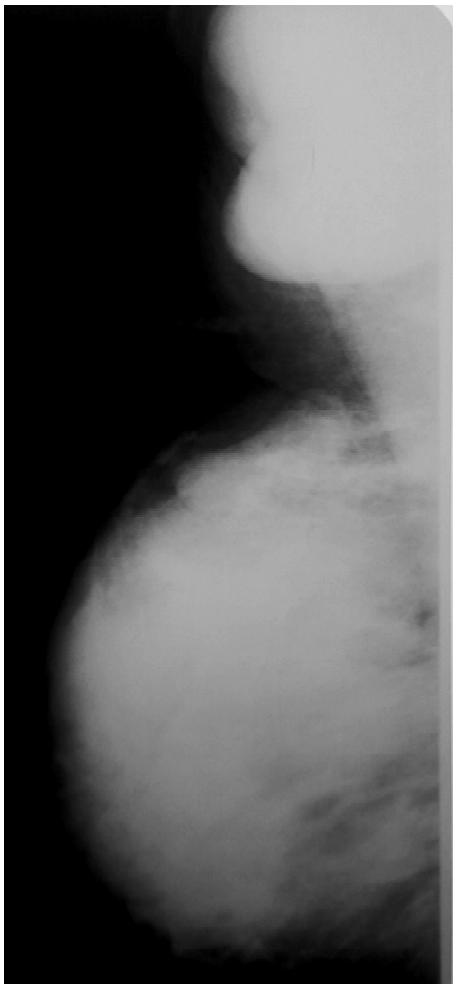
Hydatid cyst mimicking an axillary lymph node

Hydatid disease, caused by the larval form of Echinococcus granulosus, is endemic in cattle and sheep-raising regions, such as Central Europe, the Mediterranean, the Middle East, South America, Australia, New Zealand, and North Africa. Dogs are the principal host and sheep are the common intermediate host [1, 2]. Humans are infected through the oral-fecal route by ingestion of food or milk contaminated by dog feces that contain ova of the parasite or by direct contact with dogs. When ingested, the eggs loose their enveloping layer in the stomach and release the embryos. The embryos pass through the intestinal mucosa and reach the liver via the portal vein, where most larvae become trapped and encysted. Some may reach the lungs and, occasionally, some may pass through the capillary filter of the liver and lungs and enter the circulation [3].
We report two cases of uncommon primary Echinococcus cyst that developed in the subcutaneous tissues of the axillary region.

Figure 1: Bi-lobulated opaqueness in the left axilla



Case n°1
A 27 year-old rural woman, was complaining of a growing painless mass of the left axilla. Physical examination showed a 5 cm well circumscribed mobile mass with smooth surfaces. Bilateral mammary palpation was normal and the rest of lymph node areas were frees. Routine blood chemistry was normal. The axillary ultra sound showed a heterogeneous well limited mass measuring 5x6cm with calcifications. The mammogram showed no mammary abnormalities but a bi-lobulated opaqueness in the left axilla (figure 1). Computed tomographic (CT) scan of the thorax showed a nodular-hypodense-multiseptated mass, 7x3 cm in diameter at the inferior part of the left axilla. The chest x ray and abdominal sonography were normal. The axillary mass was completely excised under general anesthesia without any incident. Recovery was uneventful and the patientwas discharged on the sixth day.Pathologic examination of both liverand axillary masses revealed hydatid cysts.

Case n°2
A 28 year-old rural woman was complaining from axillar right mass evoloving since one week. Physical examination showed a 4 cm mobile lymph node right axilla with oedema of the upper right limb. The bilateral mammary palpation was normal. The axillary ulltra sound sonography showed multiple heterogenous lymph nodes. A surgical resection of the lymph nodes was performed throw a vertical right axillary incision. The final pathology report concluded to an axillary hydatid cyst (figure 2). The chest X-ray and the abdominal sonography were done to look for another localization of hydatid cyst. A pulmonary opaqueness was found in the pulmonary right middle lobe. The post-operative course was uneventful and the patient was addressed to the infectious disease department for further investigation and treatment.

Figure 2 : Microscopic appearence of an hydatid cyst

Conclusion
The subcutaneous presentation of hydatid disease is rare, but it suggests that echinoccocosis should be considered in the differential diagnosisof any cystic mass in any

anatomicallocation, with or without visceral involvement, particularly in endemicareas (3–4). Pre-operative diagnosis is necessary to avoid accidental per-operative rupture causing a loco regional dissemination or in some cases ananaphylactic shock. The prevention remains the best treatment.

References

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Duplication duodénale traitée chirurgicalement

Les duplications digestives sont des malformations congénitales rares. Elles peuvent toucher n'importe quel segment du tractus digestif notamment le duodénum.
Nous rapportons un cas rare de duplication duodénale traité chirurgicalement.

Observation

Patient de 26 ans sans antécédents qui a consulté pour des épigastralgies post prandiales associées à des vomissements intermittents évoluant depuis six mois. L'examen physique était sans anomalies. Le bilan biologique était normal notamment le bilan pancréatique et hépatique. Le patient a eu initialement une fibroscopie œsogastroduodénale, elle était normale. Une tomodensitométrie puis une IRM abdominales ont été réalisées (Figures 1 et 2). Elles avaient conclu à une lésion kystique mesurant 4 cm de grand axe, prenant naissance de la paroi du deuxième duodénum (D2) et sans rapport évident avec les voies bilio-pancréatiques. La duodénoscopie avait objectivé, au niveau de D2, une grosse formation arrondie prenant naissance à partir de la muqueuse duodénale (Figure 3). L'instillation d'eau au niveau de D2 ne faisait pas augmenter le volume de cette lésion. L'écho endoscopie avait confirmé la nature kystique de la lésion dont la paroi avait les caractéristiques d'une paroi digestive (Figure 4). Nous avons conclu à une duplication duodénale non communicante.

Figure 1: Image scannographique de la duplication duodénale : lésion kystique (flèche rouge) à l'intérieur de la lumière de D2 (flèche bleue)

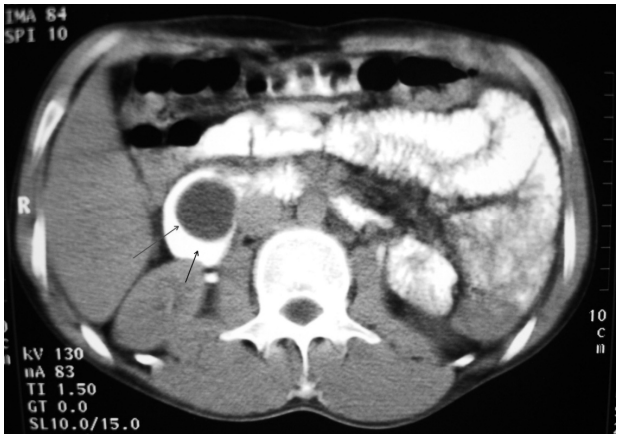

Figure 2: Images d'IRM : A : lésion kystique (flèche rouge) à l'intérieur de la lumière de D2.

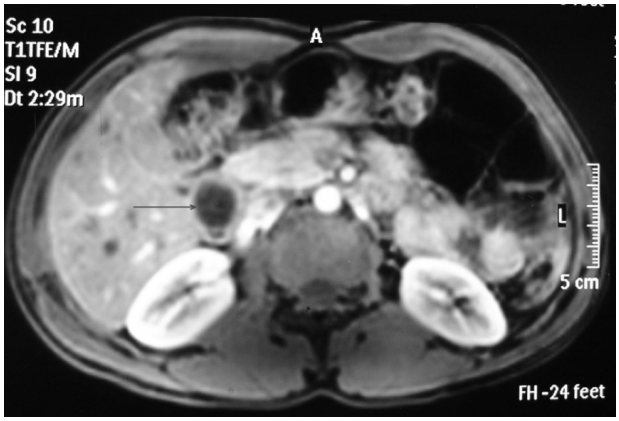

Figure 2: B : Rapport de la duplication (flèche rouge) avec le cholédogue (flèche verte) et la lumière duodénale (flèche bleue)