A 38-year-old housewife, mother of four children, presented with abdominal swelling for eight months along with early satiety and gradual weight loss for six months. The swelling first appeared in the upper abdomen and gradually progressed in size so as to occupy the entire abdomen. She also noticed early satiety since last six months resulting in significant weight loss probably due to her diminished food intake. Patient had no history of abdominal trauma, jaundice, vomiting, overt gastrointestinal bleeding, diarrhoea, pedal swelling and shortness of breath, dysuria or fever. Her past and personal history was non-contributory. All her family members were engaged in cattle rising.

On examination, she had a low body mass index (15.2) and moderate pallor; jaundice, oedema or lymphadenopathy was absent. Abdomen was distended with multiple ill-defined intra-abdominal cystic-nodular swellings of various sizes without any tenderness, appreciable movement, pulsation or bruit (Figure 1). There was no superficial venous

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**PICTORIAL CME’s**

**Those Mystifying Intra-Abdominal Cysts!**

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prominence or free fluid in the abdomen. Rest of the examination was unrevealing.

Routine haematological and biochemical investigations were normal except a low albumin (2.6 gm/dl). Trans-abdominal ultrasonography showed multiple complex cysts in liver, spleen and peritoneum with echogenic material in some of them (Figure 2). CECT abdomen revealed multiple cysts of varying sizes with thin enhancing walls involving both lobes of the liver. Multiple daughter cysts, enhancing septations and solid components were seen within some of the cysts (Figures 3, 4, 5). Pancreas was compressed by a large cyst lying in the lesser sac. Multiple cysts were also seen in the spleen. Multiple cysts of varying sizes with high-density particles (sand, septae and daughter cysts) were seen within the peritoneal cavity pushing the gut loops medially and inferiorly. The largest cyst measured 120 X 97 mm. Hydatid serology was positive (anti-echinococcal IgG 46 units/ml by ELISA; positive if >12). CT scan of thorax and brain were normal. A final diagnosis of disseminated intra-abdominal Echinococcosis was made.

Multiple intra-abdominal cystic-nodular swelling, producing generalised abdominal distension is a rare clinical experience. The causes include primary and secondary peritoneal and mesenteric cysts, cystic degeneration of metastatic malignancy and polycystic disease – all of which are rare entities. Peritoneal Echinococcosis is more often secondary to liver involvement, either due to asymptomatic micro rupture or leakage during surgery. Spontaneous rupture of hepatic hydatid cysts into peritoneal cavity occurs in around 12% of cases. Though usually asymptomatic, peritoneal hydatid cysts manifest as complications due to enlarging cysts. Asymptomatic small cysts can be managed conservatively though symptomatic or large cysts require surgery. Unfortunately in this patient of disseminated intra-abdominal Echinococcosis, we could only offer anti-helmintic treatment and advice for regular follow up.

References