

CASE REPORT

Huge Peritoneal Hydatidosis Mimicking Ovarian Cyst

Chowdhury Gopa · Singh Nita

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Introduction

Hydatid disease is zoonosis caused by dog tapeworm *Echinococcus*, *E. granulosus* species and is the commonest one having world wide distribution. Here a rare case of huge primary peritoneal hydatidosis is presented, misdiagnosed as huge ovarian cyst.

Case Report

Mrs. XYZ 18-years-old, primipara, presented with dyspnea and progressive enlargement of abdomen since 9 months. She was thin built, 145 cm tall, 46 kg, sick looking woman with waddling gait and huge abdomen. Pallor ++, Pulse 88/min, B.P. 110/64 mmHg and orthopnea present.

On abdominal examination—abdomen was tense with engorgement of veins over the lateral sides and abdominal girth 128 cm (Fig. 1). The lump was huge, cystic in consistency with well defined margins; fluid thrill present, but

shifting dullness was absent. On vaginal examination uterine size could not be assessed, cervix and vagina were normal and healthy, fornices were clear.

Clinical features suggested a huge serous ovarian cyst. Her hemoglobin percentage was 8.5 gm/dl, blood group was O positive, hepatic and renal function tests were normal, ECG was within normal limits and chest X-ray PA view was normal. Ultrasonography was diagnostic of peritoneal hydatidosis, showing whole abdomen filled with single huge cyst, extending from xiphisternum to pelvis, with small echogenic cysts of 2.5 × 2.5 cm size within the larger cyst; occupying the whole abdomen (Fig. 2). Liver, kidney, spleen and uterus were of normal echo-texture and

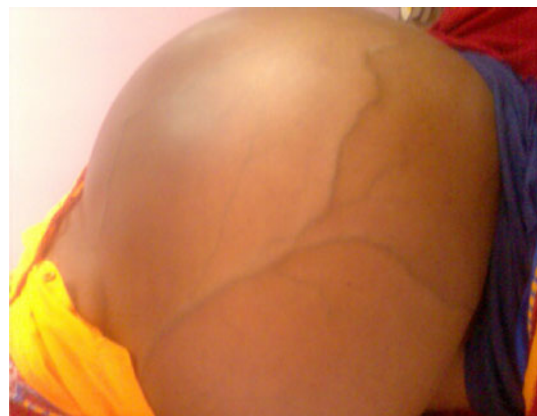


Fig. 1 Huge abdominal distention with engorged veins

Chowdhury G. (✉) · Singh N.
Department of Obstetrics & Gynaecology, Rajendra Institute of
Medical Sciences, Ranchi, Jharkhand 834009, India
e-mail: adarsh_26@yahoo.com

Chowdhury G.
Adarsh Clinic, Lalpur Chowk, Ranchi, Jharkhand 834001, India

Singh N.
Gautam Budha Marg, Bariatu Road, Ranchi, Jharkhand 834009, India

ovaries could not be visualized. No communication between the cyst wall and adjacent organs could be detected.

Oral albendazole 400 mg was started and one unit of packed cell transfused. Suddenly after 2 days she became very dyspneic and emergency laparotomy by right paramedian incision was undertaken. As the peritoneum was nicked, thousands of small cysts of varying size gushed out. A wide bore suction cannula was attached to it and about 16 l of pale yellow colored hydatid fluid along with thousands of daughter cysts were removed (Fig. 3). Thin germinal layer was removed completely (Fig. 4). The outer pericyst and ectocyst were adherent to the inner surface of anterior abdominal wall, bowel, inferior surface of liver, bladder and other pelvic organs, which could not be separated and hence left as such. Cyst wall had no communication with any adjacent organ. Peritoneal cavity was lavage with scolicidal agent 20% hypertonic saline and povidone-iodine solution and abdomen was closed after keeping a peritoneal drain. One unit of fresh whole blood was transfused during surgery. Oral albendazole 400 mg/day was started from second post operative day. She developed minor febrile illness and abdominal distension, which was managed by broad spectrum antibiotics and antifatulents. Abdominal drain was removed on second day and stitches on ninth post operative day. She was discharged on tenth day and advice albendazole 400 mg daily for 6 weeks. Follow up could not be done as the patient did not turn up.

Discussion

Hydatid disease is endemic in many parts of the world, where there is a close association of humans with dogs, the definitive host and sheep or cattle, the intermediate host. Human beings are the accidental dead end host. Liver

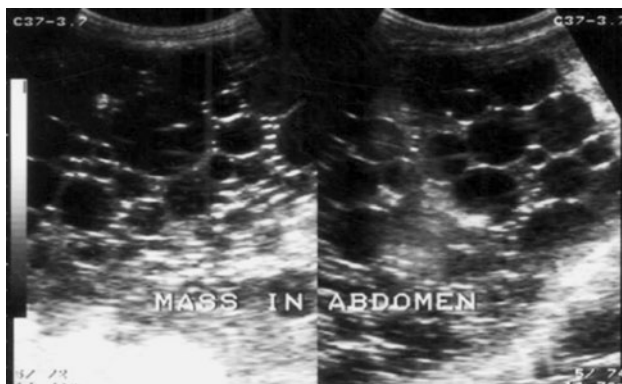


Fig. 2 Multiple echogenic cysts filling whole abdomen



Fig. 3 Daughter cysts with hydatid fluid



Fig. 4 Germinal layer/endocyst

(55–75%) and lungs (18–35%) are the most commonly affected sites. Studies have shown that peritoneal hydatidosis is rare; it is usually secondary to hepatic, splenic and mesenteric cyst or having concomitant to liver and retro-peritoneal hydatidosis [1].

The infection is usually acquired in childhood and remains asymptomatic until late adulthood. Symptoms of cyst depend upon its localization, pressure effect on the surrounding structure and rupture of cyst. Abdominal pain is the most commonly encountered symptom followed by pressure effect like nausea, weight loss and breathlessness on exertion and orthopnea [2, 3]. In this woman the predominant symptom was breathlessness and huge lump in abdomen.

Ultrasonography is the investigation of choice. In this case the clinical finding was suggestive of serous cyst of ovary, but by ultrasonography diagnosis was confirmed. The treatment of choice is surgical and complete removal of cyst. Unroofing and drainage of cyst is safe alternative if the pericyst is adherent to the underlying structures [4].

Conclusion

Primary peritoneal hydatidosis is a rare entity but always to be kept as differential diagnosis in case of lump in abdomen in endemic areas. Availability of newer imaging techniques help in diagnosis and follow up of cases. Surgery remains the mainstay of treatment. Use of scolicedal agents and antihelminthic, oral albendazole prevents the recurrence of the disease and should be given as a long term treatment.

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