Bartholin's Gland Cyst and Abscess Treatment

See also Disease Monograph

Indications

1. Treatment of symptomatic (painful or growing) Bartholin's gland duct cyst
    - Initial episode may be treated with incision and drainage, but recurrence rate is high
    - Insertion of Word catheter or marsupialization may also be appropriate initially, or in recurrence
2. Treatment and culture of Bartholin's gland abscess
3. Biopsy of the cyst wall in patients >40 yrs old in an unresolving or recurrent cyst/abscess to rule out malignancy

Contraindications

1. Small, asymptomatic glands should not be treated
2. Incision and drainage also contraindicated in abscess that is not localized

Materials

1. Antiseptic solution
    - Povidone-iodine, chlorhexidine, or benzalkonium chloride
2. Gauze pads
3. 2 small hemostats
4. Pickups with teeth
5. #11 blade
6. Packing material (iodoform gauze) 1/4 to 1/2 inch
7. 1-2% lidocaine, 25 to 30-guage, 1.5 inch needle and syringe for anesthesia
8. Word catheter (Rusch and Milex), 3 ml syringe, and 22-gauge, 1-inch needle if being placed
9. Consider materials for hemostasis:
    - Suture 3-0 or 4-0 vicryl, hand held cautery

Positioning

1. Patient should be placed in dorsal lithotomy position

Step-by-Step

1. Explain procedure to the patient
    - Risks, benefits and obtain informed consent
2. Vestibule should be prepared with antiseptic solution
    - It is preferred to go through the vaginal mucosa side of introitus unless a very deep incision is required
3. Inject lidocaine (about 3 ml) inside the introitus (mucosal surface proximal to hymen)
4. Incise cyst or abscess with #11 blade until there is free flow of mucus/pus and you have penetrated the cyst/abscess
    - If Word catheter is being placed, incision must be 3-4 mm in length
5. Extrude all contents and culture contents if indicated
    - Common organisms to be cultured include N. gonorrhoeae and polymicrobial infections

6. Probe the abscess cavity with hemostats by moving the instrument throughout the cavity, breaking any loculated collections of pus
7. Biopsy of cyst capsule is indicated if malignancy is suspected or in a postmenopausal patient
8. After all pus is cleared from the cavity, you may place packing gauze into cavities that are 2 cm in size or greater, leaving a small length of gauze protruding outside
    - Smaller abscesses are best treated by keeping the wound open and allowing it drain, typically for about 4-6 weeks and allowing it to close up on its own
9. Premature closure can predispose to recurrence

Post-Procedure

1. Consider empiric antibiotics in cases with surrounding cellulitis
2. Confirm patient is up-to-date with tetanus vaccine
3. Be sure to educate the patient about dressing changes
    - Small amount of bleeding or oozing onto dressing is expected
    - Packing and dressing should be kept dry the first 24 hrs
    - If long strip of packing was required (1-2 feet), it may be necessary to remove few inches of gauze every 3-4 days
    - Dressings should be changed regularly as the abscess drains
    - Ointment may be used over the wound/wick to prevent it from sticking to the dressing between changes
4. Post-procedure pain should not be so severe to require opioid treatment
    - Warm compresses may be used to ease the pain
    - Patient should watch for signs of infection/cellulitis including fever, chills, increased pain, increased redness or red streaks leading away from the site
5. After first 24 hours, daily showers and or sitz bath should be encouraged
6. No intercourse until after first follow-up visit

Pearls

1. Patient may be taught to change/remove packing if able to properly self-care
2. Lidocaine may not work well in a very large abscess due to acidic environment, but should be adequate for lesions treated in the office
3. If recurrence occurs, Word catheter placement or marsupialization may be indicated
4. Antimicrobials indicated in immunocompromised pts or if cellulitis develops

Complications

1. Vulvar pain, dyspareunia, bleeding, recurrence, fistula formation, cellulitis or secondary infection

Follow-Up

1. Patient should follow-up in about 7 days for recheck and to assess signs of infection, or sooner if needed
    - May need subsequent visits depending on healing process, pre-existing medical conditions, or signs of cellulitis

References

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