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## Clinical Communications: Adults

# AN UNUSUAL CASE OF ANAPHYLAXIS AFTER BLUNT ABDOMINAL TRAUMA

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**☐ Abstract—Background: Due to current human migratory patterns, emergency physicians in developed countries are facing emergent clinical presentations of neglected tropical diseases with increasing frequency. In those situations, the clinician's diagnosis is often delayed due to a lack of familiarity with the disease. Case Report: We present the case of a 25-year-old Peruvian man who presented to the Emergency Department complaining of dyspnea and abdominal pain after upper abdominal trauma. His physical examination revealed mouth and eyelid edema in association with epigastric pain. An abdominal computed tomography scan revealed a liver hydatid cyst. Emergent surgical evacuation of the cyst was required to control the anaphylactic reaction. Why Should an Emergency Physician Be Aware of This?: Anaphylaxis in the setting of a complicated hydatid cyst is a life-threatening disease. Critical care management and emergent surgical evacuation of the cyst are indicated. © 2016 Elsevier Inc.**

**☐ Keywords—anaphylaxis; complicated hydatid cyst; echinococcosis**

## INTRODUCTION

Human echinococcosis is a neglected tropical zoonotic infection [(1), p 107–12]. The annual incidence of this disease can range from < 1 to 200 per 100,000 inhabitants in various endemic areas around the world (2). Although most of these cases are reported in developing countries, sporadic cases affecting immigrants and recent travelers are being reported with increasing frequency in developed countries.

We report the case of a patient with human echinococcosis (liver hydatid cyst) presenting with anaphylaxis after experiencing blunt abdominal trauma.

## CASE REPORT

After being involved in a street fight, a 25-year-old Peruvian man presented to the Emergency Department (ED) of a local hospital in Cusco, Peru with 30 min of acute-onset dyspnea and severe abdominal pain. He had been kicked in his upper abdomen just prior to the onset of his symptoms. The patient denied history of asthma, recent ingestions, exposure to medications, or any other trauma. His physical examination revealed tachypnea and tachycardia. His blood pressure and temperature were both normal. The patient was in moderate respiratory distress. Eyelid and lip swelling were noted (Figure 1A). His lung auscultation was unremarkable except for a prolonged expiratory phase without wheezing or stridor. His abdominal examination revealed tenderness on palpation of his right upper quadrant with no peritoneal signs. The rest of his physical examination

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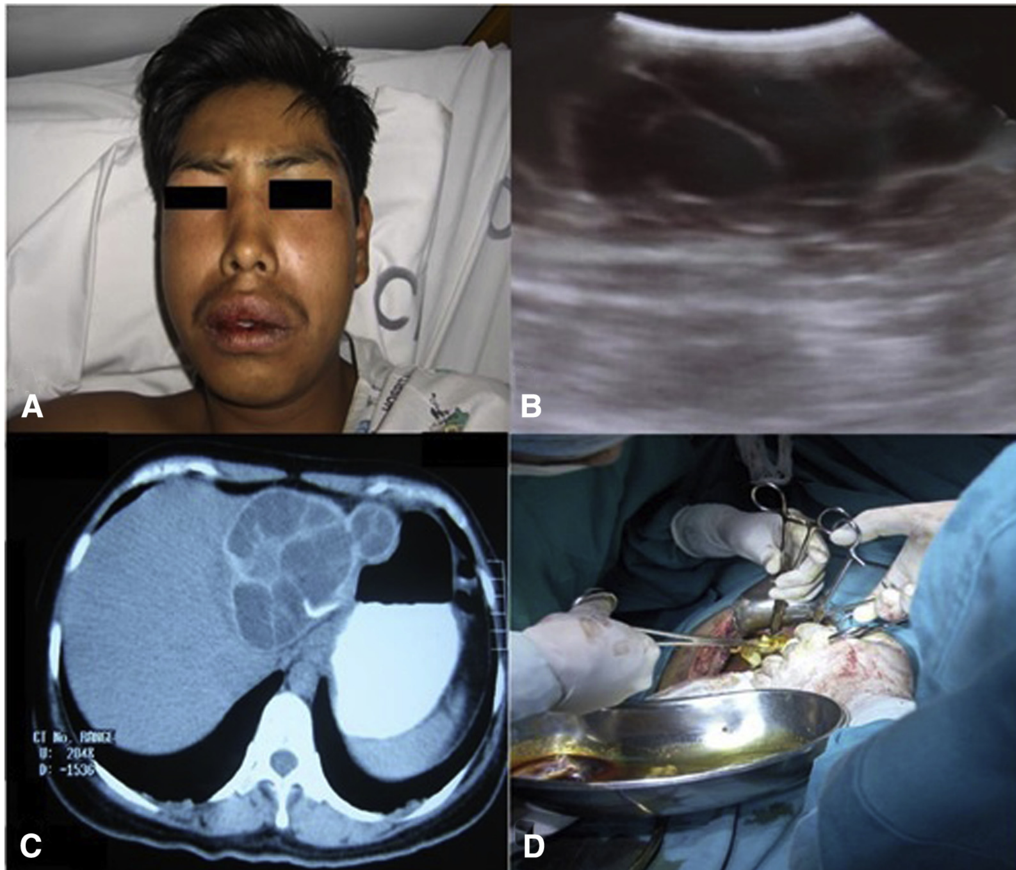


**Figure 1. (A) Swollen eyelids, mouth, and lips were noted on initial presentation. (B) A bedside abdominal ultrasound revealed a multi-loculated cystic lesion within the liver parenchyma. There was no evidence of free fluid in the abdominal cavity. (C) An abdominal computed tomography revealed a thick-walled, multi-loculated cystic lesion over the liver segments II and III. There is no radiographic evidence of cyst rupture. (D) Emergent surgical intervention with successful removal of a complicated hydatid cyst.**

was unrevealing. Laboratory work and chest x-ray study were performed and were unremarkable. Bedside ultrasonography performed by the emergency physician revealed a cystic lesion within the liver parenchyma (Figure 1B). Abdominal computed tomography revealed a thick-walled, multi-loculated cystic lesion over liver segments II and III. The lesion was reported as concerning for liver hydatidosis (Figure 1C). The patient was diagnosed with anaphylaxis secondary to a complicated liver hydatid cyst. The patient underwent immediate emergent surgery with successful removal of a complicated hydatid cyst (Figure 1D). Prior to going to the operating room, the patient received one dose of intravenous hydrocortisone and one dose of a histamine blocker.

Serologic analysis (enzyme-linked immunosorbent immunoglobulin G assay) for *Echinococcus granulosus* was positive (1/256).

During the immediate postoperative period, the patient was started on albendazole (10 mg/kg/day) for 4 months. One year after his initial presentation, there was no clinical or radiographic evidence of disease.

## DISCUSSION

Human echinococcosis is a neglected global zoonotic infection (1). It is caused by the larval stages of cestodes of the genus *Echinococcus*. *Echinococcus granulosus* is the most frequent species infecting humans (2).

The adult stage of *Echinococcus granulosus* resides in the small bowel of carnivores and canids. The gravid adult parasite releases eggs that are passed in the feces. Humans get infected after ingestion of contaminated food. Once ingested, the egg hatches in the small bowel and releases an immature stage of the parasite that penetrates the intestinal wall and migrates through the circulatory system into various organs. In these organs, the larval parasite develops into a cyst (2). In humans, 50–75% of these cysts occur in the liver (3). Cystic hydatidosis is an important public health problem in South America,

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