Hydatid cyst of liver

M J Kumar, K Toe, R D Banerjee

Hydatid disease is still endemic in certain parts of the world. The diagnosis of non-complicated hydatid cyst of the liver depends on clinical suspicion. Ultrasonography and computed tomography, the most important diagnostic tools, are helpful for determining the complications and planning treatment. The modern treatment of hydatid cyst of the liver varies from surgical intervention to percutaneous drainage or medical therapy. Surgery is still the treatment of choice and can be performed by the conventional or laparoscopic approach. Percutaneous drainage and treatment of the cyst with hypertonic saline or alcohol seems to be a good alternative to surgery in selected cases.

CASE REPORT

A 71-year-old woman presented to the radiology department for an ultrasound examination of her abdomen, although the abdominal pain, which was the initial problem, had disappeared and she felt fine. She also informed us that she had lived for a few years in Australia and since then her abdomen had been slightly rigid but this was not a problem as her general health was good. There was no other concern to indicate referral for ultrasound.

Ultrasound revealed a huge mixed echogenic predominantly cystic mass in the region of the liver. The normal liver parenchyma was replaced with this cystic septated mass (fig 1); the liver parenchyma was not visible. There were a few specks of calcification and septation was also noted. The right kidney was displaced to the midline by this mass. Because of the nature of the mass a provisional diagnosis of hydatid cyst was made and she was referred for urgent computed tomography. The computed tomogram revealed a large cystic mass with septations that had almost completely replaced the right lobe of the liver (figs 2 and 3). A diagnosis of hydatid cyst was made. Further investigations like complement fixation confirmed this diagnosis.

DISCUSSION

In humans, hydatid disease is caused by the larvae of a flat tapeworm, *E echinococcus granulosus*. Dogs and some wild carnivores like foxes are definitive hosts, harbouring worms in their intestine. Eggs are passed in the faeces and eaten by the intermediate hosts, and larval encyst in the liver, lungs, and other organs.

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Treatment

Hydatid cyst of the liver must be treated surgically. Albendazole 10 mg/kg/day for 3–6 weeks before surgery should be given to sterilise the cyst. During surgery special care should be taken not to spill the hydatid fluid. Precautions include packing the area with povidone iodine soaked sponges, aspiration of some of the hydatid fluid to reduce the tension, instillation of a scolicidal agent like hypertonic saline, and use of a suction cone. The pericyst is incised so that the hydatid cyst extrudes. The cyst is usually held with a sponge.
holder and removed very carefully (with daughter cysts inside). The residual pericystic cavity can be partially excised, filled with saline, and closed or obliterated with multiple purse string sutures. If endoscopic retrograde cholangiopancreatography reveals any daughter cysts in the common bile duct the duct should be explored, cleared, and drained with a T tube. After the operation the patient should continue albendazole for at least 6–8 weeks to clear up any spilled hydatid fluid containing live scolices.

Recent reports of percutaneous aspiration and obliteration of hydatid cyst of liver with sclerosant have appeared in the literature, but the role of this treatment method still remain unproved.  

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