Neutrophilia

This is usually a reactive phenomenon and only rarely will represent a primary haematological malignancy. The finding of basophilia points towards a myeloproliferative neoplasm;

especially chronic myeloid leukaemia. If there is an associated monocytosis which is

persistent, see section on monocytosis.

Causes

- Infection – especially bacterial, leg ulcers, bronchiectasis
- Chronic inflammation, eg smoking, autoimmune disease
- Medications e.g. corticosteroids, GCSF, lithium
- Solid malignancy
- Haematological malignancy usually carries additional features eg thrombocytosis for MPN, basophilia for CML (neutrophilia is not specific for lymphoid tumours/myeloma)
- Stress events e.g. trauma, seizures, myocardial infarction, eclampsia etc.
- Hyposplenism

History and examination

Clinical evaluation asking about infective symptoms, travel history, smoking

Examine for features of autoimmune disease, lymphadenopathy and splenomegaly.

Suggested investigations

- CRP
- Blood film
- Dependant on history and examination

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Management

The management will vary from patient to patient depending on differential diagnosis, prior blood counts, result on repeat and clinical concern.

Referral

Referral or A&G (depending on clinical situation) to haematology is indicated

- additional thrombocytosis with normal CRP and no obvious underlying cause
- persistent (more than once) basophilia
- persistent eosinophilia without obvious reactive cause eg severe asthma/eczema
- splenomegaly

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