Abstract
Hydatid disease or echinococcosis, a systemic zoonosis is caused by Echinococcus granulosus larvae. This is a common disease found all over the world, especially in the Mediterranean region. We report a 40 year old male with no known comorbidities who came with complaints of fever with rigors and chills, right hypochondriac pain, and yellow discolouration of the sclera. A CT scan abdomen with endoscopic retrograde cholangiopancreatography (ERCP) gave a diagnosis of hydatid cyst of the liver with pancreatitis, cholangitis and jaundice due to involvement of the biliary tree and common bile duct ERCP was done and a stent was placed after which the patient was referred to general surgery department where the resection of cyst was performed under general anesthesia. Pancreatitis was managed conservatively. We could not find any case reported in the literature, which showed manifestation of hydatid cyst of liver with pancreatitis, cholangitis and jaundice simultaneously, which made us report this case.

Keywords: Hydatid cyst, Pancreatitis, Hepatobiliary fistula.

Introduction
Hydatid disease or echinococcosis, a systemic zoonosis caused by Echinococcus granulosus larvae, is endemic and a common health problem in the Mediterranean region, where there is a close association among sheep, dogs, and humans.1-3 Hydatid disease can occur anywhere in the body. The liver (45-75%) and the lungs (10-50%) are the most affected, with involvement of other anatomical regions such as the brain, spine, kidneys, heart, spleen, adrenal gland, and musculoskeletal system.3

Since hydatid cysts grow slowly, a considerable portion of affected patients may remain asymptomatic for years. In symptomatic patients, however, the symptoms are varied and depend on location, size, and position relative to neighbouring organs.4,5 Clinical tools routinely used to diagnose Hydatid Cyst are ultrasonography (USG), computed tomography (CT) along with serological testing whereas magnetic resonance cholangio-pancreatography (MRCP), endoscopic retrograde cholangio-pancreatography (ERCP) are used as imaging modalities for complicated hydatid cyst indicating cysto-biliary fistulas and collection.5 In this case we will be presenting a rare manifestation of hydatid cyst of liver with pancreatitis, cholangitis and jaundice due to formation of Hepatobiliary fistula.

Case Presentation
On 20th October 2015, a 40 years old male patient came to Liaquat National Hospital, department of Gastroenterology, with no known comorbidities. He complained of fever with rigors and chills, right hypochondriac pain, yellow discoloration of sclera for 12 days. Pain was severe in intensity and associated with vomiting and fever. His past medical history showed recently diagnosed Hydatid Cyst in peripheral hospital in Quetta. No intervention was done. He was advised

Figure-1: CT scan showing a large hydatid cyst and a fistula commutating between hydatid cyst and the biliary system.
Tab Albendazole (800mg/day in two divided doses).

On Examination, patient was conscious, well oriented with time, place and person. The Blood Pressure was 110/70 mmHg, he was Tachycardiac, Tachypneic and had fever (101°F) with jaundice (yellow) sclera. On abdominal examination hepatomegaly was found along with right hypochondriac and epigastric tenderness. Rest of the examination was unremarkable.

Investigations showed Hb: 11gm/dl, Total Leucocyte Count was 23,000 with of Platelets count of 140,000, Urea, creatinine and electrolyte (UCE) were within normal limits. The Serum Amylase levels were: 450(normal range 40-140U/L) and Serum Lipase levels were: 392. LFTs showed Tb: 7.78, Direct: 6.5, Indirect: 1.28, ALT: 32, Alkaline: 312 Gamma GT: 220. HBs Ag and Anti HCV were negative. CT abdomen showed a large hypodense area, with thick enhancing walls and internal septations in left lobe of liver. There were multiple rounded hypodense areas within it arranged at the periphery measuring 9.7×9.7×9.6cm (AP×TS×CC) (Figure-1). Pancreas appeared diffusely swollen, largely hypodense and enlarged, which signified that the pancreas was swollen and the patient had pancreatitis. Gall bladder was of normal thickness, with no evidence of gall stones. There was a significant peri-pancreatic fat streaking. Findings were most likely due to acute severe pancreatitis along with hydatid cyst. Possibility of biliary communications was high.

ERCP was performed, cholangiogram (Figure-2) showed filling defect in distal CBD and a communication between intra-hepatic biliary duct with the hydatid cyst. Sphincterotomy was performed. Balloon sweep done, hydatid cyst membrane was removed and sent for microbiology analysis which confirmed the hydatid cyst (Figure-3). Plastic stent was placed and good flow of bile was noted. The pancreatitis settled and the general surgical team performed de-roofing surgery of the cyst and fistula was repaired.

Discussion
Cystic hydatid disease usually affects the liver (50-70%) and less frequently the lung, the spleen, the kidney, the bones, and the brain.6 Clinical presentation is the result of pressure generated by the cyst on adjacent structures, and depends largely on the size and anatomic location of the cyst. Although hydatid cysts disease commonly arises from the liver, but the complications such as cholangitis and jaundice due to the involvement of biliary tree is rare. In this case multiple complications were manifested with the hydatid cyst of liver, including pancreatitis, cholangitis and jaundice simultaneously. Intrabiliary rupture of a hepatic hydatid may occur in 2 forms: an occult rupture and frank rupture. In our case occult rupture is seen in which only the cystic fluid drains to the biliary tree and is observed in 10-37% of the patients. Intrabiliary rupture occurs in the right hepatic duct (55-
Manifestation of hydatid cyst of liver with pancreatitis, cholangitis and jaundice: A case report

Consent of Patient: Written informed consent of patient is taken for publishing this case and ethical approval letter was taken from head of gastroenterology department.

Disclaimer: None to declare.

Conflict of Interest: None to declare.

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References