Approved: March 2024
Next Review: March 2027

Lymphocytosis
In younger patients lymphocytosis is often reactive but this is less common in the elderly where a clonal (malignant, i.e. lymphoproliferative) disorder (LPD) is more likely.

Causes
- Viral infection
- Bacterial infection especially tuberculosis, pertussis
- Hyposplenism
- Smoking
- Autoimmune disorders
- Stress response e.g. post myocardial infarction
- Lymphoproliferative disorder

History and examination
Review older blood tests. Ask about recent infections, weight loss, sweating and smoking. Consider autoimmune conditions. Examine for lymphadenopathy and hepatosplenomegaly.

Investigations
- Blood film
- Monospot (and if negative EBV/CMV serology) if EBV suspected

Management
- *Lymphocyte count >10 and/or clinical suspicion of haematological disorder* (drenching nightsweats, unexplained weight loss, generalised itching without rash, palpable lymphadenopathy, hepatosplenomegaly)
    - please send FBC for immunophenotyping at HMDS (FBC sample beginning of week via haematology laboratory). If blood film has been reviewed in the department, this *may* have already been actioned directly (see blood film report).
    - If clinically well and FBC preserved refer haematology outpatients routinely
    - If clinical concern or additional FBC abnormalities, refer haematology OP urgently
- *Lymphocyte count <10 with otherwise normal FBC and no clinical suspicion of LPD*
    - Repeat the full blood count in four to six weeks to look for resolution
    - We do not routinely immunophenotype in this situation. While in older patients a persistent lymphocytosis may represent an early haematological malignancy (lymphoproliferative disorder, such as chronic lymphocytic leukaemia), there is no advantage of early treatment, and therefore early diagnosis, in these patients. Many never develop symptoms. Making a diagnosis of malignancy which is unlikely to affect life expectancy in asymptomatic patients may cause anxiety and affect insurance coverage.