

DOI: <https://dx.doi.org/10.18203/2320-1770.ijrcog20264035>

Case Report

Vulvar endometriosis away from a previous episiotomy scar mimicking a vulvar boil: a case report

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Received: 25 September 2026

Accepted: 19 October 2026

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ABSTRACT

Vulvar endometriosis is an uncommon form of extra pelvic endometriosis. It is frequently associated with previous perineal trauma or episiotomy, although lesions may occasionally occur away from sites of previous trauma. The condition may mimic other common vulvar lesions and therefore requires a high index of suspicion. A 40-year-old woman, para 1, presented with a painful vulvar swelling that was initially treated as a vulvar boil. She had undergone a full-term vaginal delivery with right mediolateral episiotomy 8 years earlier. Examination revealed a small, approximately 1–2 cm haemorrhagic cystic lesion on the right labia majora, distinctly away from the episiotomy scar. The lesion was tender and mobile, with no attachment to the underlying perineal muscles or abnormality of the overlying skin. Initial treatment with antibiotics and topical antifungal therapy did not result in improvement. On subsequent presentation around the premenstrual period, the lesion had enlarged and developed bleeding, with symptoms showing a clear cyclical relationship with menstruation. Complete surgical excision was performed under sedation and local anaesthesia. Histopathological examination confirmed vulvar endometriosis. There was no recurrence during 1 year of follow-up. Vulvar endometriosis should be considered in the differential diagnosis of a painful or recurrent vulvar lesion, particularly when symptoms show a cyclical relationship with menstruation, even when the lesion is located away from a previous episiotomy or other site of perineal trauma. Complete excision with histopathological confirmation is an effective diagnostic and therapeutic approach.

Keywords: Vulvar endometriosis, Extra pelvic endometriosis, Perineal endometriosis, Vulvar lesion; Episiotomy, Case report

INTRODUCTION

Endometriosis is a benign, chronic condition characterized by the presence of endometrial-like tissue outside the uterine cavity. It predominantly involves the pelvis, although extra pelvic sites can also be affected. The reported epidemiology of endometriosis varies substantially according to the population and method of diagnosis.¹

Vulvar endometriosis is an uncommon manifestation of extra pelvic endometriosis. In a systematic review of vulvo-perineal endometriosis comprising 283 patients,

most cases were associated with previous vulvo-perineal trauma or surgery, particularly episiotomy or obstetric laceration; only a small proportion occurred without such a history.²

The clinical presentation may include a vulvar nodule, pain, swelling, discoloration or bleeding, and symptoms may demonstrate a cyclical relationship with menstruation. Because these manifestations can resemble common vulvar conditions such as cysts or abscesses, diagnosis may initially be delayed. Previous reports have also described vulvar endometriosis presenting in unusual locations and mimicking other vulvar disorders.³

We report a case of histopathologically confirmed vulvar endometriosis in a woman with a previous right mediolateral episiotomy, in whom the lesion developed on the right labium majus away from the episiotomy scar, initially mimicking a vulvar boil and subsequently demonstrating cyclical enlargement and bleeding.

CASE REPORT

A 40-year-old woman, para 1 with one living child, presented to the gynaecology outpatient department with a painful swelling over the vulvar/perineal region for approximately 4–5 days.

She had a history of one full-term normal vaginal delivery 8 years previously, during which a right mediolateral episiotomy had been performed. There was no history of previous hormonal replacement therapy, dysmenorrhoea or diagnosed endometriosis. She was a known case of type 2 diabetes mellitus and hypothyroidism and was receiving treatment for both conditions.

On local examination, a small, approximately 1–2 cm, haemorrhagic cystic lesion was noted over the right labium majus. The lesion was tender and mobile. It was situated away from the previous episiotomy scar and had no apparent attachment to the underlying perineal muscles. There was no significant abnormality of the overlying skin.

Based on the initial clinical presentation, the lesion was considered to be a vulvar boil. The patient was treated with antibiotics and topical antifungal medication. However, there was no significant improvement in the lesion or symptoms.

The patient subsequently returned for reassessment around the premenstrual period. On this occasion, the lesion had increased in size and the patient reported worsening symptoms in relation to the menstrual cycle. Of particular clinical significance was the development of bleeding/spotting from the vulvar lesion around menstruation. This cyclical relationship raised the possibility of an underlying endometriotic lesion.

No ultrasonography or magnetic resonance imaging was performed. In view of the small, superficial and clinically accessible lesion, complete surgical excision was planned.

The lesion was excised completely under sedation and local anaesthesia. The mass was removed in toto and was not adherent to the vagina or underlying perineal muscles. The wound was closed with catgut sutures. The excised specimen was sent for histopathological examination.

Histopathological examination of the vulvar biopsy was reported as showing features consistent with vulvar endometriosis.

The patient was followed clinically for 1 year following excision. There was no evidence of recurrence during the follow-up period.

Written informed consent for publication of the case and accompanying clinical photographs was obtained from the patient.

DISCUSSION

Vulvar endometriosis is an uncommon manifestation of extra pelvic endometriosis. Although the exact prevalence is difficult to establish, the available literature indicates that vulvo-perineal disease is rare and is frequently associated with previous perineal trauma or surgery. In a systematic review of 90 studies involving 283 patients, 249 cases were associated with episiotomy or obstetric laceration, whereas only 13 cases were classified as spontaneous.²

The present case is clinically notable because, although the patient had undergone a right mediolateral episiotomy 8 years earlier, the endometriotic lesion was located on the right labium majus away from the episiotomy scar and had no attachment to the underlying perineal muscles. Thus, the lesion did not have the typical appearance of an episiotomy scar endometrioma.

The initial presentation also posed a diagnostic challenge. The patient presented with a painful vulvar swelling of short duration, and the lesion was initially managed as a vulvar boil. Failure to respond to antimicrobial treatment prompted reassessment. The subsequent observation of enlargement and bleeding in temporal association with menstruation was an important diagnostic clue. Cyclical vulvar pain, swelling and discoloration or bleeding have been described in previous reports of vulvar endometriosis.³

Previous case reports illustrate that vulvar endometriosis can occur at unusual sites. Singh and Naik reported spontaneous vulvar endometriosis involving the labium minus, presenting as a tender vulvar mass with cyclical symptoms and confirmed histologically after excision.³

Sarpietro et al reported a mobile lesion of the labium majus that was detached from the underlying perineal muscle and was treated by complete excision.⁴ These observations support the importance of considering endometriosis even when the lesion does not directly involve a previous surgical scar.

The diagnosis of vulvar endometriosis is ultimately established by histopathological examination. Imaging may be useful in selected patients, particularly when the lesion is large, deep, recurrent or when involvement of adjacent structures is suspected. In the present case, the lesion was small and superficial and was directly amenable to excision; therefore, imaging was not performed.

Complete surgical excision provides both tissue diagnosis and treatment for a localized vulvar lesion. Published reviews indicate that surgical excision is the predominant treatment approach for vulvo-perineal endometriosis, although recurrence has been reported during follow-up.² In the present patient, complete excision was achieved and there was no recurrence during 1 year of follow-up.



Figure 1: Clinical appearance of the haemorrhagic cystic lesion involving the right labium majus, located away from the previous episiotomy scar.

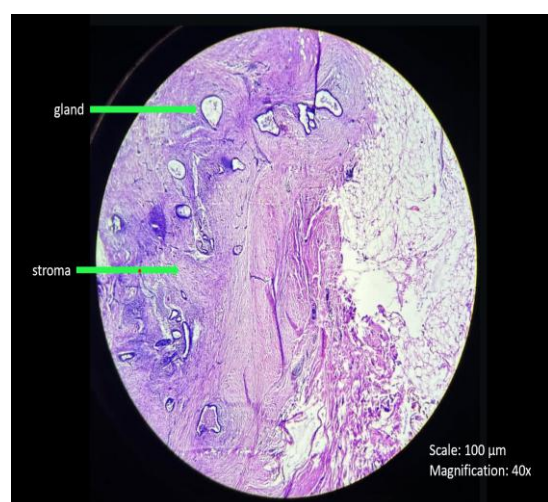


Figure 2: Histopathological examination of the excised vulvar lesion demonstrating features consistent with vulvar endometriosis.

The principal clinical lesson from this case is that a painful vulvar lesion that appears to be a boil or cyst should be reassessed when it fails to respond to conventional treatment, particularly if there is a cyclical relationship with menstruation. The absence of a lesion directly at a previous episiotomy scar should not exclude vulvar endometriosis from the differential diagnosis.

CONCLUSION

Vulvar endometriosis is an uncommon diagnosis that may mimic common vulvar lesions such as boils or cysts. A cyclical increase in pain, swelling or bleeding associated with menstruation should raise suspicion for endometriosis. Importantly, vulvar endometriosis can occur away from a previous episiotomy scar, despite the presence of a remote history of perineal trauma. Complete surgical excision with histopathological confirmation provides definitive diagnosis and treatment for a localized lesion.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Sarkar S, Saha A. Vulvar endometriosis away from a previous episiotomy scar mimicking a vulvar boil: a case report. *Int J Reprod Contracept Obstet Gynecol* 2026;15:4675-7.