ECTOPIC BARTHOLIN CYST.

by

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It is scarcely necessary to emphasize that an intelligent interpretation of the many congenital anomalies which are encountered in the female generative organs is not possible without some understanding of the embryology of these organs. On certain points regarding the embryological development of the female generative organs there is general agreement, but as to others there is still much confusion and difference of opinion. This paper reports an interesting case of muco-purulent discharge per vaginam, this discharge was through a sinus which was situated in the right vaginal wall about one inch below the right fornix and turned out to be an abnormally situated Bartholin's cyst with chronic inflammation.

Case Report

Mrs. S. S., aged 23 years, Hindu female was admitted in the septic ward of S. N. Hospital, Agra, on 20th September 1966, with a complaint of muco-purulent offensive discharge per vaginam for 6 months. She had two full-term normal deliveries and the last childbirth was one year ago. Her menstrual cycle was regular, duration of 4-5 days with a cycle of 28 days. On enquiry she stated that she had some sort of operation after her childbirth due to descensus. The nature of operation was not known to her. After a few months of her last childbirth she started having throbbing pain and heaviness during coitus.

General examination revealed nothing abnormal, there was no inguinal glandular enlargement. No lump was palpable per abdomen.

On speculum examination, there was a small sinus, on the right side of the vaginal wall, one inch below the right fornix, pouring muco-purulent offensive discharge. There was no apparent swelling; cervix was healthy.

Biruannal examination, uterus was anterior, mobile, normal in size, both fornices being clear. On palpation on the right side of the vaginal wall, there was a swelling about 2½" X 2" size, soft in consistency, not reaching up to the fornix. By pressing that swelling, purulent offensive discharge came out through that opening.

Investigation

1. general blood picture: Hb. — 11.5 gm%, R.B.C. — 4.12 Mill/cmm., W.B.C. — 9510/cmm. differential count $P_{75}L_{20}E_5$.

E.S.R. — 25 mm/1st hour, P.C.V. — 36%, corrected E.S.R. 22 mm of Wintrobe/1st hour.

Blood picture: Normocyte predominant, with mild degree of hypochromia.

2. **Pus swab culture:** E. Coli grown, sensitive to Terramycin and Streptomycin.

3. **Urine culture:** Sterile 48 hours.

Excision of the cystic swelling was decided on.

An incision was made round the sinus and by blunt dissection, the anterior

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/aginal wall was separated from the ystic wall and then that cyst was gradual- enucleated and space was closed by in- irrupted sutures. Vaginal wall was closed with interrupted sutures. The patient had an uneventful recovery.

Macroscopic, the enucleated cyst was pyriform in shape, 3 cm. in diameter in upper part and 1½ cm. in lower part, length was 4 cm., both surfaces being rough and greyish pink.

Microscopic, infected Bartholin cyst, wall showing chronic inflammation.

Discussion

It is very rare to find the Bartholin gland situated in an abnormal position. The vulvo-vaginal or Bartholin's glands are lobulated racemose glands situated one on each side of the vaginal orifice between labia minora and majora at about the middle or placed deeply in the perineal structures. These glands, presumably of entodermal origin, arise rom the vestibule known as greater vestibular (Bartholin's glands), the female homologues of the bulbourethral glands (Hamilton and Boyd 1959).

These are frequently the seat of gonorrhoeal infection. There is no question, however, that other organisms may at times be concerned such as the colon bacillus or the micrococcus catarrhalis, even the trichomonas vaginalis may occassionally invade the glands and produce an inflammatory reaction; Abscess is the common termination.

Chronic bartholinitis may persist for many years. A history of initial acute attack may or may not be obtained. The only clinical evidence of the disease may be the presence of a small nodular swelling. The patient herself is not infrequently unaware of the existence of such a nodule. The course of chronic bartholinitis is frequently punctuated by acute exacerbation with recurrence of abscess from time to time (Novak and Novak 1959).

In other chronic cases, as a result of occlusion of either the main duct or one of its subdivisions, cysts of Bartholin's gland develop, and these are very common while often producing little or no discomfort, they frequently undergo suppuration and abscess formation, as above described.

The pathologic changes in chronic batholinitis or cyst of the gland are those of chronic inflammation. The obstruction of the ducts by adhesive inflammation produces retention cysts of either large or small size. These are lined by transitional epithelium if the larger ducts are involved, though often this is flattened out or destroyed. In the walls of these cysts areas of Batholin's gland tissue are practically always demonstrable.

Summary

1. A case of Bartholin's cyst is being reported due to its abnormal situation which has not yet ever been reported.

2. The aetiopathology of chronic bartholinitis is briefly discussed.

References

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