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Case Report

Hydatic Cyst of the Gluteal Muscle with Intra Pelvic Extension: A Rare Localization

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Abstract

Muscular echinococcosis represents only 1-4% of hydatidoses [4], and can take the appearance of a soft tissue tumor. We report the case of a 62-year-old patient hospitalized in our formation for Gluteal hydatid cyst with intra pelvic extension: a rare localization.

Keywords: Hydatic cyst, gluteal muscle, intra pelvic extension.

INTRODUCTION

Echinococcosis is a cosmopolitan disease affecting both humans and many mammals [1]. Due to development in the organism of Echinococcus granulosus cestode. Its frequency remains high in South America, around the Mediterranean, in the Middle East and in East Asia [2]. Hydatidosis is characterized by the formation of predominant intratissular cysts in the liver and lungs [3]. The muscular involvement represents only 1-4% of the hydatidoses [4], and can take the appearance of a soft tissue tumor.

OBSERVATION

We report the observation of a 62-year-old patient living in Morocco, with no medical history of surgery, sent to a traumatology-orthopedic consultation for paresthesia of the left lower limb with sciatica that had been evolving for a year and a half; whose evolution was marked by progressive onset tumefaction in the left gluteal region. The clinical examination found a patient in good general condition, lameness when walking with steppage, without signs of vascular compression opposite the left buttock. The palpation revealed the presence of a non-beating swelling with firm consistency, movable with respect to the superficial plane and adhere to the deep plane. The neurological examination objectified paralysis of the sciatic nerve.

Standard X-rays showed normal bone. Ultrasound and MRI (Figures 1, 2B, and 2C) were performed to assess the seat, extent and nature of the mass. The biological assessment did not show eosinophilia. The requested hydatid serology was strongly positive.

Total excision of cystic formations was performed associated with hypertonic saline lavage. Albendazole treatment was initiated for 3 months with monthly monitoring of the liver.

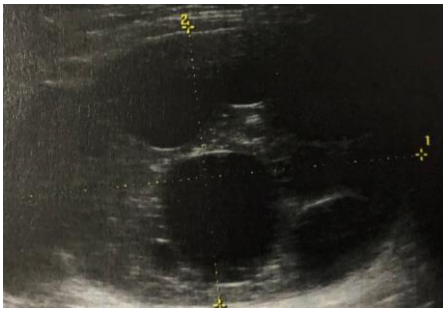

Fig-1: Ultrasonography of the gluteal region showing well-defined multivesicular cystic formation

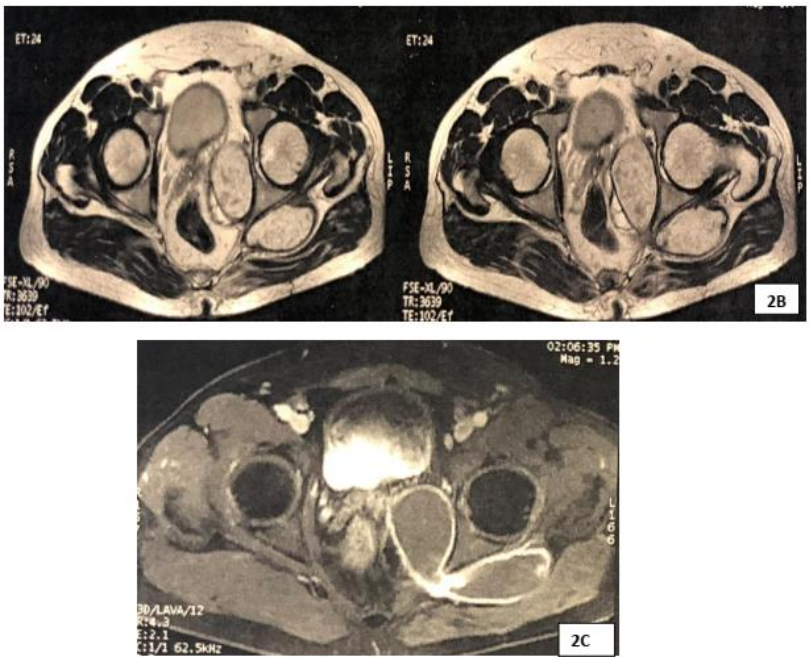

Fig-2 (B, C): Axial section Magnetic resonance imaging of the pelvis in T1 (B) and T2 (C) showing a cystic formation in bissac

DISCUSSION

Primary muscular hydatidosis is rare even in endemic areas, and its incidence is poorly defined [5, 6]. This scarcity could be explained by local conditions; such as the contractile activity of muscles and the production of lactic acid toxic to larval development [7]. The primary muscular involvement described in the literature concerns the musculature of the chest wall [8], the pectoralis major [9], the sartorius [10], the quadriceps [11] and the gluteus [12].

Clinically, the muscular involvement is manifested by the gradual appearance of a mass, often painless, and without alteration of the general state. Sometimes in the case of a large cyst, it is functional discomfort or compression neuropathy that leads the patient to consult [13]. This is the case of our patient.

Ultrasound is the key consideration for any suspicion of soft tissue hydatidosis [5, 14, 15]. In typical cases, it makes it possible to show a round, hypoechogenic, more or less heterogeneous, smooth-walled image with visualization of daughter vesicles [3, 7]; giving a honeycomb appearance. The WHO classification of hydatid cysts as active and inactive is valid only for hepatic locations [16].

MRI is the test of choice for diagnosing muscle hydatidosis; it allows a careful analysis of the cysts, and a cartographic study of the locoregional extension of the lesion as well as its relationship with the vascular-neural pedicles [6, 14, 15].

In doubtful and atypical cases, ultrasound-guided or ultrasound-guided biopsy can be useful for diagnosis without major risks for many authors [6, 12, 18]. However, the results of microscopic analyzes of needle biopsy are not always conclusive [18].

In hepatic and pulmonary forms the serology of hydatidosis is very sensitive, whereas it is only positive in about 25% in the other forms [4]. Negative serology does not exclude the diagnosis.

The treatment of choice for muscular echinococcosis is surgical. Consisting of monobloc resection with total peri-cystectomy taking the entire cyst without breaking the wall, associated with washing with a scolicidal agent, and using fields soaked with hypertonic saline, to avoid local dissemination [12, 18, However, the excision in monobloc is not always easy to achieve; especially in the absence of cleavage planes, when the cyst is infected and adhesions to the vasculo-nervous elements are tight [20].

Due to their poor diffusion in the cystic fluid [19], medical treatment with imidazole derivatives (albendazole) in the solitary localisations of the musculoskeletal system remains controversial, and is mainly reserved for inoperable cases or in addition to surgery when the cyst complicated itself with rupture [12, 21].

Long-term clinical, radiological and biological monitoring (every 3 months for 2 years) is necessary to detect local or distant recurrence [22].

CONCLUSION

Muscular hydatidosis is a rare pathological entity; imaging and serology guide the diagnosis. Excision is the treatment of choice, but prevention is the best way to fight against hydatid disease, regardless of its location.

DECLARATION OF LINKS OF INTERESTS

The authors declare that they have no links of interest.

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