



Screening for Hyperviscosity Syndrome

***Choosing the right
technology***

Benson Viscometers

Research Sources & References

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Introduction

This discussion document is primarily aimed at plasma hyperviscosity especially concerning the detection and the importance of regular monitoring of the patient condition. The clinical summaries below are derived from the wealth of literature available in print and on the web, consequently further reading is recommended for a fully comprehensive view of clinical opinion.

Key points of discussion

- ❖ Clinical Implications of hyperviscosity and hyperviscosity syndrome
- ❖ Patient management
- ❖ Correct monitoring technology

Background

Plasma hyperviscosity is a secondary condition which may be present in a large number of clinical states. The increase in the viscosity of plasma usually results from increased circulating monoclonal (paraproteinaemic) and polyclonal immunoglobulin disorders. The excessive intravascular paraproteins result in rheologically impaired microcirculation, together with hypervolaemia. This forms the basis of HVS¹

Increases in fibrinogen, α_2 macroglobulin and immunoglobulins increase both plasma viscosity and red cell aggregation which correlate well with non-specific measurements made by Plasma Viscosity and ESR systems. However in extreme cases of plasma hyperviscosity, the suspending plasma may decrease cell aggregation. In this situation, ESR falls to low or zero levels as well as the increased plasma density decreasing the sedimentation of aggregates. This has consequences for monitoring patients with these complex conditions.

Hypoviscosity, normally the result of low immunoglobulin or fibrinogen as seen in hypoproteinaemia is not discussed in this article.

Associated Diseases

Hyperviscosity in adults is most commonly seen in association with^{2,3,4}

- Acute and chronic Infections such as pneumonia, tuberculosis and HIV
- Myocardial Infarction
- Plasma cell neoplasia
- Myeloma
- Connective tissue diseases
- Chronic hypoxia
- Paraneoplastic syndromes; when it results from the high concentrations of circulating immunoglobulins, cryoglobulins and paraproteins,

Common Conditions:

Common conditions in which hyperviscosity occurs are as a result of a raised Haematocrit, or due to increased levels of circulating plasma components. Many conditions may produce this state including^{5,6,7}.

- Waldenströms Macroglobulinaemia (most common cause)
- Multiple Myeloma
- Connective tissue disorders e.g. rheumatoid arthritis
- Any Inflammatory Conditions

Plasma Hyperviscosity Syndrome

Table 1 shows a summary of the pathological impact of relevant paraproteins in relation to Hyperviscosity Syndrome.²

Disease	Basic Mechanisms of HVS	PV Range (mPa)■
Macroglobulinaemia of Waldström	IgM-paraproteins High Concentrations and polymers	>3.00
Multiple Myeloma	IgG-paraproteins- Extremely high concentrations Unstable or stable aggregates High concentration of asymmetric paraproteins IgA-paraproteins Polymer formation IgE-paraproteins	2.01-3.00
Autoimmune and rheumatic diseases	Aggregates of rheumatoid factors and intermediate complexes Polyclonal IgG-polymers	1.75-2.00
	Normal Range	1.5-1.72

Table 1 Causes and basic mechanisms of Plasma Hyperviscosity syndrome

■ Data from Benson Viscometers Ltd

Complications

Increased Viscosity and reduced blood flow are included in the complications associated with this syndrome which include

- Bleeding from the mucous membranes caused by Paraproteins interfering with platelet function
- Cardiopulmonary symptoms such as shortness of breath, hypoxaemia, acute respiratory failure and hypotension
- Confusion and mental status changes as a result of the increased viscosity and decreased cerebral blood flow together with CNS manifestations such as lethargy, headache, Nystagmus, deafness, convulsions and loss of vision
- Dilation of the retinal veins and retinal haemorrhages
- Renal Failure

Rapid relief from Hyperviscosity is critical to ensure immediate reduction of the risk from these associated complications.

Investigations for Hyperviscosity Syndrome

- Plasma viscosity – Definitive test
- Blood film may show rouleaux formation- suggestive of increased viscosity
- FBC and differential cell count
- Platelet count
- Clotting screen

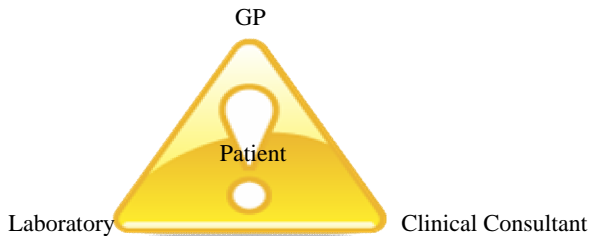
Other investigations to determine the underlying cause e.g. bone marrow aspiration, urine and serum electrophoresis, auto-antibody levels and testing for Bence Jones Proteins.

Treatment Strategies

Management of patients with Hyperviscosity Syndrome will depend on the underlying conditions. Strategies may include plasmapheresis or plasma exchange as the most efficient or rapid means by which harmful paraproteins can be removed from the circulation. Concomitant Treatment of the underlying cause of the hyperviscosity with specific cytotoxic drugs or chemotherapy may be required.

Patient Management

Post the acute stage of patient diagnosis, regular review and blood testing is required in order to ensure that there is no deterioration of the patient's condition. Use of the correct monitoring tests is essential in order to ensure appropriate management by Healthcare Professionals



Referral guidelines for treatment of many of the underlying conditions and associated conditions may refer equally to Erythrocyte Sedimentation Rates, Plasma Viscosity or C reactive protein as one of the screening tests⁷.

C - Reactive Protein

Given that C-Reactive Protein levels may be a better indicator of the acute phase response during the first 24 hours of an inflammatory process⁸, and considering that they are more expensive and more time consuming to perform, then ESR and Plasma Viscosity tests are more appropriately performed as part of the patient review process.

Erythrocyte Sedimentation

Scientific study and several publications have demonstrated that the use of ESR for monitoring hyperviscous states is inaccurate and misleading.

G.D.O Lowe in Baillière's Clinical Haematology argues quite clearly that 'while ESR has a time honoured place as a non-specific screening test for organic disease and monitoring disease activity, it may give misleading results since it is also affected by variations in Haematocrit'

Haematocrit affects the degrees of red cell interaction before settling and so ESR increases as the Haematocrit falls and is therefore a poor measure of the effect of plasma or red cell abnormalities on blood flow. ESR is unreliable as a quantitative measure unless corrected for the effect of Haematocrit.

Additional issues, such as difficulties in appropriate quality control testing and adjustments for age and sex of the patient questions the reliable use of ESR for Hyperviscosity screening. Table 2 provides more detail of potential issues.

Erythrocyte Sedimentation is not directly linked to plasma viscosity and so can give misleading results.

Plasma Viscosity

Since Harkness⁹ in 1971 early investigations into the potential of measurement of Plasma Viscosity, there have been a number of research publications that have compared the advantages of plasma Viscosity over ESR measurements.

Patient	Screening/ Treatment	Plasma Viscosity	ESR
Chronic Arthritis	Prediction in patients with early rheumatic disorders	YES (combined with Serum Viscosity)	NO
Plasma Hyperviscosity	Diagnosis without false negatives	YES	NO
Poikilocytosis Rheumatology Chronic Malignancy	Associated with Anaemia	PV correlates well with disease progression ¹⁰	ESR rate increase will be difficult to interpret Use of ESR to monitor therapy becomes
Polycythaemia	>50%	PV measurements unaffected	Normal ESR results found irrespective of underlying disease

Patient	Screening/ Treatment	Plasma Viscosity	ESR
Anti-inflammatory Treatments	Steroids	PV results improve only with arrest of the inflammatory process	ESR readings will give normal results even with elevated Plasma viscosity levels ¹¹
	Salicylate Therapy	PV results NOT affected directly by the drug	Drug effect lowers ESR reading
	Glucocorticoids	PV Monitoring prediction of Flare ups ¹²	NO
Variation of reference ranges with age, sex, smoking and pregnancy		Normal range the same for both sexes Less variation for other factors	Normal ranges for men and women different. More variation for other factors
Patient Management	Inter system effect	One standard for universally comparable results	System variations and methods will not allow comparisons

Table 2

Final Comments

Use of ESR has become the routine requirement for screening and monitoring patients with inflammatory conditions. Considering that ESR is not directly linked to plasma viscosity and has un-correctable dependence on Haematocrit limits, its use to monitor plasma protein changes can sometimes give misleading results.

ESR shows poor sensitivity in the range of screening for organic disease or diagnosis – the very reasons for which most physicians request an ESR test.

Rapid relief from Hyperviscosity is critical to ensure immediate reduction of the risk from associated acute complications.

Technological advances in monitoring technology now mean that plasma viscosity can be determined simply and rapidly to give indications of the underlying patient condition without the disadvantages seen with ESR

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