Multiple Yerleşimli Kist Hidatik Olgusu / A Hydatid Cyst with Multiple Localization

Özet

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Kistik Ekinokokkoz; Hidatik Kist; Benzimidazoller

Abstract
Cystic echinococcosis, caused by the larval stage (metacestode) of Echinococcus granulosus, is endemic in sheep raising areas and is among the most neglected diseases. Once ingested, parasitic eggs may penetrate intestine and settled via portal circulation to whole body especially to liver and lung as being major filter ing organs. Our case is a interesting case, because of presenting multiple cysts in different regions of the body. With Albendazol treatment, some radiologic regression was shown, but also perforation of some hydatid cysts, surgery was needed for treatment.

Keywords
Cystic Echinococcosis; Hydatid Cyst; Benzimidazoles

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Introduction

Cystic echinococcosis (CE) is a zoonotic disease produced by the larval stage of the cestode, Echinococcus granulosus. Tapeworms live in the intestine of dogs or other canines (definitive host) and their eggs are passed out with faeces. The eggs disperse widely and can survive for at least 1 year in external environment. Once ingested by a suitable intermediate host (sheep, cattle, goats, pigs, horses, or camels), eggs transform to embryos in intestine, penetrate the intestinal lining, spread through the portal circulation, and lodge into tissues, mostly to liver and lung as being major filtering organs. Embryos then transform to cystic metacestodes in which the infective protoscolices will develop. When a canine eat the cystic visceral organ, protoscoleces attached to the intestine of canine and develop into mature adult tapeworms in about 40–45 days. Human beings can act as intermediate hosts if they ingest the eggs and after many years large cyst develop [1,2,3,4]. In 40–60% of patients, there were no symptoms and sign. The presenting symptoms of pulmonary CE are due to the mass effect of cyst. The common presenting symptoms are as follows: Cough (53–62%), chest pain (49–91%), dyspnea (10–70%), and hemoptysis (12–21%). Other symptoms described less frequently include dyspnea, malaise, nausea and vomiting, and thoracic deformations [5]. Cysts can leak to bronchi and become infected [6]. Radiological studies are the primary step in the detection and evaluation of pulmonary CE, the role of serology is mostly limited to case confirmation. Ultrasonography of the abdomen still remains the major noninvasive screening and may confirm the diagnosis of CE, by demonstrating the pathognomic daughter cysts [7]. The computerized tomography (CT) does not confirm the diagnosis of CE, as it may mimic malignant and benign conditions such as congenital cyst, pseudocyst, or hematomas [8]. However, the presence of daughter cysts, germinal epithelium detachment and calcification may confirm the diagnosis. Similarly, MRI can reveal a cystic mass containing daughter cysts, with rim sign and “water lily sign” [9]. Surgery is the main therapeutic approach [10]. The use of presurgical medical treatment reduces the chances of seeding and recurrence [2]. WHO guidelines for CE stated that treatment containing benzimidazoles (mebendazole or albendazole) are preferred when surgery is not available or complete removal is not feasible. Medical treatment can result in reduction of the cyst size, but may not effective for large cyst. Long term treatment of albendazole, with dose of 400 mg twice a day, is somewhat effective for pulmonary CE [2].

Case Report

A 30-year-old woman presented cough and sputum with 4 months period in the 27th week of pregnancy. Physical examination of respiratory system was normal. With abdominal ultrasonography, multiple cysts with 5 cm the largest diameter were revealed and suggested the diagnosis of CE and the patient was followed-up during pregnancy. After vaginal delivery, CT was shot and multiple cysts were detected in liver, lung and also in the mediastinum and the abdominal wall (Figure 1A, 1B, 1C). Fine needle aspiration was performed to the cyst settled at the abdominal wall, scolexes of EG were determined in microscopic examination of the cystic fluid. Albendazol (10-15 mg/kg/day) treatment was started. At the 12 th day of the treatment, pa-
for having multiple cysts in different regions of the body, for showing radiologic regression and perforation of cysts during albendazol treatment and for requiring the surgical treatment.

**Competing interests**
The authors declare that they have no competing interests.

**References**

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