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Is long-term follow-up without surgical treatment a valid option for hepatic alveolar echinococcosis?

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Abstract

We read the article titled, "Long-term follow-up of liver alveolar echinococcosis using echinococcosis multilocularis ultrasound classification," by Schuhbaur J with great interest. However, we found some worthwhile issues that we believe should be discussed with the authors, and have provided our comments in this letter. It would be valuable if the authors could provide further information about the clinical stages, follow-up time, and clinical outcomes of the patients.

Key Words: Alveolar echinococcosis; Albendazole; Surgical treatment; Ultrasound; Follow-up

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Core Tip: Although many experts suggest that radical surgery combined with albendazole treatment is the optimal option for alveolar echinococcosis patients, no clear consensus has been reached on whether long-term treatment using albendazole alone without any surgical intervention can cure or control the disease. Therefore, some professional issues need to be clarified by discussion with peers, in order to benefit as many patients as possible.

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TO THE EDITOR

We read the article titled, “Long-term follow-up of liver alveolar echinococcosis using echinococcosis multilocularis ultrasound classification,” by Schuhbaur *et al*[1] with great interest. In this significant study, the authors observed changes in sonomorphology during the follow-up of hepatic lesions using a sonomorphologic classification scheme. However, after reading the article carefully, we found some worthwhile issues that we would like to discuss with the authors.

Alveolar echinococcosis (AE) is an infectious zoonotic parasitic disease, which has been a major public health problem in its epidemic area[2]. In the large majority of cases, the liver is the first organ to be infested by the larvae. Hepatic AE often invades the surrounding vessels and adjacent organs in its advanced stages. The mortality rate within 10 years after diagnosis is more than 90% if the lesion is inadequately or not treated[3]. According to the World Health Organization Informal Working Group on Echinococcosis criteria[4], radical surgery combined with albendazole treatment is the optimal option for AE patients. In this article, the authors included 59 patients from Germany’s national echinococcosis database, who were “considered” to have hepatic AE, and long-term follow-up using ultrasound was performed. However, they did not mention the clinical stages, specific follow-up time, and clinical prognosis of these patients. Hepatic AE is known as “parasitic cancer,” due to its tumor-like characteristics with infiltration of vessels or biliary structures and distant metastasis. To date, no clear consensus has been reached on whether long-term treatment using albendazole alone without any surgical intervention can cure or control the disease. A 5-year analysis of two distinct cohorts in Bern, Switzerland and Besancon, France demonstrated that conservative treatment was less effective than surgical therapy[5]; however, longer follow-up results have not been available. Currently, “watch and wait” is not recommended unless complete inactivity of the AE lesion can be confirmed, in order to avoid delayed treatment resulting in adverse outcomes[6].

The authors’ team proposed an ultrasonographic classification scheme for hepatic AE in 2015[7], which was used to follow 59 patients. However, we noted that the authors stated that all but 1 patient received antiparasitic drugs, but they also claimed that more than half of the patients (55.9%) were defined as “probable” hepatic AE. In such a case, the use of albendazole and other drugs with hepatotoxicity may cause unnecessary harm to patients. According to a recent study with long-term observation of 117 AE patients, about 44.4% experienced adverse reactions when taking albendazole, and severe liver toxicity occurred in 7.7% patients[8]. We believe that the authors should have provided a more detailed explanation about whether the use of albendazole is indeed necessary for these patients. The high rate of inoperable disease at diagnosis underscores the need for an early, definitive diagnosis. However, in cases that cannot be confirmed by conventional examination, supplementary tests such as serology and positron emission tomography (PET)/computed tomography (CT) may be useful.

Bresson-Hadni *et al*[9] suggested that “surgical resection, if feasible, is the gold standard for treatment.” We also believe that early radical resection of the lesion should be considered in patients with hepatic AE, unless it is defined as unresectable. Based on the clinical guidelines and previous reports, the objectives for the treatment of hepatic AE should include the following: Completely removing the parasitic lesion, combined with 2 years of albendazole treatment after surgery; if this is not possible, reducing the proliferating potential of echinococcosis multilocularis by continuous administration of albendazole; and lesions that are massively calcified and/or negative by CT or PET may benefit from a “watch-and-wait” approach.

In summary, we admire the efforts of the authors in using ultrasound to assess sonomorphology changes over time in hepatic AE lesions. Nevertheless, it would be valuable if the authors could provide further information about the clinical stages, follow-up time, and clinical outcomes of the patients.

FOOTNOTES

Author contributions: Maimaitinijati Y performed the research and wrote the letter; Meng Y and Chen X revised the letter.

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