PERICARDIAL CYST MASQUERADING HYDATIC CYST; A CASE REPORT

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ABSTRACT

Pericardial cysts are unusual abnormalities of the mediastinum that was generally acquired but also be congenital. They are typically located in the cardiophrenic angle on the right side. Pericardial cysts are a subgroup of mesothelial cysts and generally do not cause any symptom. If cysts have become greater dimension symptoms and complications could come to existance.

Keywords: Mediastinal cysts, paracardiac area, surgery

CASE

A 60-year-old woman was admitted with generalized weakness, dyspnea, back pain. She had hipertension for three years and had medical treatment. She was a housewife living in village and had two children. On physical examination, the patient had mild respiratory distress, dyspnea and decreased respiratory sound in the right basillar hemithorax. Posteroanterior chest roentgenogram revealed a well-arranged bordered mass on the cardiophrenic angle at the right hemithorax. (Figure 1-2) Computerised tomography reported a round, unilocular, 6x5x5 cm diameter homogeneous cystic lesion in the paracardiac area; (cardiac hydatic cyst?) (Figure 3). Right posterolateral thoracotomy was performed. The mass lesion had been sawn on the right cardiophrenic angle which contains a waterlike fluid and connected to the pericardium with a pedincule. Cyst was exiced totally and pathologic examination revealed a pericardial cyst. The patient was discharged on the tenth day after the operation.

DISCUSSION

Pericardial cysts are unusual abnormalities of the mediastinum that occur in 1 person per 100000 and constitue 7% of all mediastinal tumors (1). Most are due to developmental abnormalities. Less common causes include pericardial echinococcosis, benign teratoma, cavernous hemangioma, and trauma. Especially seems in 30-40 years old adults (2). Localization of the pericardial cysts are right cardiophrenic angle (51-70%), left cardiophrenic angle (28-38%) and rarely in other mediastinal locations not adjacent to the diaphragm (8-11%) (3). Twenty percent of the cysts connected to the pericardium with a

pedincule (4). In this case we determined a pericardial cyst located at the right cardiophrenic angle as seeems typically and connected to the pericardium. The size of these cysts varies from 2 to 3 cm to as large as 28 cm (5). Our case's pericardial cyst size was 6x5x5 cm and had a great enormity.

Histologically these cysts are lined with a single layer of mesothelial cells and the remainder of the wall composed of connective tissue with collagen and elastic fibers. They contain a clear water-like fluid and thus referred to as 'spring water cysts' (6). İntraoperatively, we saw waterlike fluid inside of the cyst.

Pericardial cysts rarely causes symptom. If they become a great dimension symptoms had come to existance due to the pressure of the cysts on adjacent organs. Feigh et al. reported symptoms of atypical chest pain, dyspnea, and persistent cough in about one-third of patients (10). In our case atypical chest pain, dyspnea and cough had been occured.

Pericardial cysts are usually occored as an incidental finding on a chest roentgenogram in an asymptomatic patient. Diagnosis can be confirmed with CT, transthoracic or transesophageal echocardiography, and magnetic resonance imaging. CT was still gold-standart for the radiologic diagnosis. Pericardial cysts are radiologically misdiagnosed with hydatic cyst (7-9). In our cases radiological findings revealed a hydatic cyst. Transesophageal echocardiography can be useful if transthoracic echocardiography is in adequate in delineating the diagnosis (8) and can help identifying a pericardial cyst in a typical locations and distinguising it from other posteriorly located lesions. İn our cases, A transthoracic echocardiography showed normal left ventricular function and a mass compressing the right side of the heart.

If pericardial cyst was asymptomatic they ususally followed up closely. Traditional treatment of pericardial cysts includes thoracotomy and rarely percutaneous aspiration. Recently videoassociated thoracic surgery had been used successfully for the treatment of pericardial cysts (6). In our case, radiologic findings revealed a hydatic cyst and we could not exclude this with laboratory examination than prefered posterolateral thoracotomy.

Pericardial cysts have been associated with multible complications including right ventricular outflow tract obstruction, pulmonary stenosis, related to extrinsic compression,

partial erosion into the superior vena cava, erosion into the anterior wall of the right ventricle (1,3). Our patient had not have any complication.

RESULT

Pericardial cysts are rarely seen abnormalities. Radiologic findings can interfere with other pathologies like hydatic cyst. If there had been any suspicion thoracotomy was preferable. Here we report of a pericardial cyst masquerading hydatic cyst which was diagnosed and treated with surgical approach.

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FIGURES

Figure 1: Posteroanterior reontgenogram

Figure 2: Lateral reontgenogram

Figure 3: Thorax computerised tomography

Figure 1:

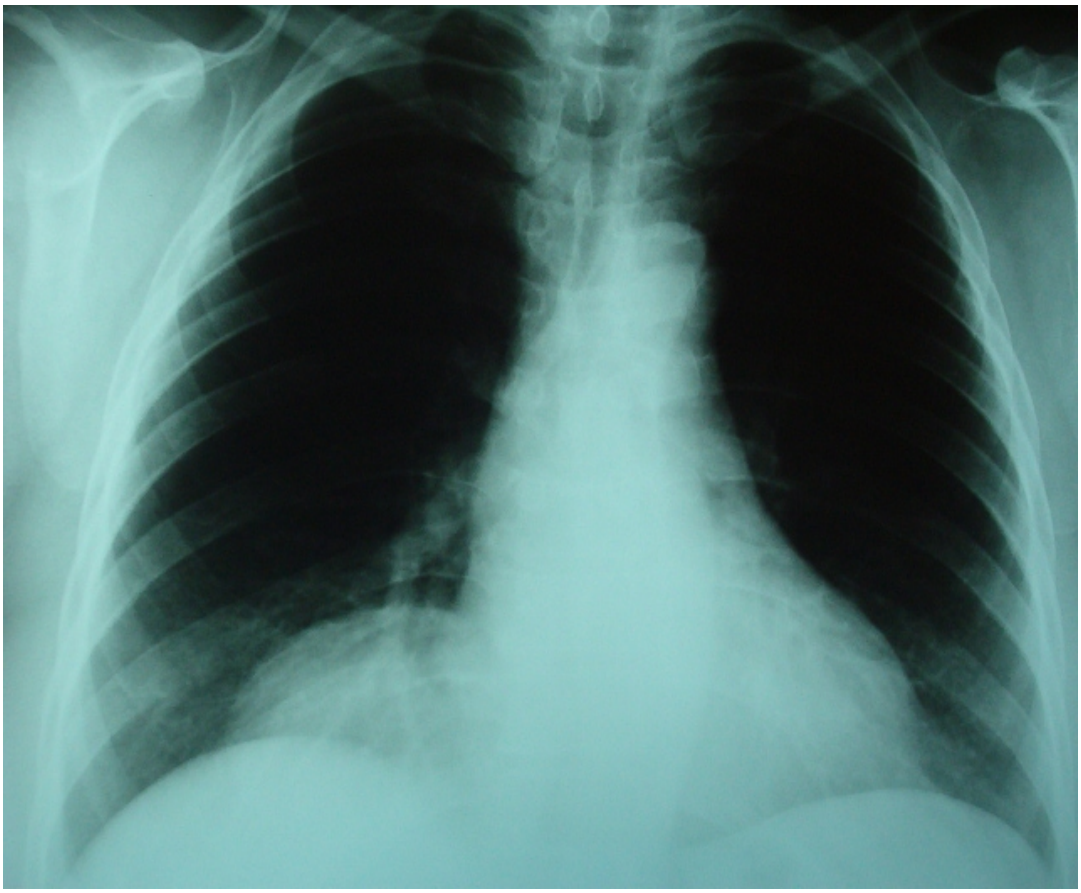


Figure 2:

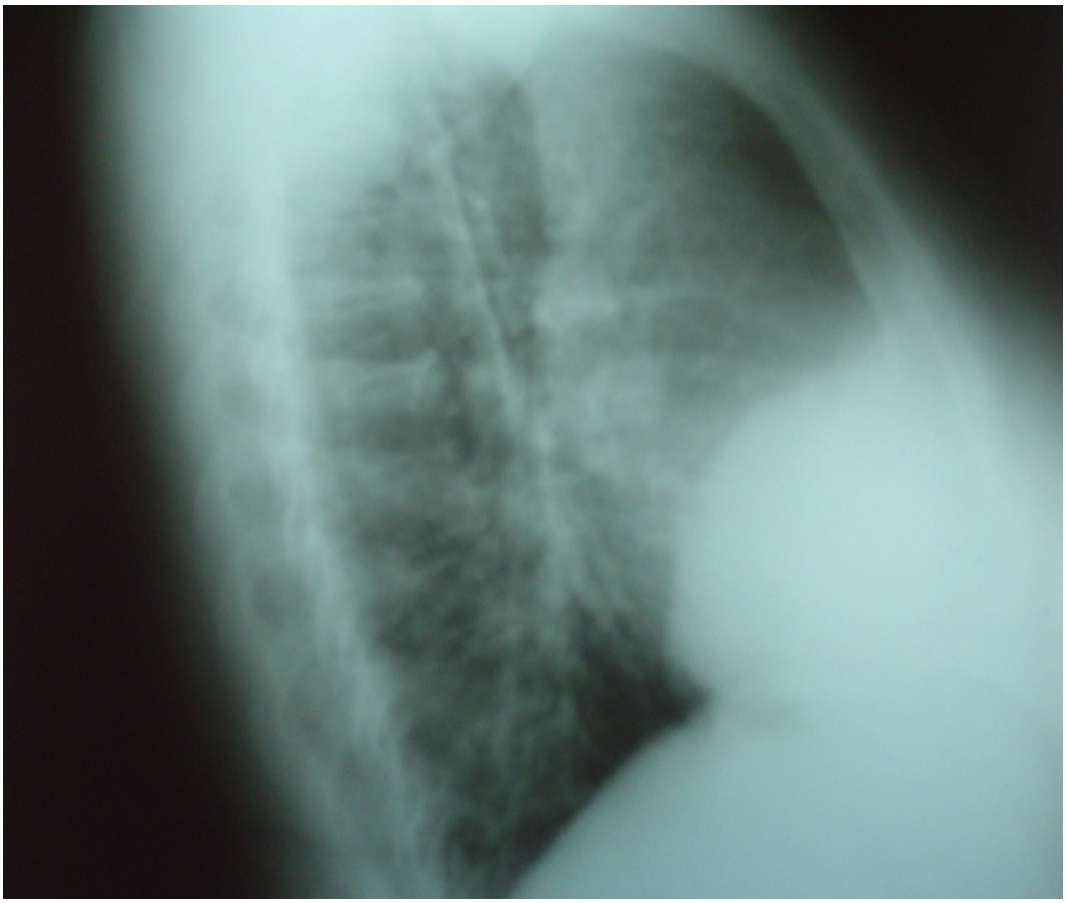
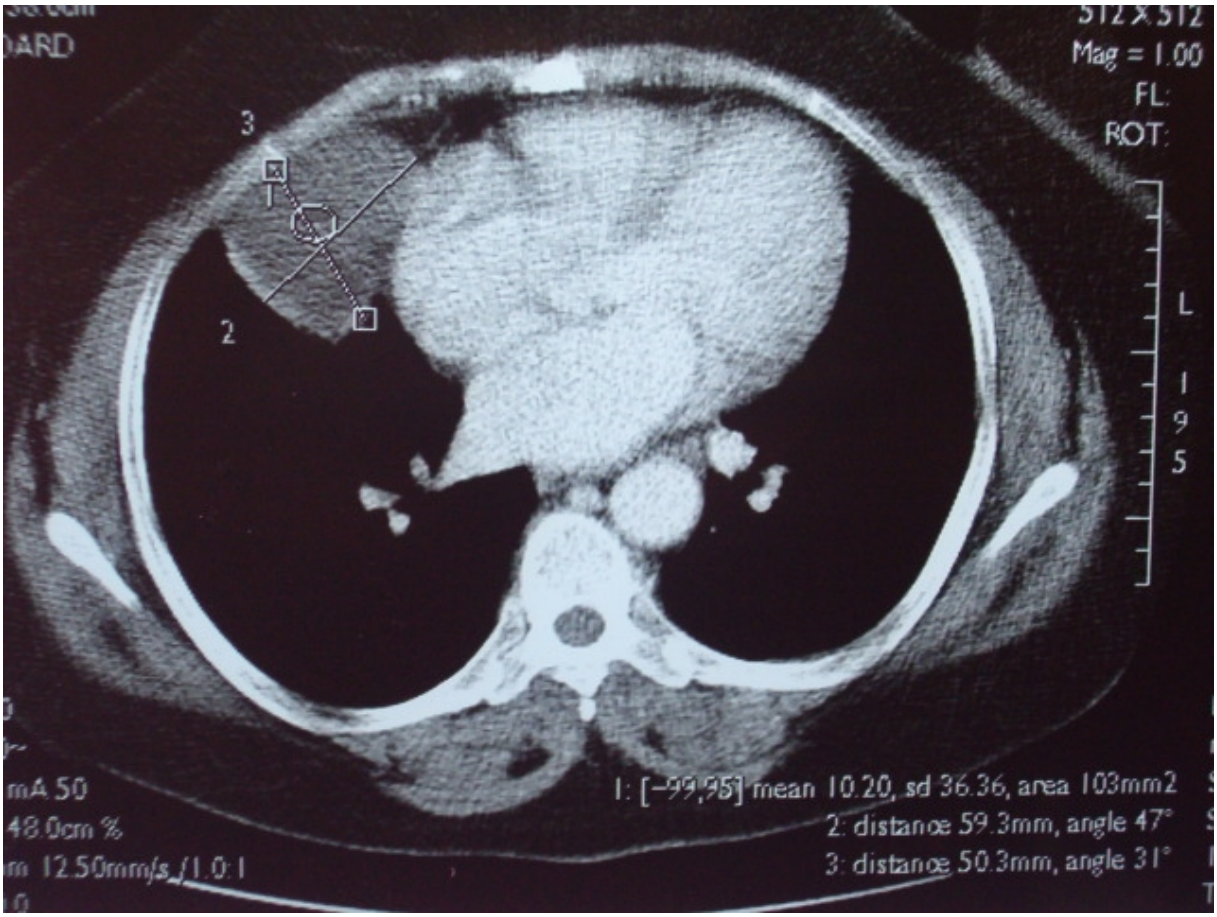


Figure 3: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