Haematology Specialist Clinics at Western Health:

Western Health runs MBS funded Specialist Clinics for patients who require assessment and management of Haematology conditions.

Patients will be triaged by Consultant Haematologists into one of the following pathways:

1. **Neutropenia:**

- <0.5 x 10^9/L level of neutrophils – refer immediately
- >0.5 x 10^9/L to <1.5 x 10^9/L level of neutrophils, please include evidence that neutrophil levels between these ranges have been detected on more than one occasion.
- >1.5 x 10^9/L – suggested management as per guidelines detailed in HealthPathways.

2. **Thrombocytopenia:**

- Platelet count < 80 x 10^9/L – refer immediately
- Platelet count > 80 x 10^9/L – suggested management as per guidelines detailed in HealthPathways.

3. **Lymphocytosis:**

- If persistent lymphocytosis and lymphocyte immunophenotyping confirms a clonal population - refer for Haematology opinion.

4. **Iron deficiency anaemia:**

   Anaemia with a ferritin <30, with contraindication to oral iron or in a patient with known malabsorption that cannot be managed in the community (see HealthPathways)

5. **Elevated serum ferritin:**

- Refer only when ferritin levels > 300.

Haematology Alarm Symptoms:

If a patient presents with the following symptoms please refer to the Emergency Department:

- Significant bleeding
- Severe thrombocytopenia (< 10 x 10^9/L)

Access & Referral Priority Haematology:

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

URGENT **Appointment timeframe 30 days**	ROUTINE **Appointment timeframe greater than 30 days, depending on clinical need.**
NEUTROPENIA: Level of neutrophils: • <0.5 x 10^9/L **THROMBOCYTOPENIA:** • If any significant bleeding, request immediate haematology assessment. **Refer immediately to Emergency Department:** • Severe thrombocytopenia (< 10 x 10^9/L)	**NEUTROPENIA:** Level of neutrophils: • 0.5 – 1.5 x 10^9/L – include evidence that neutrophil levels between these ranges have been detected on more than one occasion. **THROMBOCYTOPENIA:** If platelet count < 80 x 10^9/L **Lymphocytosis** Persistent lymphocytosis and lymphocyte immunophenotyping confirms a clonal population **Iron Deficiency Anaemia:** • Ferritin < 30ug/L • Ferritin 30- 110ug/L and evidence of systemic inflammation • Contraindication to oral iron e.g. previous side effects • Known malabsorption syndrome **Elevated Serum ferritin:** • Ferritin > 300

Condition Specific Referral Guidelines:

Key information enables Western Health to triage patients to the correct category and provide treatment with fewer visits to outpatients, creating more capacity for care. If key information is missing, you may be asked to return the referral with the required information.

Condition:	Key Information Points:	Required Clinical Investigations:
Neutropenia	• <0.5 x 10^9/L – refer immediately • 0.5 – 1.5 x 10^9/L – include evidence that neutrophil levels between these ranges have been detected on more than one occasion. • ≥1.5 x 10^9/L – suggested management as per guidelines detailed in HealthPathways.	• Antinuclear Antibody • Rheumatoid Factor • Serum protein electrophoresis • Liver Function Tests • HIV/Hep B and Hep C serology • Vitamin B12 and folate
Iron Deficiency Anaemia	**Clinical Information:** Ferritin <30ug/L or Ferritin 30-100ug/L and evidence of systemic inflammation: • Contraindication to oral iron • Known malabsorption syndrome e.g. active inflammatory bowel disease • Oral iron therapy trial of Maltofer® (iron polymaltose) may be appropriate if oral supplements cause side effects Ferritin >100ug/L & Hb <110g/L • Consider other causes of anaemia e.g. B12/Folate deficiency, anaemia of chronic disease **Extra Information:** Please include known or investigated cause of iron deficiency- bleeding or malabsorption	• Iron Studies • Full Blood Examination • If required gastroscopy/ Colonoscopy if no other causes or iron deficiency is present **Please note:** consider Gastroscopy/ Colonoscopy if no other causes or iron deficiency is present e.g. menorrhagia, especially if there are symptoms or signs of GI malignancy or GI bleeding

Condition:	Key Information Points:	Required Clinical Investigations:
Thrombocytopenia	**Please include:** <u>History:</u> • Bleeding symptoms • Recent viral illness, night sweats, weight loss, arthralgia and rashes. • Family history of bruising or bleeding, or low platelets. • Nutritional and alcohol history. <u>Examination:</u> • Lymphadenopathy and/or hepatosplenomegaly • Skin for sites of bleeding. <u>Desired (if available):</u> • CNS bleeding is the most common cause of death in severe thrombocytopenia.	• Platelet count • Coagulation screen (if not already done) • Liver function including gamma-glutamyl transferase • Serum B12 and folate • HIV serology (low platelet may be the only feature in early disease) • Anti-nuclear factor

Thrombocytopenia Clinical Management:

<u>Clinical considerations for platelet count levels:</u>

- Levels: 50 to 150 - no risk of bleeding.
- Levels: 30 to 50 -rarely causes bleeding even with trauma.
- Levels: 10 to 30 - may cause bleeding with trauma but is unusual with normal day to day activity. Many patients are asymptomatic.
- Levels: < 10, may have spontaneous bruising or bleeding. Many are still asymptomatic.

<u>Other:</u>

- Bleeding risk is also dependent on whether other parts of the haemostatic process are involved e.g. coagulation factor abnormalities in liver disease.
- Also known as Thrombopenia.
- A low platelet count (< 150 x 10^9/L) is extremely common in clinical practice.

Condition:	Key Information Points:	Required Clinical Investigations:
Elevated Serum Ferritin		• Full Iron studies (Fasting) • Full Blood Examination • Liver Function Tests • C-reactive Protein • Haemochromatosis gene studies • Hep B Serology • Hep C Serology • Antinuclear Antibody, Smooth Muscle Antibody • Caeruloplasmin • Fasting glucose • Fasting lipid profile • Liver ultrasound scan
Lymphocytosis	• Known autoimmune conditions, e.g. rheumatoid arthritis • Smoking • Post splenectomy .	• Full blood examination • Immunophenotyping by flow cytometry

Lymphocytosis Clinical Management:

<u>Please consider:</u>

- Monoclonal B-cell lymphocytosis (a clonal lymphocytosis similar to B-CLL but with clonal lymphocytes < 5 x 10^9/L and without other features of B-CLL)
- B-Cell chronic Lymphocytic leukaemia (B-CLL)
- If lymphocyte immunophenotyping does not confirm a clonal population, suggested management as per guidelines detailed in HealthPathways