



## **THE PRIMITIVE HYDATIC CYST OF THE PANCREAS: A rare location**

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### **Summary :**

The pancreatic site of hydatidosis remains exceptional even in countries with high hydatid endemicity, which explains its lack of knowledge. We can consider that for hydatid cyst of the pancreas the difficulty is not therapeutic, this having been codified in the report by Mallet Guy and Mercadier, but lies in the diagnosis. The advent of ultrasonography and tomodynamometry has greatly facilitated the diagnosis, which was often an operative discovery.

### **Introduction:**

The hydatid cyst of the pancreas is rare or even exceptional even in countries with high hydatid endemicity, only 163 cases has been grouped in the world, which explains its ignorance. We can consider it that for the hydatid cyst of the pancreas the difficulty is not therapeutic, since it has been codified but lies in the diagnosis.

### **Material and method:**

B.Y.(351/10) 24 years old, student without any particular history, is hospitalised for a painful epigastric mass accompanied by a subicteria, unquantified weight loss, without vomiting or transit disorders.

At the examination, we are in the presence of a patient with an infected complexion, subfebrile at 37°8, subicteric.

Palpation of the abdomen reveals an epigastric mass of a firm, sensitive consistency, fixed in relation to the deep level.

X-rays of the lung and abdomen are normal.

Ultrasonography reveals a heterogeneous, multicompartimentalized mass in the pancreas, 6 cm of big axis with a predominantly liquid component, to a body-cephalic location.

On abdominal CT scan, the pancreatic mass is more extensive on the surface than the ultrasound suggested. It occupies almost the entire pancreatic gland [fig. 1]. This multipartitioned, non-contrast-absorbing, net-bound mass has a thickened wall which rises after injection [Fig. 2]. There are two diagnoses: a multivesicular hydatid cyst of the pancreas and a cystadenoma or cystadenocarcinoma of the pancreas. The biological assessment shows a slight cholestasis and a sedimentation rate of 56 mm (1st hour).

fig.1: CT scan aspect

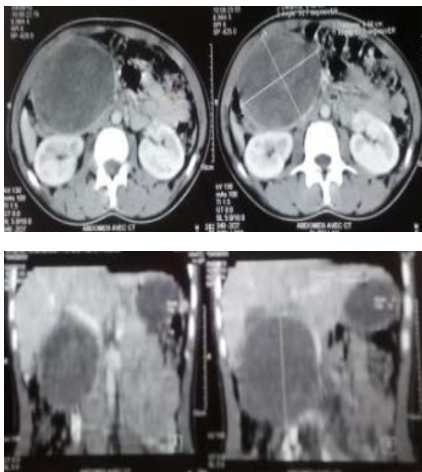
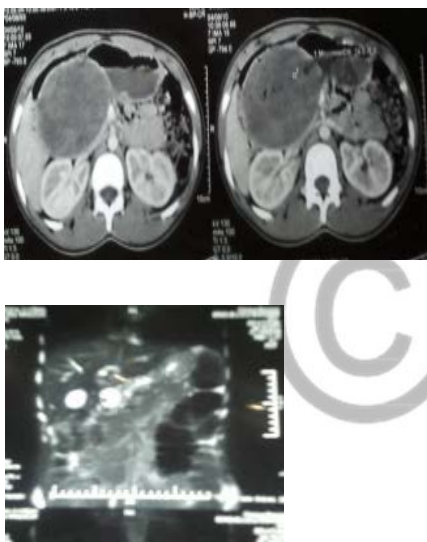


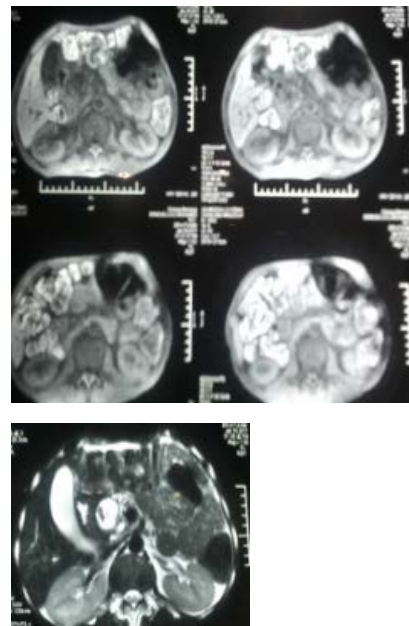
fig. 2: CT scan II



### **Results:**

The patient is operated on and a retrogastric mass is discovered, pushing the stomach forward. The liver is normal, the common bile duct is not dilated. The pancreatic site of the mass is discovered: it is body-cephalic. The puncture, after protection of the operating field, brings back infected liquid with debris of the proligerous membrane. After sterilization of the cyst, multiple vesicles are removed. As the cyst wall does not lend itself to anastomosis, the protruding dome is resected and the residual cavity is drained. The post-operative follow-up was simple and the follow-up at 6 months without particularity.

fig3: control CT scan



### **Discussion :**

The pancreatic site of hydatidosis remains exceptional even in countries with high hydatid endemicity (0.2%-1.6%) [1, 2, 3], with only 163 cases worldwide, which explains why it is not well known. We can consider that for hydatid cysts of the pancreas, the difficulty is not therapeutic, as this was codified in the report of Mallet Guy and Mercadier [1], but lies in the diagnosis. Only 163 cases have been grouped together in the world. The infestation mode of the pancreas is by hematogenesis way after passing through the hepatic and pulmonary filters [4].

In the pancreas, the cyst gradually increases in volume, represses the pancreatic parenchyma, compresses and then erodes the neighbouring organs. Infestation of the pancreas occurs via the bloodstream after passing through the liver and lung filters [4]

This location is usually unique and isolated. Association with other locations is only encountered in 9% of cases (hepatic or pulmonary).

The site of the cyst is cephalic in 57% of cases. Ultrasonography, tomodensitometry and magnetic resonance imaging (MRI), allow the diagnosis of a pancreatic cystic lesion to be made without difficulty.

[5,6,8,9], but the preoperative diagnosis of the hydatid nature of the cyst is extremely difficult to recognise [10,5,9].

The treatment can only be surgical [11]. The choice of surgery depends on the location of the cyst and whether or not there is a cystocanal fistula [12]. In fact, it is currently accepted by the majority of authors that for corporo-caudal locations, the morbidity of drainage after resection of the protruding dome (pancreatic fistula) should lead to a preference for left splenopancreatectomy type operations [13,9]. On the other hand, for cephalic cysts, the reference treatment is resection of the protruding dome associated, in the case of ductal fistula, with a cysto-digestive anastomosis [14].

Cephalic duodenopancreatectomy is a radical procedure but seems excessive for a benign pathology [12].

Compression of the main bile duct regresses after treatment of the cyst and requires no action on the bile duct [12].

In our observation, the location of the cyst did not allow us to perform pancreatic resection, only the resection of the protruding dome or cysto-gastric anastomosis was available to us. We opted for the second view the morbidity of the resection of the protruding dome.

### **Conclusion :**

The rarity of pancreatic hydatidosis should not lead to a lack of awareness of its diagnosis; it should be mentioned in front of any pancreatic cystic mass, particularly in endemic countries such as ours.

Currently, advances in medical imaging (ultrasound, CT scan) have supplanted conventional radiological explorations.

The treatment can only be surgical. The indications depend on the location of the cyst in relation to the mesenteric-portal venous axis and the canal and vascular repercussions, bearing in mind that it is a benign condition.

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**Disclosures:**

The author does not declare any conflict of interest in relation to this article.

