mortality rate (1-3) and in quite a few articles, mortality is reported to associate with HHV-6, which is a "harmless" virus in normal individuals (4). Although there was no sign of HHV-6 activation in our patient during or after corticosteroid therapy, in cases with high serum titers, it might be mortal under immunosuppressive drugs. Therefore, screening for HHV-6 in patients with DRESS syndrome before administration of immunosuppressive drugs should always be on the agenda.

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Spontaneous cutaneous fistula of infected liver hydatid cyst

Cilde spontan fistüle enfekte karaciğer kist hidatiği

To the Editor,

Hydatid disease is a parasitic infection usually caused by Echinococcus granulosus. It is endemic in the Middle East, South America and the Mediterranean region. Patients with hydatid disease are mostly asymptomatic until incidentally diagnosed or complications occur (1). A 93-year-old female patient was admitted to the emergency service with the complaints of fever, abdominal pain, nausea, vomiting, and yellowish green drainage from the abdominal wall for the last two days. Her physical examination revealed a skin defect located 4-5 cm superior to the umbilicus and approximately 1 to 2 cm in size; a whitish membranous structure was seen protruding from the defect (Figure 1). She had a history of cholecystectomy 40 years before.

Laboratory examination revealed the following: hemoglobin (Hb): 9.8 g/dl, white blood cell (WBC) count: 18400/mm3, platelet count: 4350000/mm3, and indirect hemagglutination test (IHAT): 1/2400. Other biochemical parameters were normal. On abdominal computed tomographic examination, a hypodense irregular mass of 6 to 9 cm in size at liver segment 4 was seen, which contained a calcific area of 2 to 4 cm consistent with hepatic cyst hydatid. There was also an incision tract from the cyst to skin.

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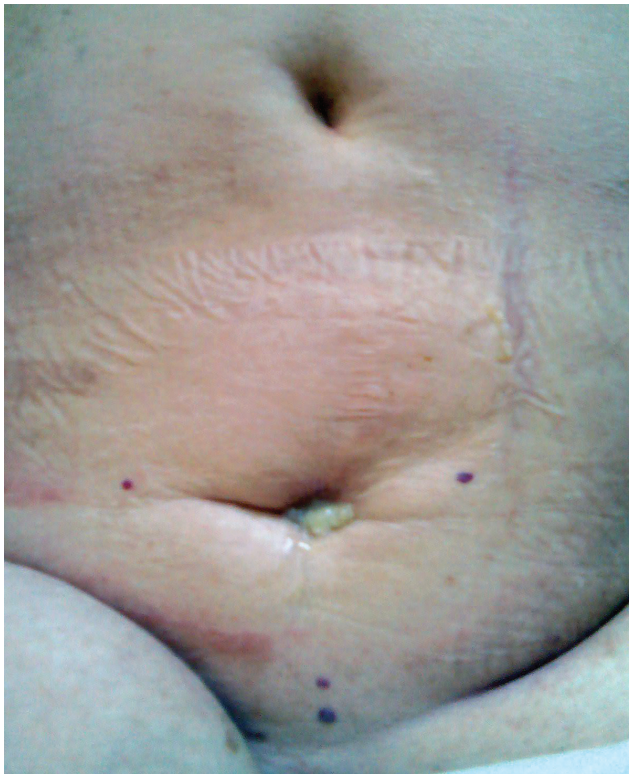

Figure 1. Whitish membranous structure protruding out of the skin defect.

With these findings, it was planned to hospitalize the patient with the diagnosis of infected hepatic hydatid cyst with cutaneous fistulization. The patient and her relatives did not give consent for surgical treatment so she was discharged with medical treatment of 10 mg/kg/day albendazole.

Complications are observed in one-third of patients with liver hydatid cyst. The most common complication is the rupture of the cyst, either internally or externally, followed by secondary infection, jaundice and an anaphylactic reaction (1). Spontaneous cutaneous fistulization is a very rare complication of liver hydatid cyst (2). There are only five case reports in the literature (3-7). Our case is the first in the literature of a spontaneous cutaneous fistula of an infected liver hydatid cyst.

A viable hydatid cyst is a space-occupying lesion with a tendency to grow. In less-restricted areas, the symptoms depend on the site and size of the cyst. Another consequence of cyst enlargement is that it can rupture. Viable hydatid cysts can rupture into physiologic channels, free body cavities or adjacent organs. The other factor responsible for fistulization of hydatid disease is inflammation. Inflammation leads to necrosis and causes fistulization (2).

Treatment depends on stage, localization, size, and complications of the cysts. Chemotherapy should be the first choice for disseminated disease and for patients who have a prohibitively high risk for surgery. Appropriate surgical treatment of hydatid cysts of the liver depends on communication of the cyst and the bile duct. If the cyst is localized peripherally, total cystectomy or hepatic resection is recommended because of the low rate of recurrence. However, partial cystectomy and omentoplasty are the most frequently used operations for intraparenchymal hydatid cysts.

In conclusion, it should be kept in mind that hepatic cyst hydatid can result in complications like cutaneous fistulization, even in later stages.

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