



## **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



## **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