A 45-year-old man was admitted for pain in the upper right abdominal quadrant that had been evolving for months. His previous medical history was unremarkable. The physical examination showed a painful and tense abdomen in the right hypochondrium but the rest was pain free. Biological analysis showed an inflammatory syndrome (C-reactive protein 29.54 mg/L). Liver enzymology and urine medium remained negative. Peritoneal lavage was negative. The culture on the Löwenstein-Jensen agar plate and literature review. Case Rep Surg 2012, article ID 457272.


References


Bibliography

DOI http://dx.doi.org/10.1055/s-0033-1358804
Endoscopy 2014; 46: E1
© Georg Thieme Verlag KG Stuttgart - New York
ISSN 0013-726X

Corresponding author

Stéphanie Rouhard, MD
Department of Gastroenterology
Clinique St Luc
Rue St Luc 8
5004 Bouge
Namur
Belgium
Stephanie_rouhard@hotmail.com

Stéphanie Rouhard1, Philippe Maldague1, Adrien Ramboux2
1 Department of Gastroenterology, Clinique St Luc, Bouge, Namur, Belgium
2 Department of Surgery, Clinique St Luc, Bouge, Namur, Belgium

Competing interests: None

Fig. 1 CT scan: fluid in the perihepatic space in a 45-year-old man with Fitz-Hugh–Curtis syndrome.

Fig. 2 Celioscopy: “violin string” adhesions, a finding specific for Fitz-Hugh–Curtis syndrome.

Fitz-Hugh–Curtis syndrome in a man

A 45-year-old man was admitted for pain in the upper right abdominal quadrant, which had been evolving for months. His previous medical history was unremarkable. The physical examination showed a painful and tense abdomen in the right hypochondrium but the rest was pain free. Biological analysis showed an inflammatory syndrome (C-reactive protein 29.54 mg/L). Liver enzymology and urine and blood culture were negative. Abdominal ultrasonography and CT scan showed the presence of fluid in the perihepatic space, the right paracolic gutter, and the Douglas cul-de-sac. Celioscopy showed an inflamed liver parietal peritoneum with “violin string” adhesions, which are specific for Fitz-Hugh–Curtis syndrome [1,2]. A quinolone- and metronidazole-based treatment was administered. The pain resolved partially after the adhesiolysis, as often described [3,4]. Bacteriological analysis of perihepatic membrane biopsies, ascites, and urine samples remained negative. The intradermal reaction was positive. The culture on the Löwenstein-Jensen agar plate and literature review. Case Rep Surg 2012, article ID 457272.


Bibliography

DOI http://dx.doi.org/10.1055/s-0033-1358804
Endoscopy 2014; 46: E1
© Georg Thieme Verlag KG Stuttgart - New York
ISSN 0013-726X

Corresponding author

Stéphanie Rouhard, MD
Department of Gastroenterology
Clinique St Luc
Rue St Luc 8
5004 Bouge
Namur
Belgium
Stephanie_rouhard@hotmail.com

Stéphanie Rouhard1, Philippe Maldague1, Adrien Ramboux2
1 Department of Gastroenterology, Clinique St Luc, Bouge, Namur, Belgium
2 Department of Surgery, Clinique St Luc, Bouge, Namur, Belgium

Competing interests: None