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 medium remained negative. Peritoneal cytology 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 perihepatic membrane biopsies, ascites, and urine samples remained negative. The intradermal reaction was negative. The culture on the Löwenstein medium remained negative. Peritoneal cytology 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].

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.

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