A 44-year-old woman was admitted to our institution with a history of shortness of breath on mild exertion, cough, fever, and weight loss of 20 pounds. Past history was not significant until 2 months before the hospitalization, when she developed weakness and cough with occasional mucoid sputum. She did not smoke or take any medication. Examination revealed no lymphadenopathy, jaundice, or neck vein engorgement but did show mild hepatomegaly. A chest radiograph and CT of the thorax showed multiple nodules 2 to 3 cm in diameter in both lung fields suggestive of multiple pulmonary emboli. A lung ventilation/perfusion scan was positive for multiple pulmonary emboli. Leg ultrasound was negative for deep venous thrombosis. An ECG showed sinus tachycardia. Laboratory tests demonstrated marked eosinophilia, with negative Brucella, Q fever, rheumatoid factor, anti-nuclear antibody, anti–hepatitis C virus, and hepatitis B surface antigen tests.
Figure 1. Transthoracic 4-chamber view. Top, Cystic image within right atrium that penetrates into right ventricle. Bottom, Cystic image septated into 2 compartments and partially compressing right ventricle.

Figure 2. Transesophageal short-axis view of ascending aorta and main pulmonary artery. Cyst (1.2 cm) within lumen of main pulmonary artery bifurcation.
Figure 3. Surgical findings. Top, Encapsulated cyst protruding from acute margin of right ventricle (arrowheads). Middle, Open cyst after evacuation of clear fluid. Thin-walled transparent daughter cysts within lumen of larger cyst. Bottom, Opening into a second compartment containing multiple daughter cysts (arrow). Inner aspect of this second compartment bordered a thinned-out right ventricular wall, which perforated after complete evacuation of cyst contents.
Hydatid Cysts of the Heart
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