A 62-year-old female patient was referred to the hospital with fever, acute urinary retention, and hydatiduria associated with a 5-month left flank pain. Hematological data showed slight leukocytosis (12,700 mm$^3$) and moderate eosinophilia (9%). Serological tests were positive for antibodies against *Echinococcus granulosus*. Computed tomography (CT) of the abdomen revealed multiple hydatid forms ranging from 0.5 to 2.0 cm in diameter, involving all renal segments (Figure 1). The patient had end-stage chronic renal failure and underwent radical nephrectomy. Hydatidosis of the kidney was massive with numerous large and small cysts, which was suggestive of multivesicular renal hydatid infection (Figure 2a and b).

A polymerase chain reaction (PCR) was performed using hydatid fluid. The specific primers MS1 and MS2 were used to amplify the mitochondrial NADH subunit I (*nad1*) gene. For amplification of the mitochondrial cytochrome c oxidase subunit 1 (*cox1*) gene, JB3 and JB4.5 primers were used. The pathological and molecular findings confirmed *E. granulosus* and G1 genotype (Figure 3a and b).

The patient was treated with albendazole 10 mg/kg/day in two divided doses for 3 weeks in order to ensure protective protoscolicidal doses during the surgical procedure. Cystic hydatid disease is extremely rare, and the incidence of renal involvement is about 2% in all hydatidosis cases. In endemic areas, physicians must have good knowledge about the disease and must be aware of its clinical presentation and complications. Molecular methods such as PCR of hydatid fluid may be necessary for the differential species diagnosis.
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Conflict of interest: The authors declare that there is no conflict of interest.

REFERENCES

