Case Reports

Hydatid cyst-colonic fistula: endogenic with ectogenic vesiculation

Introduction

The liver is the most common site for development of a hydatid cyst. Rupture into the bile ducts is the most common complication and its incidence varies from 2.6 to 37%.[1] However rupture of hydatid cyst into the colon is extremely rare and there have been only a few reports in the literature.[2-5] We report a case of a liver hydatid cyst communicating with the hepatic flexure of colon.

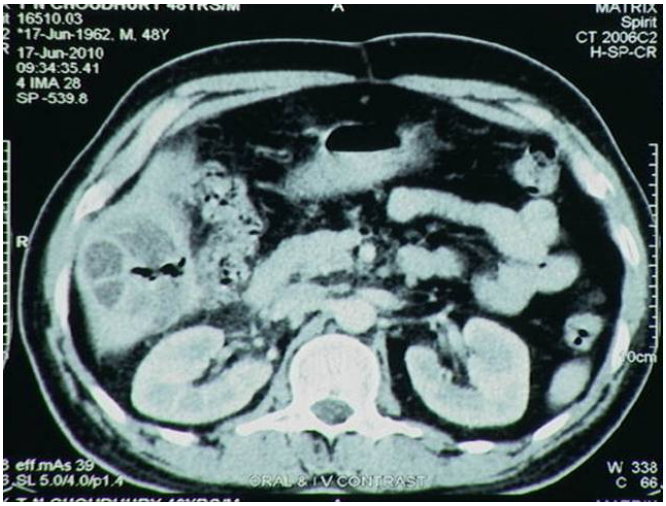

Figure 1: CT scan showing cystic lesion in right lobe of liver with multiple daughter cysts

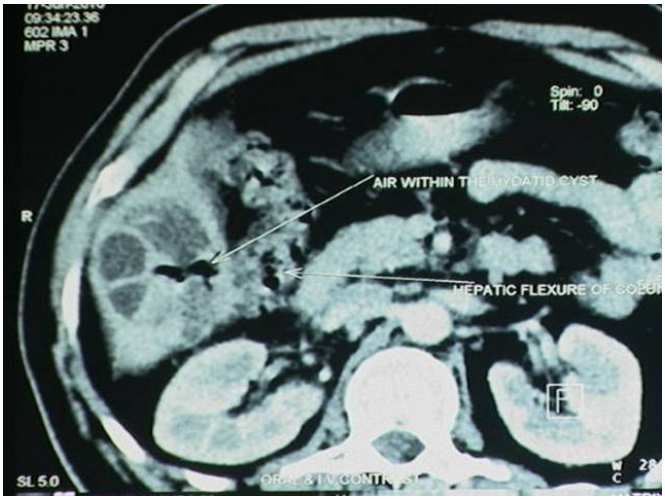

Figure 2: CT scan showing air within cystic lesion with adherence to hepatic flexure suggestive of a colonic communication

Case report

A 48-year-old male presented with complaints of fever with chills and abdominal pain of 15 days duration and passage of membranous structures in his stools for the last five days. There was no history of jaundice. He had hemoglobin of 12.8 gm/dl, total leukocyte count of 13000/cumm and platelet count of 3.8 lakhs/cumm. The liver and renal function tests were within normal limits. Contrast enhanced computed tomography (CECT) of his abdomen (**Figure 1**) revealed the presence of an exophytic cystic lesion, 8×4.5×5 cm in size, in the right lobe of liver with multiple daughter cysts. There was also an intra-cystic air fluid level suggestive of communication with the ascending colon (**Figure 2**).

The patient was started on oral albendazole which was followed by an exploratory laparotomy. Intraoperatively, a cystic lesion, 10×8×8 cm in size was seen in the right lobe of

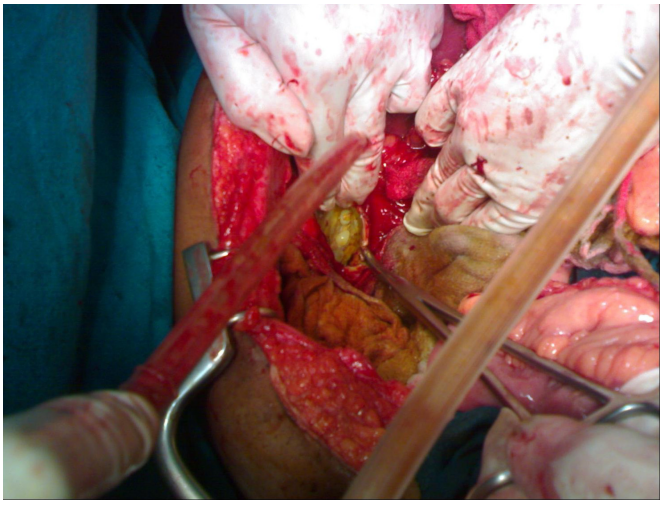

Figure 3: Cyst filled with multiple daughter cysts. Isolation of cavity with multiple povidone-iodine soaked swabs

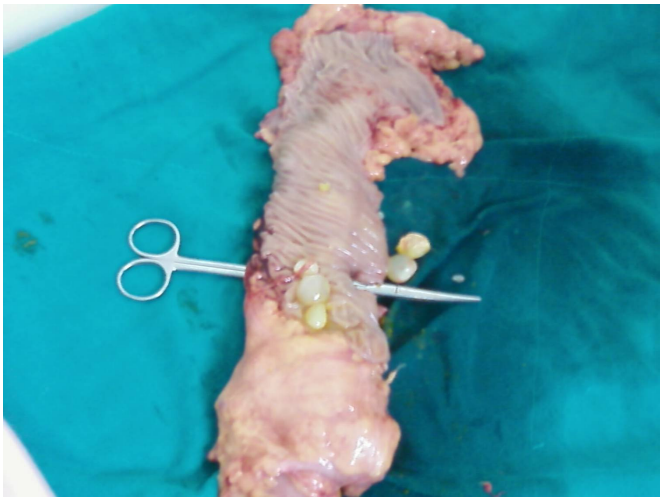

Figure 4: Resected colon specimen shows small fistula with multiple daughter cysts inside colon

liver, filled with daughter cysts (**Figure 3**). The cyst was communicating with the hepatic flexure with multiple daughter cysts in the colon (**Figure 4**). The cyst fluid was clear and non-bilious and there was no evidence of other sites of hydatidosis.

The cyst was isolated with sponges soaked in povidone-iodine solution and a partial excision of cyst with drainage and right hemicolectomy with ileo-transverse anastomosis was performed. In the immediate postoperative period, the patient developed high grade fever with chills which was managed with intravenous antibiotics and steroids. The rest of his hospital course was uneventful and the patient was discharged on oral albendazole on the fifth postoperative day.

Discussion

Hydatid cyst of the liver is a slow growing zoonotic parasitic disease with the liver being the most commonly affected organ. A mature hydatid cyst of the liver has two structural components. The inner layer is the endocyst which contains the laminated membrane and the germinal layer. The outer layer is called the ectocyst or pericyst, which is formed by the host tissue. The daughter cysts are formed by endogenic vesiculation from the germinal membrane. In case of a rupture or a defect in the laminated membrane, the germinal layer passes through and creates a satellite hydatid cyst by a process known as ectogenic vesiculation. The presence of daughter cysts in the colonic lumen and absence of peritoneal hydatidosis in our report, is an example of endogenic with ectogenic vesiculation.

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Post cholecystectomy pseudotumor: beware of this masquerader!

Introduction

The usually nontoxic and inert surgical sutures can at times incite a disproportionate inflammatory reaction leading to granuloma formation which is frequently misdiagnosed as a malignant lesion due to its confounding appearance on imaging.[1,2] This report emphasizes that even though the appearance of the lesion may be suggestive of malignancy, the possibility of a benign suture granuloma should be considered in the differential diagnosis, especially if the lesion appears at or near the site of prior surgery.

Case report

A 60-year-old male presented with worsening jaundice, anorexia and weight loss for last 8 weeks. There was no significant past history except for prior cholecystectomy 5 years back. The patient had an uneventful recovery following the surgery except for a small periportal biloma which was successfully drained by percutaneous ultrasound guided aspiration. He remained asymptomatic until 8-weeks back when he started noticing darkening of urine and progressive discoloration of his eyes. At the time of presentation, his serum bilirubin was 10.9 mg/dl, and AST and ALT 35 and 40 IU/L, respectively. Contrast-enhanced CT abdomen revealed bilobar biliary dilatation with a dilated proximal common duct (**Figure 1A**). There was abrupt narrowing seen at the proximal mid-third of the common duct junction, due to an enhancing soft-tissue mass lesion. This soft-tissue lesion was seen in close proximity of the cystic duct stump (**Figure 1B**). MRCP confirmed the findings depicted at CT (**Figure 2**). In light of these imaging findings, a diagnostic