Clinical update no. 555

18 March 2020

Triage Category	COUGH AND FEVER NESB LAST NIGHT UNWELL. DENIES TRAVEL OR CONTACT WITH SOMEONE WHO HAS TRAVELLED. NESB HR 129 SATS 96% TEMP 38.5
3	

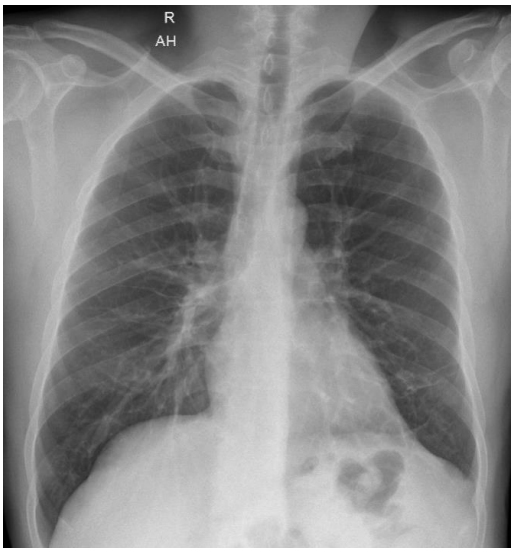
53yr-M originally from rural China, living in Australia about 5 years with no recent travel. Presents with fever and viral like symptoms, myalgia, and abdominal pain more in LUQ. No medical history of note, on no medications.

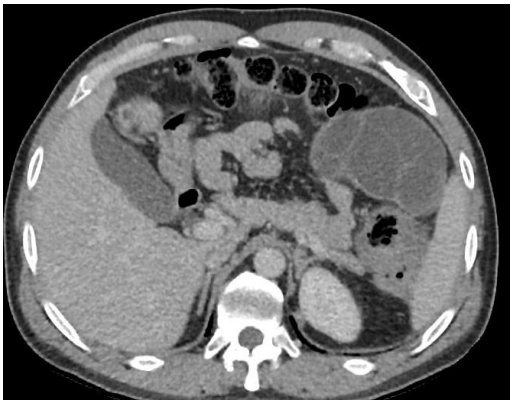
HS dual, chest clear.

Abdomen soft, tender LUQ with rounded mass, ? spleen.

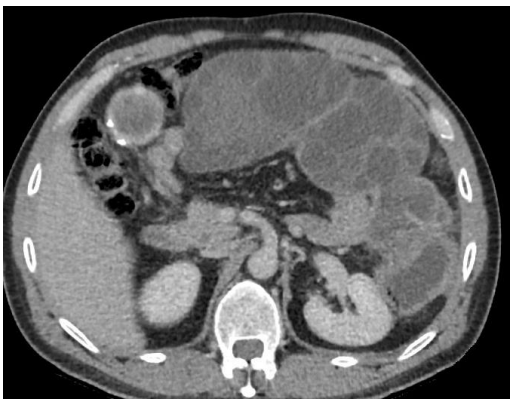
Time:	15:50
Hosp.:	
BLOOD COUNT	
Hb	143
WCC	20.2H
Plat	347

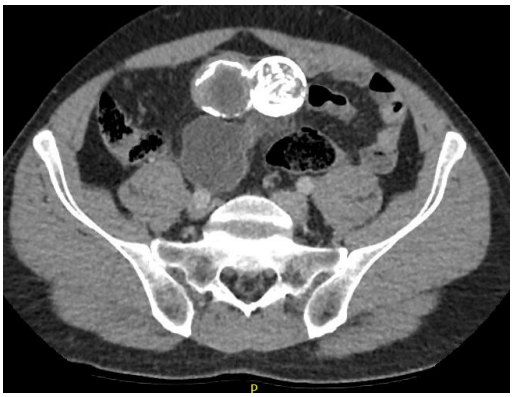
CRP 81; UEC/LFTs normal except Alk Ph 130; gluc 6.8, CRP 81

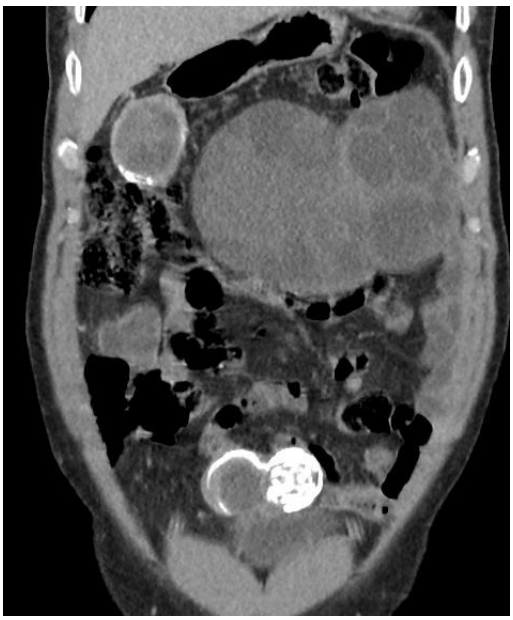




It wasn't an enlarged spleen, with a multicystic mass adjacent and other lesions diffusely throught the abdomen, incuding calcified lesions in the pelvis.







Multiple complex deposits throughout the peritoneum, containing fluid and calcification. Differentials include infective (such as extrahepatic hydatid or tuberculosis) or neoplastic processes. Stranding associated with the splenic flecture may suggest inflammation and account for the current presentation.

CT-chest showed no lung involvement.

Radiology gave a differential but ID were confident it was hydatid cysts and to start oral treatment with albendazole for tapeworm.

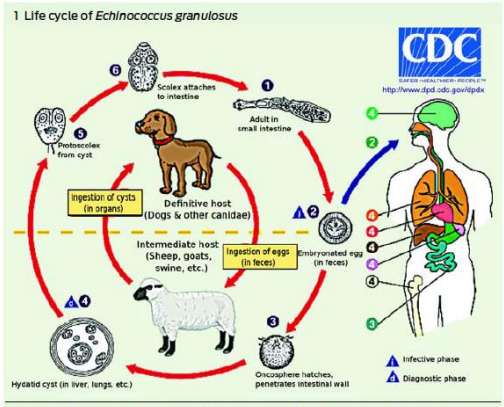
Research

A description of human hydatid disease in Tasmania in the post-eradication era

MJA 199 (2) · 22 July 2013 117

https://www.mja.com.au/system/files/issues/199_02_220713/ohe11745_fm.pdf Eradication programs have been successful in Australia.

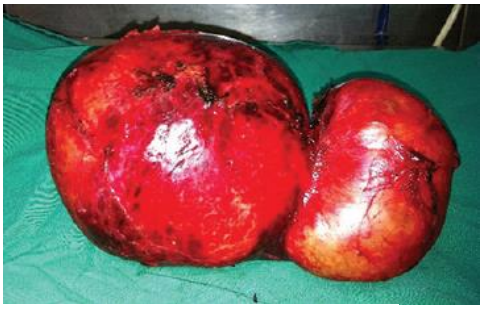
This was an imported case, obviously chronic, with an acute presentation likely from cyst rupture giving pain and a febrile response.



Source: DPDx Laboratory Identification of Parasites of Public Health Concern. Echinococcosis [Internet image library]. Atlanta: Division of Parasitic Diseases and Malaria, Centers for Disease Control and Prevention. http://dpd.cdc.gov/dpdx/HTML/ImageLibrary/Echinococcosis_il.htm (accessed Feb 2013). The adult worm resides in the small intestine of the definitive host (1). It releases eggs into the environment (2), which are then ingested by an intermediate host. In the small intestine of the intermediate host, the oncosphere hatches, penetrates the intestinal wall (3) to enter the bloodstream, whereby it migrates and is deposited in other organs (4) and forms a cyst. The cyst produces protoscoleces (5). The cycle is complete when the intermediate host is eaten by a definitive host and ingests the protoscoleces, which go on to develop into the adult worm.

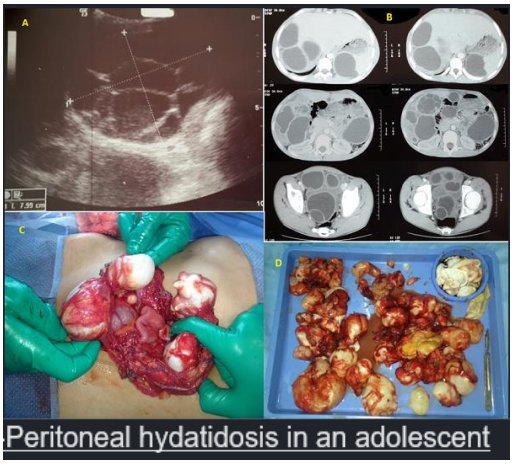
Dogs are the definitive host, with spread to an intermediate host and potentially to humans. There can be multisystem involvement.

There is cyst formation as shown.



Pericystectomy of recurrent cyst.

Cross-section of the cyst



Peritoneal hydatidosis in an adolescent

www.who.int/news-room/fact-sheets/detail/echinococcosis

Human echinococcosis is a parasitic disease caused by tapeworms of the genus Echinococcus.

The two most important forms of the disease in humans are cystic echinococcosis (hydatidosis) and alveolar echinococcosis.

Humans are infected through ingestion of parasite eggs in contaminated food, water or soil, or after direct contact with animal hosts.

Surgery is generally required to remove cysts.

eTG complete

Hydatid disease

If treatment of hydatid disease is required, seek expert advice.

Options include open or laparoscopic surgery, ultrasound-guided percutaneous drainage (such as the PAIR technique for liver cysts [puncture, aspiration, injection of a protoscolicidal agent such as hypertonic saline or ethanol, then re-aspiration after at least 15 minutes]) or antimicrobial therapy.

Surgery has the lowest recurrence rates.

For both surgery and percutaneous drainage, adjunctive albendazole is recommended

For both surgery and percutaneous drainage (eg PAIR), adjunctive albendazole is recommended; use:

albendazole 400 mg (child older than 6 years: 7.5 mg/kg up to 400 mg) orally with fatty food, 12-hourly, starting 1 week before and continuing for 4 weeks after surgery or PAIR.

These updates are a review of current literature at the time of writing. They do not replace local treatment protocols and policy. Treating doctors are individually responsible for following standard of care.