INTRODUCTION

Hydatid disease, although endemic, mostly in sheep-farming countries, remains a public health issue worldwide. The hydatid cyst most commonly affects the liver and may remain asymptomatic for a long period. Biliary complications of hepatic hydatidosis are often difficult to detect and manage. ERCP is helpful in confirming the involvement of biliary tract and may have a therapeutic value in some cases. Occasionally, whitish, glistening membranes of cyst are seen impacted in the papilla of Vater. Dilated ducts with debris and daughter cysts may appear as radiolucent filling defects on contrast X-ray. Irregular leaf-like material that alters shape with changes in pressure, differentiates this condition from other causes of obstructive jaundice. Endoscopic sphincterotomy is a safe and effective treatment for biliary complications of hepatic hydatid disease. We report a case of intrabiliary hydatid cyst rupture managed by ERCP.

CASE REPORT

A 55-year-old man was referred for an ERCP examination to diagnose a possible post-cholecystectomy complication. He had recently undergone cholecystectomy for cholelithiasis. He was known to have an asymptomatic hydatid cyst in right lobe of the liver. He was having fever and right upper quadrant discomfort following surgery with mild jaundice. His serum bilirubin was 2.8 mg/dl and white cell count was elevated. On duodenoscopy, the papilla was bulging and a white elongated material was projecting from it. ERCP showed a few rounded filling defects in the common bile duct. Sphincterotomy was performed. It resulted in gush of large quantity of sandy fluid followed by rounded cysts and elongated yellow material. A balloon catheter was passed up the bile duct, which swept down a few more cyst-like objects. Repeat cholangiogram showed no residual filling defects. No communication was identified with the cyst. Patient had complete resolution of symptoms. During follow-up, patient again developed an episode of biliary colic, which resolved without intervention. He has been advised right hepatectomy for residual lesion.

DISCUSSION

Intrabiliary rupture of hepatic hydatid cyst causes serious morbidity and mortality. The incidence varies from 5-25%. Early diagnosis and appropriate management is vital for patient's recovery. The reported morbidity and mortality rates of all patients in the literature are 19-43% and 1.8-4.5% respectively.

In frank intrabiliary rupture, the parts of the cyst drain into the biliary ducts and cause intermittent or complete biliary obstruction with resultant obstructive jaundice or cholangitis. Diagnosing intrabiliary rupture pre-operatively reduces morbidity. Intrahepatic biliary dilatation is a constant feature. Echogenic or non-echogenic material without acoustic shadowing seen in the biliary tree is suggestive of sludge and daughter cysts.

In difficult cases, MRI is a useful tool, as both ultrasound and CT may be inconclusive in diagnosing the intrabiliary rupture. ERCP and MRCP are considered confirmatory for intrabiliary rupture. On ERCP, a swollen ampulla of vater may be seen, with hydatid material protruding out. ERCP also detects hydatid vesicles within the bile duct and clearance of the duct can be accomplished without complications. In this case, ERCP helped in making diagnosis as well as treating the patient as he recovered following the procedure.
REFERENCES


