Cholangitis in a patient with hepatic hydatidosis

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Hydatid disease is highly endemic and mainly occurs in the regions of livestock husbandry, including central Europe, North America, Russia, northwestern Canada, and western China [1]. The larvae can penetrate the intestinal mucosa, subsequently flow into portal circulation and settle on the liver, and finally evolve into hepatic hydatidosis [1]. Two rare cases recently published in the Annals of Gastroenterology demonstrated that cholangitis was secondary to liver hydatid disease due to intrabiliary rupture of hydatid cysts or compression of bile ducts by cysts [2,3]. Herein, we report another case presenting with cholangitis associated with hepatic hydatidosis.

In December 2011, a 76-year-old male was referred to our hospital due to fever, right upper quadrant abdominal pain and jaundice. He had also developed light-colored stools and dark urine for about one week. He was born in Ningxia Province and worked in a livestock farm. About 40 years ago, he was diagnosed with hepatic hydatidosis and underwent surgery and oral albendazole therapy at his local hospital. On admission his temperature was 39.2 °C. Physical examination revealed tenderness of the right upper quadrant of his abdomen and yellowing of the skin and eyes. Laboratory tests were as follows: white blood cell, 10.01×10⁹/L (normal, 3.97-9.15×10⁹/L); neutrophil, 80.3% (normal, 50-70%); albumin, 30.5 g/L (normal, 35-55 g/L); total bilirubin, 354.4 μmol/L (normal, 3.4-20.5 μmol/L); direct bilirubin, 287.5 μmol/L (normal, 0-6.8 μmol/L); indirect bilirubin, 66.9 μmol/L (normal, 6.8-12.0 μmol/L); alkaline phosphatase, 330 IU/L (normal, 15-150 IU/L); and γ-glutamyl transferase 409 IU/L (normal, 0-52 IU/L). Testing for hepatitis B and C viruses and the human immunodeficiency virus was negative. Abdominal computed tomography scans demonstrated a relatively large cystic lesion in the right hepatic lobe with calcification of cyst well (A-B) and intrahepatic bile duct dilation (C-D). Thus, cholangitis associated with hepatic hydatidosis was considered. Two plastic biliary stents were placed under endoscopic retrograde cholangiopancreatography to keep the bile duct open. He also received intravenous antibiotic treatment for 7 days. The patient's temperature and white blood cells normalized 5 days later.

In conclusion, it should not be neglected that cholangitis could be secondary to hepatic hydatidosis, especially in patients who lived in regions of livestock husbandry.

References