Case Report
Volume 7:1, 2023

Clinical and Medical Case Reports

ISSN: 2684-4915 Open Access

Hepatic Fibrosis in a Male Patient, Could It Be Fitz Hugh Curtis Syndrome?

Francis Basimbe[1,2]*, Hakim Din Iman[1], Hussein Bili[1], Dionizi Muganga[1] and Jama Abdisamad[1]

[1]*Department of Gastrointestinal Surgery, Uganda martyrs University, Nkozi, Uganda*
[2]*Department of Gastrointestinal Surgery, St Francis Hospital Nsambya, Kampala, Uganda*

Abstract

Fitz Hugh Curtis syndrome has been described mainly in females with characteristic peri hepatic fibrosis sparing the liver parenchyma and presence of pelvic inflammatory disease. The peri- hepatic fibrosis is usually between the liver capsule and the diaphragm. This has been mainly described in female patients and thought to be as a result of Pelvic Inflammatory Disease (PID). However in our setting we have noticed cases occurring mainly in young men that fit the above description. These have presented with mainly pain in the upper abdomen. Epigastrium, left and hypochondrium. In our setting some of these patients have had upper GIT Endoscopies done and a diagnose of esophageal reflux and hiatus hernias diagnosed. Pelvic manifestations of inflammation have not been present in any of these patients An abdominal CT scan may report per capsular thickening in some of these patients, however in our setting, the majority of these patients are diagnosed at laparoscopy. We therefore report a case of Fitz Hugh Curtis diagnosed at laparoscopy, the patients symptoms of upper abdominal pain have completely resolved after lysis of these peri hepatic adhesions.

Keywords: Fitz hugh curtis syndrome • Peri hepatic fibrosis • Diagnostic laparoscopy

Introduction

Fitz Hugh Curtis syndrome has been described mainly in females with characteristic perihepatic fibrosis sparing the liver parenchyma and presence of pelvic inflammatory disease.

The perihepatic fibrosis is usually between the liver capsule and the diaphragm.

This has been mainly described in female patients and thought to be as a result of Pelvic Inflammatory Disease (PID). However in our setting we have noticed cases occurring mainly in young men that fit the above description.

These have presented with mainly pain in the upper abdomen. Epigastrium, left and hypochondrium.

In our setting some of these patients have had upper GIT Endoscopies done and a diagnose of esophageal reflux and hiatus hernias diagnosed.

Pelvic manifestations of inflammation have not been present in any of these patients.

An abdominal CT scan may report per capsular thickening in some of these patients, however in our setting, the majority of these patients are diagnosed at laparoscopy.

We therefore report a case of Fitz Hugh Curtis diagnosed at laparoscopy, the patients symptoms of upper abdominal pain have completely resolved after lysis of these peri hepatic adhesions.

***Address for Correspondence:** Francis Basimbe, Department of Gastrointestinal Surgery, Uganda Martyrs University, Nkozi, Uganda, E-mail: basimbef@yahoo.co.uk*

Received: 03 February, 2023, Manuscript No. cmcr-23-90941; **Editor assigned:** 06 February, 2023, PreQC No. P-90941; **Reviewed:** 17 February, 2023, QC No. Q-90941; **Revised:** 22 February, 2023, Manuscript No. R-90941; **Published:** 01 March, 2023, DOI: 10.37421/2684-4915.2023.7.248

Case Presentation

40yr old male presented with longstanding right upper quadrant and epigastric pain for 3 years, patient is married and reported no history of sexually transmitted infections. On examination, patient was stable, afebrile with normal vital signs. Abdominal exam revealed normal fullness soft, non-tender with no palpable masses. Laboratory workup revealed a white cell count of 15,000/L with normal liver functional tests, patient was HIV Negative, Hepatitis B and Hepatitis C Negative, he had a gastroduodenoscopy that was done and was normal, had a normal colonoscopy as well.

Abdominal ultrasound and CT scans were done and were found normal as well.

Patient was admitted to our gastrointestinal surgical service and due to the worsening abdominal pain, a decision to do a Diagnostic laparoscopy was made. He was taken to the operating room on the second day of admission.

The caecum, appendix and ascending colon were normal with no scaring or adhesions seen., the rest of the large bowel was also assessed and found normal. The small bowel was assessed in a retrograde fashion from the ileocecal junction all the way up to the jejunum and no strictures masses or perforations were noted.

There were extensive Adhesions involving both lobes of the liver and the anterior abdominal, the adhesions were lysed using Harmonic Endo shears, samples were taken for culture and there was no growth reported. Patient made a full recovery and there was complete resolution of symptoms. He tolerated his diet well and was discharged on postoperative day 2 in good condition. Peri hepatic adhesions involving the right lobe of the liver (Figure 1) perihepatic adhesions involving the left lobe of liver (Figure 2) are taken during the procedure.

Discussion

Fitz –Hugh – Curtis syndrome was first described in the 1920s and over the years, it has been associated with pelvic infections especially in females [1].

Of recent we have increasingly seen men who present in our setting

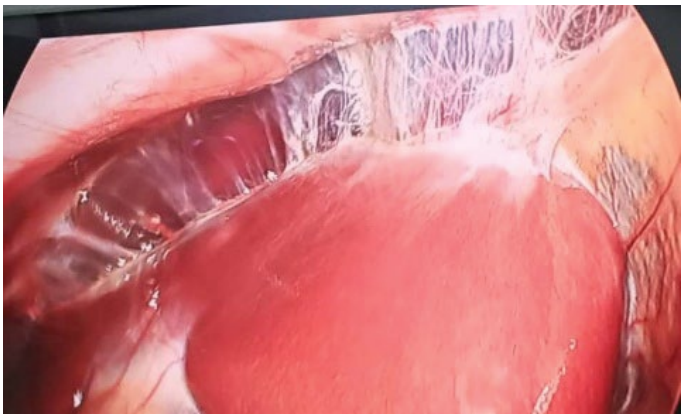

Figure 1. Perihepatic adhesions involving the right lobe of the liver.

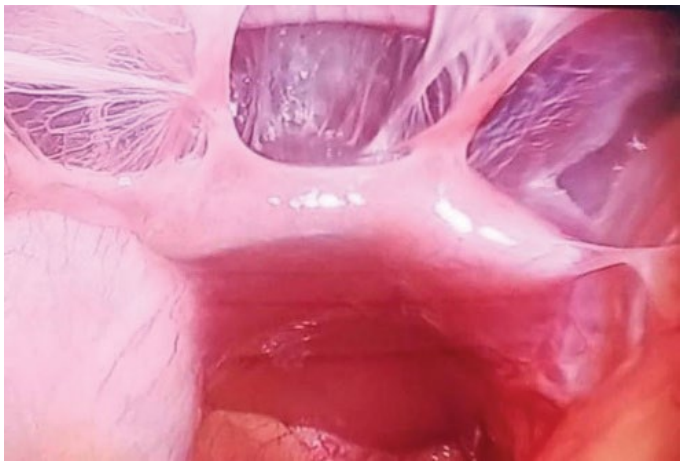

Figure 2. Perihepatic adhesions involving the left lobe of liver.

with similar symptoms and operative findings. Some have been discovered incidentally while performing upper gastrointestinal anti reflux surgery [2-4].

The pathogenesis of Fitz –Hugh – Curtis syndrome is poorly understood, in women the peri hepatic adhesions have been attributed to a direct bacterial spread from the fallopian tubes in the pelvis in cases of pelvic infections and ascending *via* the right para colic gutter into the peri- hepatic area [5,6].

However in men, lymphatic and haematogeneous spread have been postulated [6].

May patients present with abdominal pain mainly in the right upper quadrant, however this is usually not specific and in our setting, many of these patients are discovered during diagnostic laparoscopy procedures for unexplained pain or during upper gastrointestinal surgeries especially anti reflux surgery.

Therefore the symptom can pause a diagnostic challenge and can sometimes be confused with biliary pathology [6].

In the laboratory, total white cell count has been shown to be normal in nearly half of the patients, while liver functional tests are usually normal as seen in this particular patient [6].

Radiological investigations like abdominal ultrasound and abdominal CT Scans have been shown miss it, it has been reported that in some cases there might be sub capsular fluid collection and thickening of the hepatic capsule [3,4,6].

Conclusion

Fitz – Hugh – Curtis syndrome has been defined as inflammation with fibrosis of the liver capsule and has historically been associated with pelvic inflammatory conditions in women, however for over fifty years now, there has been an increasing number of male cases reported with similar presentation and findings, the role of laparoscopy in diagnosis and therapy cannot be over emphasized and has shown to lead to complete resolution of symptoms.

Acknowledgement

None.

Conflict of Interest

None.

References

1. Fitz-Hugh, T Jr. "Acute gonococcic peritonitis of the right upper quadrant in women." *J Am Med Assoc* 102 (1934): 2094-2096.
2. Owens, S., T. R. Yeko, R. Bloy and G. B. Maroulis. "Laparoscopic treatment of painful perihepatic adhesions in Fitz-Hugh-Curtis syndrome." *Obstet Gynecol* 78 (1991): 542-543.
3. Peter, Nadja G., Liana R. Clark and Jeffrey R. Jaeger. "Fitz-Hugh-Curtis syndrome: A diagnosis to consider in women with right upper quadrant pain." *Cleve Clin J Med* 71 (2004): 233-241.
4. Wu, H. M., C. L. Lee, C. F. Yen and C. J. Wang, et al. "Laparoscopic diagnosis and management of Fitz-Hugh-Curtis syndrome: Report of three cases." *Chang Gung Med J* 24 (2001): 388-392.
5. Kimball, Michael W. and Steven Knee. "Gonococcal perihepatitis in a male: The Fitz-Hugh-Curtis syndrome." *N Engl J Med* 282 (1970): 1082-1084.
6. Saurabh, S., E. Unger and C. Pavlides. "Fitz–Hugh–Curtis syndrome in a male patient." *J Surg Case Rep* 2012 (2012): 12-12.

How to cite this article: Basimbe, Francis, Hakim Din Iman, Hussein Bili and Dionizi Muganga, et al. "Hepatic Fibrosis in a Male Patient, Could It Be Fitz Hugh Curtis Syndrome?." *Clin Med Case Rep* 7 (2023): 248.