this category are mainly meats and meat products, milk and cream, cheese, and cakes and biscuits. Equally, caterers should provide similar information in appropriate ways.

The concentration of alcohol (ethanol) in beers, ciders, wines, spirits, and any other drinks containing more than 1.2% of alcohol by volume should be printed on the container in percentage by volume. The concentration in drinks that are dispensed should be displayed prominently at retail outlets.

Where appropriate, foods or food products with lower contents of saturated plus trans fatty acids and/or common salt than is at present customary should be made available to the general public. Examples are milk, meats, and meat products such as sausages, hamburgers and minced meats, margarines (trans fatty acids), and breads and other cereal products.

Recommendations to government

Means should be found to educate the general population of the United Kingdom in habits of eating and physical activity that will minimise the risk of cardiovascular disease and of obesity. The process of education should be started in schools.

Consultations should take place between the relevant government departments and the producers, manufacturers, and distributors of food and drink and caterers which will lead to legislation and to codes of practice to improve public knowledge of the composition of foods, improve public awareness of the alcohol content of alcoholic drinks, and lead to the provision of alternative preparations of some foods with lower contents of saturated and of trans fatty acids and/or common salt.

Consideration should be given to ways and means of encouraging the production of leaner carcasses in sheep, cattle, and pigs (for example, by adjustments to the operation of the carcass grading systems).

Consideration should be given to ways and means of removing from the Common Agricultural Policy those elements of it which may discourage individuals and families from implementing the recommendations for dietary change.

An inquiry should be made into the cost and benefit that may accrue from more vigorous attempts to identify people who have an increased risk of coronary heart disease. Research into cheaper and more simple methods which may facilitate more widespread measurement of blood lipids and of blood pressure should be encouraged.

Lesson of the Week

Chlamydial perihepatitis (Curtis-Fitz-Hugh-syndrome) after hydrotubation

JAY N L SIMSON

A 31 year old woman with a history of chlamydial infection of the genital tract was investigated for primary infertility. Two weeks after hydrotubation she developed biliary-type pain. A diagnosis of chlamydial perihepatitis (Curtis-Fitz-Hugh syndrome) was confirmed by raised antichlamydial IgG titres and a rapid response to tetracycline. This case is the first to be reported after hydrotubation and highlights the typical features of the condition, which is often not recognised.

Case report

In 1978 a 26 year old nurse was admitted as an emergency with constant right upper quadrant abdominal pain of acute onset. The pain closely simulated biliary tract pain, was worse on breathing, and was associated with nausea and anorexia. She had been fitted with an intrauterine contraceptive device two months previously and had a vaginal discharge. Temperature was 37.5°C but she was not jaundiced. There was tenderness in the right hypochondrium but no sign of an enlarged liver or mass. For five days her temperature swung intermittently up to 39.5°C and then settled without treatment. The pain was constant and severe for 10 days, then slowly disappeared, without specific treatment, over the next three months. Results of the following investigations were normal: full blood count; electrolyte and urea

Biliary-type pain in a sexually active woman may be due to chlamydial perihepatitis (Curtis-Fitz-Hugh syndrome). Chlamydial infection of the genital tract is very common in infertile women and invasive investigation may precipitate an attack of perihepatitis

concentrations; liver function tests; serum amylase activity; glucose, calcium, and phosphate concentrations; Venereal Disease Research Laboratory and fluorescent treponemal antibody tests; autoantibody titres; serum lead concentration; brucella agglutination titre; urine analysis and culture; urinary porphyrins excretion; chest x ray picture; oral cholecystogram; and barium meal. The erythrocyte sedimentation rate rose transiently to 73 mm in the first hour. She spent 10 days in hospital. No diagnosis was made and no specific treatment given.

In 1981 a cervical swab, taken because of recurrent vaginal discharge, grew *Chlamydia trachomatis* but she received no treatment. She got married and in 1981 was investigated for primary infertility.

The next year laparoscopy showed pelvic adhesions. Hydrotubation disclosed spill from the left fallopian tube but clubbing and no spill on the right. Two weeks after hydrotubation she developed right upper quadrant abdominal pain with fever, identical with the illness in 1978. Full blood count, sedimentation rate, liver function, and results of biliary ultrasound were normal. Erythromycin and metronidazole given for four days had no effect and she was referred to the general surgical team. A provisional diagnosis of chlamydial perihepatitis (Curtis-Fitz-Hugh syndrome) was made and blood taken for type specific chlamydial antibodies (table). Erythromycin and metronidazole were stopped and oral tetracycline (250 mg four times daily)

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Reciprocal titres of IgG during attack and at six and 12 weeks. (Titres of IgM zero throughout)

<i>C trachomatis</i>	During attack	At six weeks	At 12 weeks
A-C	1024	512	256
D-K	2048	1024	256

instituted. Her pain and fever disappeared in four days. Tetracycline was continued for one month. Chlamydial serology, repeated at six and 12 weeks, showed a very high initial IgG titre which fell progressively. Gonococci were not detected. Eighteen weeks after this episode she underwent laparotomy, left salpingolysis, and right salpingostomy. There were no perihepatic adhesions. Swabs of cervix, fimbriae, and liver capsule did not grow chlamydia. When last seen she remained symptom free but had still not conceived.

Comment

Biliary-type pain in a sexually active woman with genital tract infection, in the absence of biliary tract disease, is known as the Curtis-Fitz-Hugh syndrome.^{1,2} The pain is due to an infective perihepatitis, spread transperitoneally from the genital organs, resulting in flimsy adhesions between the liver capsule and the peritoneum of the anterior abdominal wall. It had been thought that all cases were due to *Neisseria gonorrhoeae*, but in 1978 high antibody titres to *C trachomatis* were found.³ Since then several reports have shown unequivocally that *C trachomatis* alone is responsible for most cases of Curtis-Fitz-Hugh syndrome.⁴⁻⁹

Some 83 000 cases of salpingitis in women aged 15-34 occur each year in England and Wales.¹⁰ *C trachomatis* is responsible for around half of these^{10,11} and may also be found in asymptomatic women.¹²⁻¹⁴ The frequency of Curtis-Fitz-Hugh syndrome in acute salpingitis has been estimated as 4.4-27.7%,¹⁵ and it is therefore probable that this syndrome is often not recognised despite recent publications.^{7,16} Some three quarters of infertile women with tubal damage have evidence of chlamydial infection.¹⁷ Our patient shows that chlamydial perihepatitis may be precipitated by hydrotubation. This probably occurs far more often than is currently recognised.

The present patient showed the typical features associated with the Curtis-Fitz-Hugh syndrome. She was a sexually active but infertile young woman with a history of genital tract infection and growth of chlamydia on cervical culture. She had two episodes of severe right hypochondrial pain closely simulating biliary tract disease. The first attack occurred after insertion of an intrauterine contraceptive device. Thorough investigation

(but without a search for chlamydia) failed to give the diagnosis and resolution was slow. The second attack occurred two weeks after hydrotubation for infertility. The diagnosis on that occasion was confirmed by positive chlamydial serology¹⁸ and negative gonococcal serology. This is the first record of the Curtis-Fitz-Hugh syndrome after hydrotubation; probably *C trachomatis* in the genital tract was carried into the peritoneal cavity by spillage from the left tube. The symptoms disappeared rapidly with tetracycline, the antibiotic of choice.¹⁶

The Curtis-Fitz-Hugh syndrome may present to the general practitioner, genitourinary specialist, gynaecologist, or surgeon. The diagnosis is made by history, examination, exclusion of biliary tract disease, growth of chlamydia on culture, serology, exclusion of gonococcal infection, and a rapid response to tetracycline. Gynaecologists should be aware that perihepatitis may be precipitated by hydrotubation in infertile women with chlamydial infection, which therefore should be excluded before manipulation of the genital tract.

I thank Dr J D Treharne, of the Institute of Ophthalmology and Virology, London, for the serological findings.

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Are there any absolute medical contraindications to the progestogen only oral contraceptive?

Both the *British National Formulary*¹ and the manufacturers' data sheets² are unhelpful on this subject. The *BNF* refers the reader to the contraindications to combined oral contraceptives. The manufacturers' data sheets differ for each preparation and include a variable number of accepted contraindications to the combined oral contraceptives. This is in part because direct information about progestogen only contraceptives is limited, necessitating extrapolation from the putative contribution of the progestogen component to the adverse effects of the combined contraceptives, or from the known effects of progestogens given in larger doses than those used for contraception. Undiagnosed vaginal bleeding is an absolute contraindication because the progestogen may stop the bleeding and confuse or delay diagnosis. Active liver disease, recurrent cholestatic jaundice, or a history of jaundice in pregnancy are usually given as absolute contraindications but it would be reasonable to treat a history of jaundice in pregnancy

as a relative contraindication, discontinuing the progestogen immediately if jaundice occurred. Carcinoma of the breast is usually given as an absolute contraindication but this appears to be mainly for theoretical reasons.

Progestogens used for oral contraception produce a rise in plasma triglycerides and a fall in the high density lipoprotein fraction. So it would seem sensible to include hypertriglyceridaemia as an absolute contraindication. Enzyme inducing drugs such as rifampicin and the anticonvulsants phenytoin, phenobarbitone, primidone, and carbamazepine increase the metabolism of progestogens and reduce their contraceptive efficacy.³ It would be unwise to rely on the progestogen only contraceptive in women requiring any of these drugs.—LINDA BEELEY, consultant clinical pharmacologist, Birmingham.

¹ *British National Formulary No 7*. London: British Medical Association and the Pharmaceutical Society of Great Britain, 1984:255.

² *ABPI Data Sheet Compendium 1984-5*. London: Datapharm Publications Ltd, 1984.

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