We read with great interest Karaman et al.’s rare case concerning lung infection with *Echinococcus alveolaris* [1]. We would like to highlight two points concerning the conservative treatment and imaging characteristics of alveolar echinococcosis (AE).

AE is a severe disease, with a mortality of over 90% in untreated patients. Radical surgery combined with chemotherapy for up to 2 years after surgery is recommended. Inoperable cases or patients who have undergone liver transplantation require continuous chemotherapy for many years. Long-term chemotherapy may significantly prolong survival [2]. Benzimidazoles, albendazole and mebendazole are presently used as chemotherapeutic agents. Failures in drug treatment as well as the occurrence of side effects have been reported, leading to the discontinuation of treatment or to progressive diseases [3]. Intravenous amphotericin B (preferably as a lipid emulsion) may be used as rescue chemotherapy in patients resistant or intolerant to benzimidazoles. Pilot trials with interferon-gamma and nitazoxanide were unsuccessful. Interferon-alpha has yet to be tested in a pilot trial.

With regard to diagnosis, ultrasonography, computed tomography (CT) and magnetic resonance (MR) with standard and diffusion-weighted sequences all provide useful information and serve complementary roles in detecting and characterizing echinococcal lesions. Cross-sectional imaging is crucial for differentiating echinococcosis from malignant processes. CT is most useful for depicting the peripheral calcifications surrounding established echinococcal cysts, and MR imaging is most helpful for identifying echinococcosis of the central nervous system [4].

**Conflict of interest:** none declared

**References**


