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Clitoral abscess: A rare gynecologic entity– case report & literature review

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ABSTRACT

Clitoral abscesses are rare clinical entities with no standardized treatment protocols, mainly due to the limited number of reported cases, and recurrence is common regardless of initial therapeutic approach. We report a 24-year-old nulliparous woman with a three-day history of pelvic-perineal pain and a palpable vulvar mass. Initial antibiotic therapy with ciprofloxacin and paracetamol failed to relieve symptoms. Examination revealed a 3×3 cm fluctuant, tender mass beneath the clitoral prepuce. Laboratory tests showed mild neutrophilic leukocytosis and elevated inflammatory markers. Ultrasonography confirmed a localized abscess, and pelvic magnetic resonance imaging—used for the first time in this context—demonstrated a well-defined fluid collection without osteomyelitis or adjacent involvement. Surgical incision and drainage were performed preserving neurovascular integrity. Histopathology revealed chronic active inflammation, and microbiology indicated polymicrobial infection. The patient recovered uneventfully, with no recurrence at six-month follow-up. This case, with literature review, underscores individualized evaluation and highlights limited data guiding clinical decision-making.

Keywords: Abscess; clitoris; magnetic resonance imaging; vulvar diseases; case report

INTRODUCTION

Spontaneous clitoral abscess is a rare gynecological emergency. Although some cases are associated with identifiable etiological factors such as pilonidal disease, female circumcision, or genital trauma, no clear cause has been identified in most cases reported in the literature.[1] This localized inflammatory lesion in the nerve-rich clitoral region can cause severe pain and significant morbidity.[2] Management approaches include antibiotic therapy alone or surgical interventions such as incision and drainage (I&D) and marsupialization. Due to the limited number of reported cases, no standard treatment protocol has been established.[1,3] In this article, a rare case of clitoral abscess is presented, and the clinical management process from diagnosis to treatment is discussed in light of current literature.

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CASE REPORT

A 24-year-old nulliparous woman presented to the emergency department with a three-day history of pelvic-perineal pain and a palpable vulvar swelling. She had previously been prescribed ciprofloxacin (2×500 mg/day) and paracetamol (3×500 mg/day) at another facility; however, due to lack of clinical improvement, she was referred to our institution.

The patient was sexually active, reported condom use, and had no new partner in the past six months. She denied unusual sexual behaviors, use of sex toys, prior sexually transmitted infections, or additional genitourinary/systemic symptoms such as vaginal discharge, dysuria, abdominal pain, fever, or chills. Vital signs were normal. Her medical history was unremarkable, except for tobacco use, with no evidence of immunosuppression.

On examination, marked tenderness and swelling were present in the clitoral region. A 3×3 cm, tender, fluctuant, mildly erythematous spherical mass was palpated beneath the clitoral prepuce, causing noticeable enlargement (Figure 1). Due to severe tenderness, direct visualization of the clitoris was not possible. Vaginal speculum examination was normal.

Laboratory tests showed mild neutrophilic leukocytosis (11,000/mm^3), elevated C-reactive protein (14 mg/L), and increased erythrocyte sedimentation rate (40 mm/hour), while urinalysis, biochemistry, and coagulation parameters were within normal limits.

Grayscale ultrasonography demonstrated a well-defined, hypoechoic, heterogeneous fluid collection in the clitoral body, suggestive of abscess formation. Color Doppler imaging revealed peripheral hyperemia, consistent with active inflammation.

Given the atypical localization and severity of pain, magnetic resonance imaging (MRI) was performed to evaluate deeper extension and potential complications, including osteomyelitis, fistulization, or involvement of adjacent urogenital and neurovascular structures. To our knowledge, this represents the first reported MRI of a clitoral abscess (Figure 2). Pelvic MRI showed a ~3 cm T1-hypointense, T2-hyperintense fluid collection with diffusion restriction (b=1000) and peripheral gadolinium enhancement. No bone marrow signal abnormality was detected in the pubic symphysis, excluding osteomyelitis. Adjacent soft tissues and neurovascular structures were normal, with no evidence of pilonidal sinus. Combined ultrasonography and MRI findings confirmed an isolated clitoral abscess.

During I&D, care was taken to preserve the dorsal clitoral artery and surrounding neurovascular structures. No sinus tract was identified. Histopathological examination of the capsule-like

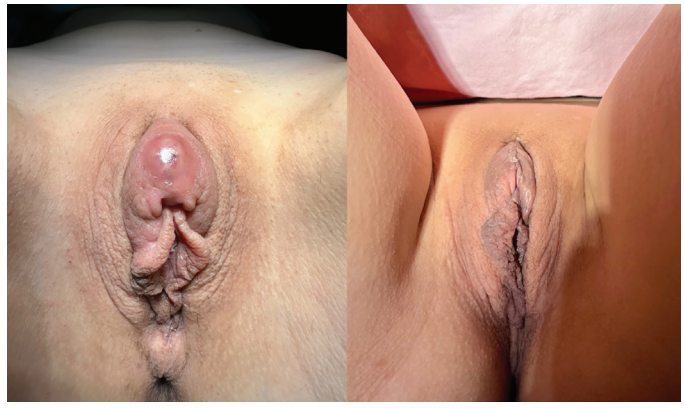

Figure 1. Clinical appearance of the clitoral abscess at presentation and at one-month follow-up

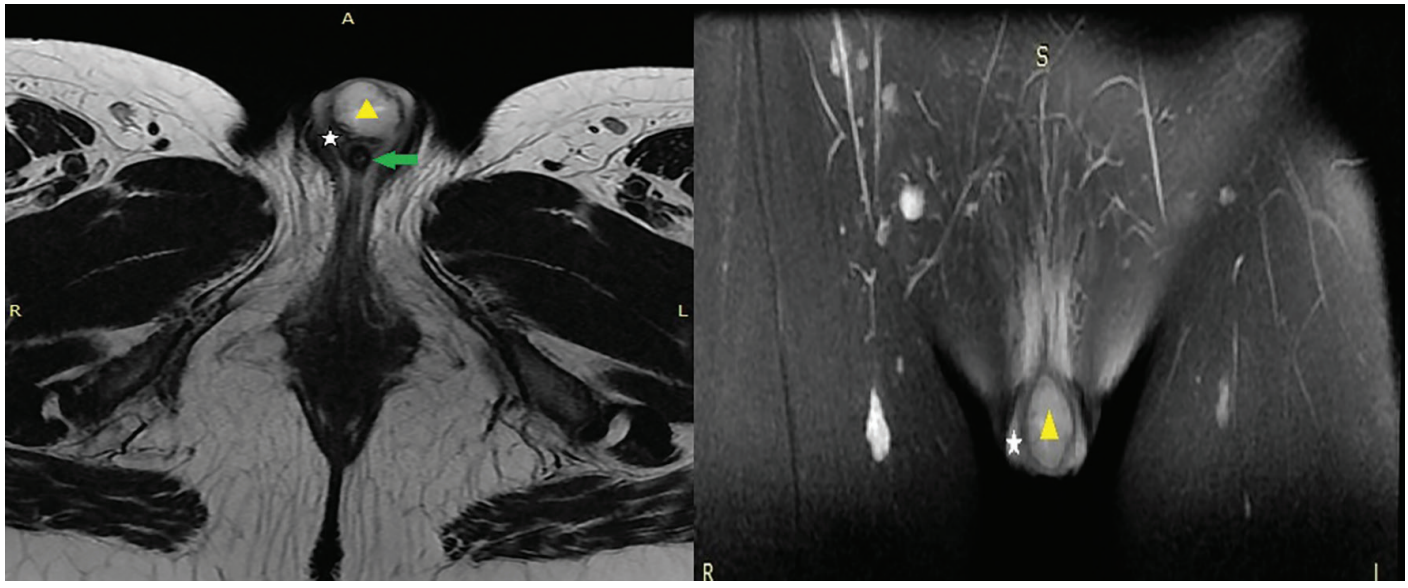

Figure 2. Pelvic MRI demonstrating a clitoral abscess asterisk: Clitoral body; triangle: Abscess cavity; arrow: Urethra
MRI: magnetic resonance imaging

tissue showed chronic active inflammation with epithelial reparative atypia, without malignancy. Microbiological analysis of purulent material revealed no specific pathogen; however, microscopy demonstrated abundant polymorphonuclear leukocytes, anaerobic Gram-negative *Bacilli*, and Gram-positive *Cocci*, consistent with a polymicrobial infection. Postoperatively, edema and tenderness resolved completely, with full relief of pain.

In the postoperative period, the patient was prescribed a seven-day course of oral ampicillin-sulbactam (2×750 mg) and metronidazole (3×500 mg), providing broad-spectrum coverage against Gram-positive, Gram-negative, and anaerobic organisms, consistent with the polymicrobial nature of vulvar abscesses and supported by microbiological findings in this case. At one-month follow-up, she was asymptomatic, with no neurological deficits or cosmetic abnormalities (Figure 1). The prepuce had healed completely, and no recurrence was observed at six months.

Written informed consent for publication of this case report and accompanying images was obtained from the patient. Formal ethics committee approval was not required for this single case report. The study was conducted in accordance with the principles of the Declaration of Helsinki (2013 revision).

DISCUSSION

Spontaneous clitoral abscess is an extremely rare condition in gynecological practice, and no standardized approach to diagnosis, treatment, or follow-up has been established. Although specific risk factors remain unclear, smoking and pregnancy have been reported in some cases as potential contributors.[4]

The clitoris is highly sensitive due to its rich neurovascular network and complex anatomy. Therefore, in surgical interventions involving the clitoral region—particularly invasive procedures such as abscess drainage—preservation of anatomical integrity and function is essential. Ultrasound is generally preferred as the first-line imaging method because it is widely available and, with Doppler, allows vascular assessment while distinguishing cystic from solid lesions. In cases of atypical presentation, large or deep collections, or suspected complications such as osteomyelitis and fistulization, MRI provides a more detailed and reliable assessment owing to its superior soft tissue contrast. Although clitoral abscesses are often diagnosed clinically, in our case MRI images were obtained for the first time in the literature (Figure 2). MRI may be valuable when severe pain limits examination or when a detailed anatomical evaluation is required. Notably, since clitoral abscesses are usually identifiable through clinical examination, routine MRI is not necessary.

Including our case, 24 clitoral abscess cases have been reported in the English literature (Table 1). As available data are largely based on case reports and the number of documented cases is limited, management decisions are mostly left to the clinician's experience. Findings suggest that definitive surgical approaches—such as marsupialization or sinus tract excision—may be more effective in reducing recurrence. Among 24 cases, recurrence occurred in 16, and 12 required subsequent definitive surgery. These observations indicate that invasive procedures supported by histopathological diagnosis may improve long-term outcomes, although larger patient series are needed to confirm these findings.

When the histopathological evaluations of the 24 clitoral abscess cases reported in the literature are examined, more than half of them did not receive a specific histopathological diagnosis. "Non-specific inflammation" was reported in five cases,[5,6] "inflammatory changes" in three;[4,6] and in seven, no histopathological examination or biopsy was performed.[1-3,7] Although very rare, specific pathologies causing clitoral abscess have also been mentioned in the literature, including Crohn's disease and ectopic breast tissue—each reported in only a single case.[8,9]

Among cases with an established diagnosis, the most frequent pathology was pilonidal abscess in the clitoral region, observed in seven cases. This shows that pilonidal disease, although rare, can occur in this area and should be considered in the etiology of clitoral abscesses. Initial treatments included spontaneous drainage in three cases, I&D in two, and local excision in one. Recurrence occurred in five of six diagnosed cases, often with multiple episodes. As definitive treatment, surgical excision of the sinus tract was performed in four cases.[1,7,10] These findings suggest that clitoral abscesses originating from pilonidal sinus carry a high recurrence risk, and in most cases surgical excision is required for permanent resolution.

Of eight cases with histopathological findings of inflammatory changes but no specific diagnosis, recurrence was reported in six. Marsupialization was performed in five of these to achieve permanent resolution, while one was managed conservatively despite prolonged recurrences.[5,6] In one of the remaining two cases—our own—no recurrence occurred during six months of follow-up, whereas in the case reported by Ferhi et al.,[4] lack of long-term follow-up prevented assessment of recurrence.

Data from the seven cases without biopsy are limited, restricting clarification of etiological factors and analysis of treatment responses. Although surgical interventions such as marsupialization or repeat drainage were used in some recurrence-reported cases without biopsy, the lack of histopathological

Table 1. Reported spontaneous periclitoral abscess cases								
Year	**Author**	**Age**	**Initial management**	**Antimicrobial therapy**	**Microbiological culture**	**Recurrence**	**Definitive treatment**	**Histopathological examination**
1957	Palmer	29	Spontaneous drainage	Sulfadiazin	None reported	1 year	Excision of cyst-track	Pilonidal
1962	Betson et al	29	Spontaneous drainage		None reported	1 year	Excision of cyst-track	Pilonidal
1972	Radman and Bhagavan	22	Incision & drainage		None reported	Multiple times within 2 years	Excision of cyst-track	Pilonidal
1975	Devroede et al.	28	Spontaneous drainage		*S. aureus, S. epidermidis, Peptostreptococcus*	None (5 months follow-up)		Crohn's disease
1980	Reeves and Kaufman	29	Incision & drainage		None reported	8 days later	Excision of mass	Ectopic breast tissue
1982	Kent and Taxiarchis	24	Incision & drainage		None reported	Multiple times within 11 years	Conservative	Non-specific
1982	Kent and Taxiarchis	23	Spontaneous drainage		None reported	Multiple times within 6 years	Marsupialization	Non-specific
1982	Kent and Taxiarchis	29	Spontaneous drainage		*Bacteroides, Diphtheroids*	10 years	Marsupialization	Non-specific
1982	Kent and Taxiarchis	31	Incision & drainage		Coag-positive *Staphylococcus*	Multiple times within 1.5 years	Marsupialization	Non-specific
1983	Sur	41	Incision & drainage		*Streptococcus bovis*	2 months	Marsupialization	Non-specific
1983	Sur	16	Incision & drainage		None identified	3 months	Marsupialization	Inflammatory changes
1990	Werker and Kon	23	Local excision		None reported	Multiple times within 1 year	Excision of cyst-track	Pilonidal
2003	Chinnock	41	Conservative	Cephalosporin	None reported	None (no follow-up reported)		No biopsy
2004	Lara-Torre et al.	11	Spontaneous drainage	Unspecified	None reported	None (6 months follow-up)		No biopsy
2007	Mendilcioglu	33	Spontaneous drainage	Ampicillin/ sulbactam	None identified	21 years	Marsupialization	No biopsy
2008	Baker et al.	30	Incision & drainage	Cefazolin + metronidazole	None reported	Multiple times within 2 years	Excision of cyst-track	Pilonidal
2010	Maor-Sagie et al.	8	Local excision		None reported	3 months	Excision of tract	Pilonidal
2011	Koussidis	17	Incision & drainage		Coag-positive Staphylococcus	None (8 months follow-up)		No biopsy
2017	Jain	21	Incision & drainage	Unspecified	None reported	None (no follow-up reported)		No biopsy
2020	Zeitoun	53	Incision & drainage	Co-amoxiclav	*S. anginosus*	None (no follow-up reported)		Pilonidal

Table 1. Continued

Year	Author	Age	Initial management	Antimicrobial therapy	Microbiological culture	Recurrence	Definitive treatment	Histopathological examination
2022	Dielentheis	17	Incision & drainage	Trimethoprim/ sulfamethoxazol	*S. anginosusand Staphylococcus*	2 days later	Incision & drainage	No biopsy
2023	Palacios	42	Incision & drainage	Amoxicillin	*Actinomyces turicensis*	6 weeks	Marsupialization	No biopsy
2023	Ferhi	26	Incision & drainage	Flucloxacillin	Polymicrobial organisms, no specific bacterial identification.	None (no follow-up reported)		Inflammatory changes
2025	Our case	24	Incision & drainage	Ampicilline/ sulbactam + metronidazol	Polymicrobial organisms, no specific bacterial identification.	None (6 months follow-up)		Inflammatory changes

(A review of English-language literature was conducted through the PubMed database (National Library of Medicine, Bethesda, MD), covering publications from January 1, 1950, to May 31, 2025. The search utilized various combinations of the following keywords: "periclitoral abscess," "clitoral abscess", "clitoral inflammation," "periclitoral inflammation," and "clitoral pilonidal")

information restricts interpretation of underlying causes. Indeed, even among the cases where biopsy was performed, a specific diagnosis could not be established in approximately half. While histopathological diagnosis is important for clinical management, it should also be acknowledged that biopsy may not always be sufficient to explain the underlying etiology.

In the limited number of abscess cultures evaluating the microbiological etiology of clitoral abscesses, various microorganisms have been isolated, including *Streptococcus bovis*, coagulase-positive *Staphylococcus* species, *Bacteroides* species, and *Diphtheroids*.[1,4] Culture results were reported in only 10 cases, insufficient to implicate a single specific pathogen. In most culture-positive cases, a polymicrobial flora was identified; additionally, *Actinomyces turicensis* was isolated in only one case.[3] Current data reveal a heterogeneous microbial profile and provide no evidence for a role of sexually transmitted infections in the etiology of these abscesses.[4]

CONCLUSION

Spontaneous clitoral abscesses require an individualized approach due to their high risk of recurrence and the absence of a standardized treatment algorithm. Findings in the literature suggest that I&D alone may be insufficient; particularly in recurrent cases, definitive surgical approaches such as marsupialization or sinus tract excision may yield more successful outcomes. Although histopathological examination obtained through biopsy can support clinical management, a specific diagnosis cannot be established in approximately half of cases. Advanced imaging methods can be helpful in the diagnostic process—especially when clarification of anatomical relationships is necessary—but are not recommended for routine use. Given the limited number of reported cases and the heterogeneity in therapeutic approaches, further well-documented case series and systematic analyses are needed to better define optimal management strategies and reduce recurrence rates in clitoral abscesses.

ETHICS

Informed Consent: Written informed consent for publication of this case report and accompanying images was obtained from the patient. Formal ethics committee approval was not required for this single case report. The study was conducted in accordance with the principles of the Declaration of Helsinki (2013 revision).

FOOTNOTES

Contributions

Surgical and Medical Practices: H.Ö.A., B.E.T., E.Ç., Concept: H.Ö.A., Design: H.Ö.A., Data Collection or Processing: H.Ö.A., B.E.T., D.D., Analysis or Interpretation: H.Ö.A., B.E.T., Literature Search: H.Ö.A., B.E.T., E.Ç., D.D., Writing: H.Ö.A., B.E.T.

DISCLOSURES

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

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