Echinococcal cyst affecting the mandible

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INTRODUCTION

Echinococcosis (hydatid disease or hydatidosis) is a near cosmopolitan cyclo-zoonotic infection in humans caused due to infestation by the larval stages of taeniid cestodes of the genus Echinococcus. Six species have been recognized, but four are of health concern: Echinococcus granulosus (which causes cystic echinococcosis), Echinococcus multilocularis (which causes alveolar echinococcosis), and Echinococcus vogeli and Echinococcus oligarthrus (which cause polycystic echinococcosis). Two new species have recently been identified: Echinococcus shiquicus and Echinococcus felidis, but their zoonotic transmission potential is unknown.\(^1\) It is endemic in regions where close and continuous contact exists among dogs and sheep. Highest prevalence of the disease is found in the Mediterranean and parts of Central Asia, South America, Australia, and Africa.\(^1\) The life cycle of Echinococcus involves a definitive host (dog) and an intermediate host (usually sheep) with humans as an accidental host following ingestion of the larvae. Once ingested, the larvae pass into the blood stream through the intestinal mucosa, where they enter portal circulation to infest the liver as this is the first organ that they pass through. However, in all cases of echinococcosis, a thorough systemic investigation should be performed, as 20–40% may have multiorgan involvement.\(^1\)

Although the occurrence of a single echinococcal cyst is common in most cases, it is atypical that a cyst will occur in the maxillofacial region without evidence of additional hepatic or lung involvement, although the embryos must have passed through the organs. Echinococcal cysts in the maxillofacial region are rare, and only a few cases (<0.1%) have been reported in the English literature.\(^1\) Recommendations for diagnosis and management are substantially available for hepatic and pulmonary diseases, and maxillofacial surgeons are left with diminutive guidance when coming across such rare disease.\(^4\) We present a case of a middle-aged woman with a single echinococcal cyst affecting the mandible and emphasizing the need to consider it in the differential diagnosis of slow-growing lesions of maxillofacial regions.

CASE REPORT

A 35-year-old married female from countryside with poor socio-economic background reported to our department with a complaint of mild pain and pressure sensation on right side of temporomandibular joint (TMJ) area on mastication and opening and closing of mouth. She was unemployed and managed all domestic chores at home.
On examination, there was no gross facial asymmetry, deviation of jaw toward left side on opening and closing was appreciated with acceptable mouth opening. Clinical examination revealed a painless, soft mass in the right TMJ area with egg shell cracking and no evidence of a sound condylar unit. TMJ movements were diminished on right side. Intraorally, occlusion was good with healthy gingiva. The general health of the patient was normal with no cervical lymphadenopathy.

An orthopantomogram of the region revealed an ill-defined osteolytic lesion involving the ramus condyle unit of the right side of size 3 cm × 1.5 cm. Computerized tomographic scan showed a well encapsulated fluid filled cystic lesion of size 4.9 cm × 3.8 cm with osteolysis and thinning out of the condylar unit encroaching the infratemporal region and abutting the pterygoid plates on right side [Figures 1-3]. USG liver and plain posteroanterior view chest radiograph were normal with only a slight increase in eosinophil count. Surgical procedure under general anesthesia was planned. The region was approached via an extended Risdon’s approach extending and curving near the lower ear lobe. Dissecting sub platysmally, pterygomasseteric sling was incised. The cyst was judiciously dissected out of the surrounding tissues in toto. The intraoperative and postoperative course were uneventful.

The gross macroscopic specimen revealed two cystic cavities. The outer was tough reddish-brown and the inner was thin, slimy and fragile [Figure 4]. In histopathology, scanner view, × 10 view and × 40 view showing daughter cysts with scolex and germinal layers [Figures 5-7]. The patient was followed up for 2 year with no recurrence.

DISCUSSION

Maxillofacial zoonosis with an echinococcal cyst is a rare event. The Greek word “Echinococcus” meaning, “Hedgehog Berry” is a term to describe the gross pathology of the lesion, meaning “a drop of water.” Hippocrates very well described the disease affecting the liver masking it’s appearance and aptly described it as “liver filled with water.” Apart from the present case there are only 3 other cases of echinococcal cyst of the mandible reported in the literature. Other than mandible, echinococcal cyst has been reported to affect the neck, maxilla, pterygopalatine fossa,
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The diagnosis of Echinococcus infection can be based on the clinical history, physical examination, diagnostic imaging, aspiration, and serologic test. Regardless of location, the sensitivity of serologic tests is inversely related to the degree of sequestration of the echinococcal antigens inside cysts; for example, healthy, intact cysts can elicit a minimally detectable response, whereas previously ruptured or leaking cysts are associated with strong responses. The indirect hemagglutination test is sensitive, but has now been replaced by the enzyme immunoassay (ELISA) for initial screening of sera. In the present case, the diagnosis of the disease was not considered before surgery, and a definitive diagnosis was made only by postoperative histopathology.

Until the 1980s, surgery was the only option for treatment of echinococcal cysts; however, chemotherapy with benzimidazole compounds and, more recently, treatment with cyst puncture, aspiration, injection of chemicals and re-aspiration (PAIR) have been introduced and increasingly, have supplemented or even replaced surgery as the preferred treatment. However, surgical removal of intact echinococcal cysts, whenever possible, remains the treatment with the best potential to remove cysts and lead immediately to complete cure. Surgical technique is also relevant to the further clinical course of the patient, as spillage of cyst content can lead to dissemination or local recurrence of disease and, therefore, an excision of the cyst in toto is highly desirable. The intraoperative use of scolicidal compounds is questionable. There is no ideal agent that is both effective and safe. For optimum efficacy, compounds require a 15 min “dwell time” within the cavity. Compounds that seem to be fairly safe and effective include 70–95% ethanol, 15–20% saline, and 0.5% cetrimide solution. Surgery is contraindicated in patients who refuse it, are pregnant, have preexisting medical conditions that put them at risk, or have multiple cysts that are difficult to access.

Another feasible option can be image-guided PAIR of scolecidals method for percutaneous treatment of hydatid cyst of parotid gland, have been reported as effective procedure and as an alternative to surgery, however, controversy exists regarding aspiration of cystic contents, as there is possibility
of leak of cystic fluid, precipitating acute and fatal anaphylaxis and risk of recurrences and dissemination due to spillage of daughter cyst.

The benzimidazole compounds – albendazole and mebendazole – have been the cornerstone of chemotherapy for cystic echinococcosis. However, it has a proven adjunctive role to surgery in cases of management of patients with recurrence and high-risk contamination. Sporadic indications of pharmacotherapy as a sole modality of treatment in cases of poor general condition of patients who cannot tolerate surgical procedures, multi organ involvement or cysts located in some inaccessible areas are noted.

Although no route other than the portal route has been implicated in humans, it is likely that systemic diffusion through the lymphatic system may play a role in cases with solitary cysts at uncommon sites.

**CONCLUSIONS**

Although hydatid cyst rarely appears in the maxillofacial region, it should be considered in the differential diagnosis of benign growths especially in areas where it is endemic. In the surgical treatment of cysts of the maxillofacial region in which definite diagnosis cannot be made before the operation, great care must be taken to avoid spilling of the cystic contents. Maintenance of a high index of suspicion for this disease offers the best opportunity for a rapid and accurate diagnosis and prompt treatment.

**REFERENCES**


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