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RESEARCH ARTICLE

FITZ HUGH CURTIS SYNDROME – A RARE PRESENTATION

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ABSTRACT

Perihepatitis associated with pelvic inflammatory illness is termed to as Fitz-Hugh-Curtis syndrome. One of the most common etiologies is Chlamydia trachomatis. This illness typically manifests as upper right quadrant abdominal discomfort that resembles other gastrointestinal and hepatobiliary disorders, creating a clinical challenge in situations with few diagnostic resources.

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INTRODUCTION

A rare condition known as Fitz-Hugh-Curtis syndrome (FHCS) is characterised by perihepatic inflammation and an ascending vaginal infection. The condition can mimic many other conditions, including acute cholecystitis, right pyelonephritis, pneumonia, and even acute appendicitis, making the diagnosis challenging and subject to misdiagnosis.[1,2] Right upper quadrant (RUQ) pain is the typical first indicator of this illness, which is typically accompanied with PID symptoms (fever, lower abdominal pain, vaginal discharge), the RUQ pain is frequently referred to the right shoulder or the inside of the right arm and is typically acute, pleuritic, made worse by movement. It may be accompanied by chills, fever, night sweats, nausea, vomiting, hiccups, headache, and malaise[3]. FHCS affects between 12 and 14 percent of women with PID who are childbearing age.[1]The disease syndrome was first described by Curtis showing adhesions of the anterior surface of the liver, called "violin-string" adhesions, in patients with coincident residual gonococcal tubal disease[4]. Four years later, Fitz-Hugh described clinical characteristics of this syndrome[5]. Although the disease was originally described in the literature in the 1930s, doctors still lack sufficient knowledge of it, which leads to the possibility of doing unnecessary surgery. We therefore sought to showcase a young woman who was identified as having FHCS and received medical care at our hospital.

CASE REPORT

A 20 year old female patient with P2L2 presented with complaints of chronic abdominal pain mostly over the right hypochondrium for 15 days, pain was insidious in onset and progressive in nature and aggrevated by doing work. She also complained of whitish vaginal discharge for past 2 weeks intermittent in onset not associate with fever, burning micturition or dyspareuia. On physical examination she was afebrile, no pallor, no icterus and she had underwent cholecystectomy 2 years. She has no previous history of sexually transmitted diseases, chronic disease or previous history of abdominal trauma. She was previously treated in obstetrics and gynaecology department for pelvic inflammatory disease one month before. Now she presented to department of medicine for persistant right hypochondrial pain for 15 days. Persitence of right hypochondrial pain suggested for futher evaluation. On abdominal examination there was severe tenderness in right hypochondrium both superficial and deep, there was no organomegaly. Vaginal examination revealed offensive mucoid yellowish vaginal discharge, with mild adnexal tenderness. Her laboratory paramaeters revealed Hb- 10.8, Total white blood count – 15,000, Neutrophils – 88%, Lymphocytes – 7%, Eosiniophils- 2%, Monocytes – 1%, Basophils – 1%, ESR – 25, Liver function test showed AST – 558, ALT – 650, Total bilirubin – 1.8, Alk phosphatase – 118, Abdominal ultrasound revealed post

bladder fossa. On further evaluation with ct abdomen with hypernhancement of the hepatic capsule, minimal perihepatic fluid, mild free fluid in pouch of doughlas and pelvic cavity, left sided mild pleural effusion was also seen with features suggestive of perihepatits (Fitz- hugh Curtis syndrome). Gram stain stain and culture of endocervical swab showed no growth of organism. Chlamyydiatachomatis (ELISA) was positive. A diagnosis of Fitz Hugh Curtis syndrome was made based on correlation findings of chronic right hypochondrial pain with CT abdomen finding and patient was treated accordingly.

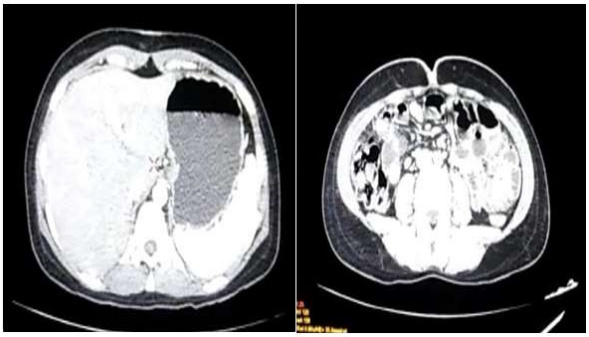

Fig. 1, 2. CT images showing hyperenhancement of the hepatic capsule with minimal perihepatic fluid and mild fluid in POD and pelvic cavity

DISCUSSION

FHCS is a rare situation of perihepatic capsule inflammation brought on by PID[1]. The direct intraperitoneal transmission of infection from the original pelvic inflammation to the perihepatic area is presumed to be the cause of the inflammation[7]. The following are the suggested pathways for the disease's progression from pelvic inflammation to the subphrenic or perihepatic region: 1) Hematogenous spread; 2) Translymphatic spread; 3) Transperitoneal ascending spread of the inflammation from the pelvis via the bilateral paracolic gutters, according to the ascitic fluid flow, notably on the right side; and 4) An Enhanced Immune Response [6,3,7,8]. The majority of FHCS patients are childbearing, sexually active women who seek treatment in the emergency room because to severe pain and tenderness in the right upper abdomen. It can be challenging to identify from acute cholecystitis, occasionally acute appendicitis, and the other kind of peritonitis due to the physical findings and pain features[1,2]. PID prevalence, a history of STI treatment, or a gynaecological procedure should increase suspicion of this condition [2]. In the past, the perihepatic adhesions were seen during open or laparoscopic surgery to make the diagnosis, and adhesiotomy was used to cure the condition. However, with to the advancement of imaging techniques and antibiotherapy regimens, it may now be identified and treated using minimally invasive techniques[1,9].

All of these Imaging results matched to our patient. FHCS was indeed identified quickly. On the other hand, surgical intervention is only recommended when circumstances in which antibiotic treatment was ineffective.

CONCLUSION

Particularly in sexually active women of childbearing age, FHCS should be taken into consideration when making a differential diagnosis of diseases causing acute abdominal pain. With the help of this case report, we hope to draw the attention of physicians to this uncommon syndrome, preventing the need for unnecessary surgery and testing.

Abbreviations: FHCS - Fitz-Hugh-Curtis syndrome, RUQ - Right upper quadrant, PID – Pelvic inflammatory disease.

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