HAEMATOLOGY TOP TIPS

General Tips:	Many blood tests can be requested prior to review in the Haematology OPD. This can result in shortening the time to diagnosis and reduce the amount of follow – up visits.
Iron Deficiency Anaemia	**Do not refer to Haematology** Consider referral to Gastroenterology or Gynaecology (refer to 2ww guidelines). Treat until MCV, MCH and RDW normalise. **Refer to Haematology** if suspected intolerance oral Fe and parenteral therapy needed.
Macrocytosis:	Check blood film, Haematinics, Drug history, Alcohol intake, LFTs, TSH Ask for further advice or guidance if no cause is apparent
Raised Haematocrit:	**Do not refer based on one value** Think of secondary causes such as diuretics, COPD, hypoxia, alcohol and smoking. If haematocrit is >0.52 in men and >0.48 in women repeat Take two separate samples 8 weeks apart (BCSH Guidelines). If above values are persistent without an explanatory cause, then refer. If Hct > 0.60 in men and >0.56 in women Refer directly- absolute erythrocytosis by definition.
Mild Thrombocytopenia:	Check new drugs, haemorrhagic manifestations, clotting screen and old blood counts. **Refer if <100, symptoms or abnormal FBC** Otherwise monitor
Thrombocytosis	**>450** is especially significant Rule out secondary/reactive causes. Check for organomegaly especially splenomegaly Check CRP, ESR, blood film, exclude iron deficiency **Refer** if persistent and negative inflammatory markers and no evidence of Iron deficiency
Mild Lymphocytosis:	<10x10*9/L should **not** be investigated unless there are other adverse features. Check for peripheral lymphadenopathy, hepato-splenomegaly, Igs and B symptoms (drenching night sweats, wt loss>10%, unexplained itching, constitutional upset)
Thalassemic Indices/Sickle carrier (microcytic hypochromic red cell indices)	**Do not refer, for advice only** Check Iron status, ethnic origin, and blood film. Formal review needed only if specific counseling is required around pregnancy issues.
Low-level monoclone: (new monoclonal band on serum electrophoresis)	**Refer directly if :-** Any red flag symptoms especially if features of bone pain and/or B symptoms, significant Bence-Jones proteinuria (e.g. >500 mg/l); IgG monoclone >15 g/l; IgA or IgM monoclone > 10 g/l; IgD or E monoclone irrespective of concentration. Check urine for Bence Jones proteinuria, FBC, Renal function, Calcium, skeletal survey and seek guidance on appropriate monitoring.
Polyclonal increase in immunoglobulins:	**Do not refer to Haematology** Exclude underlying inflammatory causes. Consider viral hepatitis.

It must be emphasised that all of the above are **Guidelines** and **Do Not** replace the practitioner's clinical judgment. Where there is a doubt a referral should be made or the patient should be discussed via the Virtual Clinic(haemviryualclinic@rothgen.nhs.uk) For more information follow the link:
http://www.bcshguidelines.com/documents

Consultant:	Dr Arun Alfred, Consultant Haematologist, RFT
GP Lead:	Dr J Kitlowski, Clinical Commissioning Group, NHSR
Date Approved:	25/04/2012 – Reviewed April 2014
Review Date:	25/04/2016