Primary Hydatid Cyst Of The Spleen: A Rare Site Of Presentation
S Sahu, R Srivastava, D Bahl, P Sachan

Citation

Abstract
The larval form of Echinococcus granulosus is the most common causative organism of hydatid disease. The most common sites of hydatidosis are liver and lungs. We present a rare case of a primary hydatid cyst of the spleen that was detected incidentally. Splenectomy was the procedure advocated.

INTRODUCTION
Hydatid disease caused by the genus Echinococcus is endemic in Middle East, South America, North Africa, Indian subcontinent, Australia and New Zealand. Echinococcus granulosus is the commonest organism involved, with dogs as the definitive host and human beings acting as an accidental intermediate host. Rarely infestation with Echinococcus multilocularis and Echinococcus vogeli may also cause hydatid disease. After ingestion, the eggs hatch and the resultant oncospheres penetrate the intestinal mucosa of humans and enter the circulation. They primarily lodge either in the liver, lungs or kidneys which are the organs acting as filters of the circulation of the body. In the organs where these organisms lodge, they slowly develop into a cavity lined with germinal epithelium, outside of which develops a laminated acellular area.

CASE REPORT
A 78-year-old female with diabetes, asthma, hypertension and heart block with apparently no abdominal complaints, undergoing medical consultation was advised an X-ray of the chest, which revealed a well-defined, rounded soft-tissue opacity with calcified margins in the left hypochondrium. She was referred to the surgical department for further investigations. On examination, her vital parameters were within normal limits. Examination of the abdomen revealed no abnormality.

Routine investigation revealed: hemoglobin 11.1gm/dl, total leukocyte count 11.800 /mm³ and differential leukocyte count: neutrophils 67%, lymphocytes 21%, eosinophils 8%, monocytes 2%, basophils 2%. Renal and liver function tests were within normal limits.

Plain radiological imaging of the abdomen revealed a well-defined, rounded soft-tissue opacity with calcified margins in the left hypochondrium (FIG-1).

Figure 1: Plain X-Ray Of The Abdomen Revealing A Well-Defined Rounded Soft-Tissue Opacity With Calcified Margins In The Left Hypochondrium

Contrast-enhanced computed tomography of the abdomen showed a well-defined rounded mass with dense calcification in the superior pole of the spleen suggestive of old calcified cyst or abscess (FIG-2).
Primary Hydatid Cyst Of The Spleen: A Rare Site Of Presentation

**Figure 2**
Figure 2: CT Scan Of The Abdomen Showing A Well-Defined Rounded Mass With Dense Calcification In The Superior Pole Of The Spleen Compressing The Stomach

Surgical exploration was planned which revealed an infected hydatid cyst of the spleen with abscess formation (FIG-3).

**Figure 3**
Figure 3: Specimen Of Infected Hydatid Cyst Of The Spleen With Abscess

Splenic hydatid cysts are usually asymptomatic but may present as a painful mass in the left upper quadrant. An enlarged spleen may be found. The complications of untreated splenic hydatid cyst are mainly infection, intraabdominal rupture and fistulization to the bowel, mainly colon. Rupture of splenic hydatid cyst into the thorax leading to splenothoracic fistula has also been reported. Severe anaphylactic reactions due to rupture of the cyst are also reported leading to fever, pruritus, dyspnea, stridor and edema of the face. Portal hypertension is also described with splenic hydatidosis.

**DISCUSSION**

Splenic hydatid disease is rare and the incidence is reported between 2-3.5% by different authors. Primary infestation of the spleen usually takes place by the arterial route after the parasite has passed the two filters (hepatic and pulmonary). A retrograde venous route, which bypasses the lung and liver, is also reported. Secondary splenic hydatid disease usually follows systemic disseminated or intraperitoneal spread following ruptured hepatic hydatid cyst. The hydatid cyst consists of three layers. The outer adventitia is formed of compressed splenic tissue, a middle layer of friable ectocyst and an inner germinal layer from which a large number of scolices are produced.

Splenectomy was done. The patient had an uneventful postoperative recovery and was discharged on the 8th postoperative day with a regimen of albendazole.

Histopathology of the specimen confirmed a hydatid cyst of the spleen.

**Hydatid immunoelectrophoresis**, enzyme linked immunosorbent assay (ELISA), latex agglutination and indirect haemagglutination test are the different serological tests for diagnosis, screening and follow-up for recurrence.

Splenectomy has been the traditional treatment of choice for splenic hydatid cyst. Laparoscopic approach has also been advocated for uncomplicated hydatid cyst of the spleen. Albendazole and or praziquantel are the drugs recommended for the treatment of this disease.
CONCLUSION

Splenic hydatidosis is a rare site of presentation of hydatid disease and should be suspected on detection of a splenic cyst in endemic areas of hydatid disease. Computed tomography is the most sensitive investigation for diagnosis. Splenectomy is the treatment of this rare disease.

CORRESPONDENCE TO

Dr. Shantanu Kumar Sahu
Assistant Professor, Department of General Surgery
Himalayan Institute of Medical Sciences
Swami Ram Nagar Post: Doiwala
Dehradun Uttarakhand
India
Mob.: 0-9412933868
Email: lntshantanu@yahoo.co.in

References

Author Information

Shantanu Kumar Sahu, MS (General Surgery)
Assistant Professor, Department of General Surgery, Himalayan Institute of Medical Sciences

Rajendra Srivastava, MD(Radiology)
Assistant Professor, Department of Radiology, Himalayan Institute of Medical Sciences

Dig Vijai Bahl, MS (General Surgery), MCh (Cardio-thoracic Surgery)
Professor, Department of General Surgery, Himalayan Institute of Medical Sciences

Praveendra Kumar Sachan, MS (General Surgery)
Professor and Head, Department of General Surgery, Himalayan Institute of Medical Sciences