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Case Report

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PANCEREATIC HYDATID AS A CAUSE OF EPIGASTRIC MASS, A CASE REPORT

Mushtaq Ch Abu-AlHail

CABS, Specialist Surgeon, Department of Surgery, Basrah General Hospital, Basrah, IRAQ.

Abstract

Primary hydatid cyst in the corpus of pancreas is a rare. A woman of 35 Years old came with a two-month history of epigastric Pain, occasional vomiting and an epigastric mass. On Physical examination the vital sign were normal. The only Positive sign besides ahard epigastric mass was mild tenderness. Ultrasonography and CT Showed a cyst at the Corpus of the Pancreas 4X5cm Diameter. The Patient under went midline laparotomy and an isolated hydatid cyst of the Pancreas was found. This is a rare manifestation of this disease.

Introduction

Hydatid cyst disease still constitutes a serious public health problem in areas where it is endemic. It is a tissue infestation caused by the larval stage of the parasite Echinococcus granulosus. Although the liver and Lung are the most commonly involved organ. Hydatid disease can occur in all viscera and soft tissue[1].

Isolated pancreatic localization of the disease is rare; it has been estimated to be From 0.14 to 2% in other studies[2-5].

Case Report

The patient is a 35 year old woman who presented in January 2007 to Basrah General Hospital with epigastric pain, occasional vomiting and an epigastric mass of 2 month duration.

She had no history of fever; no weight loss, no Jaundice, no change in bowel habit, no history of abdominal trauma or abdominal surgery.

Physical Examination revealed a palpable mass in the epigastric area.

Routine blood tests were all within the normal limits.

Abdominal ultrasonography (US) revealed a cystic mass with echogenic content in body of pancreas. Abdominal computerized Tomography (CT) was done and revealed a multiloculated non-enhancing cystic mass with hyper dense thin wall and strands in the body of pancreas about 4x5cm.

Figure 1. suggest a hydatid cyst of pancreas. Upper GIT endoscopy was normal.

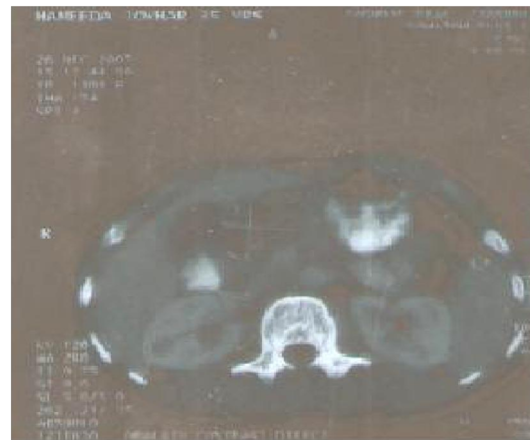

Figure 1: Abdominal CT scan; cystic mass 4x5 cm in the body of pancreas.

Laparotomy was performed and the cystic mass was found to be bulging from body of pancreas (figure 2).

After protecting the operative area by a scolicidal solution (Hydrogen peroxide

20%) the aspiration of the cyst yielded transparent fluid. Further, the cyst was

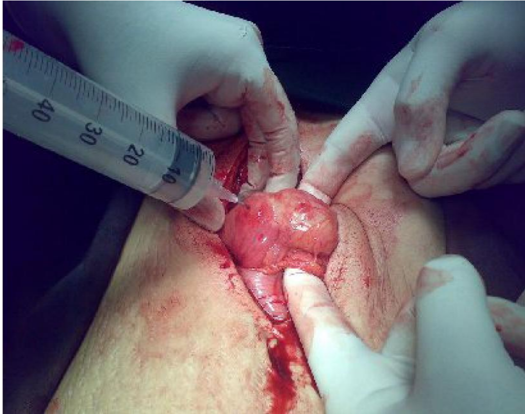

Figure 2: The corpus of pancreas occupied by hydatid cyst and aspiration of transparent fluid

opened and germinative membrane was extracted (figure 3).

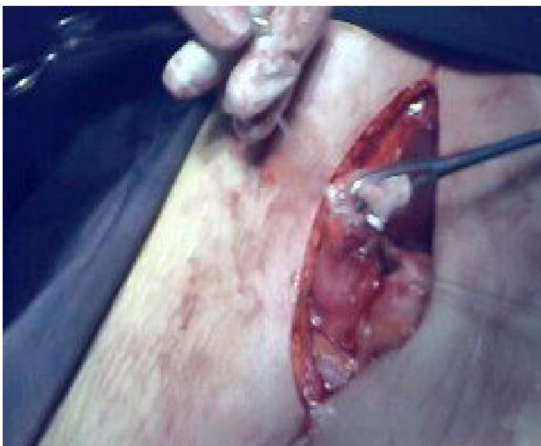

Figure 3: Germinative membrane extraction.

Partial removal of the cyst was performed with drainage of the residual cavity by a tube drain. The patient was put on treatment regimen with albendazole at a dose of 10 mg/kg/day for 3 months. She was followed up without any compliant or recurrence for one year.

Discussion

Hydatid disease is often manifested by a slow growing cystic mass. The liver and lungs are the organs most frequently involved. The cysts may be single or multiple uni or multi loculated with thin or thick wall[6,7]. The presence of calcium in the wall of the cyst requires more than ten years to develop and total calcification indicates that the cyst is mostly non viable.

Isolated pancreatic localization of the disease is rare, it has been estimated to be from 0.14 to 2% in other studies.

The location of the cyst in the pancreas has different distributions: head 57% corpus 24% and tail 19%.[8-9].

Establishing a precise diagnosis may be difficult because the presenting symptoms, findings and investigations may be similar to other more commonly encountered cystic lesions of the pancreas. Clinical presentation varies according to the anatomical location of the cyst. Abdominal pain, and vomiting are the main clinical symptoms. The patient may present with obstructive jaundice, weight loss, an epigastric mass, and/or recurrent attack of acute pancreatitis[10-11]. The diagnosis is based on an enzyme–linked immunoadsorbent assay (ELIZA) test for echinococcal antigens which is positive in over 85% of infected patients[12]. Ultrasongraphy will typically demonstrate a cyst with a wall of varying thickness. Computed tomographic finding, such as rounded cystic lesion with curvilinear calcification may allow the diagnosis to be made in the appropriate clinical setting[13]. A definitive diagnosis of hydatid disease of the pancreas can be made only at surgery and during surgical treatment of hydatid cysts, extreme caution must be taken to avoid rupture of the cyst which would release protoscolices into peritoneal cavity.

Many surgical techniques are available to remove the cyst; however pericystectomy with drainage of the residual cavity is the technique of choice[14].

Distal pancereatectomy with splenic conservation is the treatment of choice for hydatid cyst localized in the tail of pancreas.

Percutaneous drainage of the cyst is good alternative to surgery in patients

with high surgical risk and in this case it must be combined with medical chemoprophlaxis using albendazole. In conclusion, Primary hydatid cyst in the corpus of pancreas is extremely rare even in endemic Areas. Hydatid cyst should be included in the differential diagnosis of cystic lesions of the pancreas.

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