

Pelvic hydatid: the great masquerader

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Accepted 30 September 2018

DESCRIPTION

A 52-year-old man presented with urinary frequency and occasional lower abdominal pain for 4 months. His uroflow study and postvoid residual urine were normal and his digital rectal examination had grade 2 prostatic enlargement. His urinary symptoms were attributed to benign prostatic hyperplasia, and he was prescribed tamsulosin (0.4 mg) and solifenacin (5 mg) for his symptoms. One week later he only had partial relief of symptoms, thus an ultrasound was done that showed a cystic lesion abutting the urinary bladder in the region of right iliac fossa (figure 1). A contrast-enhanced CT (CECT) scan was then done, which showed a cystic lesion (3.8×4 cm) with enhancing internal septa and peripheral wall enhancement abutting the urinary bladder (figure 2). There was no other cyst in the abdomen so a provisional diagnosis of primary pelvic peritoneal hydatid cyst was made. We then carried out a cystoscopy to ascertain there was no communication of the cyst with the urinary bladder. Cystoscopically the external compression by the hydatid cyst on the urinary bladder could be demonstrated (figure 3). The patient was advised surgical removal of the primary pelvic hydatid cyst. Preoperatively he was given albendazole 400 mg twice daily for 7 days and then the cyst was removed (figure 4). Postoperatively albendazole was continued for 3 weeks and after a gap of 2 weeks another 28-day course of albendazole was given. The patient is doing fine 4 months post surgery, and his urinary symptoms have resolved.

The tapeworm *Echinococcus granulosus* most commonly causes hydatid disease in humans. Liver followed by the lungs is the most commonly affected organs. Pelvic hydatid cysts are rare and can be either primary or secondary. Secondary pelvic hydatid cysts are more common and occur following rupture of primary hepatic, splenic or

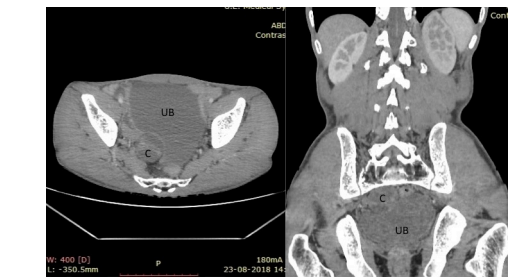


Figure 2 Contrast-enhanced CT showing the cyst (C) compressing the urinary bladder (UB) in transverse and coronal sections.



Figure 3 Cystoscopic view of the external compression by the cyst on the urinary bladder.

mesenteric hydatid cysts. When there is no other associated cyst in the abdomen, the pelvic hydatid cyst is said to be primary.¹ In a pelvic hydatid cyst, the presenting symptoms are usually due to its mass effects. It may be confused with obstructive uropathy (due to compression of urinary tract), ovarian cysts or even appendicitis and pelvic sepsis (when they rupture). An ultrasound followed by a CECT scan is usually required for diagnosing this condition. MRI in most instances is not required as it does not offer much advantage over CECT.² The best treatment for this condition is surgical excision followed by chemotherapy with albendazole or

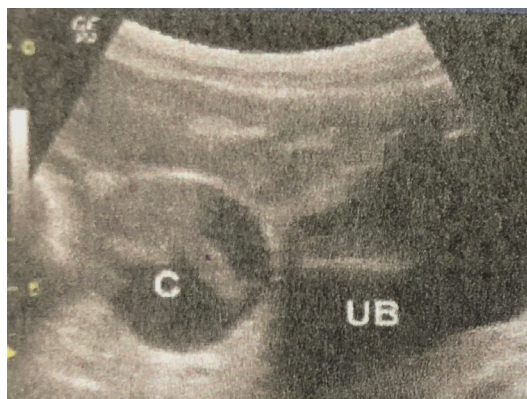


Figure 1 Ultrasound showing the cyst (C) abutting the urinary bladder (UB).



Figure 4 The removed cyst was opened with multiple daughter cysts within it.



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To cite: Pandey S, Singh V, Sinha RJ, et al. *BMJ Case Rep* Published Online First: [please include Day Month Year]. doi:10.1136/bcr-2018-227409

Learning points

- ▶ Pelvic peritoneal hydatid cysts are rare and may be primary or secondary, but they have non-specific presentation usually due to its mass effect on adjacent organs and on initial workup the patients symptoms may not be attributed to them.
- ▶ The best treatment is preoperative chemotherapy with albendazole or mebendazole followed by surgical excision and postoperative chemotherapy.

mebendazole. Usually albendazole is given at a maximum dose of 800 mg/day for 28 days. This course is repeated after a drug-free period of 14 days. Preoperative chemotherapy for 7 days is usually recommended.³

Contributors SP conceived the case report. SP and VS were major contributors towards the writing of the manuscript. VS, RJS and SP treated the patient and also interpreted the patient data. SP and AS were involved in the review. All authors read and approved the final manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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