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Clonal eosinophilia with FIP1L1-PDGFRA rearrangement

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Introduction: Eosinophilia is defined as an elevation of the eosinophil count above normal, i.e. above 0.5 x 10^9/L and categorized as primary, secondary (reactive) and idiopathic. Primary or Clonal eosinophilia refers to a disease entity where the eosinophilia occurs as a part of the neoplastic clone in a haematological neoplasm such as myeloid and lymphoid neoplasms with PDGFRA, PDGFRB, FGFRI rearrangements, JAK 2 rearrangements, tyrosine kinase fusion genes like ETV6-ABL1, ETV6-FLT3 and ETV6-ABL1. It should be suspected in patients presenting with unexplained isolated eosinophilia of >1.5 x 109/L because they can be treated according to that particular molecular target.

Case Report: A 39 year old man, who has been previously well, presented with a 2 months history of significant constitutional symptoms and left hypochondrial pain. On physical examination he had a palpable, firm spleen 4 cm below the left costal margin. Investigations revealed leucocytosis with marked eosinophilia (absolute eosinophil count being 27000/mm^3), moderate thrombocytopenia, mild anaemia, high ESR and CRP with ultra-sonic evidence of splenomegaly (17 cm) and hepatomegaly (16.3 cm). Molecular genetic tests revealed FIP1L1-PDGFRA rearrangement by FISH and the absence of BCR-ABL1. He has been treated with tyrosine kinase inhibitor, imatinib at a daily dose of 100mg and showed a satisfactory haematological response with normalisation of blood counts, resolution of symptoms and splenomegaly within 3 months.

Discussion: Clonal eosinophilia with FIP1L1- PDGFRA rearrangement is an uncommon disorder, which is known to respond well to tyrosine kinase inhibitor, imatinib mesylate at a low dose. Although imatinib is the treatment of choice for FIP1L1/PDGFRA-positive clonal eosinophilia, little is known about optimal dosing, duration of treatment, risk of relapse following discontinuation and the possibility of cure in this disorder. However the available data suggest the continuation of treatment to control the disease along with molecular monitoring.

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Error in medical judgment: How to categorize these avoidable deaths?

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Introduction: Human error cannot be eradicated. It could however be minimized with genuine interest of the art and adhering to standard protocols. Awareness of the possibility of error of judgment is the crucial factor for preventing medical mishaps due to this preventable entity which is not classified in the International Classification of Diseases (ICD) 10.

Case Report: A 34 year old woman with three children had an uncomplicated para-umbelical hernia for two years. She defaulted admission for the repair but was admitted to the same ward with features of acute abdomen two weeks later. She was kept under observation for four days and was pronounced dead due to sudden cardiac arrest. The judicial autopsy revealed gangrenous strangulated bowels with features of peritonitis and septicemia.

Discussion: Error in judgment does not always amount to medical negligence. The former is a medical entity while the latter is the decision by a court of law. Medical errors do contribute as the underlying cause of death while in rare occasions it becomes the immediate cause of death. It is considered as the