An Isolated Cardiac Hydatid Cyst

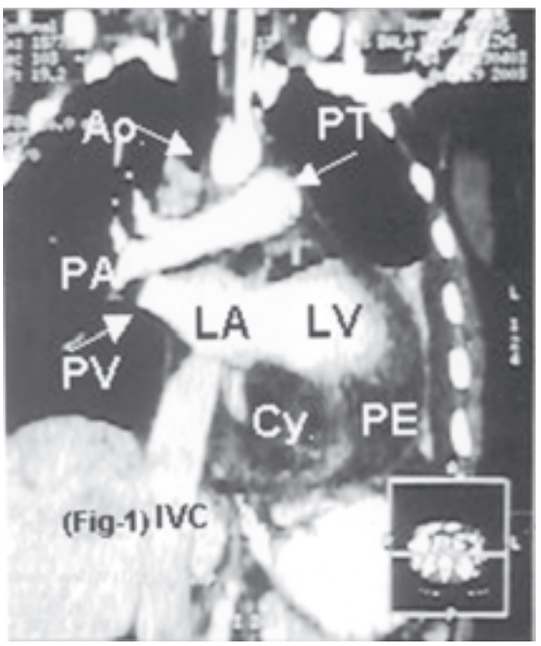

Fig. 1

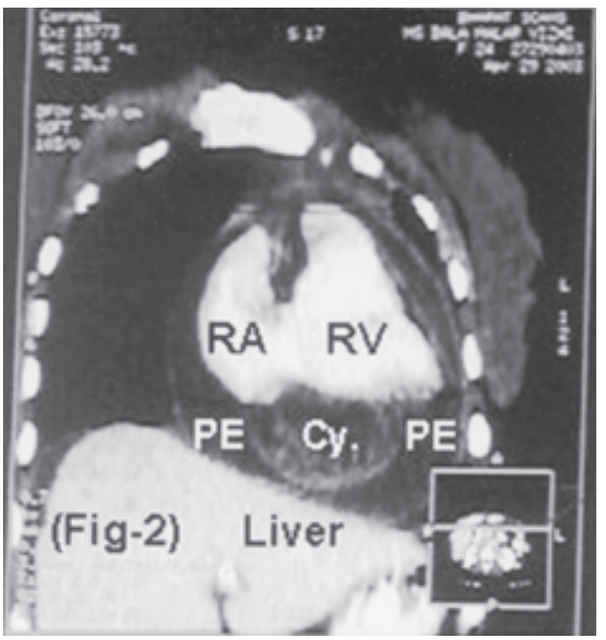

Fig. 2

Ao: Aorta; PT: Pulmonary Trunk; PA: Pulmonary Artery; PV: Pulmonary Vein; LA: Left Atrium; LV: Left Ventricle; Cy: Hydatid Cyst; PE: Pericardial Effusion; IVC: Inferior Vena Cava; RA: Right Atrium; RV: Right Ventricle

A 24-year-old female presented with a one-week history of backache and epigastric pain, and recurrent syncope of a few hours' duration. On examination, the pulse rate was 140 / min, BP 60 / 30 mm Hg, and her temperature 100.4° F. The JVP was elevated. The apical impulse was not palpable and the heart sounds were diminished in intensity. Examination of the respiratory system and abdomen were unremarkable. ECG revealed sinus tachycardia (140 / min) with inverted T waves in most leads. Chest X-ray showed enlarged cardiac shadow with clear lung fields. A provisional diagnosis of cardiac tamponade was made. Echocardiogram revealed pericardial effusion with diastolic collapse of the right ventricle confirming cardiac tamponade and also showed a large multiloculated cyst 7 X 8 cms in size on the inferior cardiac surface. A probable diagnosis of cardiac hydatid cyst was made. An echo-guided pericardial tapping was done from a lateral pocket and 230 ml of uniformly blood stained pericardial fluid was drained following which the patient improved. The haemogram showed leukocytosis with peripheral eosinophilia. Examination of the pericardial fluid showed a neutrophilic exudate; however, hooklets and scolices were absent suggesting that the cyst was intact. HRCT of the chest, abdomen and brain were done. This showed a large multiloculated cyst lying on the inferior surface of the heart straddling the AV groove, the interatrial and interventricular septum and revealed its inferior relationship to all the chambers of the heart (Figs. 1 and 2). Other organs were normal. Immediate surgical excision was done as rupture could lead to anaphylaxis and pulmonary or systemic embolism. Another small intact cyst lying free in the pericardial cavity was removed before the larger subepicardial cyst was excised without cardiopulmonary bypass on a beating heart. Pathological examination of the excised material confirmed the diagnosis. The postoperative period was uneventful and the patient was discharged on albendazole 200mg twice daily for 8 weeks. An isolated cardiac hydatid cyst of this size presenting as cardiac tamponade is exceptional.

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