Monocytosis

Monocytosis is frequently transient.

Causes

- Infections e.g. tuberculosis, brucella, malaria, syphilis, endocarditis
- Autoimmune and inflammatory diseases, including sarcoidosis
- Stress response e.g. post myocardial infarction
- Hyposplenism
- Chronic myelomonocytic leukaemia
- Solid malignancy

History and examination

Look for signs of infection including atypical infections. Ask about a travel history. Examine for splenomegaly and hepatomegaly. Ask about weight loss, rashes and night sweats. Look at older blood counts – there may be a previous blood film review.

Suggested investigations

- Blood film
- Inflammatory markers
- Renal and liver function, calcium

Management

Persistent monocytosis without obvious underlying cause, particularly with normal inflammatory markers, may represent chronic myelomonocytic leukaemia. A blood film is the first investigation. Some cases behave indolently, particularly in the very elderly, so not every patient requires haematology review.

Author: Dr Annika Whittle, Consultant Haematologist
Date published: September 24
Next Review: September 27

Suggest haematology referral or A&G (according to clinical scenario) if:

- Persistent monocyte count over 5 × 109 /L without underlying infective/inflammatory disorder
- Monocyte count over 1.2 × 10^9 /L with additional cytopenias, splenomegaly or abnormal features on blood film

Author: Dr Annika Whittle, Consultant Haematologist
Date published: September 24

Next Review: September 27