

INTRABILIARY RUPTURE OF A HYDATID LIVER CYST: A CASE REPORT

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SUMMARY

Intrabiliary rupture of a hydatid liver cyst is a rare occurrence which may result in the development of obstructive jaundice and cholangitis. In this report we discuss the diagnostic and therapeutic management of a patient in whom the parasitic nature of cholangitis was underestimated due to the small size and site of the cyst, and to the misleading concomitant presence of cholelithiasis.

KEY WORDS: *Echinococcus granulosus*, hydatidosis, liver cyst, intrabiliary rupture, cholangitis

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Hydatid disease caused by *Echinococcus granulosus* is endemic in many countries throughout the world, including the whole Mediterranean area, where this zoonosis still represents an important and challenging public health problem (Bettelli C. *et al.* 2002, Gabriele E. *et al.* 1997). The principal definitive hosts are domestic dogs, but cattle, sheep and goats are common intermediate hosts. Humans, as intermediary carriers, are infected by swallowing ova of the parasite while consuming unwashed and uncooked vegetables contaminated by feces of animals. After digestion, the embryo is released into the intestinal tract and carried to the liver by the portal circulation. The disease can affect every organ in the human body, but the most frequent site of infection is the liver with a rate of 50-70%.

Hydatid liver disease is usually asymptomatic until the cyst reaches a considerable size when complications can occur, leading to compression on bordering structures. Spontaneous cyst rupture is a rare occurrence with a reported incidence of 5-10%; sequelae of intrabiliary rupture may result in the development of obstructive jaundice and cholangitis (Cucinotta E. *et al.* 2002). We report the case of a patient in whom the parasitic nature of cholangitis was under-

estimated due to the small size and site of the cyst, and to the misleading concomitant presence of cholelithiasis. The diagnostic and therapeutic management of this patient is discussed.

A 62-year-old man, resident in Southern Italy (Apulia region), was admitted to the Clinic of Infectious Diseases of the University of Foggia with a three-day history of upper right quadrant abdominal pain, scleral jaundice and mild evening fever. Four years previously, following an episode of diffuse abdominal pain, he had undergone abdominal ultrasonography which demonstrated the presence of a cystic lesion of about 5 cm in diameter at the VIII hepatic segment, further confirmed by a computed tomography (CT) scan. A definite diagnosis of hydatid disease had been made on the basis of a positive serological test for hydatidosis and chemotherapy with mebendazole was prescribed but the patient did not complete treatment cycles. The patient has been free of symptoms for the last four years.

When admitted to hospital, laboratory tests showed a white blood cell count of 8500/mm³ with 6.1% of eosinophilia, an erythrocyte sedimentation rate of 85 mm/h, a C-reactive protein level of 46 mg/l, and a fibrinogen level of 663