Abstract: A 60 years old woman presented with abdominal distension without bowel disturbances. Imaging studies showed isolated intra and retro peritoneal hydatidosis without liver involvement, is a rare finding. Hydatid disease is one of the commonest parasitic infection of the liver and rupture into the peritoneal cavity leading to secondary echinococcosis is a difficult problem to manage. Early diagnosis and optimal choice of surgical management reduces the morbidity and mortality associated with the disease.

Figure 1: Whole abdomen was dis-

Figure 2: Omentum was filled with hydatid cysts
Figure 3 Hydatid cysts were removed from the infracolic compartment of the omentum.

Figure 4 Hydatid cysts in subhepatic region were removed.

CASE REPORT
A 60 years postmenopausal woman was admitted with complaints of progressive distension of the abdomen for 2 years with history of breathlessness, loss of appetite and weight. Detailed inquest revealed a previous laparotomy 6 years back. There was a history of exposure to dog present.

Clinical examination revealed cachectic look with protuberant abdomen. Whole abdomen was distended and multiple cystic swellings of varying sizes palpable in all quadrants of the abdomen. There was no evidence of free fluid in the peritoneal cavity except for hydatid thrill. Her laboratory examination revealed raised erythrocyte sedimentation rate (110mm at the end of one hour) and mild increase in the eosinophil count (3%). Biochemistry screen revealed normal investigations including a normal liver function profile. Chest radiograph revealed elevation of both domes of diaphragm. Ultrasonography and CT scan showed multiple septated thick walled cysts of varying sizes involving the peritoneal cavity.

Preoperatively albendazole of about 15mg/kg/day was given for 2 weeks. Since patient had respiratory difficulty and abdominal pain elective laparotomy and debulking of hydatid cysts was planned. Intraoperatively on exploration hydatid cysts disseminated throughout the peritoneal cavity. Numerous cysts found between layers of greater omentum, lesser sac, retroperitoneum, subhepatic region, mesentery, mesocolon and pelvis. Debulking of intra abdominal cysts after sterilisation with povidone iodine done. After the excision of germinal membrane the cavity was marsupialized. Numerous hydatid cysts were removed from the peritoneal cavity. Since extensive involvement of retroperitoneum and vital structures some of the cysts left inside.

Post operative recovery of the patient was uneventful and was discharged on 12th post operative day. Patient was administered albendazole postoperatively for eight weeks and never returned for follow up later.

DISCUSSION
Hydatid disease is endemic in the cattle grazing areas particularly Australia, Newzealand, Middle East, India, Africa, South America and Turkey. Hydatid disease is a parasitic infection caused by the cestode tape worm Echinococcus granulosus. The dog are the definitive host and the adult worms are found in their small intestine. Humans get infected either by contact with the definitive host or by consuming vegetables and water contaminated with the hydatid ova. Apart from common sites such as liver and lungs in humans, hydatid cyst can present in unusual sites, which include spleen, peritoneum, kidney, muscles, adrenal gland, ovary, pancreas, thyroid gland, pleura, diaphragm and brain. Peritoneal hydatid disease represents an uncommon occurrence and most of the cases are the result of traumatic or surgical rupture of a hepatic, splenic or mesenteric cysts. Hydatid disease can be easily
diagnosed preoperatively with radiological studies, including ultrasonography (USG/CT). Peritoneal hydatid disease represent an uncommon occurrence and its diagnosis is more accurate today due to the imaging techniques. The CT scan shows well defined solitary are multiple cysts that may be thin walled or thick walled. A hydatid cyst typically demonstrates a high attenuation value in unenhanced CT even without calcification. Multi vesicular cyst can depict a typical honeycomb pattern. A Wheel spoke pattern can be observed when the daughter cyst are seperated by hydatid matrix.

The principal treatment of hydatid cyst is surgical. However, pre and post operative albendazole and praziquantel should be considered inorder to sterlise the cyst, to decrease the chance of anaphylaxis, to reduce tension in the cyst wall and to reduce the risk of recurrence post operatively. In our case despite sufficient medical treatment the cyst size and number did not reduce and hence surgery remained the final resort.

REFERENCES


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