Imaging appearances of atypical hydatid cysts

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Abstract

Hydatid disease continues to be a significant health problem in many parts of the world. It can occur in any part of the body, but liver is the commonest site of involvement. The disease may remain asymptomatic for years. Symptoms occur due to compression of local structures or complications like rupture and infection. The diagnosis is clear when typical radiological appearance is observed at the common sites of involvement. Complications give rise to atypical appearances. These coupled with unusual localizations pose diagnostic difficulty. The aim of this pictorial essay is to demonstrate the atypical manifestations of hydatid cysts - atypical either due to complications or the unusual site.

Key words: Endocyst; hydatid cyst; liver; lung; pericyst

Introduction

Hydatid cyst is commonly caused by the larval stage of the tapeworm Echinococcus granulosus. The life cycle of the worm involves two hosts. The definitive host is a dog and rarely some other carnivore. The adult worm lives in the proximal small bowel of the definitive host. Its ova are passed in the feces of the infected animal. Sheep ingests the ova by grazing on the contaminated grass and is the usual intermediate host. The humans get infected by contact with the dog or by ingestion of contaminated water and vegetables.[1] The ovum releases the larva called oncosphere in the duodenum, which enters the portal circulation by passing through the intestinal wall. Thus, it reaches the liver where it grows into a cyst.

The hydatid cyst has three layers: (i) The outer pericyst which consists of modified host cells that form a dense fibrous protective layer; (ii) the middle laminated layer which is acellular and impervious to bacteria, but allows the passage of nutrients; and (iii) the inner germinallayer where the scolices and laminated membrane are produced [Figure 1]. The middle laminated layer and the germinallayer form the true wall of the cyst and are usually referred to as the endocyst.[2] The thickness of these layers depends on the tissue in which the cyst is present. The layers tend to be thick in the liver, are less developed in muscle, and are absent in bone.[3]

Hydatid disease involves the liver in approximately 75% of the cases, the lung in 15% of the cases, and other anatomic locations in 10% of the cases.[1] Based on the radiological appearance, hydatid cysts are classified into four types:

- Type I- Simple cyst with no internal architecture with or without hydatid sand or septae
- Type II- Cysts with daughter cysts and matrix
  - IIa- Round daughter cysts arranged at the periphery
  - IIb- Linear daughter cysts

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- IIb- Irregularly shaped daughter cysts occupying the entire mother cyst
- IIc- High attenuation oval or round mass with scattered calcification and occasional daughter cysts
- Type III- Dead cyst with total calcification
- Type IV- Complicated cyst with rupture and superinfection.

Sites of Involvement

Liver

Ultrasound is the screening method of choice for hepatic hydatid cyst. Computed tomography (CT) has high sensitivity and specificity and is an important diagnostic tool to recognize complications. A hydatid cyst is typically seen as a round or ovoid lesion with type I or II appearance [Figure 2]. It has water density and a high attenuation wall on unenhanced CT. Enhancement of the septae or cyst wall may be seen following contrast injection. There may be partial calcification of the cyst wall or internal matrix. This does not indicate death of the parasite. Later, dense complete calcification may occur and such a cyst is assumed to be inactive. Magnetic resonance imaging (MRI) is the best modality to demonstrate the cystic component and biliary tree involvement. The cystic part is hypointense on T1-weighted images and markedly hyperintense on T2-weighted images. Presence of hypointense rim on T2-weighted magnetic resonance images is considered a characteristic sign of hydatid cyst. It probably represents pericyst which is rich in collagen. Daughter cysts are seen as cystic structures which are hypointense relative to the intracystic fluid on T1-weighted images and hyperintense on T2 images. Irregularity of the cyst wall represents incipient detachment of the membranes.

Complications of hepatic hydatid cyst are: (a) Infection, (b) rupture, (c) exophytic growth, and (d) portal vein involvement.

(a) Infection manifests on CT as hypodense mass with typical enhancing rim like any other hepatic abscess. Gas or air-fluid level may also be seen.

(b) Three types of cyst rupture have been described: Contained, communicating, or direct.

Contained- Endocyst ruptures, but the pericyst remains intact. Detached endocyst is seen as serpentine linear membranes within the cyst. When there is complete detachment, crumpled endocyst floats freely in the cyst fluid, giving rise to the “water lily sign.”

Communicating- Passage of cyst contents into the biliary radicles that have been incorporated into the pericyst.

Direct- Spillage of hydatid material into the peritoneal or pleural cavity, abdominal wall, hollow viscera, etc.

Communicating rupture is indicated by direct and indirect signs. Direct sign is visible communication between the cyst and the biliary tree [Figure 3]. Indirect signs include deformity of the cyst indicated by loss of smooth round or oval shape, defect in the wall, and presence of beak-like projection extending from the cyst wall.

Intraductal areas
of low signal intensity due to cyst material may also be
seen on MRI.

Presence of fatty material, air-fluid level, and fat-fluid level
in the hydatid cyst also suggests communication with biliary
tree.\(^9\) The fat is thought to arise from the lipid content of
the bile [Figure 4].

(c) Complications may also arise due to exophytic growth
of cyst. The most common routes are the bare area of
liver and the gastrohepatic ligament. Involvement of
diaphragm [Figure 5] and thoracic cavity may result. CT
scan may reveal adherence to diaphragm, thickening
and lobulation of cysts, rupture into the pleural cavity or
pulmonary parenchyma, and chronic pleural fistula.\(^2\)

(d) Portal vein involvement is very rare. It is due to
compression by the cyst followed by thrombosis and
cavernoma formation.

Spleen
Splenic hydatidosis is the third most common after
the liver and lungs.\(^10\) It is usually secondary to systemic
dissemination or due to intraperitoneal spread from the
ruptured hepatic hydatid cyst. The imaging characteristics
are similar to those of hepatic cysts [Figure 6]. Identification
of daughter cysts and detached floating membranes if present
helps in the diagnosis. The differential diagnosis includes
epidermoid cyst, pseudocyst, and lymphangioma.\(^11\)

Epidermoid is seen as a unilocular fluid attenuation mass
with imperceptible walls. History of trauma and presence
of thick calcified wall are suggestive of post-traumatic
pseudocyst. Lymphangioma presents as an area of low
attenuation that does not enhance. T1-weighted images
may show high signal intensity if hemorrhage has occurred.

Peritoneum
Peritoneal hydatid cysts are almost always secondary to
hepatic hydatidosis. These are generally multiple and
can occur anywhere in the peritoneal cavity. Presence of
hepatic hydatid, multiple lesions in the peritoneum, and
characteristic appearance of daughter cysts allow the
diagnosis [Figure 7]. However, unilocular type I cysts are
difficult to differentiate from mesenteric cyst and intestinal
duplication cyst.\(^3\)

Retroperitoneum
Retroperitoneal hydatid is rare, usually secondary to
involvement of other organs, especially liver. The infection
reaches the retroperitoneum by spontaneous rupture or
by inoculation during surgery.\(^3\) Visualization of daughter
cysts helps in the diagnosis.\(^3\) However, other appearances
like unilocular cyst, cyst with detached membranes,
partially or totally calcified cyst may be seen [Figure 8].
This needs to be differentiated from lymphangioma which
appears as a large, thin-walled cystic mass that may involve
more than one compartment of retroperitoneum. Other
entities like mucinous cystadenoma, cystic teratoma, and
pseudocyst can be differentiated based on age and other
findings in the abdomen.
Lung

Lung is the second most common site of involvement. Hydatid cyst can grow very large due to compressibility of lungs. It initially develops as type I cyst which may be round or oval. Daughter cysts are rarely seen. Erosion of the bronchiole included in the pericyst results in air between endocyst and pericyst, giving rise to the “crescent or meniscus sign.” Presence of crescent-like rim of air in the posterior part of cyst is sometimes seen and is termed the “inverse crescent sign.” With continued leak, two layers may separate. The cyst shrinks and ruptures allowing the passage of air into the endocyst. An air-fluid level in the endocyst with air between the endocyst and pericyst constitute “the cumbo sign.” Air-fluid level with collapsed floating membranes can be seen inside the cyst – “water lily sign” [Figure 9]. All of the liquid content may be expelled to the bronchial tree – “dry cyst sign.” Other complications of lung hydatid are secondary infection, rupture into lung parenchyma leading to consolidation, rupture into pleural cavity, and very rarely, pulmonary embolism. In the absence of typical features, necrotic lung mass, metastasis, and intraparenchymal bronchogenic cyst should always be included in the differential diagnosis.

Bone

Bone involvement is seen in 0.5-4% of cases. Spine, pelvis, femur, tibia, humerus, skull, and ribs are the frequent sites involved. Due to lack of pericyst formation, aggressive proliferation causes replacement of medulla, cortical destruction, and extension into soft tissues. Extraosseous cysts may calcify. The radiological appearance consists of areas of osteolysis with expansion, thinning, and destruction of cortex and extension into soft tissues [Figures 10-12]. Complications include...
deformity, pathological fracture, secondary infection, neurological deficit, compression of adjacent structures, and transarticular extension.\textsuperscript{15}

**Muscle**
Skeletal muscle is a rare site as it does not favor the growth of hydatid cyst because of its contractility and high lactic acid level.\textsuperscript{16} Muscles of the neck, trunk, thigh, or upper extremities and around the hip are generally involved, but any part can be involved.\textsuperscript{15} Ultrasound done as part of initial workup of suspected soft tissue lesion may reveal findings typical of hydatid cyst. These vary from unilocular cyst to cyst with daughter vesicles, detached membranes, and water lily sign [Figures 13 and 14]. CT is helpful in the detection of osseous extension and cyst wall calcification.\textsuperscript{17} Complicated cysts may simulate abscess, hematoma, metastases, or soft tissue tumors like myxoid liposarcoma. CT and MRI show rim enhancement in an abscess and variable enhancement in metastases and soft tissue tumors. Blood products are seen in hematoma on MRI.

**Brain**
Involvement of brain is extremely rare. Hydatid cyst is mostly located in the middle cerebral arterial territory.\textsuperscript{18} On CT scan, it is seen as unilocular cyst with attenuation similar to the cerebrospinal fluid [Figure 15]. Fine peripheral enhancement may be seen. Edema is absent. There may be erosion of adjacent calvarium. Atypical findings include edema, irregularity of cyst wall, multiple locules, heterogeneity of cyst content, and calcification.\textsuperscript{19}

**Breast**
Breast hydatid cyst is very rare. Diagnosis is difficult unless ultrasound reveals membranes or fluid level due to debris in the cyst [Figure 16]. Ring-shaped structures within a dense, well-circumscribed lesion on mammography are also suggestive of hydatid.\textsuperscript{18} Presence of hydatid cysts in other organs adds to the diagnostic confidence.
Hydatid cyst can occur in other anatomic sites also. These include the heart, pericardium, orbit, mediastinum, kidney, adrenal glands, and subcutaneous space. Involvement of kidney is seen in about 3% and that of orbit in less than 1% of cases. It is even rarer in other locations. Imaging appearances are similar to those described for other organs. The orbital hydatid is typically unilocular, may be extra or intraconal. Thus, hydatid cyst should be included in the differential diagnosis of cystic masses of a specific organ, even when the typical appearance of cyst with multiple daughter cysts is not seen. This is particularly important if the patient belongs to an endemic region and has cystic lesions in the liver or lung.

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Conflicts of interest
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