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| Purpose or Principle or Introduction | This document defines the policy for proper workflow of handling CBC samples that are severely hemolyzed due to intravascular (in vivo) hemolysis. |
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| Scope | This policy is intended for use at all hematology departments at the medical centers, urgent care centers and regional laboratories. |
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| Policy | When you encounter severely hemolyzed samples, this is the workflow to resolve the issue.   * If first draw is hemolyzed – ask the collector how the blood was collected (syringe, vacutainer, IV start, needle size, hard draw, etc.) * Perform a redraw by a laboratory staff once information from first specimen is known. * If the repeat specimen that was carefully and properly collected is still hemolyzed, the CLS will contact the nurse/physician and find out more about the patient. There should be some discussion about the clinical picture of the patient. If there is a suspicion of sepsis or other reasons for hemolysis (incompatible IV fluid, amniotic fluid embolism, thermal burns, hemolytic transfusion reactions – acute or delayed), the CLS will discuss with the physician the potential for inaccurate results. Depending on the physician’s response, contact a pathologist if needed (even if it is at night) to discuss the case. * If provider insist on reporting available results: You can report **WBC, Differential, HGB, and PLT-F for Sysmex sites and a Platelet Estimate for the DxH sites**, add a disclaimer below:   “Specimen is extremely hemolyzed; Phlebotomy induced hemolysis ruled out; Intravascular hemolysis cannot be ruled out, correlate with clinical picture.”   * Check also for: * Previous Cellavision images – if there’s previous samples, check for presence of schistocytes. * UA sample – check for presence of HGB in urine. * Finally, recommend that these cases be reviewed by the pathologist if not discussed with them prior to release of results. |
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