A 45-year-old housewife was referred to our center with a two-week history of moderate to severe pain and fullness of the epigastric and left upper quadrant area. She had no history of fever, jaundice, abdominal trauma, weight loss, or other symptoms. She gave a history of epigastric fullness and dyspepsia of one year duration, for which she was taking ranitidine on demand. Physical examination was normal except for the presence of a large, smooth, and nontender mass in the epigastric area extending to the left upper quadrant. Paraclinical investigations, including a complete blood count, liver and kidney function tests, serum lipase, blood chemistry, CA19-9, CEA, urinalysis, and stool examination for ova, parasites, and occult blood were reported normal except for an erythrocyte sedimentation rate of 50 mm after the first hour and a serum amylase of 300 IU/dL. Chest X-ray was normal. Abdominal ultrasonography revealed a large cystic mass measuring about 15 cm in diameter compatible with a large pseudocyst of the pancreas. An abdominal computerized tomography (CT) scan was taken (Figure 1).

What is Your Diagnosis?
See the next page for the diagnosis.
CT scan (Figure 1) revealed a well-defined cyst measuring 16 × 15 × 9 cm in the body and tail of the pancreas. For her persistent pain, she ultimately underwent laparotomy with an impression of pancreatic pseudocyst. The mass was, however, found to be a large hydatid cyst (Figures 2 and 3) originating from the body of the pancreas. No cyst was found in the liver, peritoneum, or other visceral organs. Postoperatively, serology was found to be positive for *Echinococcus granulosus*. The patient was treated with oral albendazole for six months. Currently, after two months of follow-up, she is free of the disease.

Hydatid disease has been reported to occur in all parts of the body, although liver (70%) and lung (20%) are the organs most commonly involved. About 10% of cysts occur in the rest of the body, occasionally in unusual sites. Primary hydatid disease of the pancreas is extremely rare and in almost all cases reported in the literature, the diagnosis has been made only after laparotomy.  

**References**