



Residual cavity hydrops initially misdiagnosed as recurrent hepatic echinococcosis

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A 37-year-old woman presented to our liver surgery clinic with a 12-month history of intermittent pain in the right upper quadrant of the abdomen. More than 5 years earlier, the patient had undergone routine excision of the internal capsule because of a hepatic hydatid cyst and had taken albendazole regularly after surgery (300 mg every 12 h for 6 months). A large heteroechoic hepatic mass was identified by abdominal ultrasound. Laboratory tests showed a normal white blood cell count, a normal absolute eosinophil count, and negative anti-echinococcus IgG antibody status. A CT scan showed a 5-cm low-density mass with calcification in the anterior superior segment of the right lobe of the liver, which suggested recurrence

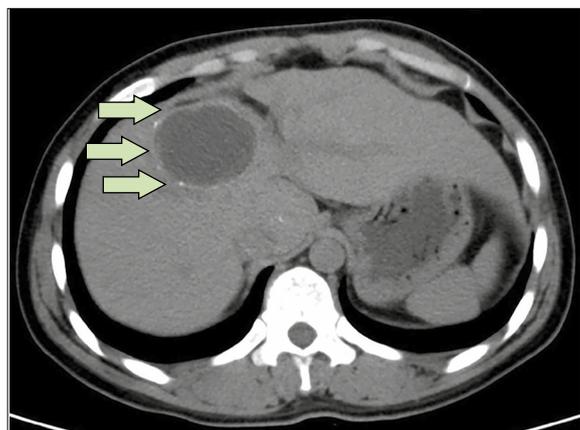


Figure: Abdominal CT scan showing a cyst with calcification in the right lobe of the liver
Arrows point to partial edge calcification.

of liver hydatid cyst (figure). The patient had a laparotomy, during which the entire cyst was removed intact. The cyst wall was white and contained a small amount of bile and pigmented stones. Pathological testing showed intrahepatic cystic degeneration of liver tissue, and a large amount of bile pigment deposition inside the cyst wall. *Echinococcus granulosus* was not detected. At follow-up 6 months after surgery, the patient had no residual symptoms.

We found that the patient had residual cavity hydrops resulting from bile leakage, which was caused by the cyst cavity not being closed completely after hepatic hydatid cyst extraction. This leakage can mimic a recurrence of cystic echinococcosis because the abdominal ultrasound shows a dark fluid area with partly calcified edges and abdominal CT shows a cyst with calcification. A misdiagnosis can be avoided by testing for anti-echinococcus IgG antibody, or with follow-up observation to monitor the size of the cyst. A patient with residual cavity hydrops, rather than a recurrence of cystic echinococcosis, will probably have a negative result for anti-echinococcus IgG antibody, and no change in the size of the cyst. Regular follow-up might be a suitable option, rather than operating immediately.

Contributors

All authors contributed equally to the clinical management of the patient and to the writing of this report. All authors have approved the final version of the report.

Declaration of interests

We declare no competing interests.

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