

Hydatid Disease

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Editorial

In India Hydatid disease still continues to be a significant problem in most General surgery wards. Most of the patients attending to our hospitals are from rural population where still river water continues to be the main source of drinking water and most of the drainage from toilets is directed into these rivers which contribute to the high incidence of this disease in rural population. Hydatid disease is a parasitic disease caused by echinococcus. In humans four species of genus Echinococcus are known to cause the disease. Echinococcus granulosus is the commonest encountered parasitic infection known to cause cystic hydatid disease. Other species are Echinococcus multilocularis, known to cause alveolar hydatid disease while as other variants Echinococcus vogeli and Echinococcus Oligarthus are known to cause polycystic hydatid disease [1].

Liver is the commonest organ to get involved after infection with Echinococcus granulosus. Rarely in some patients abdominal involvement with abdominal hydatidosis may be primary or secondary. Hydatid spleen (1.5 to 3.5%) is the second common site of involvement after liver [2-4]. The literature shows that hydatid cysts have been reported from pancreas [5,6] gallbladder [7] adrenal [8] and even colon [9] apart from the common sites like liver, lungs and spleen. Even secondary hydatidosis [10,11] has been reported from peritoneal cavity at all possible sites and invariably the primary source is liver but rarely even primary hydatidosis [12] has been reported in peritoneal cavity. There are case reports of primary hydatid cysts in the retroperitoneum [13] and even in spleen [14] or paraspinal area [15]. Hydatid cysts have even been reported from very unusual sites like bone, muscle, kidney, omentum, brain, heart and great vessels [16]. But one has to remember not to overdiagnose a hydatid in a endemic area because at times you come across surprising lesions mimicking hydatid cyst but may prove to be a bronchogenic [17] or a non parasitic cyst [18]. The unusual presentations like pyrexia [19] or rupture [20] leading to peritonitis may at times be a cause of greater morbidity in these patients of benign disease.

In endemic zones a high degree of suspicion is very important to suspect these lesions and substantiate your diagnosis by imaging and serology. In case the diagnosis is

established, then it is better to treat these patients preoperatively as well as postoperatively with Albendazole 10 mg/kg/day or praziquantal 20-25 mg /kg/day. Albendazole can be given as monotherapy or in combination but studies show that better results are obtained with combination therapy [21].

Conclusion

Ensuring safe drinking water supply, improving on sanitary measures, quality control of dietary substances, early suspicion, correct imaging and serology, preoperative and postoperative chemotherapy is going to control and eradicate the disease in endemic areas.

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