

References

1. Socié G, Henry-Amar M, Bacigalupo A, Hows J, Tichelli A, Ljungman P, et al. Malignant tumors occurring after treatment of aplastic anemia. *N Engl J Med*. 1993;**329**:1152–7.
2. Socié G, Henry-Amar M, Cosset JM, Devergie A, Girinsky T, Gluckman E. Increased incidence of solid malignant tumors after bone marrow transplantation for severe aplastic anemia. *Blood*. 1991;**78**:277–9.
3. Kishida T, Yonezawa M, Shibata Y, Tanaka S, Shinozawa I, Hoshino T, et al. Risk of colorectal cancer in patients with hematologic disease. *J Gastroenterol Hepatol*. 2000;**15**:1272–6.
4. Brodsky RA, Jones RJ. Aplastic anaemia. *Lancet*. 2005;**365**:1647–56.

Intrabiliary rupture of hepatic hydatid cyst with impacted hydatid membranes at ampulla of Vater presenting as acute pancreatitis

Introduction

Hydatid disease is endemic in Southern Australia, New Zealand, Africa, South America, Southern Europe, Middle East and the Far East.¹ Intrabiliary rupture is reportedly seen in 6–17% cases.^{2–4} But rupture causing pancreatitis has been very rarely reported.

We report a case of acute pancreatitis due to impacted hydatid membranes at the ampulla secondary to rupture of hepatic hydatid cyst into the biliary tract, which was managed successfully with endoscopic sphincterotomy, basketing of membranes and biliary stenting.

Case Report

A 35-year old man was referred to our emergency room with pain abdomen of 1-week duration. The pain was located in the epigastric region, boring to the back, and was associated with nausea and vomiting, jaundice associated with itching, and fever with chills. He also suffered mild pain in the right upper quadrant for the 1 month prior to presentation for which he was self medicating.

His history was positive for significant alcohol consumption over 6 years. On examination he was icteric and per abdomen examination showed severe tenderness and guarding in the epigastric region with tender hepatomegaly. Laboratory data

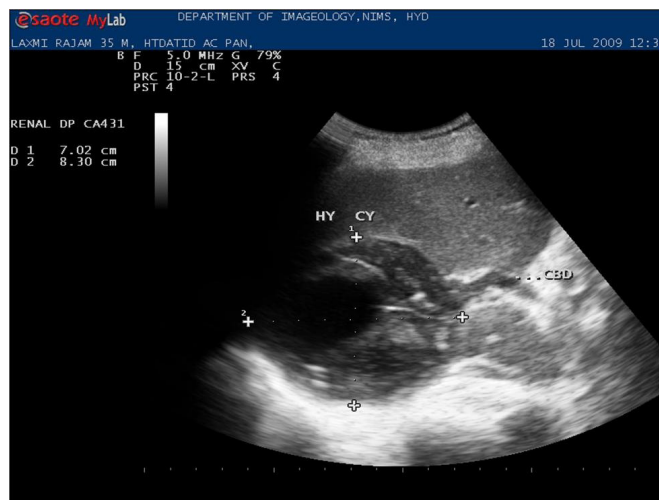


Figure 1: USG showing Hydatid cyst communicating with CBD with echogenic contents in CBD.



Figure 2: CT abdomen showing hydatid cyst in the liver with daughter cysts.

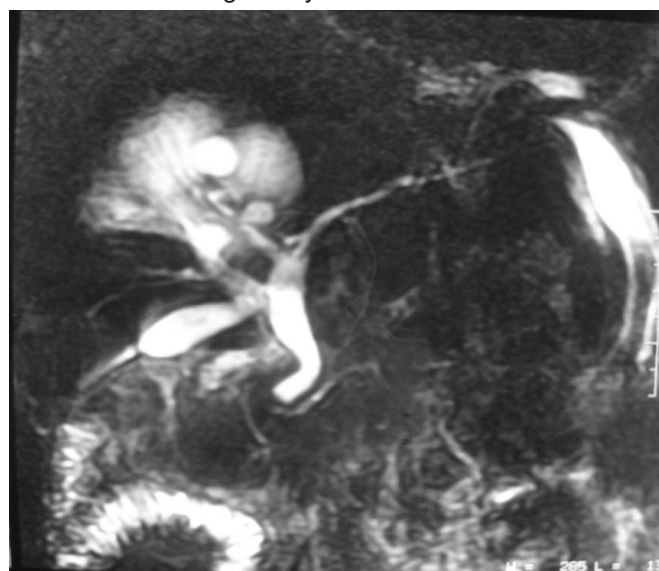


Figure 3: MRCP showing dilated CBD with echogenic contents & hydatid cyst in liver communicating with biliary tree.

revealed ALT - 43 IU/L, AST - 45 IU/L, alkaline phosphatase - 493, total bilirubin 6.5 mg/dL, amylase-547 IU/L, lipase-776 IU/L. Complete hemogram revealed hemoglobin 15.7 g/dL and TLC 16,400/cumm.

US showed complex cystic lesions in the right liver lobe with daughter cysts, the mass communicating with the CBD; echogenic contents within suggested hydatid cyst. Other findings were an enlarged pancreas, cholelithiasis, splenomegaly and ascites (**Figure 1**) Plain CT abdomen confirmed the US findings (**Figure 2**). MRCP demonstrated the communication of cyst to biliary tree with dilated CBD till ampulla (**Figure 3**).

ERCP and biliary sphincterotomy was performed and all hydatid membranes, muck and debris removed from the CBD. A biliary stent was deployed. Post-procedure hospital course was uneventful and the patient showed dramatic improvement both in clinical and laboratory parameters. The pancreatitis rapidly resolved. He was discharged on albendazole therapy.

Discussion

Hydatid acute pancreatitis, as a result of hydatid material that enters the bile duct, is a rare complication of hydatid liver disease. Only a limited number of cases have been reported in the literature.⁵

The mechanism of acute pancreatitis caused by hydatid disease of liver open to biliary tree resembles that of gall stone pancreatitis. Hydrostatic pressure inside the hydatid cyst greatly exceeds that in the bile and thus rupture of the cyst into the bile ducts. Overt communication can lead to expulsion of hydatid cyst material (membranes, scolices, daughter cyst) into the biliary tree causing cholestatic jaundice and recurrent cholangitis. The passage of this material through the papilla of Vater can cause occlusion of the pancreatic duct and / or bile reflux into pancreatic duct leading to acute pancreatitis. A local allergic reaction to ecchinococcal antigen inside the ampulla may also play a part in the initiation of pancreatitis.^{6,7}

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References

1. Sherlock S, Dooley J. Diseases of the Liver and Biliary system. 11th Ed. Oxford: Blackwell Scientific Publications; 2002:511–6.
2. Dadoukis J, Gamvros O, Aletras H. Intrabiliary rupture of the hydatid cyst of the liver. *World J Surg.* 1984;**8**:786–90.
3. Xu MQ. Diagnosis and management of hepatic hydatidosis complicated with biliary fistula. *Chin Med J.* 1992;**105**:69–72.
4. Alper A, Ariogul O, Emre A, Uras A, Okten A. Choledochoduodenostomy for intrabiliary rupture of hydatid cysts of liver. *Br J Surg.* 1987;**74**:243–5.
5. Zeytinlu M, Coker A, Yüzer Y, Ersöz G, Aydın A, Teke'in O, et al. Hydatid acute pancreatitis. *Turk J Gastroenterol.* 2004;**15**:229–32.
6. Bellara IL, Amara H, Hablani N, Harzallah L, abbassi DB, Kraiem C. Pancratite aigue d' origine hydatique: a propos d' un cas. *Ann Chir.* 2004;**129**:372–5.
7. Veyrac M, Machayekhi JP, Kirschke B, Costalat G, Barneon G, Ciurana AJ. Pancratite aigue d' revelatrice d' une rupture de kyste hydatique du foi dans les vois biliaires. Valeur de la choecystite a eosinophiles associate. *Gastroenterol Clin. Biol.* 1985;**9**:271–2.

Development of huge pancreatic pseudocyst following organophosphorus poisoning – a case report and review of Literature

Introduction

There are a number of case reports of acute pancreatitis associated with organophosphorus poisoning (1-5). A cause and effect relationship has been demonstrated in animal studies (6). However this association is perhaps still not widely recognized. Neither do commonly used surgical and medical textbooks describe acute pancreatitis as a presenting feature of organophosphorus poisoning nor is organophosphorus poisoning listed as one of the aetiological factors of acute pancreatitis and its complications. In adults the frequency of acute pancreatitis related to organophosphorus poisoning is 12.7% (7). Organophosphorus poisoning is not uncommon in our society; given the widespread availability and use of organophosphorus insecticides. Poisoning may be occupational, accidental or suicidal.