

Management of Bartholin's Cyst/Abscess, including the use of the Word Catheter

Key Points

- The Bartholin's glands are required for vulval lubrication, but blockage can cause cyst/abscess formation.
- Bartholin's cyst or abscess is a common presentation to the Emergency Gynaecology service, causing pain and occasionally sepsis.
- It can be managed in a variety of ways, such as supportive management, or incision and drainage and insertion of the Word Catheter, or Marsupialisation to encourage re-epithelialisation of the tract.
- Antibiotics are usually not necessary unless signs or symptoms of an active infection
- If recurrent despite attempting different first line measures, excision of the gland may be necessary, and must be performed by experienced clinicians.

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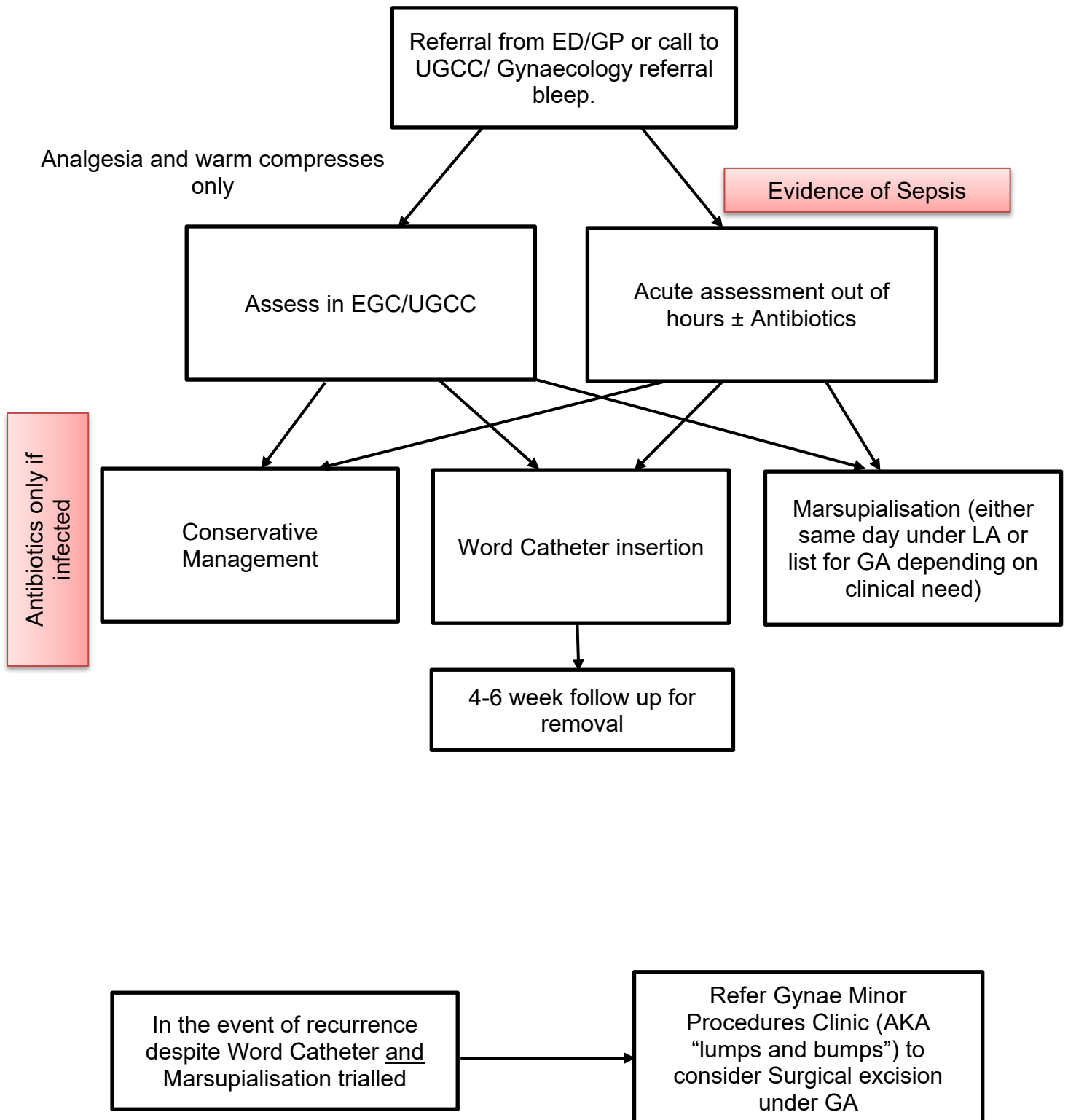
Abbreviations

BD	Twice daily
ED	Emergency Department
EGC	Emergency Gynaecology Clinic
GA	General Anaesthetic
HIV	Human Immunodeficiency Virus
HVS	High vaginal swab
IV	Intravenous
LA	Local Anaesthetic
QDS	4 times daily
STI	Sexually Transmitted Infection
UGCC	Urgent Gynaecology Care Centre

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1.0 Process Summary Table



2.0 Introduction

The Bartholin's glands are located symmetrically at the posterior region of the vaginal opening. Their openings are located either side of the vaginal orifice, just below the hymenal remnants at approximately 5 o'clock and 7 o'clock position. They secrete mucus to lubricate the vagina during sexual arousal. A build-up of mucus secretions can cause the duct of the gland to become blocked, from which a cyst can develop. The cyst itself can become infected, and if untreated, develop into an abscess.

Risk factors include personal history of Bartholin's cyst, sexually transmitted infections, history of vulval surgery. It generally presents at 20-40 years old, as the gland is inactive in pre-pubescence and atrophies post menopause.

3.0 Diagnosis

Bartholin cyst or abscess normally affects the gland on one side. It is diagnosed on vaginal examination as a classic appearance of medially protruding cystic structure arising from the base of the labium minora in the 5 or 7 o'clock position and does not cross the midline.

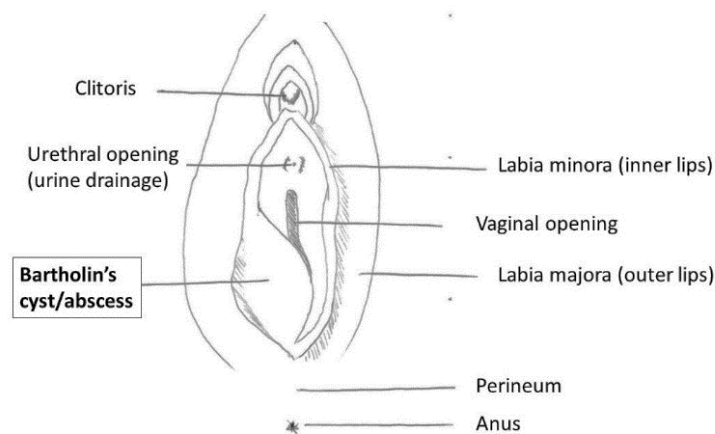


Figure 1 - identification of Bartholin's cyst/abscess

4.0 Referral

Although women may present to ED with this, they may usually be seen in the Emergency Gynaecology Clinic at the next available appointment unless there is evidence of sepsis (Fever, neutrophilia, etc). Please follow normal referral processes and recommend warm compresses +/- analgesia until seen in clinic. There is no need to prescribe antibiotics unless signs and symptoms of infection (as described below), as these will often not work, and the side effects may be distressing in addition to the pressure or discomfort caused by the cyst itself.

5.0 Symptoms

Small Bartholin's cysts are often asymptomatic and do not need any treatment. If it becomes large (usually $\geq 4\text{cm}$), it can cause vulvar pain particularly when walking and sitting, and painful intercourse. If it becomes infected, then this can lead to abscess formation. The skin over the abscess becomes red and hot and may be associated with fever and feeling unwell. It is important to differentiate between cyst and abscess, as these may impact the management.

6.0 Examination

On examination, a unilateral labial mass will be seen arising from the posterior aspect of the labia minora, although a large cyst or abscess can expand anteriorly.

- **Bartholin cyst:** normally presents as a moderately tender, fluctuant swelling. The mass may be tense, but the skin surface is often not oedematous. The cyst may be filled with blood/clot due to friction.
- **Bartholin abscess:** normally tense, hard, tender with surrounding cellulitis. This may be painful on light touch, and LA may not be effective if used. It may be associated with fever, or other symptoms of systemic infection.

7.0 Investigations

Diagnosis is based on clinical examination. No further test is required for diagnosis. However, if the patient is over 40 years old, biopsy of the cyst wall should be considered, especially if there is any solid component, to rule out vulval carcinoma. If in doubt, senior advice should be sought prior to management.

If there are risk factors for a sexually transmitted infection then the commensurate STI screening checks should be performed (HVS, Chlamydia/gonorrhoea urine/swabs and HIV screen).

8.0 Management

There are three courses of management for Bartholin cyst / abscess:

8.1 Conservative

No treatment is required if the cyst is small and asymptomatic. It will likely self-resolve. Warm baths may be recommended three to four times a day. Salt-water (Sitz) baths may help with tenderness, and warm compresses to encourage spontaneous drainage. For reassurance, a follow up appointment may be made around 2 weeks later, but this is not usually necessary. In these cases, continuity is often appreciated, so it is best practice to arrange follow up with the same clinician.

8.2 Word Catheter

This can be performed as an outpatient procedure, with local anaesthetic to the skin. It is generally well tolerated and can reduce the waiting and morbidity associated with awaiting marsupialization under GA. There appears to be a reduced rate of recurrence when Word Catheter is used with the appropriate follow up period.

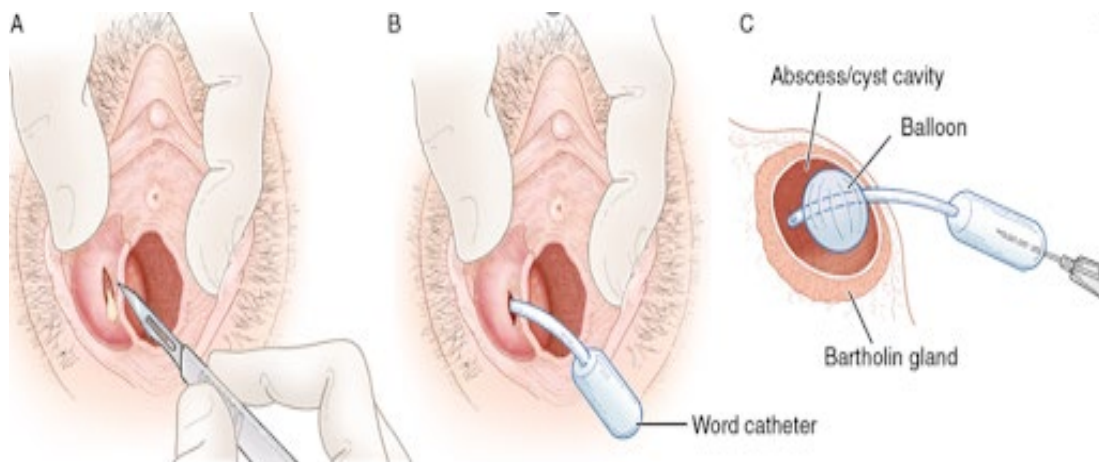


Figure 2 Technique for insertion of word catheter. "Chapter 138. Bartholin Gland Abscess or Cyst Incision and Drainage." Emergency Medicine Procedures, 2e Ed. Eric F. Reichman. McGraw Hill, 2013

Inclusion criteria	Exclusion criteria
Patient consent	Anxiety/unable to consent for procedure under local anaesthetic
Able to follow advice regarding aftercare	Infection/Abscess (relative)
Able to attend for follow up appointment	

Equipment	Procedure
• Dressing pack • Word Catheter pack – contains 3ml syringe, Word catheter, scalpel, • Sterile water • Local anaesthetic + syringe + Blue/orange needle • Trisept cleaning solution • Sterile swabs • Microbiology Black charcoal swab • Examination couch +/- stirrups and good light	1. Documented verbal consent, & aseptic technique. Ensure chaperone/assistant is available. 2. Clean the area and drape the bed/couch with sterile sheet under the buttocks 3. Apply LA just under the vulval skin - <1ml will usually suffice. 4. Make an incision with the tip of the scalpel <5mm below the hymenal ring, just big enough to drain the cyst contents and allow insertion of the black charcoal swab– making a larger cut may not allow the Word to remain in place later. The drainage of fluid often relieves the pressure and therefore discomfort. 5. Explore the cavity with the charcoal swab to obtain an appropriate aperture and break up loculations gently. 6. Insert the needle with 3ml syringe of sterile water into the Word Catheter device 7. Insert the device into the cavity and inflate the balloon 8. Remove the needle 9. Tuck the end of the Word catheter into the vagina 10. Consider showing the patient with a handheld mirror the placement of the catheter and reassuring that it is flexible and may be tucked inside to reduce discomfort from rubbing etc. 11. Document above and ensure some documentation to GP (i.e., discharge letter)

Word Catheter packs are contained within the Pink Gynaecology on-call bag for use out-of-hours if needed.

8.3 Follow up

- Leave in place for 4-6 weeks, to allow re-epithelisation of the surgically created tract and minimise recurrence.
- Arrange follow up appointment in Emergency Gynae Clinic for minimum 4 weeks with a telephone number for advice should issues occur.
- Reassure that if the catheter falls out then this does not need reinsertion, and the patient may cancel the follow up appointment if symptoms settle.
- They may perform normal activities, and baths are encouraged. Vaginal intercourse and tampon usage should be discouraged during this time.
- Complications include recurrence, infection, pain during intercourse and scarring.

9.0 Marsupialisation

Inclusion criteria	Exclusion criteria
Patient preference	Unsuitable for GA on medical grounds (consider Spinal or LA)
Severe abscess formation	Unable to consent
Sepsis	Asymptomatic – consider risk-vs-benefit

This procedure is usually performed under GA, but in selected cases may be performed under LA (usually uninflamed and as per patient choice). A small vertical incision is made into the cyst, behind the hymenal ring, allowing for drainage of the cavity. The cyst wall is then everted and approximated to the end of the vaginal mucosa by sutures (interrupted Vicryl/vicryl rapide 3-0).

Practice points:

- Advise that sutures will usually dissolve in 2-4 weeks and do not require removal or follow up
- There is no evidence to routinely pack the cavity after this procedure. If the clinician opts to pack the cavity, then a single length of ribbon gauze should be used to pack the cavity. The "Intentionally Retained Product Pathway" should be followed including attaching a purple wrist band to the patient while the pack is in place and ensuring appropriate written documentation including specific instructions for removal of the pack. The patient should be informed that a pack has been used. The pack should be removed prior to the patient's discharge from the Trust. Under no circumstances, should Jelonet paraffin gauze or any other dressings be used during or after this procedure.
- Take a Charcoal swab to send for microbiology sensitivities only if it is an abscess.

Complications include hematoma, infection, bleeding, pain during intercourse and scarring.

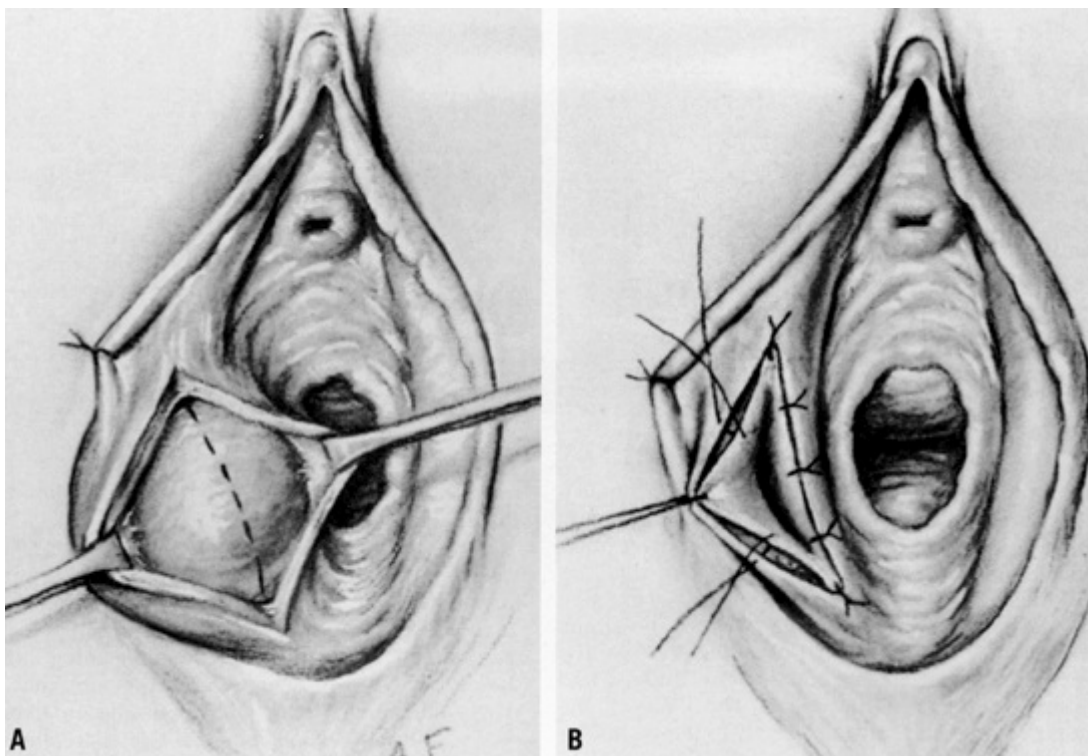


Figure 3- Marsupialisation of a Bartholin's gland cyst. "Bartholin's Cyst and Abscess", Jones, O, 2016, Accessible at <https://teachmeanbgyn.com/gynaecology/vaginal-vulval/bartholins-cyst-abscess/>

10.0 Antibiotics

- Antibiotics should be reserved for those with a true abscess. Culture from swabs is sterile or contains normal vaginal flora in 80% of Bartholin's 'abscesses'.
- At the time of marsupialization of an abscess, consider giving 1x stat dose of an IV broad-spectrum antibiotic of choice followed by oral for 7 days total. This should ordinarily only be done if evidence of significant cellulitis.
 - 1st line: Co-trimoxazole 960mg BD + Metronidazole 400mg BD
 - 2nd line: Co-amoxiclav 625mg BD + Clindamycin 300mg QDS – this regime may predispose to *C. difficile*, and as such the patient should be warned about the risk of developing *C. difficile* associated diarrhoea.
- There may be a small number of patients who have developed an abscess but are not suitable for marsupialisation or would prefer Word Catheter. In these cases, antibiotics should be given for a week prior to the procedure as LA is known to be less effective in the presence of infection.

11.0 Recurrence

A small proportion of patients may experience a recurrence of Bartholin's gland blockage. They may benefit from a repeat Word Catheter usage, with longer duration of use. If, despite this, symptoms recur, consider referral to the Gynaecology Minor procedures ("Lumps and Bumps") Clinic, for consideration of Bartholin's gland excision by an experienced surgeon. Patients should be advised that excision may lead to vaginal dryness, vulval itching/burning and dyspareunia. In addition, the recovery period may be longer compared to the above options, with the risk of haematoma formation, scarring and sepsis.

References

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Full version control record

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Key words:	Bartholin, cyst, abscess, Word Catheter, Marsupialisation, Labia, Vulva

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Version History

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Related Documents

Document Type	Document Name
FHFT Policy	Consent to Examination or Treatment Policy
Patient Leaflet	Bartholin's Cyst or Abscess