Hepatic Cystic Echinococcosis

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A woman presented to her family physician in summer 2012 with worsening right upper quadrant pain and nausea, unrelated to food intake, of 3 months duration. Additional history included a weight loss of 8 lb over the past month and no recent travel. The patient reported that she had immigrated to the United States from Uzbekistan in 1995 and that she was exposed to feral dogs in her homeland.

Physical examination revealed no jaundice or palpable Murphy sign. Computed tomography of the abdomen (not pictured) revealed 2 complex lesions measuring 53 mm × 59 mm × 61 mm and 34 mm × 39 mm × 43 mm, with invasion to the right hepatic duct and vein. The cystic lesions were morphologically associated with thin internal septae and peripheral calcifications, consistent with hepatic cysts caused by *Echinococcus granulosus*.[1] Enzyme-linked immunosorbent assay findings were positive for serologic echinococcus IgG; however, a follow-up immunoblot test performed at the Centers for Disease Control and Prevention did not confirm these findings.[2] Fine-needle aspiration biopsy revealed protoscolices (independent pathologic confirmation). The patient was prescribed albendazole prophylactic therapy (400 mg twice daily) to minimize the risk of secondary echinococcosis. Six months later, the patient was referred for surgical resection, which she tolerated well without complications.[3] The excised and transected inked cyst containing viable protoscolices is shown in the image. (doi:10.7556/jaoa.2014.069)

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