss, night sweats and fever) then check Hep B/C, HIV, toxoplasma, EBV, autoimmune screen, ACE level, serum protein electrophoresis and LDH and refer.

Author:	
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