

Patient is Italian-born and has ECHINOCOCCUS. These are asymptomatic hepatic cysts and have no relationship to P.I., which was a perforated duodenal ulcer requiring surgery.

Radiographic readings

2004 plain film:

No bowel obstruction. No free air. Mildly dilated transverse and proximal descending colon with abrupt cutoff. Neoplasm cannot be excluded distal to the cutoff and a CT is recommended for further evaluation. Several 6 to 8 cm masses with egg-shell calcification in the liver most consistent with chronic hydatid disease.

2009 plain film:

Three large calcified lesions are present in the liver without change in size or appearance from prior examination. The appearance would be most consistent with prior echinococcal disease.

There is some gaseous distention of colon without abnormally dilated small or large bowel to suggest obstruction. There is **no free abdominal air** [emphasis added]. The lung bases are clear.

Impression: No acute findings

2009 CAT:

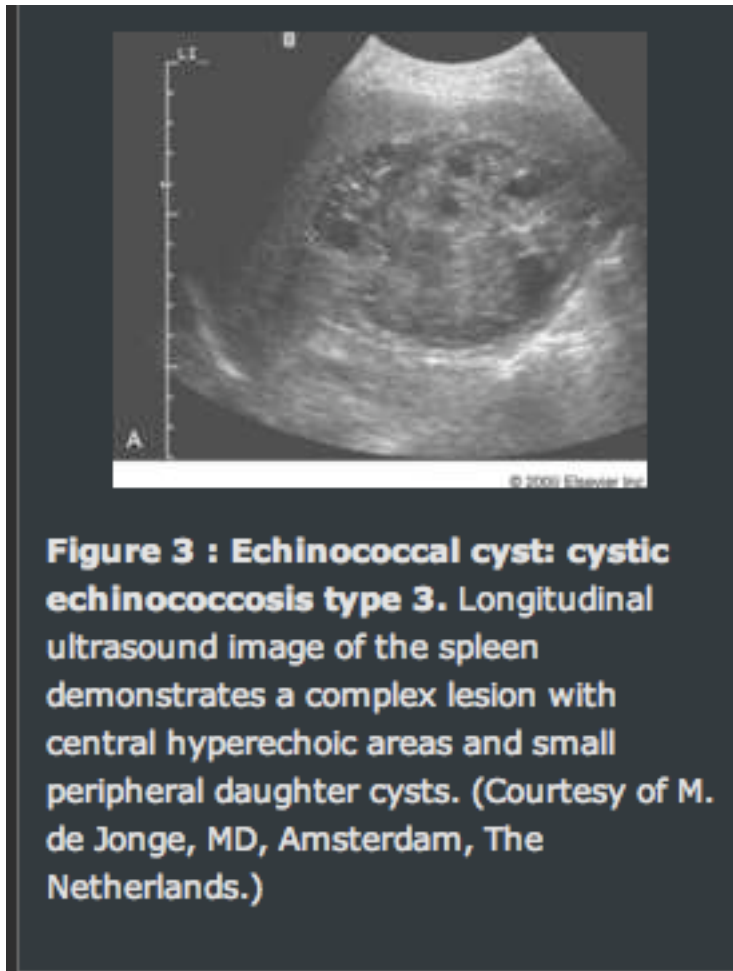
1. **Free intra-abdominal air** [emphasis added] with findings most consistent with perforated antral gastric ulcer. This Critical Result was discussed with Dr. ----- at 12:10 a.m. on September 1, 2009 and it was ascertained that the content and urgency of the report was understood at the time of direct communication.
2. Moderate atherosclerotic disease of the abdominal aorta which remains normal in course and caliber. Widely patent mesenteric vasculature without evidence of mesenteric ischemia.
3. Stable calcified lesions in the liver most consistent with prior echinococcal disease.
4. Multiple hypodensities in both kidneys are likely cysts, however many are too small to be properly characterized by CT.

Addendum:

There is circumferential wall thickening of the distal esophagus. This may be related to a Barrett's metaplasia in the setting of gastroesophageal reflux disease. Malignancy cannot be excluded. Correlation with endoscopy would be recommended.

Ultrasound image from internet, not from this patient:

([http://imaging.consult.com/image/topic/dx/Gastrointestinal?title=Cysts,%20Splenic&image=fig3&locator=gr3&pii=S1933-0332\(06\)70796-0](http://imaging.consult.com/image/topic/dx/Gastrointestinal?title=Cysts,%20Splenic&image=fig3&locator=gr3&pii=S1933-0332(06)70796-0))



Some good sites/references for echinococcus:

eMedicine:

<http://emedicine.medscape.com/article/216432-media>

CDC:

Echinococcosis

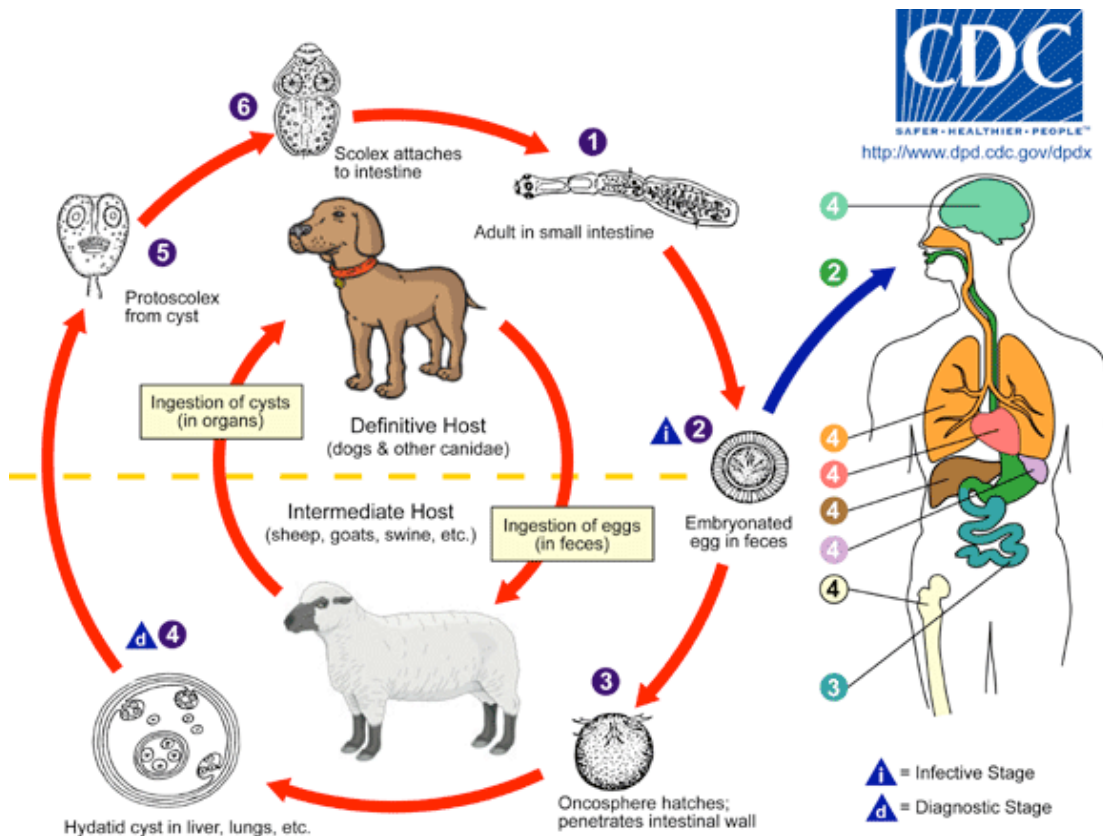
[*Echinococcus granulosus*] [*Echinococcus multilocularis*] [*Echinococcus oligarthrus*] [*Echinococcus vogeli*]

Causal Agent	Life Cycle	Geographic Distribution	Clinical Features	Laboratory Diagnosis	Treatment
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Causal Agent:

Human echinococcosis (hydatidosis, or hydatid disease) is caused by the larval stages of cestodes genus *Echinococcus*. *Echinococcus granulosus* causes cystic echinococcosis, the form most frequent; *E. multilocularis* causes alveolar echinococcosis; *E. vogeli* causes polycystic echinococcosis; and *E. oligarthrus* an extremely rare cause of human echinococcosis.

Life Cycle:



The adult *Echinococcus granulosus* (3 to 6 mm long) **1** resides in the small bowel of the definitive host, other canids. Gravid proglottids release eggs **2** that are passed in the feces. After ingestion by an intermediate host (under natural conditions: sheep, goat, swine, cattle, horses, camel), the egg hatches in the small intestine and releases an oncosphere **3** that penetrates the intestinal wall and migrates through the body into various organs, especially the liver and lungs. In these organs, the oncosphere develops and enlarges gradually, producing protoscolices and daughter cysts that fill the cyst interior. The definitive host becomes infected by ingesting the cyst-containing organs of the infected intermediate host. After ingestion,

Stanford:

<http://www.stanford.edu/group/parasites/ParaSites2006/Echinococcus/main.html>