CIRUGÍA ESPAÑOLA

www.elsevier.es/cirugia

Editorial

Hepatic hydatidosis: Which surgical technique should we use?

Hidatidosis hepática: ¿qué cirugía debemos realizar?

Hepatic hydatidosis (HH) is a zoonosis endemic to our country. A health policy involving a deparasitization campaign of dogs carried out during the 1980s drastically diminished the frequency of this disease in subsequent years. In 1996 it was no longer considered a disease for mandatory notification, and since then no reliable data exists on its incidence. Furthermore, an increase in number of patients with hydatidosis is currently being observed in certain areas, probably due to the emigration of patients from countries with higher rates of hydatidosis that have not performed the social health programs implemented in Spain (Maghreb, Romania, etc.).

HH is a disease in which practically no randomized studies have been performed that would provide acceptable levels of scientific evidence. Variability in treatments applied for the disease is very high.[1] In PubMed, only 14 of the 4,112 citations on HH correspond to randomized studies. For this reason, there are currently several unanswered questions regarding hydatidosis.[2]

The majority of HH patients require surgery. The classical theory that the calcified cysts are not viable has been invalidated. All cysts that are found in a patient of a reasonable age and without major comorbidities must be operated on, since there is a risk of rupture into the bile ducts or bronchia, and of severe complications due to growth of the lesion. Logically, we must not forget that this is a benign disease, and rationality should prevail.

No scientific evidence exists on what type of surgery should be used to treat hydatidosis.[2] Traditionally, patients were operated on using non-radical techniques (Lagrot, subtotal cystectomy, etc.) associated with capitonnage, marsupialisation, or epiploplasty. The major advantage of non-radical surgery is that it involves simple techniques with low mortality, which is what leads many surgeons to continue considering it as the method of choice. This treatment is curative in a large percentage of patients, as long as no infection occurs in the cavity or the biliary communication. The problem of non-radical surgery when compared to radical surgery is that it does present a series of inconveniences, such as higher rate of recurrence, longer hospitalization, and chronic biliary fistulas.[3,4] As a result, there is a group of patients that should be operated on using radical techniques. Radical surgery is more technically demanding. Closed total cystectomies are more frequently considered as the most adequate technique for treating HH. In those cases in which the difficulty of treating the cyst due to its size or location requires an open total cystectomy, this can be an acceptable option. Formal liver resections are necessary on some occasions, especially in cases of recurrence and clean bile ruptures or breaks in certain segments.[3,4]

A variable percentage of patients present communication between the cyst and the bile duct (5%-8%). This type of communication can be classified as an intrabiliary clean rupture (true communication between the cyst and bile duct with passage of cyst contents into the duct, producing obstructive jaundice) or small-scale cyst-biliary communication, which is resolved by a simple suture of this communication. In those cases with jaundice, the biliary duct was typically opened for extraction of the material and the placement of a Kehr tube or in order to perform a transduodenal sphincterectomy. At present, the use of preoperative ERCP in patients with jaundice can provide for a complete cleansing of the bile duct and obviate the other procedures.[5] Furthermore, cholangitis can also be produced, necessitating a complete excision of the cyst as early as possible.

No conclusive studies exist on the use of preoperative or postoperative albendazol.[1,6] If the surgical technique used is the closed radical method, there appears to be no need for its use in a systematic manner. Only in those cases in which a non-radical surgical technique or open cystectomy is used would it be logical to use. No studies have examined the proper length of time for administration.

Laparoscopic surgery of hydatidosis has not been developed with the same speed as hepatic laparoscopy for two primary reasons: the difficulty of the treatment of cysts in certain

locations (central, the right lobe, or in the dome of the liver) and the risk of dissemination in the case of accidental rupture.[1,7] We believe that laparoscopic surgery should be as radical as open surgery.

As we have already mentioned, the majority of surgeons are familiarized with non-radical techniques for the treatment of hydatidosis. This disease tends to be more frequent in health areas attended by regional hospitals. As such, patients are probably not transferred to hepatobiliopancreatic units, unlike other diseases requiring liver surgery. Furthermore, taking into account that currently the majority of patients present a chronic infection of the cyst from the communication with the bile duct, it would appear logical to transfer them to centres capable of treating them with radical techniques (hepatectomy and total cystectomy).

REFERENCES

1. Dziri C, Paquet JC, Hay JM, Fingerhut A, Msika S, Zeitoun G, et al; French Associations for Surgical Research. Omentoplasty in the prevention of deep abdominal complications after surgery for hydatid disease of the liver: A multicenter, prospective, randomized trial. J Am Coll Surg. 1999;188:81-289.
2. Dziri C, Haouet K, Fingerhut A. Treatment of hydatid cyst of the liver. Where is the evidence? World J Surg. 2004;28:731-6.
3. Priego P, Nuño J, López P, López A, Peromingo R, Die J, et al. Hidatidosis hepática. Cirugía radical vs. no radical: 22 años de experiencia. Rev Esp Enf Dig. 2008;100:82-5.
4. Yuksel O, Akyurek N, Sahin T, Salman B, Azili C, Bostanci H. Efficacy of radical surgery in preventing early local recurrence and cavity related complications in hydatic liver disease. J Gastrointest Surg. 2008;12:483-9.
5. Galati G, Sterpetti AV, Caputo M, Aduci M, Lucandri G, Brozzetti S, et al. Endoscopic retrograde cholangiography for intrabiliary rupture of hydatid cyst. Am J Surg. 2006;191:206-10.
6. Bildik N, Cevik A, Altintags M, Ekinci H, Canberk M, Gulmen M. Efficacy of preoperative albendazole use according to months in hydatid cyst of the liver. J Clin Gastroenterol. 2007;41:312-6.
7. Baltar Boilève J, Baamonde de La Torre I, Concheiro Coello P, García Vallejo LA, Brenlla González J, Escudero Pérez B, et al. Laparoscopic treatment of hepatic hydatid cysts: techniques and post-operative complications. Cir Esp. 2009;86:33-7.

José Manuel Ramia Ángel
Unidad de Cirugía Hepatobiliopancreática, Servicio de Cirugía General y Aparato Digestivo, Hospital Universitario de Guadalajara, Guadalajara, Spain
E-mail address: jose_ramia@hotmail.com

Joan Figueras Felip
Unidad de Cirugía Hepatobiliopancreática, Servicio de Cirugía General y Aparato Digestivo, Hospital Universitario Josep Trueta, Girona, Spain

0009-739X/$ - see front matter