Presentation of a Clitoral Mass in a Prepubescent Female: A Case Report and Discussion of the Evaluation

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ABSTRACT: Clitoral masses are rare. We present a case report of a prepubescent female with a periclitoral mass.

KEYWORDS: clitoral mass, periclitoral mass

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Introduction

Acquired masses of the clitoris are rare. We present a case of a prepubescent female with a periclitoral mass. Pathology revealed a hemorrhagic pseudocyst. To our knowledge, this is the first reported case of a periclitoral pseudocyst.

Case Presentation

A prepubescent African-American female presented with a three-day history of dull perineal pain and acute clitoral swelling. She denied fever, abdominal pain, vaginal discharge, dysuria, or hematuria. There is no history of voluntary or involuntary sexual activity, masturbation, or genital trauma. Limited bedside examination revealed a Tanner Stage 1 female with a tender mass between the labia. There was no inguinal adenopathy. Laboratory data and urinalysis were unremarkable. A pelvic ultrasound revealed no adnexal masses with normal Doppler flow to both ovaries. Magnetic resonance imaging (MRI) of the pelvis revealed a 3.8 cm × 2.9 cm × 2.1 cm well-circumscribed oval mass adjacent to the clitoris (Fig. 1). There were no other concerning pelvic findings. Decision was made to perform an exam under anesthesia, cystoscopy, and vaginoscopy with possible resection. Intraoperatively, examination revealed a normal urethral meatus and vaginal introitus. The mass was adjacent to the right clitoral hood. Complete resection with enucleation of the mass was achieved with reconstruction of the clitoral hood. The neurovascular bundles of the clitoris and corpora cavernosa were preserved during dissection. The mass was supplied by a single artery, which was dissected and tied off. Cystourethroscopy and vaginoscopy were performed after resection, which was unremarkable. Histological examination of the lesion revealed a hemorrhagic cyst without a true epithelial lining; this finding was consistent with a hemorrhagic pseudocyst. The patient was discharged on postoperative day 1. On clinical follow-up, her cosmetic result was excellent and her pain had resolved.

Discussion

Clitoromegaly is often the result of excess androgen in a female. This excess androgen can arise from endogenous overproduction or exogenous sources. Cysts of the clitoris are rare. Differential diagnosis includes epidermoid cysts, pilonidal cysts, paraurethral cysts, and dysontogenetic cysts of paramesonephric or mesonephric origin.[1] Benign cysts should be differentiated from other causes of acquired clitoromegaly, which may be viewed in the setting of an endocrinopathy such as virilizing tumors of the ovaries and adrenal gland, polycystic ovarian syndrome, or exogenous androgen administration.[2] This also may be mistaken for ambiguous genitalia. Nonhormonal causes of clitoromegaly include lymphoma, rhabdomyosarcoma, endodermal sinus tumor, leiomyoma, genital neurofibromatosis, and distant metastatic disease. Periclitoral mass can be because of infectious or noninfectious origin. Prior history of trauma such as genital mutilation should be considered. History and physical examination are important in narrowing a clinician's differential and assessing the need for an endocrinology evaluation. To our knowledge, this is the first case report of a periclitoral hemorrhagic pseudocyst. The inciting event is unclear and appears to be spontaneous based on her clinical history. Radiographic imaging ruled out a malignant process in the pelvis or mullerian abnormalities. Goals of surgical management include total excision of the lesion for pathologic diagnosis, alleviation of patient

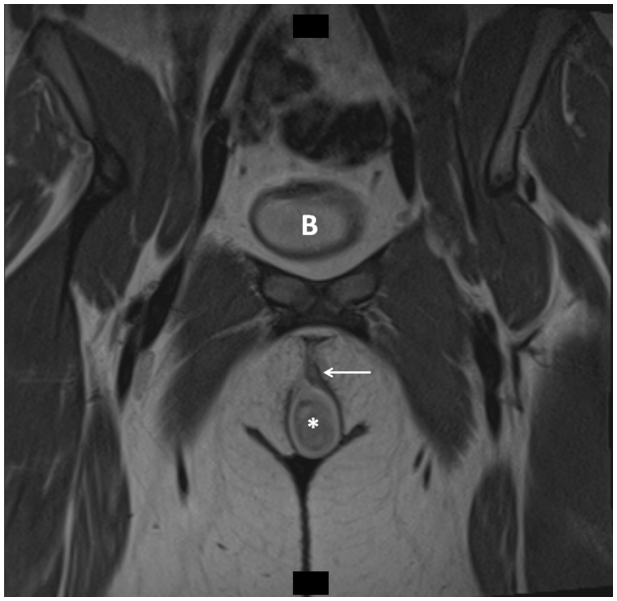

Figure 1. T2 MRI of the pelvis. Coronal reconstruction demonstrates the location of the periclitoral mass (asterisk) in relationship to the bladder (B). Note leftward displacement of the clitoral bodies (arrow).

discomfort, and preservation of clitoral sensation and future sexual function.

Author Contributions

Provided clinical treatment: MHW. Performed review of the literature: GL, KS, BK MHW. Wrote the first draft of the manuscript: MHW. Agree with manuscript results and conclusions: MHW, GL, KS, BK. Jointly developed the structure and arguments for the paper: MHW, GL, KS, BK . Made critical revisions and approved final version: MHW. All authors reviewed and approved of the final manuscript.

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