Code

 = Primary Care Management

= Routine referral or A&G

= Urgent referral or admission

**Leucocytosis**

**WCC >10.5 x 109/l**

New CML with **hyperviscocity** symptoms &/or **WCC>100x109/l**

**IMMEDIATE haematology referral**

(speak to on call haematology clinician)

**Assess:** Leukocyte differential count (proportion of neutrophils, lymphocytes etc.)

**Consider:** Blood film and CRP

**History**: ?systemic symptoms (fever, weight loss, pruritus), examine for enlarged spleen/liver.

Is it persistent, stable or progressive? Isolated or associated with other ‘cytotosis or cytopenias?

**Lymphocytosis (> 4 x 109)**

See next flowchart

**Potential causes**: infection, necrosis, inflammation, ischaemia, drugs (corticosteroids), pregnancy, smoking, myeoprofliferative disorders (incl. CML)

**Significant finding** (rapidly rising WCC, unwell, splenomegaly, abnormal blood film, cytopenias, basophilia may suggest a MPN)

New CML not meeting other criteria.

Unexplained **WCC> 50 x109/l**

**Leucoerythroblastic** blood film (from report)

**OUTPATIENT assessment via Cancer Fast track referral**

Persistent unexplained WCC > 20 x109/l

Persistent unexplained monocytosis > 1 x109/l

Neutrophilia > 15 x109/l

**ROUTINE specialist referral. Consider using Advice & Guidance**

Does not meet other criteria

Repeat FBC in 3 months to assess for progression (or sooner if clinical context changes)

**Blood film = suspected CML**

**Not Suspected CML**

**Neutrophilia**

**Basophilia/eosinophilia**

**Lymphocytosis (> 4 x 109)**

**Often reactive/transient**: viral, infection (often mononucleosis). Low level lymphocytosis can be caused by smoking
If in immunophenotyping/flow cytometry demonstrates a polyclonal lymphocytosis than this indicates a reactive cause

**Lymphocyte count >10x109/l** not fulfilling other criteria persisting for >3 months

**Lymphocytosis** with splenomegaly/ progressive lymphadenopathy, B symptoms, Hb <100, Plt <100 or neutrophils <1, lymphocyte doubling time < 6 months with total lymphocyte count >20x109/L

**Lymphocyte count 4-10x109/l** not fulfilling other criteria

New diagnosis of clonal B cells or CLL with mild anaemia, thrombocytopenia or widespread small volume lymphadenopathy

**Suspected acute Leukaemia from blood film report**

Send additional EDTA sample for flow cytometry to confirm diagnosis

**Investigate**:

Glandular fever

HIV screen

Repeat FBC in 4-6 weeks

Lifestyle modification (quit smoking)

**IMMEDIATE haematology referral**

(speak to on call registrar)

**ROUTINE specialist opinion or advice & guidance**

**OUTPATIENT** assessment via Cancer Fast track referral

For persistent lymphocytosis <10x109/L if patient asymptomatic monitor FBC 6 monthly

If lymphocyte count >10x109/L send additional EDTA sample for flow cytometry to confirm diagnosis

**Development of red flag symptoms**

If meet referral criteria at any point (anaemia, thrombocytopenia, neutropenia, B symptoms, widespread lymphadenopathy or lymphocyte count doubling in < 6 months) or any other concerns from GP or patient

**“High-count” MBL (> 0.5-5x109/l) clonal B cells** annual FBC and periodic examination for lymph nodes and hepatosplenomegaly

**“Low-count” MBL (<0.5x109/L) clonal B cells** no additional monitoring required

**CLL or other clonal B cells (>5x109/L** **clonal B cells** if not meeting criteria for referral, follow guidance in flow cytometry report or GP letter. 6 monthly FBC monitoring, vaccinations and periodic examination for lymphadenopathy and hepatosplenomegaly

**Polyclonal lymphocytes** consistent with reactive cause. Consider FBC in 6 months