The clinical relevance of an isolated increase in the number of circulating hyperchromic red blood cells

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Aims: To search for laboratory evidence of hereditary spherocytosis (HS) among apparently healthy children with the chance finding of an isolated increase in hyperchromic red cells (cells with intracellular haemoglobin concentration > 410 g/litre).

Methods: Blood and reticulocyte counts and Pink tests were performed on successive children found on routine counts to have > 4% hyperchromic red cells, and compared with age and mean cell haemoglobin concentration (MCHC) matched controls and children known to have HS.

Results: Thirty-four patients with > 4% hyperchromic red cells had significantly higher absolute numbers of such cells (p < 0.0001) and higher reticulocyte counts (p < 0.01) than age matched controls, together with higher MCHC (p < 0.0001) and haemoglobin distribution width (p < 0.0001) values and lower mean cell volume (p < 0.02) values. Significant differences were also found among hyperchromic red blood cell, reticulocyte, and haemoglobin distribution width values when subjects were compared with MCHC matched controls. Pink test values were higher in children with increased hyperchromic red blood cells, but not significantly so. In patients with HS, most variables measured were significantly different both from those of children with > 4% hyperchromic cells and controls. Despite the differences found, few MCHC, HDW, reticulocyte, or Pink test values were outside of the normal limits, and only one child with increased hyperchromic cells had both a mild reticulocytosis and a slightly raised Pink test value.

Conclusions: Subjects with an isolated increase in hyperchromic red blood cells have a profile of red blood cell changes similar to that of patients with HS, but to a lesser degree. They may carry a recessive form of the disease but lack the laboratory features of clinically manifest HS.

Abbreviations: Hb, haemoglobin; HDW, haemoglobin distribution width; HS, hereditary spherocytosis; MCHC, mean cell haemoglobin concentration; MCV, mean cell volume; RDW, red blood cell distribution width.
samples analysed before and after the one on which the above tests were performed.

**RESULTS**

Samples from 34 consecutive children with a hyperchromia flag and sufficient remaining sample to perform the full range of tests were studied over a period of 12 months, during 1996 and 1997. Their ages ranged from 1 to 14.5 years, with a median of 6. Thirty four age matched controls were also studied and controls matched for MCHC were found for the 21 subjects with MCHC values < 352 g/litre. We were unable to find MCHC matched controls with higher values than this because there was always an associated hyperchromia flag. Fourteen children with HS aged 0.5 to 11 years, median 6, were also studied. None had been splenectomised. All subjects, controls, and children with HS had a negative direct antihuman globulin test and a normal Hb electrophoresis. Proportions of hyperchromic red blood cells were 0.3–3.9% in controls, 4.0–13.0% in the subject group, and 4.0–53.3% in children with HS.

Subjects had significantly higher numbers of hyperchromic red blood cells and reticulocytes than age matched controls, together with significantly higher values for MCHC and haemoglobin distribution width (HDW; a measure of anisochromia) and lower MCV values (table 1). They also had higher Pink test values than controls, although the difference was not significant.

Significantly higher numbers of hyperchromic red blood cells and reticulocytes, and higher HDW values were also found among the 21 subjects matched for MCHC with a control group (table 2).

As expected, the HS group showed highly significant differences compared with both the subject and control groups for most variables tested (table 1).

Four subjects (11.8%) had evidence of increased red blood cell turnover, defined as a reticulocyte count greater than the mean + 2 SD value of the control group; one also had a raised Pink test value. Two other children had raised Pink test values alone.

Twenty four of the 34 subjects studied had at least one blood count performed on another occasion. Of the 14 who had counts within six months of the date of the study sample, eight gave a hyperchromia flag on at least one other occasion, whereas six did not.

Among the remaining 10, one gave a flag on only one of nine samples analysed over a four year period, whereas two others gave flags on each of three samples analysed over three years and each of five analysed over 2.5 years, respectively. No hyperchromia flags were found in the blood count records of children comprising the control groups.

**DISCUSSION**

Increased numbers of hyperchromic red blood cells are found in a variety of red blood cell disorders other than HS, including immune haemolytic states, in association with HbC (interaction of this common variant with the inner aspect of the red cell membrane leads to cellular dehydration and increased MCHC values), and in disorders of red blood cell fragmentation. The children in our subject group were free of such disorders and a mild form of HS seemed a possible cause of their blood count findings, therefore prompting further investigation.

The observation of significantly higher MCHC values and hyperchromic red blood cell numbers by comparison with the control group was to be expected from the study design. However, taken together with the significantly higher reticulocyte numbers and HDW values, these findings produce a profile of changes very similar to that found in patients with HS, albeit to a lesser degree (table 1). For instance, the reticulocyte counts and HDW values of children with HS were consistently raised above normal limits and MCHC values frequently so,
whereas in the subject group most such values were within the ranges found in the control group. This was also the case with the Pink test, where we found, as have others, that values of normal subjects and patients with HS overlap at haemolysis values around 40–45%. There were three such borderline results among the subjects and one in both the control and HS groups. The red blood cell distribution width (RDW) is typically raised in HS, and together with a raised MCHC is highly predictive of this disorder. Our findings in patients with HS support this conclusion, although in our study group RDW values were almost identical to those of the controls (tables 1,2).

It might be argued that the higher reticulocyte counts of the subject group are a compensatory feature secondary to their higher MCHC values, based on the premise that higher MCHCs are a marker of less deformable red cells, which are likely to have a reduced life span. We found no evidence for this, because significantly higher numbers of hyperchromic red blood cells and reticulocytes and higher HDW values persisted in the 21 subjects with less high MCHC values for whom MCHC matched controls could be found (table 2).

The proportion of hyperchromic red blood cells in our subjects ranged from 4.0% to 13.0%, a very similar range to that reported by Pilar Ricard and Gil sans in patients with mild and moderate forms of HS. Whereas all the subjects also had increased reticulocyte numbers and positive osmotic fragility tests, only three of our subjects had a reticulocytosis, two had a borderline positive Pink test, and one had both findings. Although some subjects with very mild HS may give negative findings with the osmotic fragility group of tests, 3 those with clinically manifest HS have a profile of red blood cell changes similar to that seen in patients with hereditary spherocytosis (HS), including significantly higher numbers of hyperchromic red blood cells and reticulocytes, and significantly higher mean cell haemoglobin concentration and haemoglobin distribution width, and lower mean cell volume values, although these were seen to a lesser degree than in patients with HS.

About 1% of North European subjects have laboratory findings indicative of a continuum between normal subjects and those with clinically manifest HS. These individuals may carry a recessive form of the disease but lack the laboratory features of clinically manifest HS.

Earlier searches for evidence of mild HS among 1008 Norwegian and 1464 German blood donors using the osmotic fragility and acidified glycerol lysis tests, respectively, produced positive findings in about 1% of those tested. Some of these subjects also had a mild reticulocytosis. We estimate the incidence of an increase in hyperchromic red blood cells in our population also to be around 1%, giving an incidence of an abnormal Pink test of about 0.1%, based on our finding of a borderline positive result in three of the 34 children studied. The reason for this approximate tenfold difference is unclear, although the number of children we tested is too small for meaningful comparison.

Our findings, using sensitive methods of red blood cell analysis and precise automated reticulocyte counts, confirm the earlier reports based on osmotic fragility tests that about 1% of North European subjects have laboratory findings indicative of a continuum between normal subjects and those with clinically manifest HS. Carrier status for a recessive form of HS might be the molecular basis for the clinically unimportant red blood cell changes in these individuals.

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