This document is currently under review – as some of the content may be out of date, it should be viewed as an archive document for information only.
If you have any queries, please email camden.pathways@nhs.net

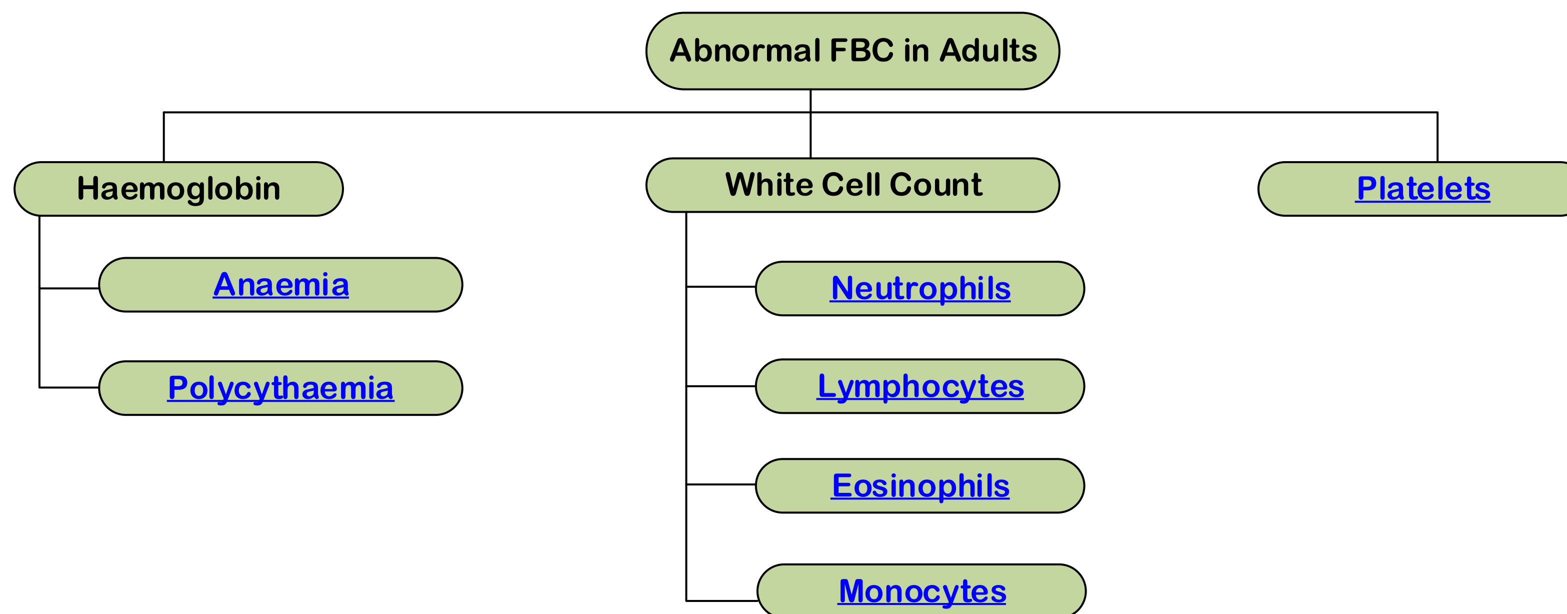
Abnormal FBC Results Guidance

NHS
Camden
Clinical Commissioning Group

This guidance has been developed from published guidance, in collaboration with local Haematologists and Gastroenterology, in response to frequently asked questions on interpreting FBCs.

This guidance is to assist GPs in decision making and is not intended to replace clinical judgment.

You may also want to seek further specific guidance using the 'Advice and Guidance' service.



NB – Abnormalities affecting more than one cell type are more likely to be due to bone marrow causes rather than reactive. Always consider earlier referral when the patient is unwell.

Produced in collaboration with local Haematologists and Gastroenterology
Contact for this pathway: sarah.morgan1@nhs.net

Pathway created by Sarah Morgan & Alex Warner
and approved by Camden PEC March 2013
Updated by Craig Seymour June 2015
Review due June 2018
V1.16 for new GP website Feb 2016

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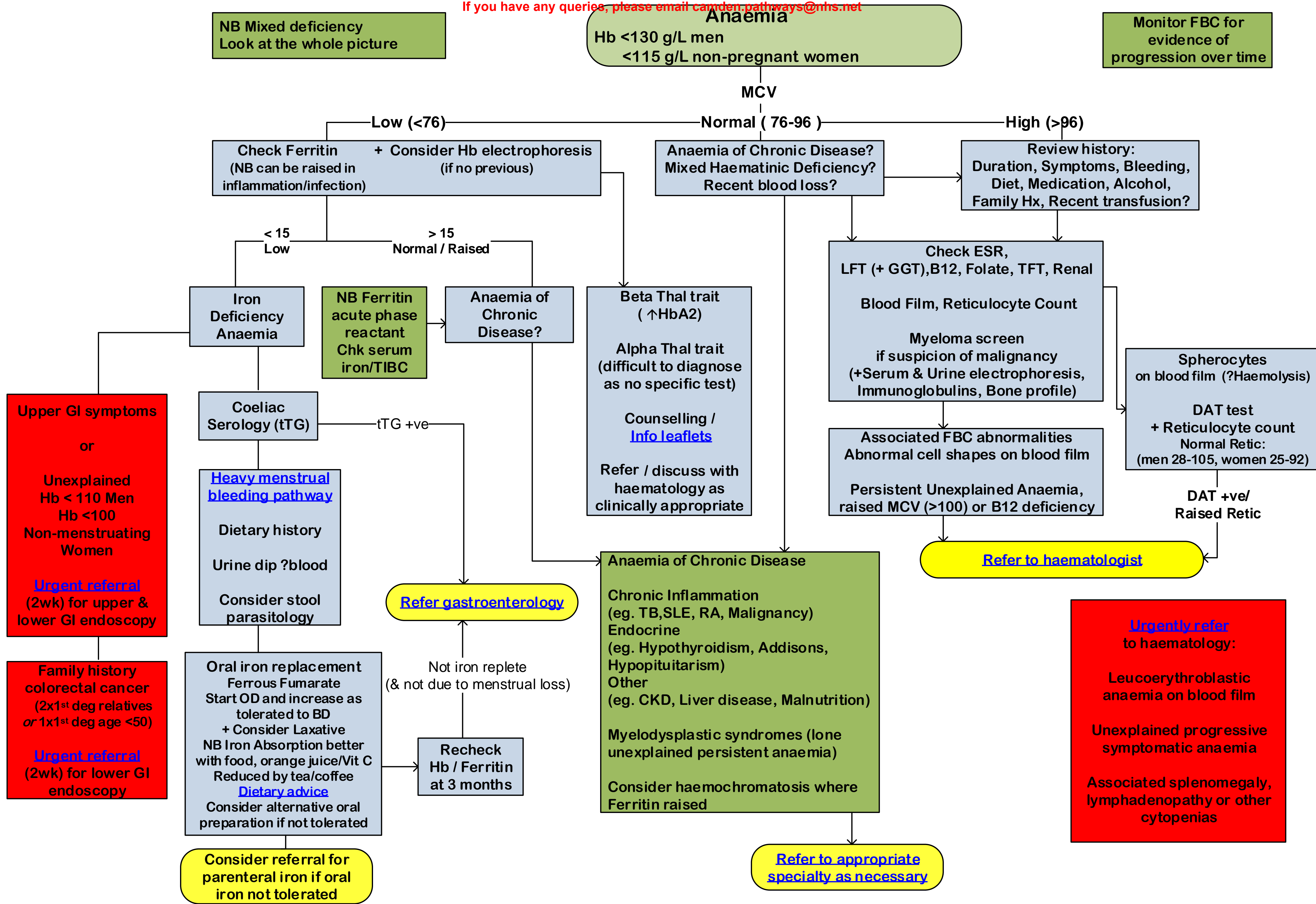

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Polycythaemia

Men: Hb > 185 Hct > 0.52
Women: Hb > 160 Hct > 0.48

May be associated with increased WCC & Platelets + Basophils
→ Probable primary polycythaemia (Ferritin usually low)

Causes of Polycythaemia

Apparent

Reduced plasma volume
Common in obese men, associated with smoking, diuretics, alcohol, hypertension, stress, dehydration
At risk of occlusive vascular episodes

Absolute

1° Polycythaemia (Rubra Vera)
(92% are JAK2 +ve)

2° Polycythaemia
Hypoxia
(COPD, Heart disease, smoking)
Abnormal EPO production
(Renal & liver tumours, fibroids)

WCC & Platelets normal
→ Probable secondary polycythaemia (Ferritin usually normal)

Modify known associated lifestyle factors
+ Monitor FBC

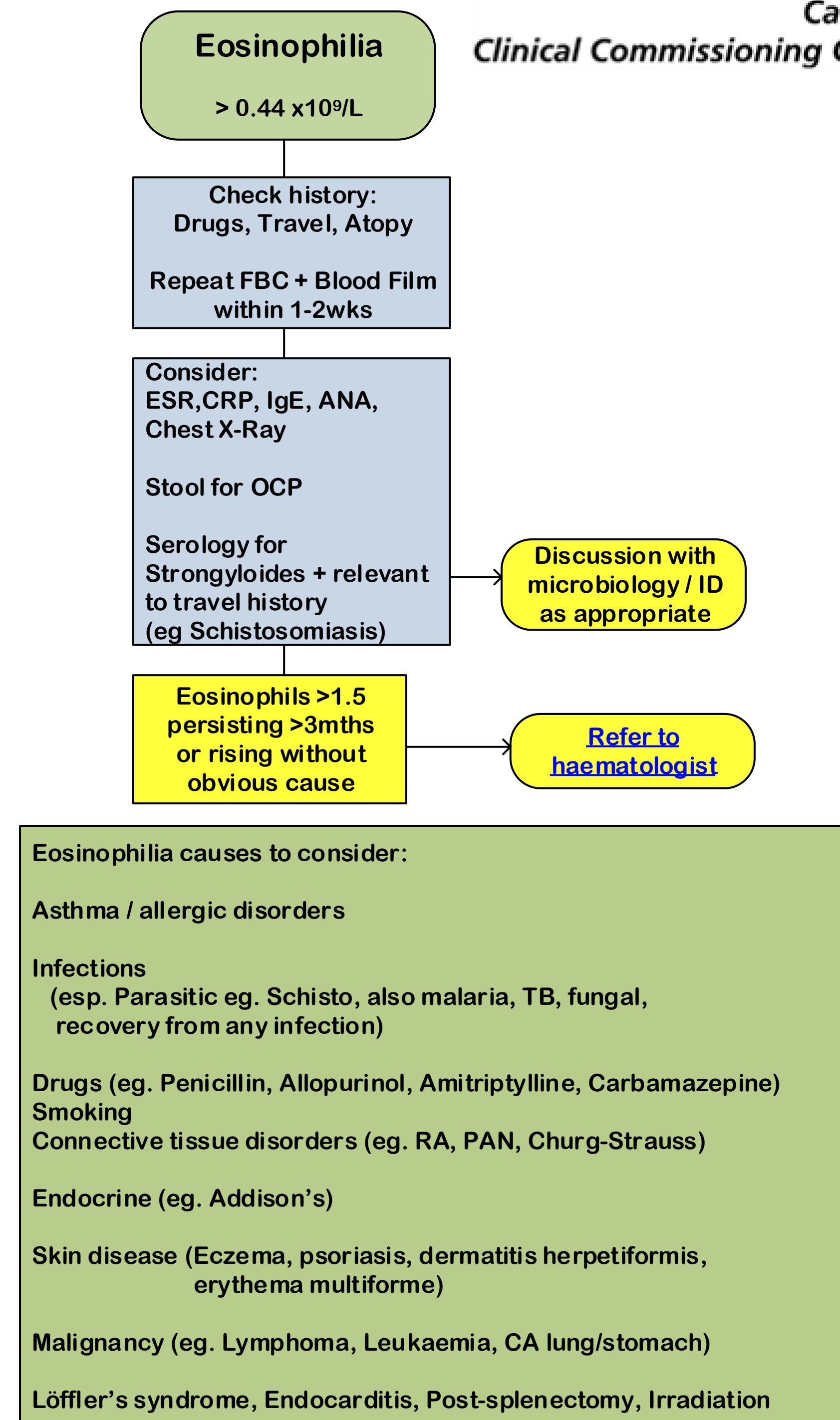
Refer if:

Raised Hct >0.52 males / >0.48 females (*uncuffed blood samples*)
+ Past history of arterial or venous thrombosis
Splenomegaly, Pruritus, Elevated WCC or Platelets

Or if persistent, unexplained raised Hct above these levels on at least 2 occasions over 4 weeks apart.

Urgently Refer: (2wks)
Hb >200 g/l / Hct > 0.60 (in absence of chronic hypoxia)

Raised Hb in association with:
- Recent arterial or venous thrombosis
- Neurological Symptoms
- Visual Loss
- Abnormal bleeding



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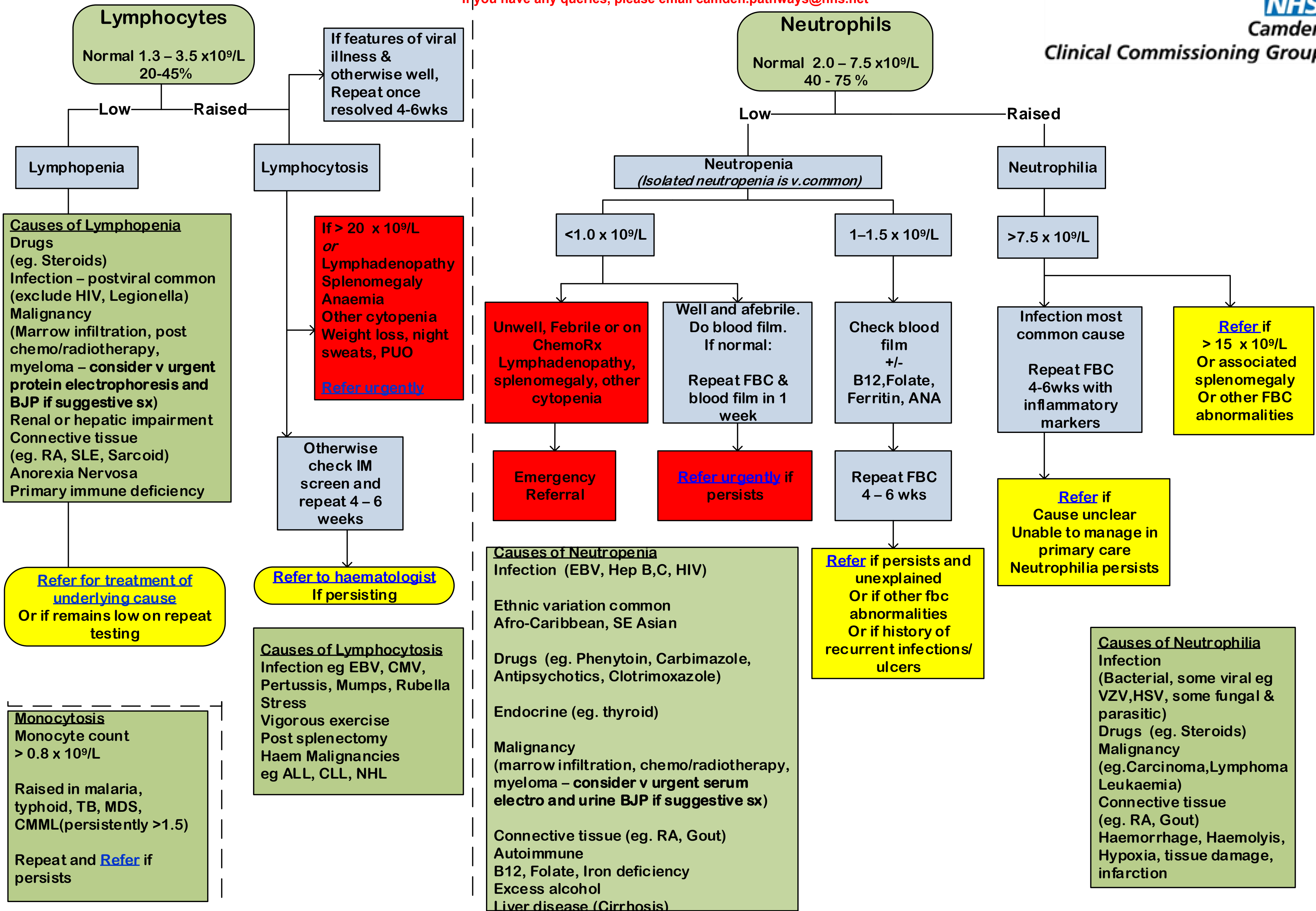

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