Correspondence

Surgery and postoperative mebendazole in the treatment of hydatid disease

Sir,

Ammari and Omari[1] have to be congratulated for the low recurrence rate of 2% after a mean follow-up period of 4 years following surgical treatment of hydatid liver disease and mebendazole therapy for 3 months. I do not think that this low recurrence is entirely attributable to postoperative mebendazole therapy. I believe that careful meticulous surgical technique, avoidance of spillage of hydatid fluid or daughter cysts, adequate isolation of the cyst during surgery and complete removal of the parasitic components is the most important factor in reducing the rate of recurrence. Scolicidal agents such as hypertonic saline, cetramide, hydrogen peroxide and others are routinely used during open surgery for hydatid disease. However, their benefit and effectiveness is doubtful and their use is not free of complications. The most feared complication is sclerosing cholangitis in presence of cyst communication with the biliary tree.[2] In my experience; double strength saline is quite safe and probably as effective.

Mebendazole is associated with side effects such as bone marrow suppression and abnormal liver function tests. It has been recently replaced by the use of the fairly newer albendazole, which is more effective and safer with less side effects.[3] The recommended dose for adults is 3 cycles of 400mg twice daily for 28 days, followed by 14 drug free days after each cycle.

Two new treatment modalities of hydatid disease are recently emerging and has been increasingly gaining popularity, but were not eluded to in the article: percutaneous drainage of hydatid cyst and the laparoscopic approach.[4-6] Major concern is risk of spillage and dissemination with subsequent recurrence. Experience with laparoscopic approach is relatively short and therefore long-term results warrant further evaluation. It seems to me that spillage may be inevitable and late recurrence is expected to be high. It is therefore wise to give 3 treatment cycles of albendazole, as recommended above, prior to percutaneous or laparoscopic drainage. This will destroy the scolices, sterilize the cyst and reduce the incidence of complications like anaphylactic shock and recurrence if intraoperative spillage occurs. Although the study contained a good number of hydatid disease cases, its major draw back is being retrospective. As hydatid liver disease is not uncommon in Jordan, the authors are urged to conduct a prospective randomized trial comparing surgery alone versus surgery and postoperative albendazole to conclude more strongly whether use of such therapy does actually reduce the incidence of recurrence or not.

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Reply from author

Sir,

The authors have read with interest the letter to the editor by Dr. A. N. Meshikhes. The recurrence rate after surgery is still high even with meticulous surgical technique. The use of mebendazole in our study is only due to availability. In this time of facts and evidence-based medicine, a comprehensive retrospective assessment of the outcome of various methods of treatment of hydatid disease in our hospital and review of the literature is timely and relevant. However, we accept and agree with Dr. Meshikhes' other comments.

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