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Hydatid cysts rarely rupture into the bowel lumen. We describe five patients presenting with passage of hydatid membranes in stool. Early surgical intervention may prevent erosion of such cysts into the hollow viscus. [Indian J Gastroenterol 2007;26:238-239]

Hydatid cyst can occur anywhere in the body. Renal hydatid cysts can be excreted out with urine (hydatiduria) and pulmonary cysts can be coughed out. Therefore, a hydatid cyst in the colon may theoretically rupture into the bowel lumen and pass out with the stool.

Case Reports

From January 2002 to November 2006 we encountered five patients (mean age 33 y; 4 females) with hydatidiarrhea (per-rectal passage of hydatid cyst membranes) (Table).

Four patients presented with an abdominal lump which disappeared following episodes of abdominal colic and ‘Hydatidiarrhea’. Two patients (no. 3 and 5) had significant hematochezia, requiring infusion of two to four units of packed red blood cells, following the passage of hydatid material.

Patient 4, a 26-year-old woman, presented with pain and fullness in the right hypochondrium. On examination, she was icteric, and had tender hepatomegaly. Her chest radiograph showed an elevated right hemidiaphragm. Ultrasonography (USG) of the abdomen showed multiple cystic lesions in both the lobes of liver some of which showed presence of laminated membranes within. One of the cysts in the right hepatic lobe appeared to have a communication with the right hepatic duct (RHD). The common bile duct (CBD) was dilated with presence of similar echogenic laminated material within the lumen. Numerous such cysts were seen implanted on to the peritoneum one of which was large and was seen in close proximity to the cecum (Fig 1). A diagnosis of hepatic echinococcosis with intra biliary rupture and passage of membranes causing obstructive jaundice with encysted peritoneal hydatidosis was made. An endoscopic clearance of CBD was attempted with partial success, hence a laparotomy was planned. An evening prior to the surgery the patient had an attack of acute abdomen with generalized abdominal distension and sudden severe pain localized to the right iliac fossa, following which she passed of a ‘bucket-full’ of whitish membranes recognized as hydatid membranes in the stools. There was relief of pain following the above episode. On laparotomy, a cecal rent was identified with notable disappearance of the large juxtacecal cyst visualized on earlier imaging, suggesting intracecal rupture and subsequent “hydatidiarrhea”. Cherry picking of rest of the peritoneal cysts was done followed by removal of hepatic cysts and biliary clearance. All patients underwent emergency surgery, and site of perforation was repaired; none of the patients developed any complication.

All patients received oral albendazole (15 mg/kg/day) which was continued for eight weeks postoperatively.

Over a mean follow-up of 27 months (range 9 to 36), all patients were asymptomatic with no imaging evidence of residual hydatid disease on abdominal USG.

Discussion

Hydatid disease is due to infestation with the larva of the cestode Echinococcus. The disease is a zoonosis in which humans are incidental hosts of the larva of the parasite. The dog or other carnivore is the definitive host. The sheep or other ruminant is the intermediate host. Established non-complicated univesicular hydatid cysts can easily be diagnosed on conventional ultrasonography utilizing the pathognomonic double wall-sign. Hydatidiarrhea

### Table: Clinical profile of five patients presenting with hydatidiarrhea

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>44</td>
<td>51</td>
<td>16</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Site of hydatid cyst</td>
<td>IC (intramesenteric)</td>
<td>IC (intramesenteric)</td>
<td>Juxta-TC (intramesocolon)</td>
<td>IC + hepaticobiliary (intramesenteric)</td>
<td>Adjacent to AC (retroperitoneal)</td>
</tr>
<tr>
<td>Additional presenting features*</td>
<td>-</td>
<td>-</td>
<td>Hematochezia</td>
<td>Fullness in RHC</td>
<td>Hematochezia</td>
</tr>
<tr>
<td>Site of rupture</td>
<td>Medial cecal wall</td>
<td>Medial cecal wall</td>
<td>Mesentric border of TC</td>
<td>Medial cecal wall</td>
<td>Medial wall of AC</td>
</tr>
</tbody>
</table>

*All patients presented with acute abdomen and lump; IC: ileocecal region; TC: transverse colon; AC: ascending colon

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is a rare complication of abdominal hydatidosis. To our knowledge this is the first series of cases describing passage of hydatid membranes in stools, one previous report described passage of calcified hydatid skeletons only. Apart from rarity of this particular complication of abdominal hydatidosis, the important point emphasized is the consideration of early surgical intervention to prevent a possible erosion of such cysts into hollow viscus.

References

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Fig: (a) Axial CECT section showing large cysts (arrow) in juxtaposition to the cecum (lying posterolateral to the cysts); (b) Coronal reformed CECT showing large cysts (Arrow) in juxtaposition to the cecum