

Case Report

Lipschutz Ulcer—A Case Report with a Narrative Literature Review

Doroteya Georgieva ¹, Yavor Kornovski ^{1,2}, Stanislav Slavchev ^{1,2}, Yonka Ivanova ^{1,2}, Angel Yordanov ^{3,*} and Stoyan Kostov ^{1,4}

¹ Department of Obstetrics and Gynecology, MHAT “Saint Anna”, 9002 Varna, Bulgaria; doroteya.georgieva@mail.bg (D.G.); ykornovski@abv.bg (Y.K.); st_slavchev@abv.bg (S.S.); yonka.ivanova@abv.bg (Y.I.); drstoqn.kostov@gmail.com (S.K.)

² Medical University “Prof. Dr. Paraskev Stoyanov”, 9002 Varna, Bulgaria

³ Department of Gynecologic Oncology, Medical University Plevan, 5800 Plevan, Bulgaria

⁴ Research Institute, Medical University Plevan, 5800 Plevan, Bulgaria

* Correspondence: angel.jordanov@gmail.com

Abstract

Background/Objectives: Lipschutz ulcers were first described in 1912 by the Austrian dermatologist Benjamin Lipschutz. The onset presents with flu-like symptoms with consecutive development of painful vulvar ulcers. The term is currently used to describe painful genital lesions associated with an immunological reaction to an extragenital source of infection, usually viral or bacterial infections or certain vaccines. This disease affects predominantly adolescent non-sexually active females and is usually self-limiting. **Methods:** We searched PubMed, Research Gate and Google Scholar using the keywords “Lipschutz ulcer”, “Ulcus vulvae acutum Lipschutz”, “Acute genital ulcer”, and “Reactive non-sexually related acute genital ulcers”. A total of 24 articles in English between the years 2000 and 2025 were selected in order to mark the latest advancements towards diagnostic and treatment plans. Only 19 provided thorough information about the treatment and follow-up of the patients, encompassing a total of 69 girls and women. Results: This review synthesizes the most common etiological factors for Lipschutz ulcers and explores the mechanism behind their development. Different treatment approaches were also investigated. Based on our findings, we propose a diagnostic and treatment algorithm depending on the patient’s general condition and severity of the ulcers. We reported a 12-year-old girl’s case, diagnosed and treated at our department. Despite our efforts, conservative therapy proved inefficient. Surgery was performed. **Conclusions:** Lipschutz’s ulcer is a diagnosis often overlooked. Therefore, further research is needed to address the best treatment strategies. Surgery should be reserved only for patients who show no improvement with conservative treatment.

Keywords: Lipschutz ulcer; premenarchal age; acute vulvar ulcer; differential diagnosis; treatment

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1. Introduction

Lipschutz ulcer was first described by the eponymous Austrian dermatologist Benjamin Lipschutz in 1912 [1]. It describes the onset of acute genital ulcers (AGUs) without evidence of sexually transmitted disease. Currently, the term is used to characterize the appearance of acute vulvar lesions linked to an extragenital site of infection. These vulvar

ulcers have been associated with several bacterial or viral infections, such as Epstein–Barr virus (EBV) [2], *Mycoplasma pneumoniae* [3], Cytomegalovirus (CMV) [4], *Salmonella* paratyphi [5], influenza [6], streptococcal infection [7], COVID-19 vaccines, etc. [8].

The incidence of the disease remains unknown, possibly due to its rare recognition. The pathogenesis remains incompletely understood. The lesions have a predilection for the labia minora but also appear at other sites, such as the labia majora, perineum, or introitus. The disease typically presents with flu-like symptoms such as fever, asthenia, and lymphadenomegaly, particularly claiming young girls and adolescent women who have not yet begun having sexual intercourse. It is a diagnosis of exclusion, as it mimics a wide variety of diseases, sexually transmitted diseases (STDs), trauma, and autoimmune conditions. We present a case report of a 12-year-old premenarcheal girl with a Lipschutz ulcer, who was treated at our department.

2. Search Strategy

A narrative literature review was conducted using PubMed, Google Scholar, and ResearchGate. The search terms included “Lipschutz ulcer”, “Ulcus vulvae acutum Lipschutz”, “acute genital ulcer”, and “reactive non-sexually related acute genital ulcers”. Articles published in English between 2000 and 2025 were considered. Publications were selected based on their relevance to clinical presentation, pathogenesis, differential diagnosis, treatment, and follow-up. Reports lacking sufficient information regarding therapeutic management or clinical outcome were excluded from the analysis of treatment strategies. Of the 24 articles identified, 19 provided detailed information on treatment and follow-up and were therefore included in the therapeutic analysis. Given the narrative design of this review, no formal assessment of the risk of bias was undertaken. Consequently, the possibility of selection bias should be acknowledged as a limitation of this review.

3. Case Report

A 12-year-old girl, Virgo intacta, presented in the ED with chief complaints of swelling, yellowish discharge on her underwear, and changes in the color and size of her labia, which were painful to the touch, as well as vulvar aphthae. A few days before the lesions appeared, her temperature rose to 39.6 degrees, and she reported tonsillitis. At the time of examination, the patient was subfebrile. The flu test was negative. The patient had no relevant medical history, and no oral aphthae were noted. The mother of the patient denied a family history of autoimmune diseases.

Gynecological examination revealed symmetrical ulcerated areas in a kissing pattern on the labia minora at the level of the introitus and posterior commissure. The lesions were a violet color, covered with fibrinous plaque, and painful to the touch (Figure 1A). No enlarged lymph nodes were detected.

Given that Lipschutz ulcer is a diagnosis of exclusion, a comprehensive diagnostic workup was undertaken to exclude infectious, autoimmune, traumatic, and malignant causes of acute genital ulceration. This included laboratory investigations, microbiological and serological testing, and multidisciplinary assessment by dermatology and infectious disease specialists.

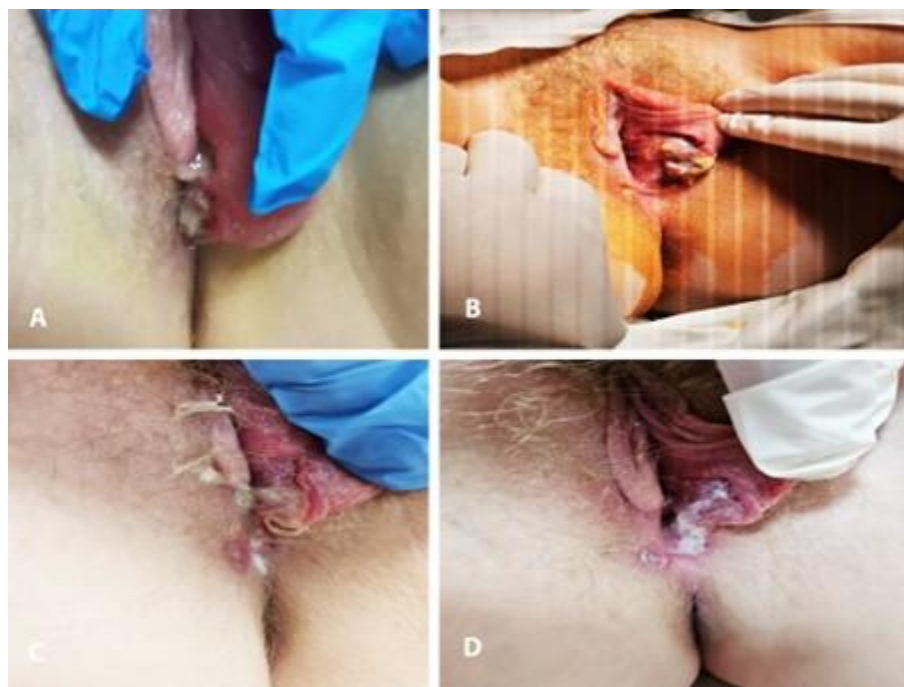


Figure 1. (A)—Lipschutz ulcer during admission. (B)—Ulcers just before surgery. (C)—Appearance of Lipschutz ulcer 3 days after the surgery. (D)—Ulcers 5 days after the surgery.

Upon admission, the laboratory findings were not specific. We noted that leukocytes ($19.1 \times 10^9/\text{L}$) and CRP (217 mg/L) were elevated. No other changes in the blood count and biochemistry were observed. Hemoculture was negative. The swab taken from the ulcer surface did not detect pathological microorganisms. Serological tests for EBV and CMV and the Venereal Disease Research Laboratory test (VDRL) were also performed, which were negative. Venereal causes of the UVAL were excluded. The patient had a recent febrile illness accompanied by tonsillitis and elevated antistreptolysin-O titers. However, no microbiological confirmation of streptococcal infection was available, and the association with Lipschutz ulcer should be regarded as presumptive. We consulted the patient with a dermatologist and an infectious disease specialist. The patient met all of the criteria for the diagnosis of Lipschutz ulcer.

The patient was treated with oral amoxicillin/clavulanic acid (1000 mg, two tablets twice daily for 7 days) and intravenous metronidazole (500 mg twice daily for 5 days). In addition, inosine pranobex (500 mg, two tablets three times daily for 10 days), ibuprofen, paracetamol, and vitamin C were administered. Local treatment consisted of ethacridine lactate compresses (Rivanol), topical liniment, and corticosteroid cream. By hospital day 6, no clinical improvement had been observed. Inflammatory markers remained elevated despite broad-spectrum antimicrobial therapy, and the patient continued to have fever (38.3°C). Therefore, surgical necrotomy was performed because of persistent symptoms and failure of conservative treatment. After the surgical intervention, an improvement in the local status of the patient was observed: the swelling of the labia disappeared, and wound granulation tissue appeared (Figure 1B–D). The patient remained permanently afebrile, and the values of the laboratory parameters were within the reference ranges. The patient was discharged, and so far, no recurrence of the disease has been reported.

Parental consent was obtained for presenting the case and using the photos.

4. Discussion

4.1. Epidemiology

The disease is typical mostly in the pediatric and adolescent populations. In a large case series, the mean age of onset was 16.6 years [9]. According to the aforementioned article, 38.46% of the patients were aged 19 years, and 15.38% were 18 years old. The rest of the patients were 11 years old, 12 years old, 14 years old, 15 years old, and 17 years old, each category amounting to 7.69% of all cases studied. The exact incidence of the disease is currently unknown because it is often overlooked and misdiagnosed.

4.2. Clinical Manifestations

As mentioned, the disease begins with asthenia, fever, and enlarged lymph nodes. Due to the location of the lesions, sometimes dysuria may also be present [6]. It is important to know that it can sometimes result in bladder retention requiring catheterization. Diarrhea, sickness, and vomiting are concomitant with gastrointestinal bacterial or viral agents [10]. The ulcerations typically appear on the labia minor but may also involve the labia major, perineum, vestibule, and lower vagina [11]. Macroscopically, the lesions appear with a round shape, with sharply demarcated borders, covered by fibrinous exudate or eschar. Edema and erythema of the labia, as well as inguinal lymphadenopathy, are also often described [12].

4.3. Pathogenesis

Pathogenesis remains enigmatic. However, it is hypothesized that the cytotoxic T-lymphocytes, found in the infiltrate, play a crucial role in the formation of the ulcers [13].

Another possible scenario is a type III hypersensitivity reaction during which immune complexes deposit in the dermal vessels, further activating the complement system, thus leading to tissue necrosis [14].

A deficit in the local immune response, particularly partial Ig A, has also been mentioned as a possible cause by Kinyó Á et al. [15].

4.4. Forms of Lu

Torok et al. [16] described three forms of the disease which we present in the table below (Table 1).

Table 1. Three forms of Lipschutz ulcer.

Type	Gangrenous Form (Most Common)	Chronic Form (Pseudo Venereal)	Miliary Form
Macroscopic characteristics	Ulcers covered with gray-yellowish exudate	Recurrent round superficial ulcers with significant swelling	Ulcers the size of a pinhead on the edges of the labia and perineum
Systemic symptoms	Prominent systemic symptoms	Subtle symptoms	No systemic complaints

4.5. Histopathological Findings

Due to the fact that LU usually occurs in younger age groups and the lesions are generally self-resolving, biopsy is rarely required. As neoplasms are part of the differential diagnosis for LU, the latter must be excluded.

Therefore, with lesions lasting more than a month or in patients with significant risk factors for neoplasia, biopsy may be appropriate [17,18,19].

Barnwal et al. documented a case of UVAL following CMV infection in a 19-year-old patient with histological findings consistent with dysplasia [20].

We give a quick reminder that the risk factors for the development of childhood cancers include radiation exposure, previous cancer treatment, Down syndrome, secondhand smoke, infections, and certain inherited conditions.

The histological picture of LU is nonspecific: dilated capillaries with lymphocytic, histiocytic, plasmocytic, and fibroblastic infiltration. Proliferation and local thickening of the vascular wall are also observed. In advanced cases, the infiltration contains predominantly polymorphic neutrophils, with the subsequent formation of miliary pseudoabscess and ulceration [16].

Major and minor diagnostic criteria have been proposed by Sadoghi et al. [18] to help evaluate the condition (Table 2).

Table 2. Diagnostic criteria of Lipschutz ulcer.

Major Criteria	Minor Criteria
Acute onset of ≥ 1 painful ulcerous lesions in the vulvar region	Localization of ulcer at vestibule or labia minora
Exclusion of infectious and other non-infectious causes for the ulcer	No sexual intercourse ever or within the last 3 months
	Flu-like symptoms
	Systemic infection within 2–4 weeks prior to onset of vulvar ulcer

According to Sadoghi, if both major and at least two minor criteria are present, the diagnosis of UVAL is warranted.

4.6. Differential Diagnosis

The differential diagnosis is vast: mechanical and chemical trauma and sexual abuse should be excluded. Venereal diseases ought to be ruled out with complementary tests. Autoimmune diseases such as Behçet's disease and Crohn's ulcerative colitis also cause lesions in the perineal and vulvar regions. Pyoderma gangrenosum and some malignancies can mimic Lipschutz ulcers as well. Because Lipschutz ulcer is a diagnosis of exclusion, a thorough diagnostic evaluation is mandatory. Infectious causes such as herpes simplex virus, syphilis, Epstein–Barr virus, cytomegalovirus, *Mycoplasma pneumoniae*, influenza, streptococcal infection, and other sexually transmitted diseases should be excluded. Non-infectious causes, including Behçet's disease, Crohn's disease, pyoderma gangrenosum, trauma, sexual abuse, and vulvar malignancies, should also be considered. Multidisciplinary assessment involving gynecologists, dermatologists, and infectious disease specialists may facilitate the diagnostic process.

4.7. Treatment

It is crucial to remember that Lipschutz ulcers are self-limiting and tend to resolve spontaneously. While recognizing that the etiology behind the appearance of LU is important regarding the overall health of the patient, there is no evidence that the treatment of the main disease promotes faster healing of the ulcers. The treatment aims to relieve the pain and help epithelialize the ulcer. Patients in many case reports have been treated symptomatically with analgesics, disinfectant compresses, topical steroids, and antibiotics when superinfection was suspected. Lipschutz ulcer is generally considered a self-limiting condition, and surgical treatment is not part of standard management. Conservative treatment consisting of analgesics, topical anesthetics, local wound care, and, in selected severe cases, systemic corticosteroids remains the preferred approach. In our patient, treatment

failure was defined by persistent severe pain, absence of clinical improvement after six days of multimodal therapy, and the presence of tightly adherent necrotic tissue. Under these circumstances, surgical necrectomy was considered a salvage procedure. Potential benefits include removal of necrotic tissue and acceleration of wound healing, whereas possible risks comprise pain, bleeding, secondary infection, and scar formation. Therefore, surgery should be reserved for carefully selected patients who do not respond to conservative measures and should not be regarded as routine treatment. In addition, treatment with a short course of systemic corticosteroids (0.5–1 mg/kg prednisolone for 7 to 10 days) may help heal severely painful, multiple, or necrotic ulcers [21].

Some authors claim positive results using colchicine for faster healing of lesions. This is likely linked to the fact that colchicine blocks the chemotaxis and phagocytic activity of neutrophils [22].

Surgical treatment is indicated in patients who have tightly adherent necrotic material covering the ulcer and show no improvement with conservative therapy [23].

Typically, the necrotic material is removed with a scalpel, followed by a saline lavage. Then the ulcer is covered by a gel containing antiseptics as well as moisturizers. Finally, alginate dressing is used to bandage the wound [24].

The authors observed a quick recovery with the aforementioned treatment.

Out of the 24 publications used as sources, 18 provide thorough information about the treatment and follow-up of the patients. The data is shown in Table 3, encompassing a total of 69 patients.

Table 3. . Summary of published case reports and case series included in this narrative review, presenting patient characteristics, presumed etiology, treatment, follow-up, and clinical outcomes of Lipschutz ulcer.

Reference	Number of patients	Age	Etiology	Treatment	Follow-up / Outcome
Lorenzo et al. (2005) [2]	2	18	EBV	Pt 1—acyclovir (discontinued), narcotic analgesics Pt 2—acyclovir, ciprofloxacin (discontinued), prednisone	• P1 healed in 16 days, no sequelae • P2 healed in 1 week, no sequelae
Kos et al. (2007) [3]	2	12, 11	Mycoplasma pneumoniae	Azithromycin for 5 days	Resolved in a few weeks, no scarring
Limão et al. (2018) [7]	1	11	Strep. A	10-day course of oral amoxicillin (500 mg twice a day), topical anesthetic (lidocaine) and antiseptic healing ointment (dexpanthenol and chlorhexidine)	Healed in 2 weeks, no recurrence
Hsu et al. (2022) [8]	3	12,14,29	COVID-19 vaccination and infection	Pt 1—topical clobetasol 0.05% ointment twice daily, lidocaine 2% jelly every 4–6 hours as needed, oral	Pt 1—healed in 2 weeks Pt 2—this was a second episode of

				acetaminophen and ibuprofen as needed, and sitz baths Pt 2—same as patient 1 + oral nortriptyline and oral prednisone taper (20 mg twice daily for 5 days followed by 20 mg once daily for 5 days) Pt 3—clobetasol 0.05% ointment twice daily	AGU, third occurrence of ulcers after SARS-CoV-2 infection, both healed in 4 weeks Pt 3—healed quickly
Farhi et al. (2009) [9]	13	11–19 years, mean 16.6	EBV in 4 patients, Behçet’s disease in 1 patient, idiopathic AGU in 8 patients	Five patients with no specific treatment; three received antibiotics only (cefepodoxime/amoxicillin); four received valacyclovir; one patient received valacyclovir, cefepodoxime, josamycine	10 patients healed in 16 days, 3 patients (23%) experienced 1 relapse of AGU during the following year, one diagnosed with Behçet’s disease
Skeens and Walker (2025) [10]	1	12	Viral gastroenteritis	Ice packs once every hour to the area, topical clobetasol ointment twice daily, and topical lidocaine gel, oral oxycodone, oral prednisone taper	Healed in 4 weeks
Moise et al. (2018) [11]	1	13	Suspected viral illness	Paracetamol, tramadol, wound care, acyclovir 200 mg 5X/day (discontinued)	Healed in a few weeks
Visentin et al. (2015) [12]	1	16	EBV	Emollients and analgesics	Healed in 20 days
Lehman et al. (2010) [13]	10	9–16 years, mean 11.5	Various viral pathogens	Analgesics, topical corticosteroids, NSAIDs	Complete resolution
Kinyó et al. (2014) [15]	2	3,25	Partial IgA deficiency	Pt 1—local steroid and antiseptic ointment Pt 2—amoxicillin/clavulanic acid, steroids	Pt 1—healed within 2 weeks Pt 2—healed in 3 weeks
Gómez Aguilar (2024) [17]	1	17	Idiopathic AGU	Doxycycline, sitz bath with potassium permanganate, betadine dressings	Healed in 3 weeks

Sadoghi et al. (2020) [18]	27	2 months–30 years, mean 15.5	Various	Topical and systemic antibiotics in 17 patients, topical and systemic cortisone in 10 patients, analgesics in 6 patients, surgery in 1 patient	Most healed in 2–3 weeks, two of which with scarring
Brambilla et al. (2022) [19]	1	12	Idiopathic AGU	Amoxicillin–clavulanic acid, Teicoplanin, Metronidazole, topical Beta-methasone, Gentamicin, Clotrimazole, Vaseline	Relapse after 15 months, HLA-B51 positivity
Barnwal et al. (2024) [20]	1	19	CMV	Acyclovir (400 mg 3x day for 7 days), oral corticosteroids (Tab prednisolone 40 mg for 3 days), additional anti-inflammatory medication (Tab paracetamol 650 mg to be taken as required)	Healed in 3 weeks
Mourinha et al. (2016) [21]	1	22	Idiopathic AGU	Azithromycin (no improvement), Doxycycline, acyclovir and analgesia (local and intravenous), topical Clobetasol	Healed in 3 weeks
Nouchi et al. (2018) [22]	1	18	EBV	Opioids and topical lidocaine, topical and systemic corticosteroids (0.5 mg/kg/day for 3 days), topical Imiquimod, Colchicine, 1 mg per day	Complete healing by day 7
Delgado-García et al. (2014) [23]	1	13	Idiopathic AGU	NSAIDs, analgesics, prophylactic broad-spectrum antibiotics (Amoxicillin/Clavulanic acid and Azithromycin), surgical removal of adherent necrotic material	Healed in 3 weeks; this was a second episode of AGU
Calles Sastre et al. (2018) [24]	1	24	Idiopathic AGU	NSAIDs, surgical debridement, followed by alginate wound dressing	Healed completely in 7 days

Abbreviations: AGU, acute genital ulcer; CMV, cytomegalovirus; COVID-19, coronavirus disease 2019; EBV, Epstein–Barr virus; IgA, immunoglobulin A; NSAIDs, non-steroidal anti-inflammatory

drugs; Pt, patient; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; Strep. A, Group A Streptococcus.

Based on research results, we propose the following algorithm leading to the diagnosis and treatment of patients with UVAL.

For practical purposes, disease severity was categorized according to clinical presentation. Mild disease was defined as isolated ulceration with tolerable pain and no urinary symptoms. Moderate disease included multiple ulcers, marked edema, and pain requiring systemic analgesics. Severe disease was characterized by extensive necrotic lesions, severe pain impairing ambulation or urination, urinary retention, or lack of response to conservative treatment. These categories are based on clinical judgment and have not been validated (Figure 2).

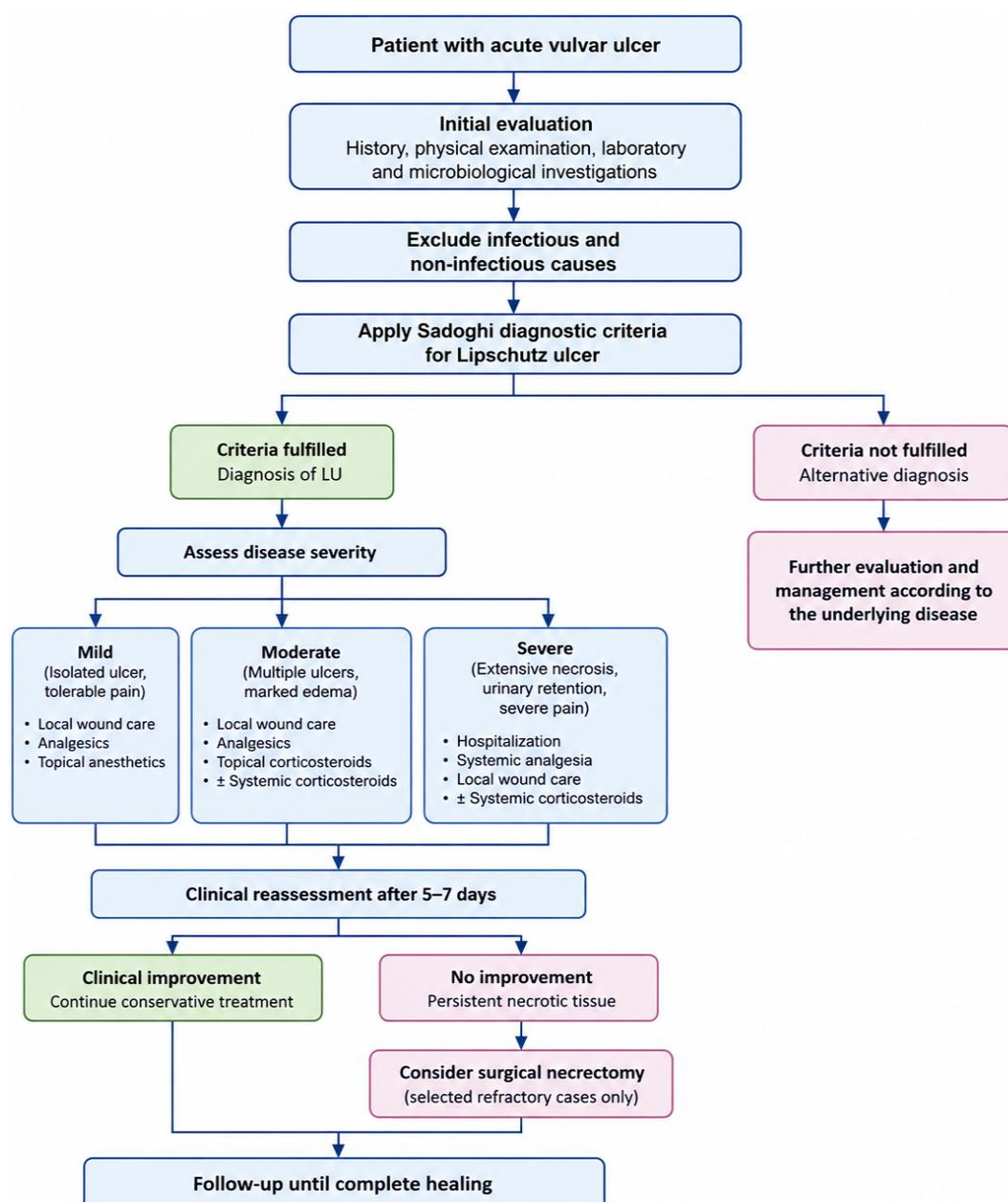


Figure 2. Proposed diagnostic and therapeutic algorithm for Lipschutz ulcer.

4.8. Follow-Up

It is important to know that most of the time, the ulcers resolve over a period of between 2 and 6 weeks without sequelae. Relapse of the disease has been reported in nearly a third of the patients over a period of one year [13]. Physicians should always remember that recurrent genital aphthosis may harbor Behcet's disease and maintain close monitoring, especially with patients suffering from recurrent oral and genital ulceration, and ocular inflammation [24]. Therefore, we consider that a gynecological exam has to be conducted once a year to rule out progression of UVAL.

4.9. Limitations of the Study

This manuscript has several limitations that should be acknowledged when interpreting its findings. First, as this study describes the clinical course of a single patient, the findings have limited generalizability and may not be applicable to broader patient populations. Second, as a narrative review, it did not employ a predefined systematic search protocol or standardized study selection process, which may have resulted in the exclusion of relevant literature sources. Third, the inclusion and interpretation of the literature relied on the authors' discretion, which may have introduced selection and interpretation bias. Moreover, as the review was carried out primarily using the literature in English, relevant evidence from other languages might have been omitted.

The review relied on published studies available through selected databases, potentially introducing publication bias by underrepresenting studies with negative or inconclusive findings. Differences in the methodological approaches, participant populations, research settings, and measured outcomes across the included studies posed challenges in comparing and synthesizing the findings.

As this review did not include a formal assessment of the methodological quality of the selected studies, the reliability and strength of the evidence may differ across the included literature. Therefore, the findings should be interpreted with caution, as they represent a narrative synthesis of the available evidence rather than conclusive proof.

Future studies employing systematic review methodologies and quantitative analyses are recommended to provide more robust and comprehensive evidence.

5. Conclusions

Lipschutz ulcer is a diagnosis often overlooked. Therefore, critical thinking as well as careful examination and evaluation are needed to recognize the clinical entity. A false diagnosis in this case causes a great distress to both patients and family. More effort is needed to spread awareness for UVAL diagnosis and treatment throughout different medical specialties that may come in contact with such patients.

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Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

AGU	Acute genital ulcer
AST	Antistreptolysin titer
CMV	Cytomegalovirus
EBV	Epstein–Barr virus
LU	Lipschutz ulcer
NSAID	Non-steroidal anti-inflammatory drug
Pt	Patient
RNRAGU	Reactive non-sexually-related acute genital ulcer
STD	Sexually transmitted disease
VDRL	Venereal Disease Research Laboratory test
UVAL	Ulcus vulvae acutum

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