**UHBristol Haematology clinic referrals (not fulfilling the criteria for 2ww)**

All referrals to clinic will be triaged and if accepted allocated an appointment in a time frame appropriate to the information supplied.

If it is felt by the triaging clinician that a clinic appointment Is not required an explanation and advice will be given

Bristol have separate streams within General Haematology. Weston assess all referrals through the same route.

|  |  |  |  |
| --- | --- | --- | --- |
| **General Haematology**  All referrals should include information on current weight/BMI, alcohol intake and smoking history in addition to ongoing comorbidities. | |  | |
| **Benign Haematology Clinic**  (Thurs morning Bristol ) | **Malignant Haematology**  (Weds pm/Fri pm) | **Bleeding and Thrombosis clinic** (Bristol-wide service)  (Tues/Wed) | **Haemoglobinopathy (clinic not currently on eRS)** |
| **Isolated thrombocytopenia** (with no features on blood film to suggest myelodysplasia, or clinical features) | **Unexplained combined cytopenias or any single cytopenia with a blood film suggestive of MDS or a Haematological anaemia** | Investigation of patients with abnormal bleeding symptoms | **Any referrals for advice or for possible review in clinic for patients with sickle cell disease or thalassaemia please email**  [**ubh-tr.haemoglobinopathybristol@nhs.net**](mailto:ubh-tr.haemoglobinopathybristol@nhs.net) |
| **Isolated anaemia** not due to iron B12 or folate deficiency and with no features on the blood film to suggest myelodysplasia/ Haematological malignancy | **Unexplained anaemia** with associated persistent monocytosis or blood film suggestive of myelodysplasia/Haematological malignancy | Patients with previous confirmed or suspected diagnoses of Haemophilia, Von Willebrand disease or other heritable clotting disorders. |
| **Isolated neutropenia** (with no features on blood film to suggest myelodysplasia) | **High risk paraproteins**  **NB serum free light chains assay** – it is the free light chain ratio that is relevant in assessing raised kappa and lambda light chains with a normal ration is consistent with a reactive process | Unprovoked venous thrombosis or venous thrombosis in women of childbearing age: this is for discussion of any thrombophilia testing and for decision making about anticoagulation duration.  Provoked VTE |
| **Haemolytic anaemia** | Persistent Lymphocytosis >10x10^9/l or associated with other cytopenias, rapidly enlarging lymphadenopathy or systemic symptoms. | Unusual site thrombosis eg cerebral venous sinus thrombosis, splanchnic vein thrombosis, upper limb thrombosis in the absence of an indwelling line |
| **Hereditary** **Haemochromatosis**  HFE genetics must be checked in Primary Care:  Raised ferritin with normal transferrin saturation: look for reactive cause including metabolic syndrome  Raised ferritin with elevated transferrin saturation but HFE genetics do not support a diagnosis of Haemochromatosis - first look for alcohol excess and/or liver disease (including liver ultrasound) | **Isolated lymphadenopathy:**  Refer for ultrasound before referral to Haematology – if reactive and no other haematological abnormalities no referral needed  **Isolated sweats:** Rarely due to Haematological cause recommend review of medication eg SSRI and hormonal evaluation incl testosterone levels in men only refer to haematology if additional symptoms/signs/blood count abnormalities | Issues around anticoagulation including complications and apparent treatment failures |
| **Any General Haematology clinic (benign or malignant)** | |  |
| Suspected Myeloproliferative disorders: JAK2 should be checked in Primary care – a negative JAK 2 does not fully exclude the diagnosis but helps with triage [BGL request form.pdf (nbt.nhs.uk)](https://www.nbt.nhs.uk/sites/default/files/BGL%20request%20form.pdf) | |  |
| **Thrombocytosis:** in patients over 40 yrs platelet count persistently > 450x10^9/l with no secondary cause (eg iron deficiency/bleeding or underlying inflammatory condition. Patients <40yrs platelet count persistently >600x10^9/l or >450x10^9/l with associated thrombosis | |  |
| **Polycythaemia:** hct > 0.48 for women and >0.52 for men where there is no evidence of secondary cause eg respiratory disease/sleep apnoea/heavy smoking/alcohol excess – there is no evidence for venesection in these conditions where there is a reversible cause (eg smoking+/- alcohol excess) repeat blood 3 months after cessation/significant reduction. | |  |
|  | | |
| **Conditions that are unlikely to require a Haematology appointment** | | |
| **Iron deficiency:** iron infusions are accessed through the acute medical team.  Address diet, malabsorption or bleeding (usually gastro or gynae)  [Guidelines for the Management of Iron Deficiency Anaemia in Adults - The British Society of Gastroenterology (bsg.org.uk)](https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-iron-deficiency-anaemia/)  Haematology are not able to manage unexplained iron deficiency if no bleeding source is found on OGD/colonoscopy gastro are best placed to decide on small bowl studies etc.  **B12 deficiency**  **Isolated mild splenomegaly:** consider the size of the patient and if an incidental finding/no associated blood count abnormalities or other symptoms/signs of a Haematological disease suggest repeat in 6 months and if stable no further investigations are required  **Abnormal bone marrow** Crossectional imaging reports esp MRI scans can identify an increase in red marrow, with a comment about excluding a haematological condition. If there is a normal full blood count and no evidence myeloma on assessment of paraprotein, urineary Bence Jones protein or serum free light chains referral to/discussion with Haematology is not required  **Isolated sweats – see above** | | |