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# Periclitoral abscess: Two case studies

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## ABSTRACT

Periclitoral abscesses are rare, with only a few cases reported in the literature. Although these abscesses are typically observed following surgical procedures such as female circumcision, spontaneous cases have also been documented. Despite various diagnostic and treatment approaches, recurrences are common. A 43-year-old patient applied with pain, sensitivity, and swelling on the left side of the clitoris, along with a mixed vaginal infection. Examination revealed a 2.5 cm abscess around the clitoris. The patient tested positive for human papilloma virus 18 and had a history of lichen sclerosus et atrophicus. She had previously undergone sling surgery, anterior colporrhaphy, and hysterectomy a year prior. She had received platelet-rich plasma and stromal vascular fraction treatment for lichen sclerosus and had been symptom-free for six months. Despite incision and empirical ciprofloxacin treatment for one week, the inflammation and abscess persisted. Complete excision of the abscess was performed, and tissue culture identified coagulase-positive *Staphylococcus aureus*. Sulbactam ampicillin (1 gram twice daily) was administered for one week based on the antibiogram results. A 43-year-old patient with diabetes mellitus and hypothyroidism, who had a copper intrauterine device for 11 years, applied with hardness, pain, and vaginal discharge on the left side of the clitoris. Examination revealed a deep-seated abscess extending from the clitoris to the urethra. The abscess was drained under local anesthesia, and empirical treatment with extended-spectrum sulbactam ampicillin (1 gram twice daily) was started. The patient was symptom-free for four months, but the abscess recurred at the same location. Drainage and excision were performed, and tissue culture revealed coagulase-negative *Staphylococci*. Consequently, clindamycin (300 mg twice daily) and gentamicin (800 mg twice daily) were prescribed for 10 days. The patient remained symptom-free for eight months. Periclitoral abscesses should be considered in cases of swelling, tenderness, and pain around the clitoris. Management may require not only incision and drainage but also excision and tissue culture for definitive diagnosis and antibiogram-guided therapy to prevent recurrence.

**Keywords:** Periclitoral abscess; tissue culture; perineal abscess; clitoris

## INTRODUCTION

Periclitoral abscesses are rare, with few gynecological cases documented. Due to the limited number of cases, no standardized treatment protocol exists, resulting in a high recurrence rate.[1] Although the exact cause of abscess formation is unknown, it may be secondary to underlying conditions such as Crohn's disease.[2] Genital traumatic procedures, including female genital mutilation or circumcision, and pilonidal disease have been identified as potential causes of periclitoral abscesses.[3]

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Periclitoral abscesses typically present as localized, painful, and fluctuant inflammatory lesions around the clitoris. They are usually seen in women of reproductive age and are associated with vulvar pain, dysuria, vulvar swelling, and erythema.[4] This study presents the definitive diagnosis and management of two cases of persistent or recurrent periclitoral abscesses despite incision and empirical antibiotic therapy.

## Materials and Methods

This retrospective study was approved by the Local Ethics Committee of Bolu Abant İzzet Baysal University (decision no: 2024/146). Two patients with periclitoral abscesses who visited a private clinic were evaluated in June 2024 after obtaining study permission. Patient files and examinations were reviewed from the pre-disease period through one year of follow-up after treatment. Both patients were informed about the use of their diagnosis, follow-up and treatments in scientific studies, and their informed consent was obtained.

## CASE REPORTS

### Case A

A 44-year-old, married, gravida 3, parity 3 (2 normal deliveries, 1 cesarean) female patient applied to our clinic in September 2022 with complaints of vaginal itching and genital condyloma. The patient had a history of hysterectomy due to uterine atony following a cesarean section in 2013. She also underwent cystocele surgery and sling surgery in 2018. The patient was treated for hypertension and was a tobacco user (1 pack per day). Cervical smear tests in July 2022 showed no intraepithelial lesions or malignancy.

Pelvic examination revealed a mixed-type vaginal infection and condyloma acuminatum on the vulva. A culture was obtained from the vaginal discharge. Transvaginal ultrasound showed no uterus due to hysterectomy, and the ovaries were normal. Metronidazole was prescribed for bacterial vaginosis, and imiquimod cream was used for condyloma. Human papilloma virus typing revealed types 16, 44, 18, 58, and 56. Despite treatment with fluconazole and weekly methylene blue applications, recurrent vulvovaginal candidiasis was noted, with *Candida glabrata* isolated and treated with amphotericin. The patient later developed dyspareunia and itching after regression of condyloma and candidiasis. Colposcopy and vulvar biopsy revealed a vaginal intraepithelial lesion stage 1. Nine months later, vulvar biopsy results from an external center indicated lichen sclerosus et atrophicus, and cervical smear results showed a low-grade cervical intraepithelial lesion. Atrophy was observed at the vaginal entrance with scar tissue on the vulva. Platelet-rich plasma and stromal vascular fraction treatments were applied.

Two months after treatment completion, the patient complained of a burning sensation in the vagina. An ulcerated area was found on the right side of the vaginal entrance, with painful swelling and erythema on the left side of the clitoris. Despite incision and drainage followed by empirical ciprofloxacin treatment, the abscess recurred. The abscess was completely excised, and tissue culture identified coagulase-positive *Staphylococcus aureus*. Sulbactam ampicillin (1 gram twice daily) was administered for one week based on the antibiogram. Histopathology of the periclitoral abscess showed fat necrosis and inflammatory granulation tissue formation. The patient has been symptom-free for six months (Figure 1).

### Case B

A 43-year-old, married, gravida 4, parity 2, with 2 abortions, applied to a private clinic in December 2023 with complaints of palpable hardness, pain, and vaginal discharge in the clitoris. Her medical history included diabetes mellitus and hypothyroidism, for which she was taking levothyroxine sodium, metformin, and sitagliptin. She had used a copper intrauterine device (IUD) for contraception for 11 years.

Examination revealed a deep-seated abscess extending from the periclitoral region to the urethra. The cervix and vagina appeared normal, but the IUD string was not visible. Transvaginal ultrasound showed a normal uterus and oviducts, with the IUD in the uterine cavity. Incision and drainage of the abscess were performed under local anesthesia, and empirical treatment with extended-spectrum sulbactam ampicillin (1 gram twice daily) was initiated. The patient was symptom-free for four months, but the abscess recurred in the same location.

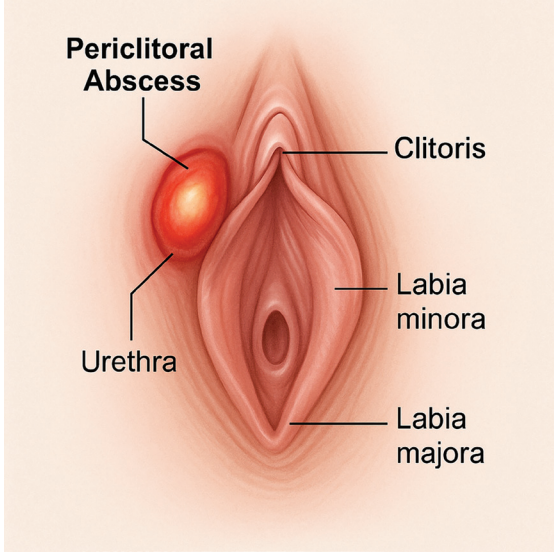


**Figure 1.** Case B periclitoral abscess

Hysteroscopic removal of the IUD, drainage, and excision of the abscess were performed. Tissue culture revealed coagulase-negative *Staphylococci*, so clindamycin (300 mg twice daily) and gentamicin (80 mg twice daily) were prescribed for 10 days. The patient has been symptom-free for eight months.

## DISCUSSION

Periclitoral abscesses are rare and present with severe vulvar pain. Trauma and the presence of an infected pilonidal cyst are thought to be potential causes.[5] Reported cases are often complications of female circumcision. In pilonidal abscesses, sinus tracts or hair follicles are observed around or within the abscess. No sinus tracts were noted in our cases, thus excluding pilonidal abscess as the etiology.[6] The cause of spontaneous periclitoral abscesses is unclear, but infectious pathogens may contribute to abscess formation due to changes in the squamous skin layer.

Case A had lichen sclerosus of the vulva and recurrent vaginal infections. Lichen sclerosus is an inflammatory mucocutaneous disease primarily affecting postmenopausal women.[7] The association of lichen sclerosus with periclitoral abscesses has not been previously reported. It is hypothesized that periclitoral abscesses may result from subcutaneous passage of infectious agents due to mucocutaneous disorders in lichen sclerosus.

Previous studies have identified coagulase-positive *Staphylococcus*, *Streptococcus bovis*, *Diphtheriae* species, and *Bacteroides*species in abscess cultures.[8] Similarly, our study found coagulase-positive *Staphylococcus aureus*in Case A and coagulase-negative *Staphylococci* in Case B. *Actinomyces*spp. was reported in periclitoral abscess cultures, with a prevalence of 8-20% in IUD users.[9,10] Although typically asymptomatic and not requiring treatment, removal of the IUD and appropriate antibiotic therapy may be necessary in cases of pelvic actinomyces infection.[10,11] In Case B, the IUD was removed, and actinomyces was excluded from the abscess culture results.

A 2012 study reviewed 18 cases of periclitoral abscesses, with sizes ranging from 1-5 cm. Among the patients, six had pilonidal abscesses, one had ectopic breast tissue, and one had Crohn's disease. Spontaneous drainage or resolution was observed in eight patients, while others were treated with incision or excision. Recurrence was noted in most cases, and excision or marsupialization was used for definitive treatment.[5,8] Our cases also experienced recurrence, but total excision or marsupialization effectively managed the condition.

No optimal treatment method for periclitoral abscesses is established in the literature. Published studies are generally case reports, and treatment varies based on individual preferences, experiences, and patient characteristics.[6,8] Some recommend less invasive methods to avoid clitoral damage, while others advocate incision, drainage, and empirical antibiotics as the first-line treatment. Culture results are essential for appropriate antibiotic therapy, and preventing recurrences may require medication and marsupialization or excision based on culture findings. Initial treatments often involve spontaneous drainage or simple incision, but recurrence necessitates marsupialization or excision for effective management.[8]

## CONCLUSION

A periclitoral abscess is a rare condition marked by severe pain and a high rate of recurrence. There is limited knowledge and experience regarding its etiology and treatment. Reports in the literature indicate that recurrence rates are high. Understanding the underlying causes and development of the abscess is crucial, as incision and drainage alone may not be sufficient. Total excision, tissue culture for definitive diagnosis, and antibiogram-guided antibiotic therapy may be necessary to prevent recurrence.

### ETHICS

**Informed Consent:** Both patients were informed about the use of their diagnosis, follow-up and treatments in scientific studies, and their informed consent was obtained.

### FOOTNOTES

#### Contributions

Surgical and Medical Practices: N.E.A., Ş.Ç., Concept: N.E.A., Design: N.E.A., Ş.Ç., Data Collection or Processing: N.E.A., Ş.Ç., Analysis or Interpretation: N.E.A., Ş.Ç., Literature Search: N.E.A., Ş.Ç., Writing: N.E.A., Ş.Ç.

### DISCLOSURES

**Conflict of Interest:** No conflict of interest was declared by the authors.

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