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CASE REPORT

Primary hydatid cyst masquerading as pseudocyst of the pancreas with concomitant small gut obstruction—an unusual presentation☆

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Abstract Isolated retroperitoneal hydatid cyst is an exceptionally rare entity. Owing to vague and varied symptomatology, it is seldom diagnosed without puncture cytology or surgery. We report an unusual presentation of primary retroperitoneal hydatid cyst with concomitant small gut obstruction. Ultrasonography and computed tomography of the abdomen showed localized abscess or pseudocyst of pancreas. Preoperatively, ultrasound-guided puncture cytology of the lesion revealed suspicious hydatid pathology. The patient was examined and, peroperatively, the cyst masqueraded as hydatid cyst of pancreas along with an inflammatory band, and the diagnostic dilemma about its exact site of origin was solved by histopathology only. Complete excision of the cyst along with the tail of pancreas was done with concomitant excision of inflammatory band, causing small intestinal obstruction. The patient was discharged in satisfactory condition on albendazole. In follow-up of 8 months, there was no recurrence.

☆ This case study was done in Government Medical College and Hospital, Sector 32, Chandigarh, Punjab, India.

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Introduction

In sheep- and cattle-rearing areas, hydatid disease is a common health problem [1]. Retroperitoneal hydatid cyst without hepatic involvement is a rare entity even in endemic areas. Immunological test may aid in diagnosis, but percutaneous puncture cytology or surgery can only accurately diagnose its hydatid nature. Owing to severe life threatening anaphylaxis by spillage of the contents during percutaneous puncture or surgery, keeping high index of suspicion of hydatid cyst in mind, every measure should be taken to treat this unexpected complication during these procedures in all cases [2—4]. Isolated pancreatic hydatid cyst is very rare. Its incidence reported in literature varies from 0.14% to 2% [5]. The location of the cyst in the pancreas has different distributions: head (57%), corpus (24%), and tail (19%) [5].

Case presentation

A 48-year-old male patient presented twice in emergency surgery department with short history of fullness in the epigastrium, intermittent fever, and dull aching abdomen. On first admission, the patient complained of severe pain in the abdomen since 1 week, more intense in the epigastrium region, which was radiating to the backside. High-grade fever was also present. There was also a history of constipation on and off since 1 week.

On abdominal examination, fullness and tenderness were found in the epigastrium region. There was no rigidity or guarding. Bowel sounds were present. Ultrasonography and contrast-enhanced computed tomography (CECT) of the abdomen revealed a well-defined, low-attenuation, pancreatic cystic lesion, 8×5 cm in size in relation to the tail of the pancreas and anterior to the splenic vessels (Fig. 1). Differential diagnoses of localized abscess or pseudo—pancreatic cyst were made on CECT. The rest of the organs were normal, including the lungs. Serum amylase was normal. Ultrasound-guided aspiration of the lesion revealed thick white purulent fluid, which was sent for culture, and it came out to be sterile. Third-generation cephalosporin and metrogyl were given parenterally. Fever subsided, and the patient improved symptomatically and was discharged after 7 days.

He was readmitted after 10 days of discharge with abdominal discomfort, fever, and vomiting. History of constipation was there since 3—4 days. Fever was high grade and continuous in nature. Physical examination revealed a pulse rate of 110/min, blood pressure of 126/86 mmHg, respiration rate of 22/min, and temperature of 39.5°C. The total leukocyte count was raised; rest of the blood test results were within normal limits, including serum amylase, lipase, and liver function tests. On abdominal examination, distention was found to be present. On palpation, a vague retroperitoneal mass of size 5.8×6.4 cm was felt, which was firm in consistency. The mass was not moving with respiration. Generalized tenderness was present. Bowel sounds were absent. Provisional diagnosis of retroperitoneal mass with intestinal obstruction was kept.

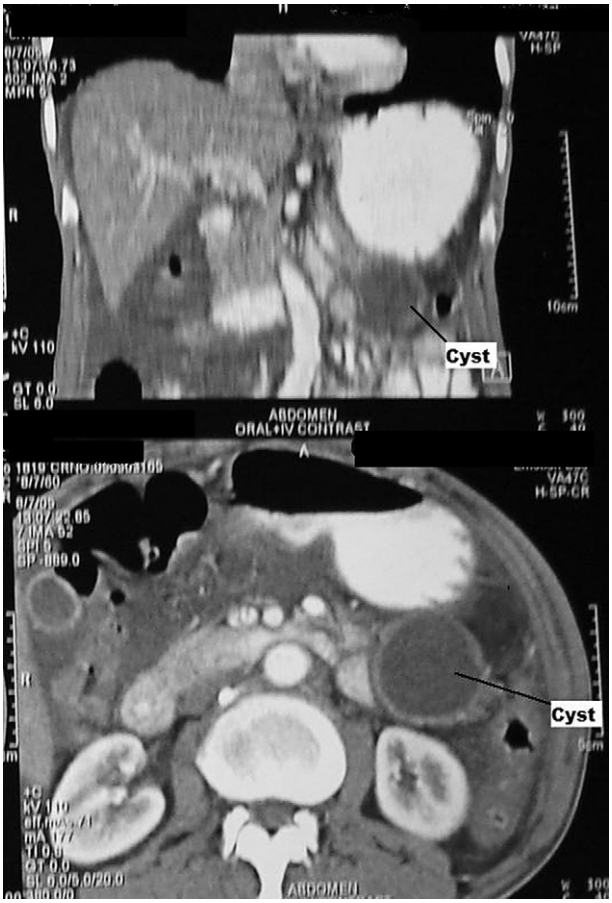

Figure 1. Contrast enhanced computed tomography of abdomen revealed a well-defined low attenuation, cystic lesion of 8 x 5 cm size in relation to the tail of pancreas and anterior to the splenic vessels.

X-ray of the abdomen in supine position showed multiple dilated small bowel loops. On erect X-ray of the abdomen, multiple air fluid levels were found, and diagnosis of small gut obstruction was made. Repeat ultrasound abdomen revealed a lesion of size 7×5 cm in retroperitoneal region in relation to the tail of pancreas. CECT of the abdomen revealed retroperitoneal lesion of size 7×5 cm in relation to the tail of the pancreas with dilated small bowel loops. The rest of the organs were normal; hence, diagnosis of primary hydatid cyst of the pancreas was made radiologically. Ultrasound-guided aspiration was done again to rule out neoplastic nature of the lesion. Cytology revealed scolices compatible with hydatidosis. Small gut obstruction could not be relieved with conservative management; hence, laparotomy was planned in emergency.

Through a midline incision, findings revealed a band arising from inferior surface of transverse mesocolon encircling completely a 5-cm loop of distal jejunum with dilated proximal jejunum and a cyst of size 5×5 cm projecting from inferior border of pancreas into the root of transverse mesocolon just proximal to the tail of pancreas (Fig. 2). The capsule and the tissue of the pancreas were inseparable from the cyst. Peroperatively, it looked like a hydatid cyst of pancreas on correlation with cytology