1. EOSINOPHILIA

1.1 SCOPE

The **common causes** of eosinophilia are allergy (asthma, eczema, seasonal allergies) and medication (sometimes self-administered).

A more extensive list of causes is found here:

http://onlinelibrary.wiley.com/doi/10.1111/bjh.14488/full

Consider intestinal/other parasites if travel/environmental/occupational history, even long ago.

Persistently raised eosinophils may be toxic especially at levels above $1.5x10^9$/l.

If there are associated new onset cardiac or pulmonary problems seek early advice.

1.2 HISTORY

- Allergic disorders
- Skin rashes
- Medication including accurate start dates, and time correlation with blood counts
- Travel history
- Thrombotic history
- Cardiorespiratory
- Gastrointestinal
- Constitutional
- Red flag malignancy symptoms (night sweats, unintentional weight loss, pruritus)

1.3 EXAMINATION

- Signs of allergy
- Skin rash
- Cardiac and respiratory systems
- Lymph nodes/Hepatosplenomegaly

1.4 INVESTIGATIONS

1.4.1 Blood tests

- FBC and blood film
- U+E, LFT, bone, LDH, CRP, vitamin B12 assay

In patients who are otherwise well with mild to moderate eosinophilia between 0·5 and $1·5x10^9$/l, further testing may not be indicated, especially if history of atopy or allergy.

Patients with systemic symptoms or those with persistent eosinophilia (at least $1·5 \times 10^9$/l), with or without suspected organ damage, should be investigated for possible secondary causes.

Further investigations in primary care can include stool culture for parasites and chest x-ray.

1.5 REFERRAL

If:

- Eosinophil count is sustained (> eight weeks) >1.5x 10^9/l
- Systemic symptoms
- Evidence of end organ damage

Refer to Haematology if no detectable secondary cause OR Refer to secondary care, specialty according to clinical impression and site of pathology