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Case Report

Gigantic clitoridal cyst: a rare presentation

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ABSTRACT

Epidermal inclusion cyst of the clitoris is a rare, benign lesion that is formed when surface epithelial cells become trapped beneath the skin in the clitoral area. It is usually acquired, and commonly after female genital mutilation. This case highlights the presentation, diagnosis and its surgical management. We report a 25-year-old patient with a vulvar swelling of 9 years duration. There was a positive history of female genital mutilation in childhood. She presented on self-referral to the gynaecology clinic for evaluation, diagnosis and treatment. Preoperative assessment was done with physical examination and investigations. Following surgical enucleation, the histological assessment of the excised tissue revealed a cystic lesion lined by stratified squamous epithelium with a granular layer. The cyst contained keratin flakes. A histologic diagnosis of epidermal inclusion cyst/ clitoridal cyst was made. Clitoridal cyst usually follows female genital circumcision. It is a rarity in this part of the world as female genital mutilation is widely condemned. A high incidence of suspicious and a thorough history and physical examination is needed to make a clinical diagnosis. However, histopathological assessment remains the cornerstone for its diagnosis. Its treatment is by complete enucleation to avoid a reoccurrence.

Keywords: Clitoridal cyst, Inclusion cyst, Genital mutilation

INTRODUCTION

Epidermal inclusion cyst of the clitoris (clitoridal cyst) are usually asymptomatic, benign, slow-growing tumors in the clitoral or peri-clitoral area.[1] They are usually found on other parts of the body, but rarely on the vulva.[2,3]

They can occur spontaneously, but they mainly result from trauma, especially trauma due to genital mutilation.[2-4] This trauma causes the epidermis to get implanted in the dermis, and the trapped epidermal cells continue to produce keratin, which accumulates and enlarges into a cyst.[2,3]

Clitoridal cyst is usually painless, soft to firm in consistency, and mobile. They may become tender if infected or traumatised.

Symptoms associated with the condition are dyspareunia, aversion for coitus, poor self-image, and stigmatisation.[3,5]

There are close differential diagnoses of this condition, thus a high index of suspicion is needed to make a diagnosis, especially if there was no history of a prior vulva trauma. The treatment for this condition is surgical.

CASE REPORT

Patient's history

We present the case of Miss. EOA, a 25-year-old nulliparous female who presented to the gynaecological clinic with complaint of vulvar swelling of nine years duration. The swelling increased gradually in size to its present size, and had not reduced since its onset. It was not painful; there was no associated itching or change its colour. There was no similar swelling on any of her other body parts. There was a history of female genital mutilation in childhood. There was no history of prior intake of hormonal medications. There was no significant

past medical history. There was no family history of such vulva tumours. There was no associated vulva pain, urinary symptoms or dyspareunia. She had occasional intimate relationships. She has not done a Papanicolaou smear. Her review of systems was essentially normal.

Clinical examination

Her vital signs and systemic examinations were unremarkable. There were no signs of virilisation. On vulva examination, there was a well-circumscribed, oval shaped mass involving the clitoris. There were no lesions nor hyperpigmentation over the mass. It was non-tender, not warm to touch, soft, fluctuant, and mobile. It measured about 8×7 cm. The urethral meatus was poorly visualized. There was a type 1 female genital mutilation. Figure 1 shows the image of the clitoridal cyst at the gynaecological clinic.

Management

Miss. EOA preoperative full blood count, electrolytes, urea and creatinine assay and urinalysis were normal. Her infection screening tests were seronegative. She was counselled on the need for surgical excision of the mass and its subsequent histological analysis. She was admitted on the day of the surgery as a day case. A saddle block was instituted followed by routine cleaning and draping of the operation field. The mass was stabilized with the index finger and the thumb. A circumferential superficial incision was made on the vulva skin, at the junction between glans of clitoris and that of its body. This incision was deepened towards the cyst wall. The vulva skin was reflected by blunt and sharp incisions over the cyst wall, until the cyst was enucleated in whole. The bed of the clitoridal cyst was closed with vicryl 2/0 continuous suture. The clitoris was reconstructed with vicryl 2/0 continuous suture. Haemostasis was secured. Figure 2 shows the image of the clitoridal cyst before the start of surgery and Figure 3-6 demonstrates the enucleation procedure in stages. Figure 7 shows the wholly enucleated clitoridal cyst.

Her postoperative recovery was satisfactory. The clitoridal cyst was immersed in sample container containing formalin and sent for histopathological assessment. She was discharged home in the evening of the day of surgery, on broad spectrum antibiotics and analgesics. She was given a two-week gynaecological clinic appointment.

At the gynaecological clinic visit, she had no complaints. She presented her histopathological report.

Histopathological findings

Tissue received 11/8/2025. Date reported 22/9/2025. Gross findings: Specimen consists of a cystic mass, fluctuant to touch, and measured 5. 0 cm x 3.0 cm x 2.0 cm. Cut section revealed a cystic cavity filled with a greyish white semi-jelly substance. Microscopic findings showed a cystic lesion lined by stratified squamous epithelium with a granular layer. The cyst contained keratin flakes. A histologic diagnosis of epidermal inclusion cyst/ clitoridal cyst was made. Figure 8 shows the vulva two weeks after clitoridal cystectomy.

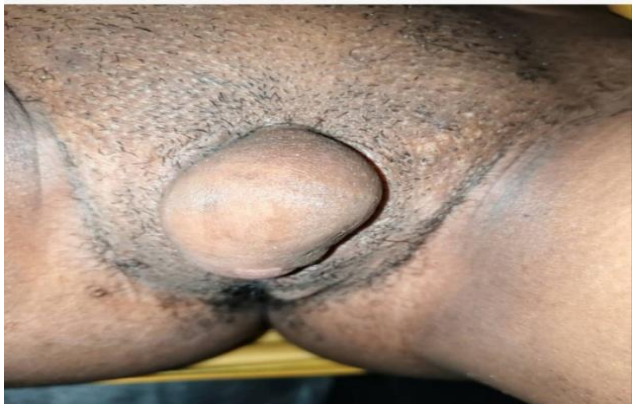

Figure 1: Clitoridal cyst as seen at the gynaecological clinic.

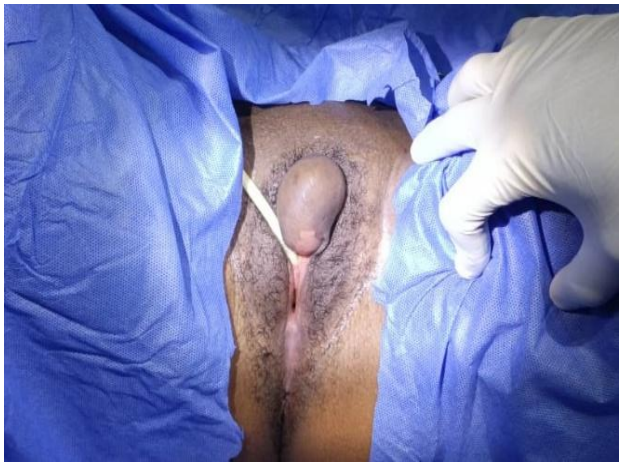

Figure 2: The clitoridal cyst before the start of surgery.

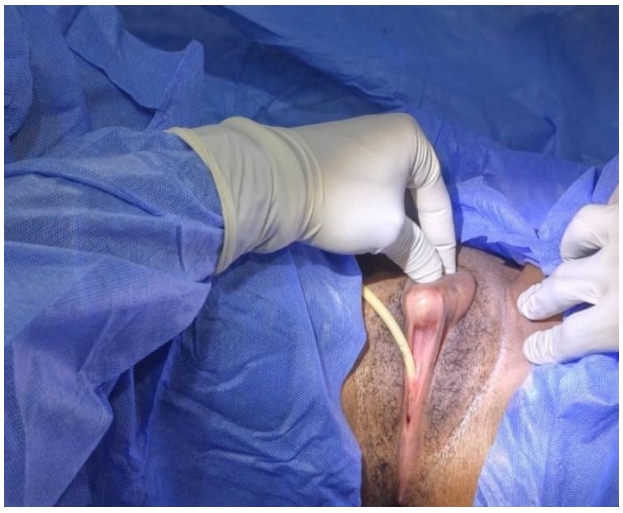

Figure 3: The enucleation procedure in stages.

Figure 4: The enucleation procedure in stages.

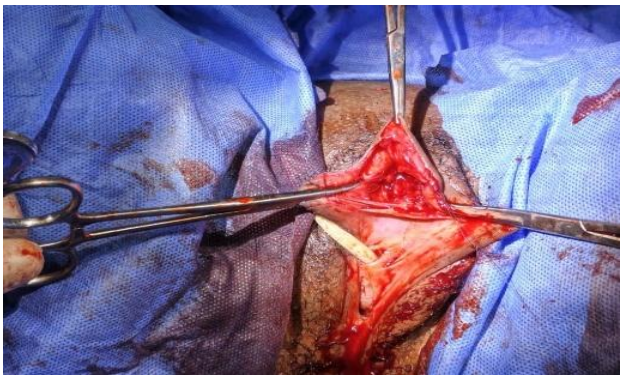

Figure 5: The enucleation procedure in stages.

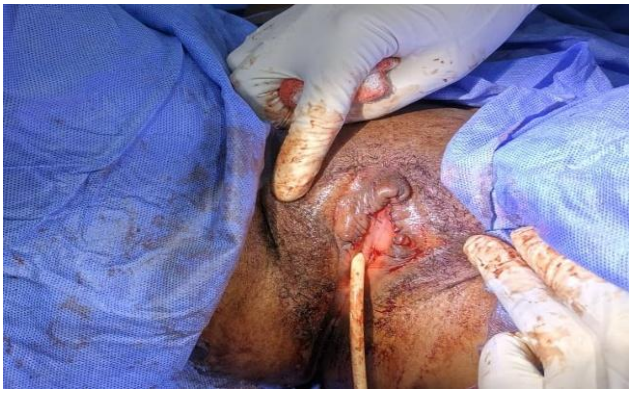

Figure 6: The enucleation procedure in stages.

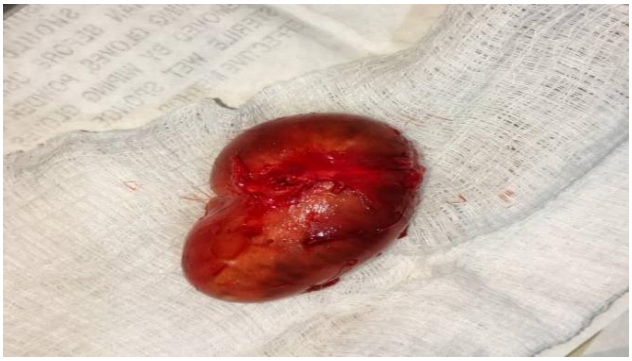

Figure 7: The wholly enucleated clitoridal cyst.

Figure 8: The vulva two weeks after clitoridal cystectomy.

DISCUSSION

When there is an implantation of the epidermis into the dermis, epidermoid or epithelial cyst results. This implantation can occur at any site of the body.[2]

Epithelial inclusion cysts of the vulva are a rarity.[3] Although they are usually seen in regions of the world where female genital mutilation is common.[6]

Epithelial cyst involving the clitoris can result from trauma or infection especially from female genital circumcision in infancy or early childhood.[2,3,7] Infection and application of herbal mixtures at the site of the excised clitoris at female genital mutilation, together with invagination of the epidermis into the dermis leads to development of clitoridal cyst.[8] They are commonly seen after type 1 female genital mutilation.[9] Miss EOA had a type 1 female genital mutilation at infancy.

The pathogenesis of this cyst is simply invagination and embedding of the epidermal keratinized squamous epithelial cells and sebaceous glands in the line of the clitoridal circumcision scar, which then desquamates into a closed space to form a cyst.[2] Thus, this cyst is an intradermal subcutaneous tumour with its walls lined with epidermis.

Clinically, the cyst grows slowly and it is usually asymptomatic. Associated symptoms are dyspareunia, apareunia, dysuria, vulva distortion, vulva pain, poor self-image, aversion for coitus and marital discord.[2,4,9-11] Miss EOA's clitoridal cyst was asymptomatic. She however engaged in sexual intercourse occasionally because of it

Important differential diagnoses include clitoromegaly, clitoral abscess and pilonidal cyst. In other to confirm the diagnosis of this condition, histologic assessment of the excised cyst must be done as was performed for this index case.

The treatment for clitoridal cyst is surgical enucleation (excision) or marsupialization of the cyst followed by surgical reconstruction of the clitoris.[2,3,9] Complications following this surgery include haemorrhage, haematoma, wound infection and anorgasmia as a late complication.[6,11,12] Recurrence is rare.[13] Miss EOA had no complications postoperatively.

CONCLUSION

Clitoridal cyst is a rare complication of female genital mutilation, a high index of suspicion is needed to identify affected patients. The treatment is clitoridal cyst enucleation with cosmetic reconstruction of the clitoris. There is a need to eradicate the practice of female genital mutilation in developing countries because of this condition and other resulting complications.

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