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Unusual presentation of hydatid disease: Solitary pancreatic cyst

***Corresponding Author:** Yassine Tlili*

Email: docteur.yassine123@gmail.com

Aymen Mabrouk; Yassine Tlili*; Anis Ben Dhaw; Oumeima Fatnassi; Adib Kefi; Mounir Ben Moussa

Department of General Surgery A21, Charles Nicolle Hospital, Faculty of Medicine of Tunis, Tunisia.

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Description

We report the case of a 54-year-old man with a history of sigmoidectomy for volvulus who developed chronic colonic dilatation requiring repeated colonic exsufflation. Abdominal CT imaging revealed pancolonic distension and a large (11 × 9 × 13 cm) multilocular pancreatic tail cyst causing segmental portal hypertension (Figure 1). Hydatid serology was positive, suggesting a diagnosis of a pancreatic hydatid cyst. The patient underwent an exploratory laparotomy. Intraoperatively, the entire colon was distended (Figure 2A), and a well-defined cystic lesion was found in the pancreatic tail, which was densely adherent to the spleen and associated with collateral venous circulation (Figure 3A). We performed a subtotal colectomy (Figure 2B) without immediate restoration of intestinal continuity, combined with partial resection of the pancreatic hydatid cyst (Figure 3B). The cyst contents, consisting of non-infected multivesicular fluid (Figure 3C), were completely evacuated. A drain was placed in the residual cavity. Postoperative recovery was uncomplicated, with no recurrence at 6-month follow-up.

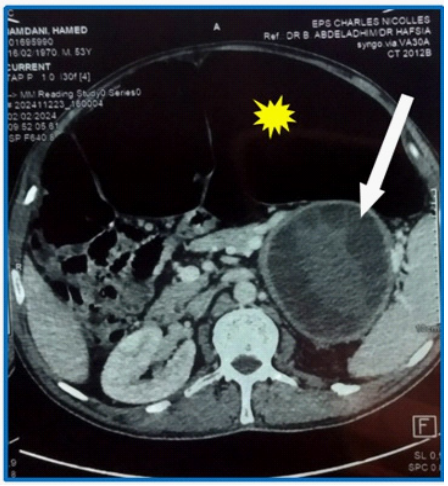

Figure 1: Axial contrast-enhanced abdominal CT showing colonic distension (*) and a multilocular pancreatic cyst (white arrow).

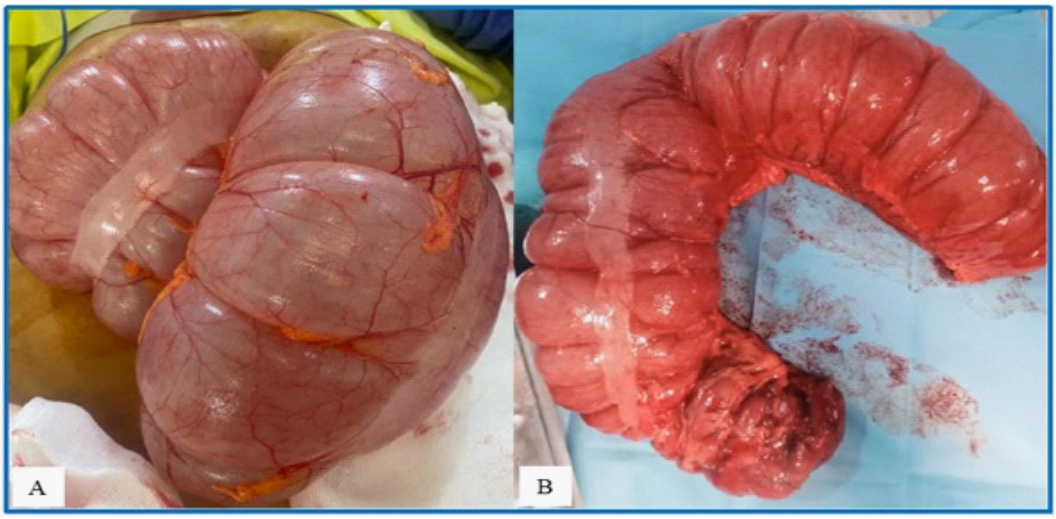

Figure 2: Intraoperative findings: **(A)** Diffuse colonic distension; **(B)** Subtotal colectomy specimen.

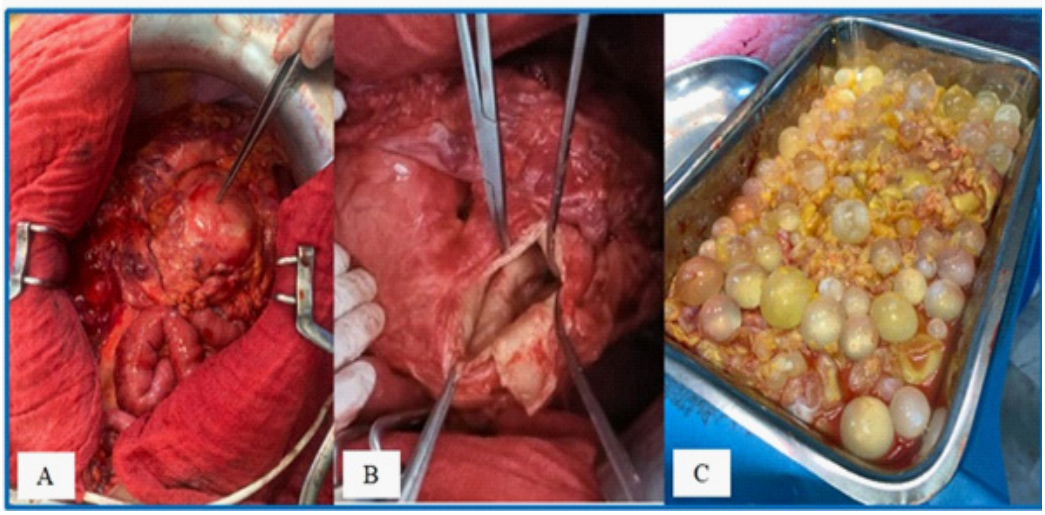

Figure 2: Intraoperative findings: **(A)** Hydatid cyst in the pancreatic tail causing collateral venous circulation; **(B)** Opened pericyst after evacuation of hydatid contents; **(C)** Hydatid contents consisting of multiple daughter vesicles.

Hydatid disease remains a significant public health concern in Tunisia [1]. Although the liver is the predominant site of infection, isolated pancreatic involvement is extremely uncommon, representing only 0.14-2% of systemic echinococcosis cases [2].

Due to their rarity, pancreatic hydatid cysts are often misdiagnosed as other cystic pancreatic lesions. Preoperative diagnosis requires multimodal imaging (contrast-enhanced CT, MRI, or ultrasound) combined with hydatid serology [2,3].

Surgical treatment is mandatory, with the approach (radical or conservative) depending on the cyst's location relative to the mesenteric-portal pedicle, anatomical relationships, and complications [3]. In our case, the cyst's proximity to the spleen, presence of segmental portal hypertension, and need for concurrent colectomy necessitated a conservative surgical approach.

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