

Anaphylaxis and Recurrent Hydatid Disease

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A 62-year-old woman presented to the emergency department with anaphylaxis. Three years before this, she had been diagnosed with multivesicular hepatic hydatid cystic disease and an associated pericardial effusion.¹ The cyst was resected, her pericardial effusion was drained, and she completed a course of albendazole therapy. In the interim period, she remained asymptomatic, and annual echocardiographic studies were unremarkable. On this occasion she presented with a 4-week history of recurrent episodes of transient chest pain, generalized pruritus, flushing, and urticaria. Initial management comprised intravenous corticosteroid and antihistamine therapy, and she was admitted for further evaluation.

In view of her history of parasitic infection that involved her pericardium, a transthoracic echocardiogram was performed and revealed a 3×5 cm cyst structure adjacent to the inferolateral wall of the left ventricle (Figure 1). Right and left heart catheterization was performed and right ventriculography revealed a localized smooth extrinsic lesion that compressed the main pulmonary artery (Figure 2). Cardiac magnetic resonance imaging confirmed the presence of multiple epicardial cysts (Figure 3). The patient was pretreated with albendazole and praziquantel for 2 weeks, at which time surgical resection was performed. Twelve cysts were removed from the chest cavity in all (Figure 4). One cyst, which was in contact with the pulmonary artery, was resected, and the vessel was closed with a patch. Histopathological analysis of the surgical specimens confirmed the presence of *Echinococcus granulosus* scolices (Figure 5). At the 6-month follow-up, the patient remained free from symptoms and exhibited no echocardiographic signs of recurrence.

Echinococcosis is endemic in many regions and remains a significant health problem in the Mediterranean region.² Recurrence >2 years after treatment is uncommon, and presentation with anaphylaxis, as in our case, is even more unusual.^{3,4} Surgical treatment is recommended in the management of cardiac echinococcosis as a result of high associated morbidity and mortality rates.⁴

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Disclosures

None.

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The online-only Data Supplement, which consists of movies, can be found at <http://circ.ahajournals.org/cgi/content/full/115/26/e643/DC1>.

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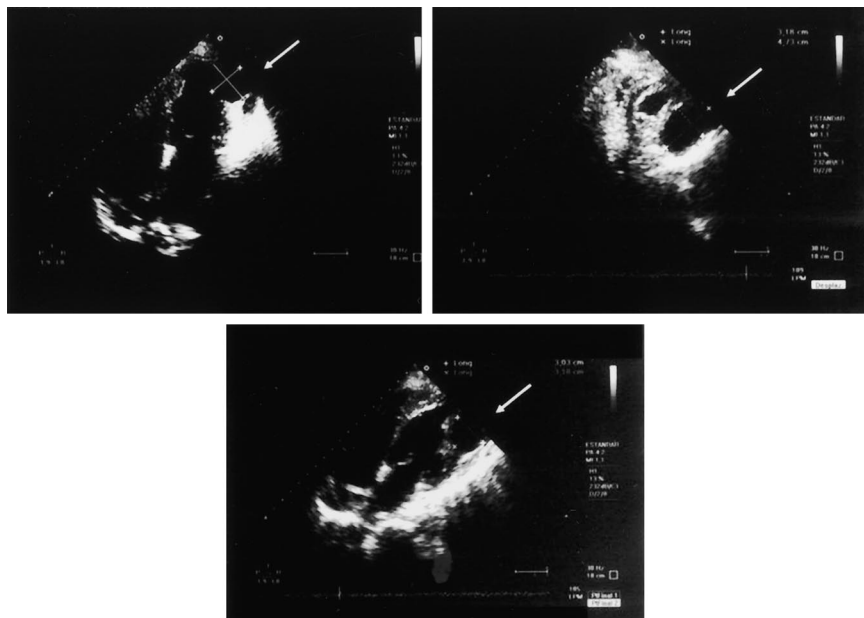


Figure 1. Transthoracic echocardiogram images show a 3×5 cm cyst structure adjacent to the inferolateral wall of the left ventricle (arrow).



Figure 2. Right ventriculography (30° right anterior oblique projection) reveals focal extrinsic compression of the main pulmonary artery (arrow).

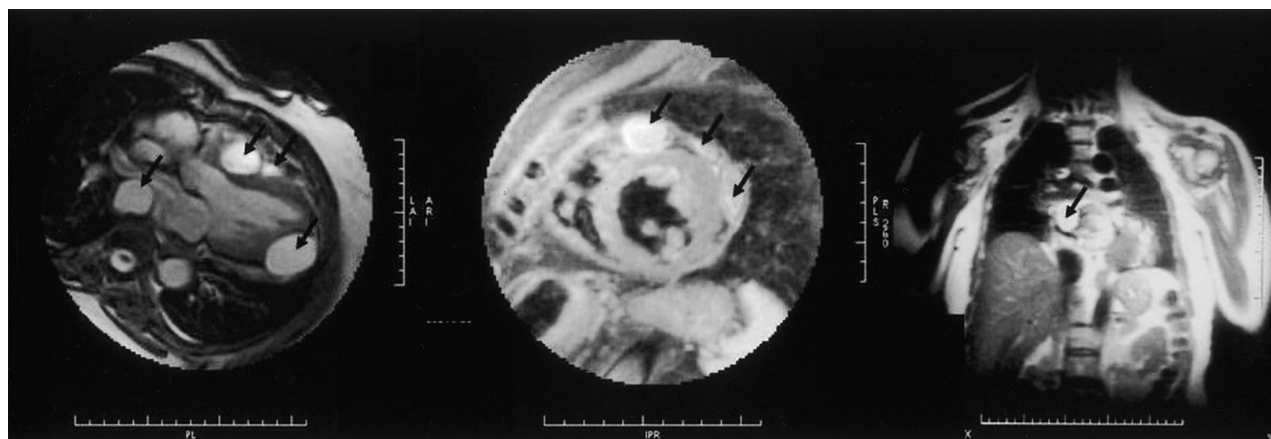


Figure 3. Coronal, sagittal, and axial cardiac magnetic resonance images demonstrate multiple hydatid cysts (arrows).

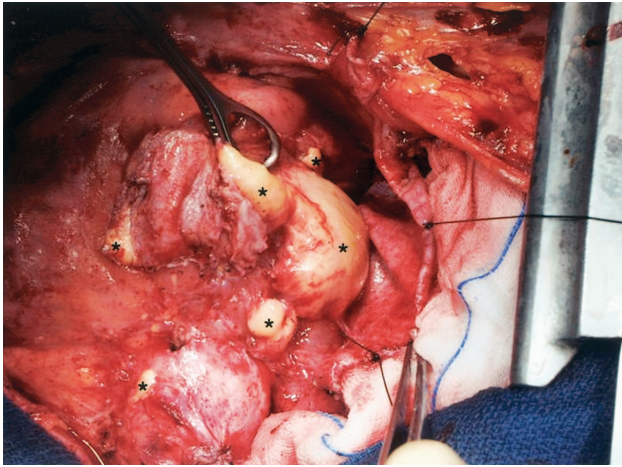


Figure 4. Intraoperative photographic image shows multiple hydatid cysts (*) adherent to the heart.

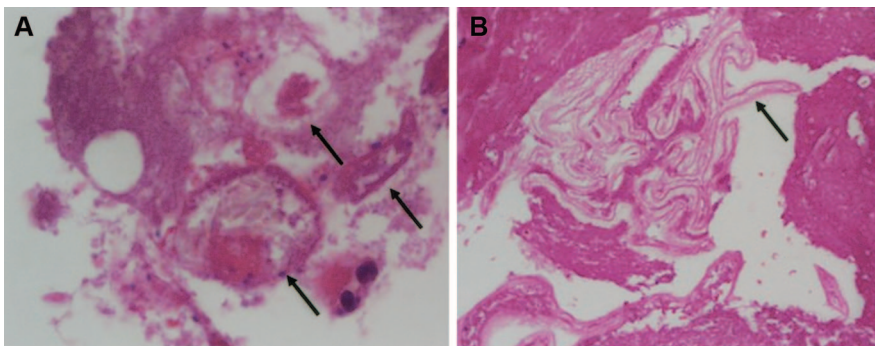


Figure 5. Pathological specimen shows (A) echinococcal scolices (arrows) and (B) the typical hydatid membrane (arrow).