

entidad. Este es el cuarto caso comunicado de tratamiento con adalimumab en eritema nudoso crónico refractario. En los otros casos, los autores Ortego-Centeno et al.³ y Callejas Rubio et al.⁴ comunican un resultado similar, utilizando la misma dosis, con rápida respuesta y manteniendo el tratamiento de 6-12 meses, sin recidiva tras un seguimiento de 18 meses.

La patogenia de esta entidad es desconocida aunque se relaciona con mecanismos basados en la formación de inmunocomplejos, la activación del complemento, los mediadores de la inflamación liberados por polimorfonucleados activados y, recientemente, con el TNF- α .⁵ El tratamiento con adalimumab es una alternativa terapéutica en aquellos casos de eritema nudoso de larga evolución y refractarios a los tratamientos convencionales.

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Fitz-Hugh-Curtis syndrome in males: Increasing prevalence of a rare clinical entity

Síndrome de Fitz-Hugh-Curtis en hombres: aumento de la prevalencia de una entidad clínica poco frecuente

To the Editor:

The recent article by Demelo-Rodriguez et al. provided for highly interesting reading.¹ Interestingly, the past few years have seen a marked increase in the prevalence of Fitz-Hugh-Curtis syndrome (FHC) in males. FHC rarely occurs in males and was first reported in males by Kimball and Knee in 1970.² The syndrome occurs secondary to the haematogenous spread of the bacteria to the hepatic capsule. Lymphatic spread of the bacteria may also occur at the same time. Lin et al. in a recent retrospective analysis have reported that nearly 33% of all cases of FHC occur in males.³ The signs and symptoms associated with the syndrome are secondary to the formation of peri-hepatic adhesions between the Glisson's capsule and the adjacent peritoneum. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* are typically the primary cause of FHC in males. Mean age of the patients is 34.5 years.⁴

Patients with FHC present with abdominal pain usually restricted to the right upper quadrant in 48% of the cases.⁵ The pain is characteristically continuous and not exacerbated by food consumption. 52% of the patients however report diffused abdominal pain. Pleuritic type of pain in the right chest may be present concomitantly.⁶ Most patients also

complain of nausea and vomiting with concurrent diarrhea.⁴ Male patients may or may not complain of urethral symptoms. Distension of the abdomen can usually be elicited on physical examination.² Hamdan recently reported the case of a male patient who was diagnosed with ectopic appendicitis that on further evaluation led to the diagnosis of FHC syndrome.^{6,7}

CT scan of the abdomen leads to confirmation of the diagnosis in males. CT imaging during the arterial phase may reveal sub-capsular hepatic enhancement due to fluid collection in 31.25% of the patients.⁸ In 75% of patients with sub-capsular fluid collection the width of the fluid collection is less than 3mm. Thickening of the Glisson's capsule can usually be appreciated in nearly 100% of the patients with FHC.⁹ Accentuated amount of free pelvic fluid may be seen. Nearly half of the males with FHC demonstrate enhanced hepatic parenchyma on CT imaging.^{5,7} The enhancement is typically wedge shaped. US may be used for making the diagnosis if CT imaging is not available but is not as sensitive as CT imaging.⁴ SGOT and SGPT are typically normal while the WBC count may or may not be elevated. Elevated ESR is seen in 47.6% of the patients.¹⁰ Laparoscopy is the ultimate diagnostic test for FHC and is recommended in patients where no clear diagnosis can be made.

Antibiotics remain the mainstay of FHC in adults.³ Failure to respond to antibiotic therapy may require laparoscopic surgery. Electro cautery is used to lyse the adhesions.³ This usually leads to a significant improvement in the intensity of the right upper quadrant pain.

The incidence of FHC is rapidly increasing in males. FHC should be included in the differential in males presenting with atypical right upper quadrant pain.

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