https://sexualsciencejournal.com/
December **2025**, Volume **1**, Issue **3**
https://doi.org/10.33719/sexscij.2512.22

International Journal of SEXUAL SCIENCE
eISSN: 3062-3561

CASE REPORT

The Rare Cause of Vulvar Pain After Oral Sex: Periclitoral Abscess

Ozan Odabaş[1], Arda Batuhan Karaduman[1], Özgün Akbaş[2], Begüm Köse Kıncı[3], Mehmet Ferdi Kıncı[3], Yaşam Kemal Akpak[3]

[1] Department of Gynecology and Obstetrics Clinic, Kars Harakani State Hospital, Kars, Türkiye
[2] Department of Gynecology and Obstetrics Clinic, Ağrı Research and Training Hospital, Ağrı, Türkiye
[3] Department of Gynecology and Obstetrics Clinic, İzmir City Hospital, İzmir, Türkiye

Received: 9 August 2025 / **Accepted:** 20 December 2025

Abstract
Clitoral abscess is a rare gynecological condition that causes severe vulvar pain. Very few cases have been reported in the literature. There are no guidelines available that include treatment protocols for this condition. Treatment may be either conservative or surgical. Most cases recover with a conservative approach. Surgical intervention is necessary in rare cases. In this case presentation, we discuss the conservative management of a perineal abscess that developed after oral sex.

Keywords: abscess, clitoris, periclitoris, trauma, vulvar pain

INTRODUCTION

The etiology of clitoral abscesses is not fully understood, but they are largely attributed to conditions such as pilonidal disease, female genital mutilation, or genital trauma. However, such abscesses can also occur in women without any known risk factors (1). A clitoral abscess typically presents as a localized, painful, and fluctuating inflammatory lesion surrounding the clitoris. Among women of reproductive age, it can lead to significant morbidity, manifesting as severe vulvar pain, dysuria, vulvar swelling, and erythema at the clitoral head (2).

Management of clitoral abscesses often involves antibiotic treatment and may also include surgical intervention, such as marsupialization and drainage. However, it has been shown that these surgical interventions have limited effects in preventing the recurrence of clitoral abscesses (3).

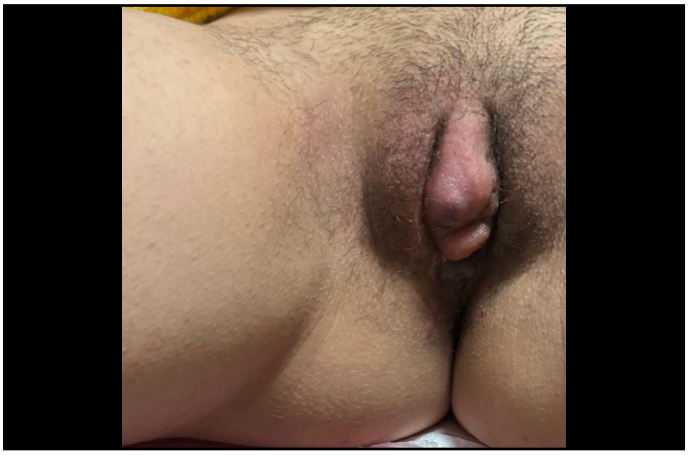
In this case presentation, we discuss the management of a clitoral abscess in a 25-year-old woman, who developed the abscess one week after engaging in oral sex, at 69 days postpartum.

CASE

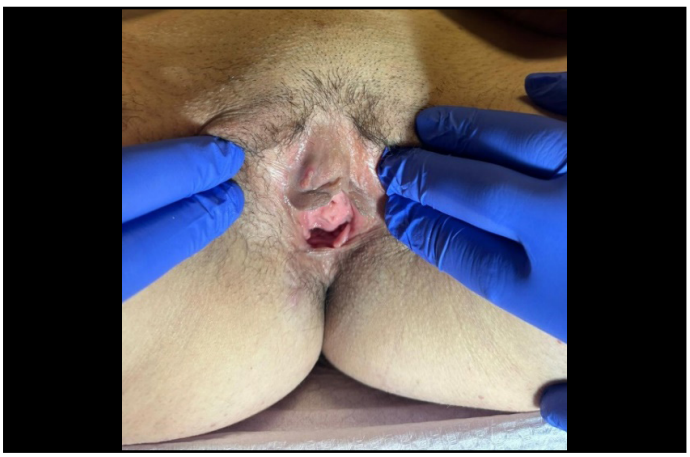
A 25-year-old woman, who had a vaginal delivery 69 days ago, presented with complaints of progressively worsening vulvar pain and swelling that began one week after engaging in oral and vaginal sex. During the gynecological examination, a tender, fluctuating, mildly erythematous mass measuring 6x3 cm, involving the right labium minus and surrounding the clitoris, was detected (Picture 1). Laboratory parameters showed a WBC of 18,300 and a CRP of 93.

Corresponding Author: Ozan Odabaş, MD, Kars Harakani State Hospital Gynecology and Obstetrics Clinic, Kars, Türkiye
Email: ozan02odabas@hotmail.com

The patient was initially managed with medical therapy for a presumptive diagnosis of clitoral abscess. A combined oral antibiotic regimen consisting of cefdinir 600 mg and metronidazole 500 mg was initiated. Cefdinir 600 mg was administered once daily, and metronidazole 500 mg was administered three times daily. On the fourth day of antibiotic therapy, spontaneous drainage occurred (Picture 2). During follow-up, infection markers showed improvement, with WBC decreasing to 12,540 and CRP to 47.6. Given the regression of both infection parameters and the patient's symptoms, the antibiotic regimen was considered effective against the underlying microorganism, and therefore no culture sample was obtained. After one week, the patient's symptoms had improved and vulvar swelling had diminished. The patient was discharged after seven days of treatment, and intravenous antibiotic therapy was stopped. To prevent recurrence, continuation with oral antibiotics was planned. Oral antibiotic therapy was maintained for a total duration of 14 days.



Picture 1. Condition of Vulva at Presentation to Clinic



Picture 2. Spontaneous drainage on the fourth day after medical treatment

CONCLUSION

The clitoris is a multiplanar structure that is broadly connected to the arcus pubis and supported by a wide tissue connection to the mons pubis and labium. It contains erectile bodies, the glans clitoris, and neurovascular structures. Embryologically, it is analogous to the penis and serves as the anatomical center for orgasmic response in women. The average size, including the external glans, hood, internal body, root, and crura, can reach up to 9-11 cm (4,5). Clitoral abscess, a rarely reported gynecological condition, can occur due to identifiable causes such as spontaneous formation or genital trauma. The abscess surrounding the clitoris can lead to significant morbidity because it is a painful inflammatory lesion (6,7). In our case, the patient is 25 years old and has a history of oral and vaginal sex, but no history of genital trauma.

A review of the literature indicates that the typical age range for clitoral abscess is 20-30 years (6). Although no specific risk factors are consistently identified, some cases have been associated with smoking or a history of pregnancy (2,3). Although rare, in older patients with comorbidities or immunosuppressed individuals, periclitoral abscesses have been reported to lead to necrotizing fasciitis (8).

Female circumcision performed for religious reasons increases the likelihood of clitoral abscess formation due to infection of inclusion cysts that develop in the tissue after the operation. The disruption of the anatomy creates challenges for the surgeon in the treatment of these patients when surgical intervention is necessary and increases complication rates (9,10).

The shaving of pubic hair or the use of various techniques for hair removal can cause hairs to become trapped in the area due to the covering and protective mechanism of the clitoral hood, creating a predisposition for folliculitis or abscess formation secondary to minimal skin damage (11).

There is no consensus on treatment, but the first-line treatment should be medical therapy to avoid damaging the clitoral components (2,6). However, in cases of recurrent periclitoral abscesses, surgical treatment (marsupialization) should be preferred. Among patients requiring surgical intervention, the incision should be made laterally to avoid damaging

the clitoral components (12).

To reduce the risk of recurrence, the literature recommends obtaining tissue or purulent material cultures—particularly in cases where the causative microorganism cannot be identified or in the presence of multiple recurrences—so that antibiotic therapy can be tailored according to culture and susceptibility results. If an underlying inclusion cyst, chronic pilonidal tract, or hair fragments are identified beneath the lesion, excision or marsupialization to create a permanent drainage tract should be considered. When surgical intervention is required, lateral incisions and meticulous dissection are preferred to preserve clitoral structures and their functional integrity. Avoidance of local trauma, patient education regarding hair removal methods, hygiene optimization, and appropriate follow-up are essential to minimize skin damage (13,14).

In conclusion, the conservative management approach implemented in our case—considering the patient's young age, the fact that this was the first episode, and the priority to preserve sexual function and anatomical integrity—is supported by the existing literature. Nevertheless, previous reports emphasize that recurrence is relatively common and, in such instances, culture sampling, surgical management of underlying cystic lesions (including marsupialization or excision), and the use of surgical techniques that preserve clitoral structures are recommended (15). In accordance with the literature, our patient was managed with oral antibiotic therapy, and no recurrence was observed during the 6-month follow-up period.

Funding: None.

Informed Consent: The patient and relatives gave informed consent to surgery and photo recording

Acknowledgments: None.

Conflict of Interest: The authors have no financial associations or any other conflicts of interest to declare.

Ethical Approval: N/A

REFERENCES

1. Koussidis, G. A. (2012). Gynecologic rarities: A case of periclitoral abscess and review of the literature. American Journal of Obstetrics and Gynecology, 207(6), e3–e5. https://doi.org/10.1016/j.ajog.2012.08.029
2. Lara-Torre, E., Hertweck, S. P., Kives, S. L., & Perlman, S. (2004). Premenarchal recurrent periclitoral abscess: A case report. Journal of Reproduc-tive Medicine, 49(12), 983–985.
3. Zeitoun, J., Pizzoferrato, A. C., Philippart, J., Gaichies, L., Benoist, G., & Fauvet, R. (2020). Clitoral abscess, a rare cause of gynecological emergency: Di-agnosis and management. European Journal of Obstetrics & Gynecology and Reproductive Biology, 252, 625–627. https://doi.org/10.1016/j.ejogrb.2020.06.033
4. Pauls, R. N. (2015). Anatomy of the clitoris and the female sexual re-sponse. Clinical Anatomy, 28(3), 376–384. https://doi.org/10.1002/ca.22524
5. O'Connell, H. E., Sanjeevan, K. V., & Hutson, J. M. (2005). Anatomy of the clitoris. Journal of Urology, 174(4 Pt 1), 1189–1195. https://doi.org/10.1097/01.ju.0000173639.38898.cd
6. Kent, S. W., & Taxiarchis, L. N. (1982). Recurrent periclitoral abscess. American Journal of Obstetrics and Gynecology, 142(3), 355–356. https://doi.org/10.1016/0002-9378(82)90743-8
7. Radman, H. M., & Bhagavan, B. S. (1972). Pilonidal disease of the female genitals. American Journal of Obstetrics and Gynecology, 114(2), 271–272. https://doi.org/10.1016/0002-9378(72)90072-5
8. Maier, S., & Eckmann, C. (2020). Fournier-Gangrän als Sonderform der nekrotisierenden Fasziitis [Fournier's gangrene as special form of necrotizing fasciitis]. Der Chirurg, 91(4), 307–312. https://doi.org/10.1007/s00104-019-01095-5
9. Rouzi, A. A. (2010). Epidermal clitoral inclusion cysts: Not a rare complica-tion of female genital mutilation. Human Reproduction, 25(7), 1672–1674. https://doi.org/10.1093/humrep/deq126
10. Dirie, M. A., & Lindmark, G. (1991). A hospital study of the complications of female circumcision. Tropical Doctor, 21(3), 146–148. https://doi.org/10.1177/004947559102100316

11. Stenson, A. L., & Leclair, C. (2018). To shave or not to shave? A series of periclitoral masses associated with depilatory techniques and a review of the lit-erature. Journal of Lower Genital Tract Disease, 22(4), 412–414. https://doi.org/10.1097/LGT.0000000000000420

12. Sur, S. (1983). Recurrent periclitoral abscess treated by marsupialization. American Journal of Obstetrics and Gynecology, 147(3), 340. https://doi.org/10.1016/0002-9378(83)91124-9

13. Palacios, D., & Wallace Huff, C. (2023). Recurrent Peri-Clitoral Abscess with Positive Actinomyces turicensis Culture. Case reports in obstetrics and gy-necology, 2023, 9912910. https://doi.org/10.1155/2023/9912910

14. Ferhi, M., Marwen, N., & Alouen, C. (2023). Clitoral Abscess: A Case Re-port Highlighting an Uncommon Source of Gynecological Emergency. Cureus, 15(12), e50114. https://doi.org/10.7759/cureus.50114

15. Dielentheis, K., Samant, S., & Dropps, K. (2022). Periclitoral Abscess: A Recurrent Problem. Journal of pediatric and adolescent gynecology, 35(3), 393–395. https://doi.org/10.1016/j.jpag.2021.11.005