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Case Report

An unusual case of hydatid cyst of the ovary and pouch of Douglas

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Introduction

Hydatid cyst in human is usually caused by the larval stage of Echinococcus granulosus. The parasite has usually "dog sheep" cycle but man becomes an accidental intermediate host. The most commonly involved organs are liver (60% - 75%) and lungs (15%-25%). Primary involvement of pelvic organs is very rare [1].

Case report

A 38 year old third para, presented with gradually enlarging hump in the lower abdomen for the last 2 years associated with a mild pain for the last 1 year. Abdominal examination revealed a cystic nontender mass of 26 week size in the lower abdomen. It had a smooth surface, with slightly restricted mobility. There was no hepatosplenomegaly or ascites. On speculum examination cervix appeared healthy. On vaginal examination, uterus was found to be of normal size, retroverted and deviated to the left side. An ill defined cystic mass encroaching into the posterior fornix was felt separately from the uterus. She was admitted on 19.7.06.

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Sonography of the abdomen showed normal uterus. A large multisepate mass was seen in the pelvis, possibly of right ovarian origin. Ovaries could not be delineated separately. Both kidneys, liver and spleen appeared normal. There was no ascites.

Decision for laparotomy was taken. She was given 2 units blood preoperatively. On 25th July, 2006. She underwent laparotomy under general anesthesia through a para median incision. A right sided ovarian cyst measuring 30X20 cm was seen. Right fallopian tube and ureter were adherent with the cyst. Uterus, left sided tube and ovary appeared normal. We also found another separate tense cystic mass in the pouch of Douglas. It was burrowing into the retroperitoneum pushing the cecum upward. On aspiration clear watery fluid came out. A total abdominal hysterectomy with bilateral salpingo oophorectomy was done. We punctured the cyst. Multiple daughter hydatid cysts came out (Figure 1). Ectocyst was removed completely. Intravenous hydrocortisone succinate, 200 mg was given to avoid anaphylaxis. Liver and spleen appeared normal. Peritoneal cavity was irrigated thoroughly with saline solution and a tube drain was inserted. Specimen was sent for histopathology. Albendazole 400 mg twice a day was given for 4 weeks. Histopathology report showed hydatid cyst. She was discharged on 26th July, 2006.

USG of the whole abdomen on each follow up visits at

regular intervals was found to be normal.

Discussion

Primary peritoneal echinococcosis is very rare and has been reported to occur in 2% of all abdominal hydatid diseases [2]. Hydatid cyst of the ovary is also a rare lesion

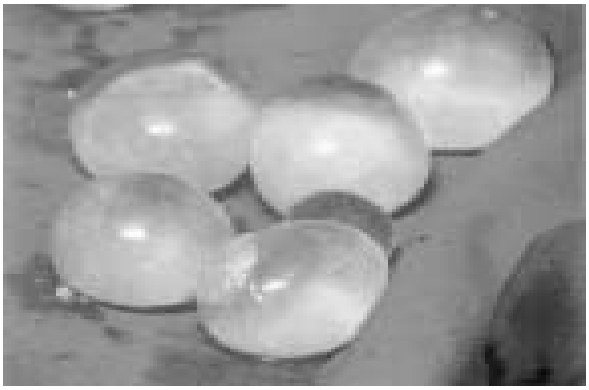

Figure 1. Multiple daughter hydatid cysts.

usually occurring as secondary to the rupture of a hepatic cyst. Bicher et al [3] reviewed 532 cases of hydatid diseases from an endemic area over 20 years period and found only 12 cases in the pelvis

Dissemination via lymphatic or systemic circulation has been implicated as a possible route to produce primary hydatid diseases outside the liver and lung.

Clinical manifestations vary with the site and size of cyst and result from complications due to the enlarging mass of the abdominal cyst.

The preoperative diagnosis may be possible by clinical finding, imaging studies and laboratory tests, including echinococcal titers [4]. Pelvic echinococcosis in women remains difficult to diagnose with sonography because of the wide variety of ultra sonographic appearances that echinococcal cyst may have [4]. CT is superior for detection of extrahepatic disease [2]. Indirect hemoagglutination test and ELISA have approximately 85% sensitivity [2]. The most important factor in its diagnosis is the awareness of hydatidosis.

Surgery is the definitive treatment and offers best hope for cure or palliation for peritoneal diseases. Although an asymptomatic small cyst may be treated with antihelminthics, complete excision is the treatment of choice. Drainage with unroofing is safer it the cyst is adherent to the viscera.

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