Lesson of the Week

Pleuritic pain: Fitz Hugh Curtis syndrome in a man

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Pleurisy of the right side that occurs as a feature of gonococcal infection and is related to a "perihepatitis" is called the Fitz Hugh Curtis syndrome.[1 2] The syndrome may also be caused by *Chlamydia trachomatis*.[3 4] This syndrome has been confused with cholecystitis, pneumonia, pulmonary embolism, and perforation of a viscus.[5] It may be overlooked and underreported.[6] There have been two reports of it in men.[7 8]

We report on a man in whom the diagnosis was confused. The case highlights the frequency with which multiple infections are acquired sexually.

Pleuritic pain may be associated with gonorrhoea

Case report

The patient was a 35-year-old bisexual who had been discharged four days earlier after he had been operated on for an acutely painful swelling in the groin. He had reported general malaise for one month. At operation matted oedematous lymph nodes were excised. He was discharged two days later to be followed up. He developed right-sided pleuritic pain, however, and presented to the casualty department. He was pyrexial and in much pain. Radiological examination showed splinting of the chest and a raised right diaphragm. He felt tenderness over the liver and lower chest, but no pleural or hepatic rub was heard. There was no evidence of venous thrombosis in the legs, though the incision in the groin was still oozing. He was treated with anticoagulants since pulmonary embolism was probable.

Over the next few days he developed a widespread sparse pustular rash, typical of disseminated gonococcaemia. There was no generalised lymphadenopathy. Further examination showed proctitis and urethritis, though no intracellular Gram-negative diplococci were seen on Gram-stained smears, and rectal, urethral, and throat cultures for *Neisseria gonorrhoeae* were negative. He also had two non-indurated ulcers on his prepuce and anus, but these were dark ground negative. He received several doses of antituberculous drugs, including rifampicin, after multiple acid-fast bacilli were found in the original excised lymph node from which *Mycobacterium chelonei* was later cultured. Histology, however, showed the typical findings of syphilitic adenitis, including Dieterle staining for spirochaetes. Serology later confirmed active syphilitic infection with a VDRL titre of $>1:32$, a positive test for the *Treponema pallidum* haemagglutination antibody, positive fluorescent treponemal antibody (abs) IgG and IgM. A ventilation perfusion scan showed no evidence of pulmonary infarction, liver function tests were normal, and he was HBsAg negative. He was treated with high doses of parenteral penicillin, his pleuritic pain settled over five days, and he made a complete recovery.

Before his first admission he had attended a venereology clinic at another hospital. Urethral smears and cultures were negative, rectal tests were not done, but throat cultures were positive for *N gonorrhoeae*. Syphilis serology was strongly positive with a VDRL of 1:16. His contacts included a man four months earlier, who proved to have early latent syphilis but not gonorrhoea. He admitted having had two other partners in the past three months (both women), of whom one had negative tests and the other could not be traced.

Comment

Litt and Cohen[6] showed retrospectively that the Fitz Hugh Curtis syndrome occurs in up to 21% of cases of gonococcal salpingitis but that it has rarely been recognised as such. The features in our patient were typical, although pleural or hepatic rubs have been reported[2] due to a fibrinous perihepatitis and originally observed at laparotomy but later through the laparoscope. Transient hepatic dysfunction occurs in up to 27% of patients.[6] Indeed, in the man reported by Kimball and Knee[7] although liver biopsy findings were normal *N gonorrhoeae* were cultured. It has been suggested that it is spread by means of the fallopian tubes and paracolic gutters to the subphrenic area,[5] and a similar mechanism may apply in a man with proctitis. Dissemination in the blood was used to explain coexistent arthritis,[8] however, and in our patient such a mechanism is likely in view of the widespread rash. The importance of the syndrome is the diagnostic confusion that it may cause.

M chelonei is a rapidly growing atypical mycobacterium and is freely found in dust and soil and is not a laboratory contaminant. It is recognised as causing subcutaneous abscesses though usually in diabetic patients who require insulin. Entry in this case was presumably through the genital ulcers.

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