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CLINICAL CASE

Disseminated peritoneal hydatidosis manifested as intestinal ischaemia☆

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KEYWORDS
Peritoneal hydatidosis;
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Abstract
Background: The hydatid disease, or echinococcosis, is endemic in Mediterranean countries, as well as in Australia, Asia, Africa, South America, and Canada. Among its complications is intraperitoneal rupture, a rare form of presentation, with highly variable symptoms. The treatment of choice is surgery plus adjuvant medical treatment in most patients.
Objective: A case is presented of a patient with disseminated peritoneal hydatidosis manifested as intestinal ischaemia.
Clinical case: A 50-year-old male was admitted to the emergency room with a history of chronic abdominal pain that worsened in the last 24 h. He showed signs of sepsis in the physical examination and was subjected to surgery, in which intestinal ischaemia was found due to a disseminated peritoneal cystic disease, which had led to mesentery retraction. An intestinal resection with an end-ileostomy was performed. The results of the biopsy of the cystic lesions was disseminated peritoneal echinococcosis. Medical treatment was started with albendazole and praziquantel.
Conclusion: This case shows a rare presentation of disseminated peritoneal hydatidosis, which led to intestinal ischaemia.

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PALABRAS CLAVE
Hidatidosis peritoneal;
Equinococosis;
Isquemia intestinal

Hidatidosis peritoneal diseminada manifestada como isquemia intestinal

Resumen
Antecedentes: La enfermedad hidatídica o equinococosis es una enfermedad endémica en los países del Mediterráneo, Australia, Asia, África, América del Sur y Canadá. Dentro de sus complicaciones, la ruptura intraperitoneal es una presentación rara, con síntomas altamente variables. El tratamiento de elección en la mayoría de los pacientes es la cirugía, agregando tratamiento médico adyuvante.
Objetivo: Presentar el caso de un paciente con hidatidosis peritoneal diseminada manifestada con isquemia intestinal.
Caso clínico: Hombre de 50 años de edad que fue ingresado al servicio de Emergencias con historia de dolor abdominal crónico que empeoró en las últimas 24 h. En la exploración física mostró signos de sepsis y fue sometido a cirugía, donde se encontró una isquemia intestinal condicionada por una hidatidosis peritoneal diseminada, la cual generó retracción del mesenterio. Se realizó una resección intestinal con una ileostomía terminal. Los resultados de la biopsia de las lesiones quísticas fueron de equinococosis peritoneal diseminada. Se comenzó con tratamiento médico a base de albendazol y praziquantel.
Conclusión: Este caso nos muestra una presentación rara de hidatidosis peritoneal diseminada la cual condicionó una isquemia intestinal.

Background

Hydatid disease, or echinococcosis, is caused by the *Echinococcus granulosus* parasite and can present anywhere in the human body, but affects the liver most (50–60%), followed by the lungs (30%) and other rare locations.[1] It is endemic in areas of the Mediterranean, South Africa, South America and Asia.[2]

Rupture of a cyst inside the peritoneal cavity is a rare and serious complication, about 2% in the primary form is reported.[3] Anaphylaxis or sudden death have been reported.[3–5] It can be silent, which is rare, and can be diagnosed years later.[6,7]

Objective

We report the case of a peritoneal hyatidosis which manifested as intestinal ischaemia.

Clinical case

A 50-year-old male, living in poor, basic urbanisation conditions with pet dogs, presented with a 2-year history of chronic abdominal pain. The patient was admitted to the emergency department with an episode of intense abdominal pain in the right hypochondrium, deterioration in general health and fever.

On examination the patient was stable, breathless, dehydrated, swollen, distended abdomen, reduced peristalsis, pain on medium and deep palpation of hypochondrium and right flank, with signs of peritoneal irritation, the remainder with no apparent changes. All the laboratory tests were normal except leukocytosis, at 12,000, with 85% neutrophilia. Ultrasound of the abdomen and pelvis showed multiple multicystic and cystic images in the abdominal cavity, some with central echogenic areas, and others that were hyperechogenic adhering to small bowel loops (Fig. 1A,B). Contrasted tomography of the abdomen and pelvis revealed multiple multicystic images in the liver, the largest was 10×8×3 cm, of rosette appearance, predominating in the right lobe; another heterogeneous image in the pancreas of the same appearance, two heterogeneous images in the pelvic cavity, facing the left side, of 5×4×4 cm and 5×4×3 cm, with an intermediate calcified image of 2×2×1 cm, inducing retraction of the mesentery at the level of the ileum, with ischaemia of the small bowel loops (Fig. 1C).

An exploratory laparotomy was performed, which corroborated intestinal ischaemia of approximately 2m of small bowel from 1.20 m from Treiz ligament to 20 cm from the ileocaecal valve and multiple cystic lesions in the liver, the largest 10×8×3 cm. In the peritoneal cavity there were 3 cystic lesions in the pelvic cavity, one calcified resulting in retraction of the mesentery.

An intestinal resection was performed with terminal jejunostomy and biopsies were taken of the cystic lesions. The histopathological result of the biopsies reported multiple collapsed yellowish-white, translucent and friable vesicles, the cyst wall was greyish in appearance, an acellular laminated membrane together with a germinal membrane and presence of a scolex (Fig. 2A–C), with a final diagnosis of disseminated peritoneal hydatid disease.

The post-operative period was event-free and the patient was discharged 2 weeks after surgery and followed-up as an outpatient, during which time he remained symptom-free. The patient was treated medically with albendazol 400 mg twice daily and praziquantel 600 mg once a day, for 6 months. His general condition improved and he adapted well to the stoma.