

Inguinal hydatid cyst Inguinal kist hidatik

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Dear Editor,

Commonly involving the liver and lungs, Hydatid disease (HD) is a common health problem in developing countries. Echinococcus granulosus infestation has world wide distribution particularly in sheep-rearing countries (1). HD occurs in the liver (55-70%), followed by the lung (18-35%); the two organs can be affected simultaneously in about 5-13% of cases and the incidence of unusual sites is about 8-10% (2). We report a case of HD in an unusual location; inguinal region.

A 25-year-old male patient was admitted to our hospital with complaint of swelling in the left inguinal region gradually increasing in size. He had a history of liver HD followed at another hospital for almost a year. The physical examination showed a mobile cystic lesion of 10x5 cm in size in the left inguinal region. The lesion was irreducible. The laboratory tests were normal except for a slight increase in transaminases (AST-Aspartate transaminase level 109 IU/L). Abdominopelvic MRI (Magnetic resonance imaging) revealed a 47x40 mm HD cyst in segment 5 of the liver and a 8.5x5.5 cm HD cyst in left inguinal region in close relationship with femoral and external iliac vasculature (Figure 1).



Figure 1. Magnetic resonance imaging of hydatid cyst of the patient located in left inguinal region.

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Partial cystectomy together with omentopexy performed for HD in the liver and inguinal HD enabled excision via vertical inguinal incision. Histopathological examination confirmed HD in both regions. The patient was discharged on the 6th postoperative day without complication. At the 6 month follow-up, no complications or recurrences were observed.

HD is an infestation caused commonly by *Echinococcus granulosus*. The definite host is dog, intermediate hosts are sheep, goat and cattle. Humans are the coincidental intermediate hosts. HD frequently occurs in the liver although it may develop in almost any part of the body, including soft tissues (2, 3). The clinical findings are non-specific and depend on the site of involvement and size of the cyst in cases with atypical locations. Usually it presents as painless, non-inflammatory, slow growing soft tissue masses which may mimic other pathological conditions such as soft tissue tumours (4). Preoperative diagnosis is important due to the risk of cyst rupture during the treatment. Contamination of surrounding tissues with the cyst contents may cause local recurrence or anaphylaxis (5). Ultrasonography is the first imaging choice in abdominal hydatid cysts with a sensitivity of 93% and 97% (6). CT scan (Computerized tomography), MRI, Casoni's skin test or complement fixation and haemagglutination inhibition serological tests may help the diagnosis (7). Surgical excision is the only treatment of inguinal HD. After excision of the cyst, irrigation of surrounding tissue with a scolocidal agent is recommended to prevent recurrence.

Inguinal HD is extremely rare in literature (2, 5, 6, 7, 8). Only five cases have been reported so far. Although our case is not primary inguinal HD, the unique feature of this

case is its size, the largest ever to be reported in the literature.

In endemic areas, hydatid disease should be considered in differential diagnosis in patients with progressive enlarging inguinal mass and surgical approach should be applied in order to prevent HD-related complications such as anaphylaxis.

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