HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Management of blood test results

Introduction

1. Ms A was diagnosed with chronic lymphocytic leukaemia (CLL) in early 2023. She has raised concerns that blood test results from as early as 2018 showed elevated lymphocytes (a potential early indicator for CLL), and that these results were not discussed with her or acted on while she was a patient at her local medical centre).

2. Having thoroughly assessed all the information gathered during my assessment and investigation of Ms A's complaint, I consider that Dr B (a GP at her local medical centre) did not provide Ms A with an appropriate standard of care in relation to the management of blood test results in November 2019 and July 2020, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

Recommendations

3. I recommend that Dr B provide a written apology to Ms A for breaching Right 4(1) of the Code. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

4. Dr B has proactively made several changes to his practice in light of Ms A's complaint and has reviewed guidance from the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners on managing test results. I am satisfied that the steps taken by Dr B are sufficient to mitigate the risk of a similar issue occurring in future.

Background

5. Ms A had a routine blood test on 16 November 2018, ordered by her General Practitioner (GP) at the time, Dr C. The test results showed elevated lymphocytes (4.8 $x10^9$/L - normal range should be 1.2-3.5 $x10^9$/L).

6. Ms A had an appointment with Dr C on 4 December 2018. The clinical record states that the appointment was to review the blood test and review her left knee. The clinical notes from that appointment state that she had had a sore on the roof of her mouth for a few months, and Dr C appears to have connected this to the lymphocytosis (abnormally high amount of lymphocytes in the bloodstream). Ms A has no recollection of having this test result discussed with her.

7. A repeat blood test done on 30 Jan 2019 (ordered by Dr C) again showed elevated lymphocytes (5.7 $x10^9$/L) and a normal total white cell count. The haematologist

[1] Right 4(1) of the Code states: Every consumer has the right to have services provided with reasonable care and skill.

comment on the results states that there were 'a few atypical lymphocytes present'. There is no record of this result being discussed with Ms A.

8. Ms A's next blood test was on 12 November 2019, ordered by Dr B (the GP who took over Ms A's care from Dr C). Ms A's lymphocytes were still elevated (8.2 $x10^9$/L) and her total white count was now elevated (13.7 $x10^9$/L - normal range should be 4.0-10.0 x 10^9/L). The haematologist comment on the results at the time notes that the lymphocytosis may be reactive or could be related to a low grade lymphoproliferative disorder (a group of conditions characterised by excessive production of lymphocytes). The haematologist comment also states:

> 'As other counts are normal, monitoring with 3-6 monthly blood tests may be appropriate. Correlate clinically, reasons for referral will be: bulky lymphadenopathy[2], hepatosplenomegaly[3], B symptoms (fever, night sweats, weight loss), anaemia [moderate to severe] or thrombocytopenia[4] with [platelet count under 100 $x10^9$/L].'

9. There is no documentation of this blood test result being discussed with Ms A, and no documented plan for monitoring or recall.

10. Ms A had a further blood test (requested by Dr B) on 31 July 2020 when Ms A presented at her local medical centre with a wheezy cough. The results showed an elevated total white cell count (14 $x10^9$/L) and elevated lymphocytes (10.3 $x10^9$/L). The haematologist comment was '[a]s before' (ie, the same as in November 2019).

11. Ms A saw Dr B again on 6 August 2020. However, the clinical record for this appointment does not include any mention of the blood test results and no plan for monitoring or recall was documented.

12. On 14 July 2021 Ms A informed her local medical centre that she was moving to another town, and her enrolment was transferred to a new practice on 23 September 2021. Following the transfer of her care, Ms A was diagnosed with CLL and she told HDC that her new GP was shocked that her elevated lymphocytes since 2018 appeared to have been 'missed'.

Response from Dr B

13. Dr B stated that his usual practice was to discuss all blood test results with patients, but that he cannot recall (due to the passage of time) whether he discussed the November 2019 or July 2020 blood test results with Ms A. He accepts that any discussion of these test results should have been documented in the clinical record along with any actions taken.

14. Dr B acknowledged that efforts should have been made to inform Ms A about a slow rise of her lymphocyte count and the potential significance of this (ie, that it may represent an early manifestation of a lymphoproliferative disorder), and that although she had not reported any 'significant symptoms'[5] (eg, night sweats, significant weight loss, extreme fatigue), he should have specifically asked about these symptoms and

[2] Significantly enlarged lymph nodes.
[3] Abnormal enlargement of both the liver and the spleen.
[4] Abnormally low platelet count.
[5] As defined in the community information portal "HealthPathways".

made a clinical correlation (as per the haematologist notes on the blood tests). He also acknowledged that negative findings of significant symptoms should have been clearly documented in the clinical record.

15. Dr B noted that as per HealthPathways, there was no indication for a referral to a haematologist in either 2019 or 2020. He acknowledged that, in retrospect, recalls for repeat blood tests six months after the 2019 blood test, and one year after the 2020 blood test would have been appropriate, and that there was no documented plan for monitoring and recall.

Response from the local medical centre

16. The medical centre noted that the elevated white cell count and lymphocytosis in July 2020 could be attributed to an infection/inflammation as Ms A presented with a wheezy cough at that point, and that a repeat blood test in 1 year would have been reasonable. The medical centre stated that in hindsight another complete blood count could have ordered in 2021 to monitor Ms A's lymphocyte count.

17. The medical centre stated that over the time Ms A was a patient there, she never presented with signs or symptoms of CLL (ie, those noted by the haematologist that would warrant referral), and that there was no indication for referral based on the haematologist's comments and HealthPathways guidance.

Expert advice

18. I sought expert clinical advice from my in-house advisor, Dr David Maplesden (GP).

Management of the December 2018 and January 2019 blood test results (Dr C)

19. Dr Maplesden noted that clinical notes from Ms A's appointment with Dr C on 4 December 2018 indicate that the 'mild lymphocytosis' identified by the blood test on 16 November 2018 may have been discussed, but that he is unable to confirm the detail of this discussion. Dr Maplesden advised that management of the mild lymphocytosis was reasonable at that time.

20. Dr Maplesden advised that following the blood test results from January 2019, best practice would have been to have scheduled a repeat blood test in approximately three months.

Management of November 2019 blood test result (Dr B)

21. Dr Maplesden advised that Ms A's persistent and slowly rising lymphocyte count was unexplained and required clinical correlation and monitoring, as per the haematologist comment and the local Health Pathways guidance. He advised that accepted practice would have been to inform Ms A of the test results, document their potential significance, and undertake some form of clinical correlation by way of a focused history and possible examination. Assuming that after this there was no indication for specialist referral at that time (as was likely in hindsight), Ms A should have been:

    - **advised of** the need to report any suspicious symptoms and for ongoing monitoring of her lymphocytes and
    - **placed on** some form of recall to facilitate this surveillance

22.

Dr Maplesden advised that this should have all been documented.

23. Dr Maplesden advised that he would be moderately critical if Ms A was not informed of the abnormal test results and their potential significance, mildly to moderately critical if no clinical correlation was undertaken, and mildly to moderately critical if a recall system was not used to facilitate appropriate ongoing surveillance. Dr Maplesden also advised that a lack of documentation of any actions taken to follow up on the blood tests was a mild to moderate departure from accepted standards.

Management of July 2020 blood test result (Dr B)

24. Noting that Dr B had reviewed both the November 2019 and July 2020 results, Dr Maplesden believes that Dr B needed to consider the previous haematologist comment rather than assume that the lymphocytosis was linked to the 'wheezy cough' Ms A had at the time. Dr Maplesden advised that he would be moderately critical if Ms A remained uninformed [three things]

- of the persistent lymphocyte abnormality,
- of the potential for this to represent the early stage of a lymphoproliferative disorder, and
- that surveillance was recommended.

He would also be mildly to moderately critical if clinical correlation was not undertaken, and moderately critical if there was no plan in place for structured surveillance of Ms A's lymphocytes.

Opinion: Dr B – breach

25. Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

26. Dr Maplesden has advised that the accepted standard of care was to inform Ms A of the November 2019 and July 2020 blood test results, document their potential significance, undertake some form of clinical correlation (eg, a focused history and possible examination), and if no referral was required at that time, set up ongoing surveillance (monitoring and recall). I accept Dr Maplesden's advice.

27. It is clear from the information gathered (and by Dr B's own admission) that the potential significance of the November 2019 and July 2020 blood test results was not documented, no clinical correlation was done, and no formal surveillance established.

28. I acknowledge that the absence of documentation of a discussion with Ms A about her test results does not necessarily mean that the discussion was not had. However, the absence of any documented follow-up actions in this case leads me to consider it more likely than not that the results (and their significance) were not discussed with Ms A.

29. On this basis, I consider that Dr B did not provide Ms A with an appropriate standard of care in relation to the management of blood test results in November 2019 and July 2020 and therefore breached Right 4(1) of the Code.

Changes made

30. Following Ms A's complaint, the medical centre had a formal meeting with all staff directly involved in her management. In this meeting, they undertook a comprehensive review of the clinical records, discussed where the care could have been improved, and identified opportunities to strengthen their systems and communication. The medical centre also reviewed its policies relating to the handling of test results and clinical reports. As a result, several changes were made to its policy on managing test results and staff have been given a copy of this updated policy. The medical centre has also:

    - **reinforced** the importance of timely and accurate documentation, appropriate follow-up, **and** patient communication, and
    - **ensured** that all GPs are using recall systems where appropriate

    Each GP is now partnered with a designated nurse who assists with completing recalls and tasks, which acts as a check-and-balance system to minimise the potential for errors.

31. Dr B told HDC that he has taken this incident seriously. He conducted a review of his clinical documentation to assess and improve the quality of this and has made several changes to his practice. These changes include:

    - Reviewing all test results received, documenting them electronically and recording any necessary actions in the clinical record. He creates recalls for patients who require follow-up appointments or tests, and files all the results at the end of each day to ensure his inbox is cleared.
    - Assigning tasks to himself and the nursing team to contact patients regarding their blood and scan results and having an allocated time each day to contact patients with their test results and take any necessary actions. He routinely documents all these discussions.
    - For results that are sensitive, significant, or require detailed explanation, he arranges face-to-face appointments, which allows him to clearly explain the findings, ensure the patient understands, and outline any necessary follow-up plans.

32. Additionally, Dr B has reviewed the Community Health Pathways guidance on CLL to ensure his management of elevated lymphocyte counts aligns with current best practice and has also reviewed guidance from the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners on managing test results.

33. I note the Medical Council of New Zealand has independently acted upon concerns Ms A raised with them about the care Dr B provided to her between 2019 and 2021. At its Notification Triage Team meeting on 30 October 2025 all information and evidence it held on this matter was reviewed and it considered an educational approach was the most appropriate and proportionate way to address the concerns raised.

Distribution or Follow up actions

34. A copy of this report will be sent to the Medical Council of New Zealand.

35. A copy of this report with details identifying the parties removed, except my expert advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from Dr David Maplesden, general practitioner:

'CLINICAL ADVICE - MEDICAL

TO : AAT

FROM : David Maplesden

CONSUMER : Ms [A]

PROVIDER : [The local medical centre]

FILE NUMBER : C23HDC00950

DATE : 1 July 2024;

Addendum 8 January 2025

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1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from Ms [A] about the care provided to her by staff of [her local medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from Ms [A]
- Response from [the medical centre]
- Clinical notes [the medical centre]
- **Further response from [the medical centre] received 17 December 2024 and incorporated into this advice on 8 January 2025**

3. Ms [A] (B: 1958) complains about a delay in her diagnosis of B-Cell chronic lymphocytic leukaemia (B-CLL) which was apparently conveyed to her by her current GP in 2023 (no current notes on file to confirm this). Ms [A] was informed by her current GP that there was evidence of B-CLL in blood tests performed at [the medical centre] from 2018 and subsequently and she is concerned she was never informed of this diagnosis or referred for further investigations or specialist review at the time.

4. Clinical notes indicate that at the time of the events in question Ms [A]'s past medical history included a chronic pain syndrome (trigeminal neuralgia – previously reviewed by neurologist and pain clinic), osteoarthritis knees, fibromyalgia, restless leg syndrome,

depression, rhinitis and hiatus hernia. Ms [A] transferred to [the local medical centre] in October 2017 and was seen there for the first time on 16 November 2017 (Dr [C] – deceased). The notes for that consultation do not appear to have been provided and should be obtained. Blood tests were requested and undertaken on 23 November 2017. Results showed lipid profile consistent with mild hyperlipidaemia, borderline elevation of liver enzymes ALT and GGT, mild reduction in eGFR but normal serum creatinine. CRP, CBC and other general screening results (thyroid, diabetes, B12/folate) were normal. I am unable to confirm if Ms [A] was notified of the results.

Comment: Accepted practice would be for Ms [A] to be notified of any significant abnormal results particularly if they varied from previous results. Any discussion of results or management recommendations arising from abnormal results should be documented. I am currently unable to determine the symptoms with which Ms [A] presented on 16 November 2017, assessment results, indications for the blood tests performed and if there was any discussion of the results with Ms [A]. While none of the results appear particularly alarming, consideration might have been given to considering and addressing possible causes of the abnormal liver function (most commonly medication/alcohol/fatty liver) and follow-up blood test within three months[6], further assessing the possible significance of the reduced eGFR (urine microscopy and/or ACR) and considering management of hyperlipidaemia in the context of Ms [A]'s overall cardiovascular risk. There was no suspicion of underlying CLL at this time based on the blood tests results reviewed. I note liver function tests were repeated in January 2019 and had almost normalized.

5. Consultation notes have been provided from January 2018. I note antihypertensive medication commenced in February 2018 with blood pressure monitored subsequently. There were multiple consultations in the first quarter of 2018 for headache and facial pain (neurology referral completed March 2018 but declined) and later that year for knee pain (orthopedic referral August 2018) and a bleeding lesion on the palate. There is no reference to presentation of any symptoms suspicious for CLL during 2018 and no apparent reluctance by Ms [A]'s providers to make specialist referrals when indicated.

6. On 15 November 2018 Dr [C] reviewed Ms [A] in relation to a persisting intermittently bleeding palate lesion. Blood tests were ordered with results (16 November 2018) showing normal CRP, ferritin and B12/folate levels. Blood count showed an isolated mild elevation of lymphocytes (4.8 – reference range 1.2-3.5 x 10^9/L) with normal parameters otherwise. On 4 December 2018 Dr [C] reviewed Ms [A] noting: *here for review bloods and L knee. See orthopod report and discuss. 2. Still having a sore in roof of mouth for few months now. See relative lymphocytosis. Refer ENT.* Following the referral Ms [A] was seen by the ENT service on 4 January and 22 February 2019 with the lesion assessed as benign and treated with cautery. Blood tests were repeated on 30 January 2019 (requested by Dr [C]) with previous abnormal ALT having resolved and GGT improved with borderline elevation. Hepatitis B and C serology was negative. Blood count showed a persistent mild lymphocytosis (5.7) and normal total white cell count. Haematologist comment was *there a few atypical lymphocytes present.*

[6] BPAC. Liver function tests in primary care. 2022. https://bpac.org.nz/2022/LFTs.aspx Accessed 1 July 2024

Comment: The clinical notes dated 4 December 2018 suggest there may have been some discussion of mild lymphocytosis although I am unable to confirm the detail of such discussion. It is also implied that Dr [C] felt there may have been a link between the palate lesion and the mildly abnormal blood result and proceeded with a specialist referral. I believe this was reasonable management given the current lymphocyte level in a patient not obviously exhibiting symptoms suspicious for B-CLL. While best practice might have been to undertake a more extensive history and assessment as outlined in Appendix 1, I believe given the palate lesion and specialist ENT advice being sought, many of my colleagues would have managed Ms [A] as Dr [C] did on this occasion. A repeat CBC was undertaken on 30 January 2019 and the lymphocyte count had not normalized although remained only modestly elevated. I believe best practice would be to have scheduled a repeat blood count in three months or so (per the local guidance on lymphocytosis[7]). The subsequent [medical centre] response notes there is no evidence of any recalls being set in relation to structured surveillance of Ms [A]'s blood count.

7. Ms [A] did not present any symptoms suspicious for B-CLL at her various presentations during 2019. On 12 November 2019 she was reviewed by Dr [B] for repeat of her usual medications and review of her chronic pain condition. There is no reference to any symptoms suspicious for B-CLL. General blood tests were ordered with results dated 12 November 2019. Relevant to Ms [A]'s subsequent diagnosis was the CBC result which showed an increase in lymphocytes to 8.2 with total white cell count now elevated at 13.7 (reference range 4.0-10.0 x 10^9/L) but parameters normal otherwise. A hematologist report was sent separately noting: *There is a mild lymphocytosis with smear cells, reactive lymphocytes and a few atypical mature lymphocytes. Lymphocytosis may be reactive or could be related to a low-grade lymphoproliferative disorder. As other counts are normal, monitoring with 3-6 monthly blood tests may be appropriate. Correlate clinically, reasons for referral will be: bulky lymphadenopathy, hepatosplenomegaly, B symptoms (fevers, night sweats, weight loss), anaemia with Hb<100 or thrombocytopenia with plt <100.* There is no reference to the CBC results being discussed with Ms [A] or any recall in place for repeating the test although I note the test was repeated eight months later (see below).

Comment: Ms [A]'s persistent and slowly rising lymphocyte count (assuming the January 2019 results had not normalised) was unexplained and required clinical correlation and monitoring per the haematologist comment and cited guidance. While Ms [A] had not volunteered any symptoms suspicious for B-CLL, she had not been questioned specifically about such symptoms or examined to rule out lymphadenopathy or organomegaly. I believe accepted practice following receipt of the November 2019 results would be to have informed Ms [A] of the results and documented and their potential significance and to have undertaken some form of clinical correlation by way of focused history and possibly examination. Assuming there were no features requiring consideration of specialist referral (as was likely in hindsight), I believe it was important Ms [A] was advised of the need to report any suspicious symptoms and of the need for ongoing monitoring of her lymphocytes and placed on some form of recall to facilitate this surveillance. It would be expected these actions were documented. The subsequent [medical centre] response includes: *I cannot find any action that was taken to follow up on blood tests only the attached consultation from the nurse*

[7] HealthPathways. *Lymphocytosis.* Accessed 1 July 2024

which says she could not be contacted [this refers to a nurse note dated 26 November 2019 – *p/c x2 no answer, requesting an appt with Dr [C]*]…*I cannot find any formal information where she was informed of blood tests but would presume she would have been told during a consultation…Also, no formal notes for a plan to follow up in one year*. There is nothing in the notes related to actions taken following receipt of the result and I believe this represents a mild to moderate departure from accepted standards of clinical documentation if actions had been taken and not documented. I would be moderately critical if Ms [A] was not informed of the abnormal results and their potential significance (see case C15HDC01387 which has some similarities) and she does not recall any such discussion being undertaken. I would be mildly to moderately critical if there was no clinical correlation undertaken as discussed above, and mildly to moderately critical if there was no use of a recall system to facilitate appropriate ongoing surveillance (which appears to be the case). There was no apparent indication for formal haematology referral at this point.

8. Ms [A] was seen on 11 December 2019 regarding insomnia and request for trial of pregabalin for her pain syndromes. She was reviewed on 10 January 2020 in relation to pain symptoms and on 28 February 2020 in relation to respiratory symptoms (?asthma exacerbated by household mould). On 29 July 2020 she was noted to be wheezy while routine cervical smear was being performed and the RN [registered nurse] undertaking the smear ordered routine blood tests, undertook some asthma education and recommended GP review. Weight was recorded as 104kg (unclear what baseline weight was). Blood results were reviewed by Dr [B] (who was listed as requestor) on 31 July 2020. Lymphocyte count was elevated at 10.3, with total white cell count elevated at 14.7. Dr [B] reviewed Ms [A] on 6 August 2020 noting *worried about B12, reassured her all normal, will get some multivites.* There is no reference to discussion of the CBC result, or any action taken in this regard. There is no reference to physical examination pertinent to surveillance of a patient with potential lymphoproliferative disorder or current respiratory symptoms. There is no reference to Ms [A] reporting any symptoms of concern for potential lymphoproliferative disorder. The provider response includes A *marginally raised WBC and leucocytosis was noted. This could be attributed to an infection/inflammation as [Ms A] presented at that point with a wheezy cough. Neutrophils were normal… There was no indication to refer to a haematologist at this point and a repeat blood test in 1 year was thought to be reasonable.*

Comment: Noting Dr [B] had reviewed both the November 2019 and July 2020 blood results, I believe he needed to consider the previous haematologist comment rather than assuming the lymphocytosis was a reaction to recent respiratory infection. I am moderately critical if Ms [A] remained uninformed of the persistent lymphocyte abnormality and potential for the abnormality represent the early stage of a lymphoproliferative disorder with surveillance recommended in this regard as previously discussed. It does not appear Ms [A] presented any concerning symptoms, and I am unable to confirm there was any assessment undertaken for lymphadenopathy of organomegaly (mild to moderate criticism if clinical correlation was not undertaken per previous discussion). The provider response refers to an apparent plan for a repeat blood test in one year although there is no reference in the notes to this plan. If there was such a plan, and there is evidence of a recall in place for repeating CBC in 12 months, I believe the surveillance plan on this occasion was reasonable and consistent with the cited guidance noting the slow increase in Ms [A]'s lymphocyte count, absence of additional hematological abnormalities, and apparent absence of any B-CLL related symptoms. If there

was no plan in place for structured surveillance per the cited guidance (CBC, focussed history and physical assessment) I would be moderately critical, and the subsequent [medical centre] response indicates there is no evidence of recalls being set to suggest a plan for structured surveillance. I agree there was no apparent indication for referral to a haematologist at this point.

9. Ms [A] saw a variety of providers at [the medical centre] over the next 12 months for various physical and psychological issues and in particular chronic pain issues (resulting in various specialist referrals). On 14 July 2021 Ms [A] requested a repeat of her usual medications per phone and informed [medical centre] staff she was shifting to [another town]. Notes were transferred on 28 September 2021. There is no reference over this period to Ms [A] reporting any symptoms suspicious for lymphoproliferative disorder. There is no reference to any assessment being undertaken in relation to surveillance for lymphoproliferative disorder. No further blood tests were carried out.

Comment: It appears Ms [A] transferred practices before a '12 month' review could be undertaken (see previous section) if this was planned. It is unclear if her blood count or symptoms have subsequently deteriorated necessitating haematologist review. I believe the issue of most concern, which appears somewhat likely based on the subsequent [medical centre] response, is that Ms [A] may never have been made aware of the potential significance of her blood abnormality (including the hematologist comments) and the need to report suspicious symptoms and undergo regular surveillance as discussed. While there was no apparent indication for hematologist referral while Ms [A] was a patient at [the medical centre], it appears there was no focussed assessment (history and physical examination) relevant to her blood abnormality undertaken over this period, or structured recall for such surveillance, which is also of some concern. However, even had these steps been taken, unless Ms [A] was shown to have developed any of the indications for referral listed in the cited management (summarised Appendix 1), her management while at [the medical centre] is likely to have been unchanged. The practice policy on management of test results is quite brief compared with others I have reviewed[8] (I presume there is another policy on managing clinical correspondence which provides more detail on issues such as inbox checking processes during planned and unplanned staff absence etc) and needs to emphasise the importance of documenting any discussion undertaken in relation to provision of blood tests results.

Appendix 1. Local guidance on B-CLL[9] includes the following information:

(i) Early stage B-CLL:

- is a low-grade B-lymphoproliferative disorder.
- is the most common type of adult leukaemia.

[8] See: https://www.rnzcgp.org.nz/gpdocs/New-website/Quality/Webinar---Indicator-23/Example-Only-Management-of-Results-Reports-Urgent-Referrals-and-Clinical-Correspondence-Policy-Use.doc Accessed 1 July 2024

[9] Community Health Pathways. *B-Cell Chronic Lymphocytic Leukaemia (B-CLL).* Accessed 1 July 2024

- is mainly found in those aged older than 50 years.
- has a low risk of disease progression in the next 5 years.
- has a median survival of more than 12 years.
- usually progresses slowly with increasing lymphocytosis, bone marrow involvement with cytopaenias, lymphadenopathy, hepatomegaly, and splenomegaly.

(ii) Other complications of B-CLL include:

- autoimmune haemolytic anaemia
- immune thrombocytopenia
- hypogammaglobulinaemia with recurrent respiratory tract infections
- herpes zoster
- transformation to high-grade disease.

(iii) Assessment

Suspect an early-stage B-CLL if persistent lymphocytosis without anaemia or thrombocytopenia (low platelets) in an otherwise well patient.
History – Ask about:

- unexplained fever.
- weight loss e.g. more than 10% in 6 months.
- night sweats.
- fatigue.
- infection.

Examination – Check for:

- lymphadenopathy in axillae, groin, and neck.
- hepatomegaly and splenomegaly.
- If persistent lymphocytosis of more than 7 x 109/L, arrange immunophenotyping

(iv) Monitoring

Early B-CLL has a low risk of disease progression.

- Assess every 6 months for the first year, then yearly if stable or slow, asymptomatic progression.
- Arrange blood tests with a CBC:
- The rise of white blood cells is less important than the development of any cytopenias, night sweats, or weight loss.
- The absolute lymphocyte count can rise to more than 200 x 109/L and is not a reason in itself to start treatment.
- The surface markers do not need to be repeated when the lymphocyte count increases.
- Ask about a history of infections, weight loss, fatigue, night sweats, enlarged lymph nodes.

- Check weight and examine for lymphadenopathy and hepatosplenomegaly.

(v) Request

Request non-acute haematology assessment if:

- patient aged younger than 60 years and is physically fit.
- significant symptoms after excluding other causes.
- symptomatic lymphadenopathy or hepatosplenomegaly.
- examination shows disease in 3 or more of the 5 sites.
- blood tests show sudden change not otherwise explained, or haemoglobin is less than 100 x 109 or platelets fall to 100 x 109 or lower.
- lymphocyte count doubles in less than 6 months.
- lymphocyte immunophenotyping confirms a clonal population other than B-CLL.
- clinical concerns related to B-CLL.
- Seek haematology advice if any concerns.'