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Changing causes of eosinophilia in London

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Background: Referrals of patients with raised eosinophils to infectious diseases clinicians is commonly associated with one or more helminth infections. Whetham et al (2003) carried out a retrospective review of 261 patients presenting to our institution with eosinophilia between 1997 and 2002. They found a helminthic cause in 64%, and more than one species in 17%.

In the last two decades there have been significant changes in the global populations risk of and exposure to these types of infections. For example; mass drug administration programs implemented in high risk regions, travel destinations have become more varied and activities more adventurous.

Helminth infections are notoriously difficult to diagnose, as history, examination and a raised eosinophil count are poor predictors of pathology. Furthermore, patients with eosinophilia may be asymptomatic making investigation costly and time-consuming.

In this paper we aim to; 1. Identify the characteristics of patients presenting to HTD with eosinophilia over the last 13 years. 2. Determine the commonest causes of eosinophilia and regional variation. 3. To understand more about changing trends in eosinophilic disease at our institution, we have also compared this cohort with historical HTD data from Whetham et al (2003), to evaluate changes in global disease distribution

Material/methods: Patients attending HTD from April 2002 to October 2015 were prospectively coded for 'eosinophilia' as reason for presentation. The laboratory, clinical and electronic patient records were retrospectively reviewed and laboratory, clinical, demographic and travel data were recorded on a proforma

Results: 528 patients were seen at HTD with a presenting complaint of eosinophilia during this time period. Of these 169 (32%) were diagnosed with strongyloides, 77 (14.6%) with schistosomiasis and 14 (2.7%) with filaria (some patients had more than one diagnosis). Other findings in those with eosinophilia included hookworm, HIV, toxocara, taenia and asthma. In 139 patients no diagnosis was made. Data on geographical distribution, patient demographics and result of laboratory investigations will be supplied.

Conclusions: Diagnostic yield for helminthic causes of eosinophilia was lower here than demonstrated in the earlier study. Changing global prevalence of helminth infections secondary to mass drug administration may underlie this finding, however additional confounding factors may be

alterations in the eosinophilia investigation protocol at HTD and a changing population of returned travelers attending clinic. Further analysis of the data will clarify this point.