International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Hubert AKT et al. Int J Reprod Contracept Obstet Gynecol. 2026 Sep;15(9):3649-3651
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20263053

Case Report

Fitz-Hugh-Curtis syndrome with intestinal obstruction in an elderly woman

Assohoun K. T. Hubert*, Koffi G. Marcellin, Dah G. Fredy, Andjemian Inguessan

Service de Chirurgie Générale et Digestive du CHU de Yopougon, UFR Sciences Médicales, Université Félix Houphouët Boigny d'Abidjan Cocody, Côte d'Ivoire

Received: 26 March 2026
Accepted: 02 May 2026

***Correspondence:**
Dr. Assohoun K. T. Hubert,
E-mail: assohoun_toussaint@yahoo.fr

ABSTRACT

Fitz-Hugh-Curtis (FHC) syndrome occurs as a complication of pelvic inflammatory disease, most commonly in young women, following *Chlamydiae trachomatis* infection of the genital tract. It is a rare condition, exceptional in elderly women and especially when it is revealed during an intestinal obstruction. This is why we report the case of a 65-year-old woman who presented with an occlusive syndrome whose diagnosis of FHC syndrome was made accidentally intra operatively. Thus, when the usual causes of febrile obstruction in a woman have been eliminated, whatever the age, the possibility of FHC syndrome must be raised by the clinician, even in the absence of pelvic symptoms.

Keywords: Occlusion, Hail, Fitz-Hugh-Curtis syndrome

INTRODUCTION

Fitz-Hugh-Curtis (FHC) syndrome occurs as a complication of pelvic inflammatory disease, most often in young women and rarely in older women.[1] It generally follows a *Chlamydia trachomatis* infection of the genital tract. The ascent of the bacteria (*Chlamydia trachomatis*, gonococcus) via the right paracolic gutter to the liver causes characteristic perihepatitis. This syndrome is found in 4 to 10% of acute salpingitis cases, whether or not there is pain in the hepatic region.[1,2] FHC syndrome is characterized by the sudden onset of intense pain and fever in the right upper quadrant, radiating to the right shoulder, during a salpingoperitoneal infection, mimicking acute cholecystitis or a biliary colic attack. It corresponds to perihepatitis with purulent exudate on the convex surface of the liver, with the progressive formation of perihepatic adhesions resembling violin strings between the liver capsule and the diaphragm.[2] Multidetector computed tomography with contrast injection is currently the preferred diagnostic tool for this condition, revealing highly suggestive signs.[3] We report the case of a 65-year-old woman presenting with an occlusive syndrome that posed diagnostic challenges.

CASE REPORT

This was a 65-year-old woman admitted to the surgical emergency department with epigastric pain that had been present for one week, radiating to both hypochondria. This pain was associated with vomiting and a fever of 38.5°C. The patient's condition progressed to constipation and gas, along with progressive abdominal distension. She had two previous cesarean sections in 1985 and 1992. Clinical examination revealed an intestinal obstruction. Laboratory tests showed leukocytosis (18,180 leukocytes/mm^3) with normal hepatobiliary function tests. No local biopsies were performed. Abdominal ultrasound was inconclusive. An abdominal and pelvic comuted tomography (CT) scan confirmed the intestinal obstruction without any abnormalities of the liver parenchyma (Figure 1). An emergency laparotomy revealed incarceration of the small bowel at the level of hepatoparial-diaphragmatic adhesions in a "violin string" pattern (Figure 2). We diagnosed a complicated hepatic effusion syndrome with an obstruction caused by an internal suprahepatic hernia. We performed a simple excarceration and adhesiolysis, with satisfactory postoperative recovery.

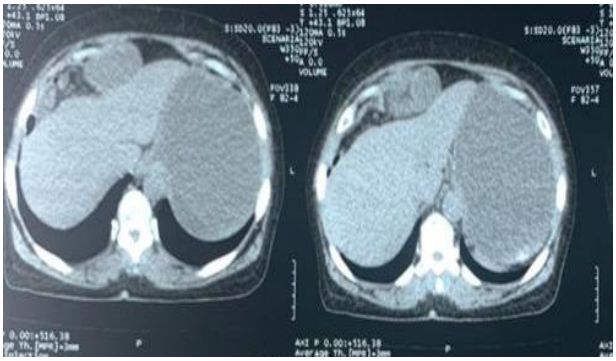

Figure 1: Abdominal scan without contrast: small bowel obstruction in addition to hepatic obstruction.

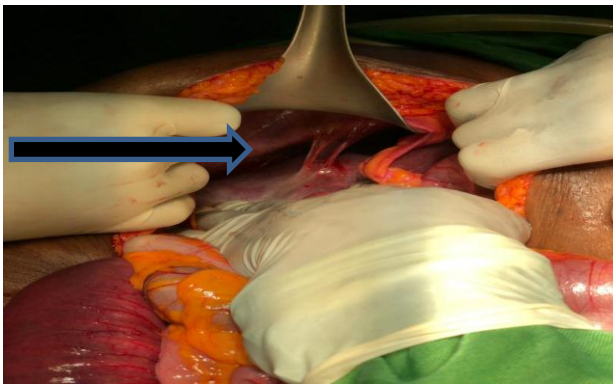

Figure 2: Intraoperative view: hepatoparial "violin strings".

DISCUSSION

Perihepatitis venereum, also known as FHC syndrome, is a capsular and peritoneal perihepatic involvement secondary to a gynecological infection of venereal origin occurring in young, sexually active women. FHC syndrome was first described by Curtis in 1930, who reported several observations of hepatoperitoneal adhesions related to gonococcal pelvic infection, and then by Fitz-Hugh in 1934, who confirmed this theory.[4,5] Its frequency is estimated to be between 4% and 14% in women with pelvic infection and can reach 27% in adolescents.[2]

In our study, the diagnosis was made in a 65-year-old woman in an emergency setting. The most frequently encountered infectious agents are *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. We were unable to isolate the causative organism in our case, probably due to the associated intestinal obstruction. A definitive diagnosis is classically established by laparoscopy, which visualizes the velamentous adhesions resembling "violin strings" between the liver surface and the abdominal wall, with biopsies taken. Associated bacteriological findings; consistent with our study where the diagnosis was established by laparotomy due to hepatoparietal "violin string" adhesions.[6]

Abdominal ultrasound is the first-line examination; it allows for the exclusion of cholecystitis and, above all, the diagnosis of upper genital tract infection by showing tubal wall thickening and the presence of fluid in the fallopian tube. However, these signs are inconsistent and difficult to interpret.[3] In our case, abdominopelvic ultrasound was not helpful, apart from the observed aerocolitis; multidetector CT with contrast injection was the gold standard for diagnosis while ruling out an obstructive tumor in an elderly patient.[7-9] In our case, we had no evidence to support the diagnosis other than confirmation of the bowel obstruction; this was because the procedure was performed without contrast injection due to the associated renal findings (creatinine: 38 mg/l and urea: 1.86 g/l). Treatment is most often conservative, in the absence of complications, combined with antibiotic therapy targeting the causative organism.[5-10]

CONCLUSION

When the usual causes of febrile occlusion in an elderly woman have been eliminated, the possibility of an occlusion complicating FHC syndrome should be considered by the clinician even in the absence of obvious pelvic symptoms.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Le Moigne F, Génicom C, Karkowski L, Martinano D. Fitz -Hugh-Curtis syndrome. J Diagnost Intervent Imaging. 2022;5(5):245-9.
2. Le Moigne F, Lamboley JL, Vitry T, Salamanda P, Milou F, Farthouat P. Usefulness of contrast-enhanced CT scan for diagnosis of Fitz-Hugh-Curtis syndrome. Clin Biol Gastroenterol. 2009;33(12):1176-8.
3. Curtis AH. A cause of adhesions in the right upper quadrant. JAMA 1930;94:1221-2.
4. Fitz-Hugh Jr T. Acute gonococcic peritonitis of the right upper quadrant in women. JAMA. 1934;102:2094-6.
5. Müller-Schoop JW, Wang SP, Munzinger J, Schläpfer HU, Knoblauch M, Tammann RW. Chlamydia trachomatis as possible cause of peritonitis and perihepatitis in young women. Br Med J. 1978;1:1022-4.
6. Cho HJ, Kim HK, Suh JH, Lee GJ, Shim JC, Kim YH. FitzHugh-Curtis syndrome: CT findings of three cases. Emerg Radiol. 2008;15:43-6.
7. Nishie A, Yoshimitsu K, Irie H, Yoshitake T, Aibe H, Tajima T, et al. Fitz-Hugh Curtis syndrome. Radiologic manifestation. J Comput Assist Tomogr. 2003;27:786-91.
8. Bouic E, Millet I, Curros-Doyon F, Faget C, Fontaine M, Taourel P. Acute pelvic pain in females in septic

and aseptic contexts. Diagnost Intervent Imaging. 2015;96(10):985-95.
9. Excoffier S, Poletti PA, Brandstatter H. Acute abdominal pain of the upper abdomen: which imaging to choose? Rev Med Suisse. 2013;9(399):1710.
10. Nana TN, Tchounzou R, Wambo AGS, Nkwele FM, Ngolile N, et al. Comparative Study between Hysterosalpingography and Laparoscopy in the Diagnosis of Tubal Factors of Female Infertility in a Reference Hospital in Sub-Saharan Africa' Setting. Arch Obstet Gynecol Reprod Med. 2023;6(2):226-30.

Cite this article as: Hubert AKT, Marcellin KG, Fredy DG, Inguessan A. Fitz-Hugh-Curtis syndrome with intestinal obstruction in an elderly woman. Int J Reprod Contracept Obstet Gynecol 2026;15:3649-51.