Fitz-Hugh–Curtis syndrome in a man

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 samples remained negative. Peritoneal lavage was negative. The culture on the Löwenstein–Jensen medium remained negative. Peritoneal fluid analysis showed an inflamed liver (Fig. 1). The ultrasound and CT scan (Fig. 1) showed the presence of fluid in the perihepatic space, the right paracolic gutter, and the Douglas cul-de-sac. Celioscopy (Fig. 2) 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 peritoneal membrane biopsies, ascites, and urine samples remained negative. The intradermal reaction was negative. The culture on the Löwenstein–Jensen medium remained negative. Peritoneal carcinomatosis was excluded by histological analysis. Sporadic cases of Fitz-Hugh–Curtis syndrome have been reported associated with pyelonephritis. Hospital das Clínicas da FMUSP 2012; 67: 1493–1405

References

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