GP Referral Guidance for Haematology

East and North Hertfordshire Teaching NHS Trust

Erythrocytosis (Polycythaemia)

Key GP Notes

- Confirm persistence before referral
- Exclude dehydration and secondary causes early
- Avoid iron replacement during assessment
- Escalate promptly if HCT rises or thrombotic risk develops

Erythrocytosis (Polycythaemia) - GP Assessment & Referral Flowchart:

Identify Persistent Erythrocytosis
(Ensure patient is adequately hydrated)
- Men: HCT >0.52
- Women: HCT >0.48
- Persistence: on >2 occasions, ≥2 months apart

Check for Very High HCT or Splenomegaly

Immediate Referral to Haematology
Refer if any of the following:
- Men: HCT >0.60
- Women: HCT >0.56
- Splenomegaly

If Not Immediate - Assess Secondary Causes
Clinical assessment
- Cardiac / respiratory disease
- Renal / liver disease

Investigations
- Assess haematinic status
  (Do not correct iron deficiency)
- Replacement testosterone
- Anabolic steroids

Lifestyle factors
- Reduce cigarette/shisha smoking
- Reduce alcohol intake

Yes → **Treat and manage the underlying condition**

No

Secondary Erythrocytosis - Ongoing Care
Some patients may require venesection.
Consider haematology referral if:
- At risk of arterial or venous thrombosis, or
- HCT >0.54

Persistent Unexplained Erythrocytosis
Does erythrocytosis persist for >8 weeks with no obvious cause?
- Men: HCT >0.52
- Women: HCT >0.48

Yes → **Routine Haematology Referral**

No

Continue management and monitoring in primary care