

CASE NOTE

Splenic hydatid cyst

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H ydatid disease is endemic in farming areas but occurs worldwide. The most common site of disease is the liver, followed by the lungs, kidney, bones and brain. Other sites such as the heart, spleen, pancreas and muscles are very rarely affected. Splenic hydatid disease has been reported to constitute up to 4% of cases of abdominal hydatid disease.¹ The rarity of splenic hydatid disease may pose a diagnostic challenge for clinicians, especially in nonendemic areas.² In this report, we present the case of a young man with concomitant splenic and liver hydatid cysts.

CASE REPORT

A 24-year-old man with kyphoscoliosis was admitted to our general surgery clinic with a mass in the left upper quadrant of his abdomen. The patient reported that the mass had started enlarging rapidly over the past 4 months. Routine laboratory tests, other than the indirect hemagglutination test for hydatid cysts (1/512), were normal. Physical examination showed an asymmetric abdomen and an exophytically growing mass on the left side. Abdominopelvic computed tomography (CT) showed a 16 × 15 × 14-cm loculated cyst with many septa, originating from the spleen, and a second cyst of 8 × 5 cm in size originating from the left lateral lobe of the liver. The cyst in the spleen appeared to fill the left quadrant of the abdominal cavity, displacing the intestines to the right (Fig. 1) A CT scan of his chest did not show any cysts. We diagnosed concomitant splenic and liver hydatid cysts.

On exploration, we found a huge hydatid cyst in the spleen filling the entire left side of the abdomen and pushing the intestines to the left and a second hydatid cyst in the left lateral segment of the liver. We aspirated the contents of the splenic hydatid cyst and then instilled it with 10% hypertonic saline. After reaspiration, we opened the cyst cavity and removed all endocysts (Fig. 2). After this, we performed a splenectomy, aspiration, cystotomy–capitonage and omentopexy to the cyst in the left lateral segment of the liver. The patient's postoperative period was uneventful, and he was discharged with albendazole treatment on postoperative day 6.

DISCUSSION

Splenic hydatid cysts are generally asymptomatic. Diagnosis is usually established incidentally during investigation of unrelated symptoms. When the cyst reaches an advanced size, the patient presents with a painful mass in the left hypochondrium.^{1,2} Other initial presentations include renal arterial compression and systemic hypertension or rupture of the splenic hydatid cyst to the other organs.¹ Our

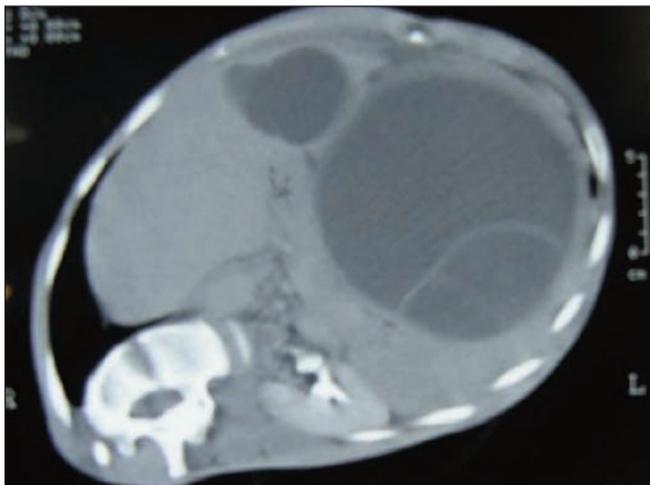


Fig. 1. Abdominopelvic computed tomography reveals a giant loculated cystic mass originating from the spleen and a normal-sized cyst originating from left lateral segment of the liver.

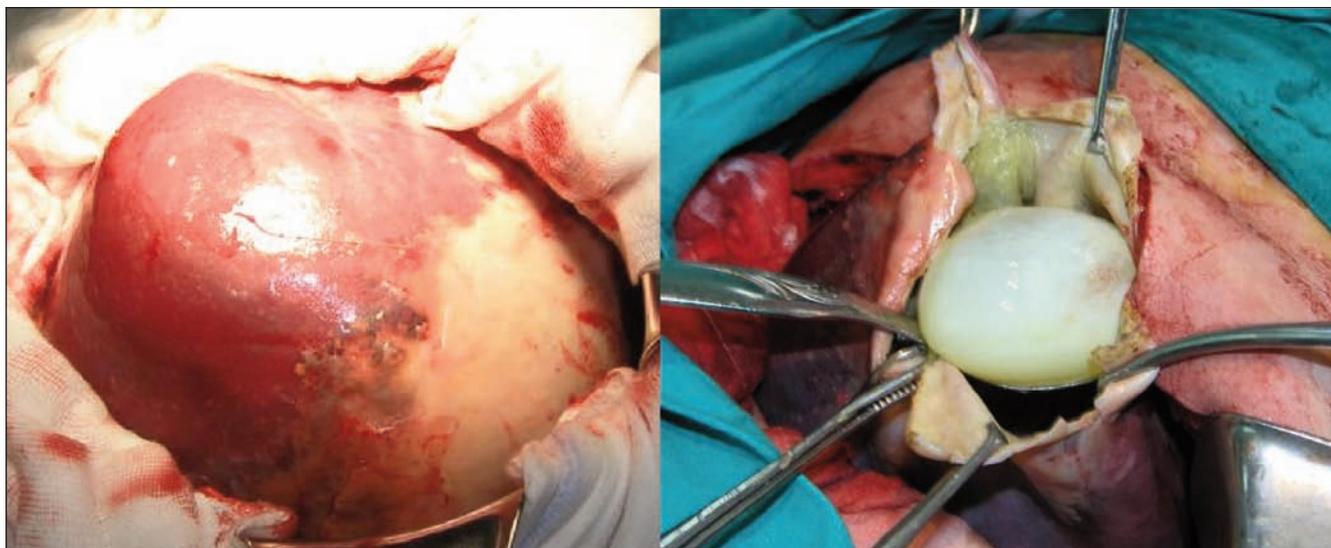


Fig. 2. Intraoperative images of (left) a huge splenic hydatid cyst and (right) cystotomy and removal of the endocysts.

patient was admitted to hospital for pain and a rapidly enlarging mass in the left upper quadrant of his abdomen.

The imaging characteristics of splenic hydatid cysts are similar to those of hydatid cysts:³ calcification of the cyst wall, the presence of daughter cysts and membrane detachment. The differential diagnosis for splenic hydatid cysts includes other splenic cystic lesions such as epidermoid cysts, pseudocysts, splenic abscesses, hematomas and cystic neoplasms of the spleen.^{3,4}

Owing to the risk of spontaneous or traumatic rupture, splenic hydatid cysts are usually treated surgically.^{1,4} The standard treatment is total or partial splenectomy. Cyst fluid can be drained with puncture and aspiration to reduce the intracystic pressure, but splenectomy without puncturing the cyst is preferable.^{4,5} We drained the splenic cyst in our patient before splenectomy because of the limited

exposure secondary to both the size of the cyst and kyphoscoliosis. Albendazole therapy is the mainstay of treatment in the postoperative follow-up period.

Competing interests: None declared.

References

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