

**(Refer to page 91)**

**Answer: Fitz-Hugh Curtis syndrome**

Fitz-Hugh and Curtis in 1930s described a syndrome that was characterised by right-sided abdominal pain secondary to perihepatitis, localised fibrinous inflammation of liver Glisson's capsule with subsequent formation of adhesions between anterior surface of liver and diaphragm or anterior abdominal wall. These are classically described as 'violin string' associated with pelvic inflammatory disease (PID).<sup>1,2</sup>

FHC is reported in 4-14% of women with PID and often in the younger age group. However, FHC can also be seen in absence of PID and interestingly, also in men.<sup>2</sup>

FHC is usually caused by Chlamydia or *Neisseria Gonorrhoeae* infection. The spread of the infection from the pelvis may be due to circulation of peritoneal fluid along the paracolic gutter. A gliding effect of liver during respiration is thought to predispose and contribute to the right sided involvement. Reports of cases in men have raised the possibility of haematogenous or lymphatic spread. FHC syndrome is a cell mediated immune response probably resulting to Chlamydia Heat shock protein 60. The geometric titer of Chlamydia antibody is significantly higher in patients with FHC.<sup>3</sup>

In acute phase, clinical picture is characterised by excruciating sharp pain in right upper quadrant referred to right shoulder or inside of the arm. Pain is increased with deep respiration, coughing and truncal movements. Other symptoms include pelvic pain, vaginal discharge, fever, chills, nausea and hiccups. Occasionally a friction rub similar to 'snow creaking' can be heard over the anterior costal margin. Pelvic examination is frequently abnormal with purulent discharge. Culture may be negative. White cell count and erythrocyte sedimentation rate are frequently elevated. Ultra sound may reveal violin string and ascitis. Contrast enhanced computed tomography scan may be show perihepatic enhancement.

The differential diagnosis includes hepatitis, pyelonephritis, pancreatitis, appendicitis, cholecystitis and peptic ulcer. The management includes intravenous antibiotics as per PID guidelines in the acutely ill patients, followed by oral antibiotics. In patients with chronic symptoms undergoing laparoscopy, peri-hepatic adhesions found incidentally can be treated with adhesiolysis.

**REFERENCES**

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- 3: Sweet RL, Gibbs RS. Sexually transmitted disease. In Infectious diseases of the female tract Clinical Infectious Diseases. 5<sup>th</sup> Ed. Philadelphia, PA, Wolters Kluwer/Lippincott Williams & Wilkins, 2009. Pg 113-8.