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Management Of Bartholin Gland Cyst and Abscess

Introduction and Aim

Vulval abscess is a common presenting complaint to the emergency Gynaecology stream, with multiple management options. This guideline aims to assist with management decisions, procedures, and follow up to guide clinical staff to providing safe, standardized care, particularly with regard Bartholin gland abscess.

Is the document supporting a policy? No
What will it achieve?

Objectives

- **Guide and standardize care for women presenting with Bartholin's cyst or abscess.**

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts.

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	
Approved by	*Gynaecology Professional Forum*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

Management of Bartholin Gland Cyst and Abscess

Introduction

Bartholin's glands are mucus secreting vulvovestibular glands at the 4 and 8 o'clock position on the introitus. Women have a 2% lifetime risk of a cyst or abscess of the Bartholin gland[1]. As a result they are a common presentation to acute Gynaecology.
A Bartholin cyst is a collection of mucus within the gland, presumably from blockage of the duct, this may be noticed as a swelling and is usually painless. A Bartholin abscess is the same swelling, but accompanied by signs of infection - Calor, Rubor, Dolor, Tumor, (Heat, Redness, Pain and Swelling). Symptoms can be severe and are usually localised, systemic symptoms of infection may also be present.

Presentation

Frequently women present via primary care having been commenced on a course of oral antibiotics which have not been effective, or sudden worsening of chronic symptoms.

Most often emergency presentations are for abscesses, cysts are usually (and more appropriately) managed electively in Gynaecology outpatients. They can occasionally present in pregnancy women. While one should be aware of a potentially increased vulval blood flow, management is no different.

Natural Progression

Abscesses will "point" finding their way to the skin's surface before spontaneously rupturing, draining and healing. Recurrence is common in the order of 1:3 if conservatively treated [2.] Symptoms can be severe if untreated, and the infection can make women feel unwell. Anecdotally, systemic sepsis from Bartholin's abscess is uncommon.

If the abscess closes before it drains it can recur and a relapsing remitting course can develop. Surgical treatments aim to facilitate the development of a "neo-duct" to promote drainage, healing by secondary intention and reduce risk of recurrence.

Treatment Options

Medical -

Oral antibiotics. Flucloxacillin 500mg - 1g QDS, or (if penicillin allergic) Doxycycline 200mg stat followed by 100mg BD. 5-7 days with review on day 3. This is more suitable if the abscess has started to drain spontaneously, “abscesses should always be incised and drained” (Microguide CAV).

Surgical -

- Incision and drainage
- Word Catheter insertion
- Marsupialisation

Clinical judgement and individualised treatment plans need to be discussed and agreed with women. Consent should be obtained and documented. Written consent will be required if going to operating theatre.

It is reasonable to manage with general, local (1% Lidocaine), regional or topical (ethyl chloride) anaesthesia as the woman and clinician/anaesthetist feels appropriate. Local / topical anaesthesia are associated with immediate treatment options. General and regional anaesthesia will necessitate a CEPOD theatre booking which may take several hours at best (often considerably longer) [4] .
Following surgical management, if the woman is well, it is reasonable not to use antibiotics, as spontaneous healing will begin. If unwell or signs of severe infection antibiotics can be considered as above.

Incision and drainage - if abscess is pointing and it is felt the woman will be poorly tolerant of a prolonged procedure.
Topical ethyl chloride or careful 1% lidocaine infiltration followed by swift incision of the most fluctuant / pointing part of the abscess to release the pus, if possible a cross (X) incision, may reduce risk of premature closure of the abscess prior to drainage and healing. The woman can be encouraged to express the pus herself to ensure drainage and reduce risk of self sealing and recurrence.

Word Catheter -

The Word catheter, first described by Buford Word in 1968. The Word catheter is a 5.5 cm long, 15-French silicone device with a 3 cm balloon, placed in the cyst or abscess with the intention of providing drainage and epithelialisation of a tract to eliminate the need for surgery. Reported recurrence rates are on the order of 4–17% [3]. Making the incision just inside the introitus gives a more anatomically correct neo-duct, and allows the catheter to be tucked inside the vagina painlessly.

The catheter is designed to be used for 4 weeks, then removed. If the patient is well, the abscess healing and the catheter falls out spontaneously then no follow up is required. If the catheter remains in-situ it should be removed after 28 days, by deflating the balloon. There need not be any specific restrictions to leisure, hygiene or sexual activities [5] .

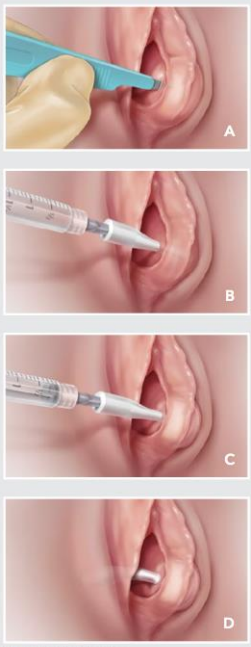
Word Catheter

SILICONE BARTHOLIN GLAND BALLOON

The Word Catheter Silicone Bartholin Gland Balloon is used for the treatment of abscesses and cysts of the Bartholin gland.

The balloon can be used in an office-based procedure. After being inserted into the area of the duct orifice and inflated with saline, the balloon can remain in place up to 28 days as the surgically created tract heals.

Procedural steps



Illustrations by Lisa Clark

1. Clean the area around the Bartholin gland with an antiseptic solution.
2. Use the enclosed scalpel to drain the abscess and break up any loculi by making an incision in the outer wall of the cyst, preferably inside the hymenal ring. (**A**)
3. After the abscess has drained, insert the deflated balloon through the incision and into the cyst. (**B**)
4. Use the enclosed syringe to inflate the balloon with sterile saline until the balloon is sufficiently anchored in the cyst. (Do not exceed an inflation volume of 3 mL.) (**C**)
5. Remove the syringe, leaving the inflated balloon in the cyst. Place the free end of the catheter inside the vagina. (**D**)
6. After the new orifice has completely healed, deflate the balloon with a sterile syringe and remove the catheter.

Note: Healing time may vary with each patient. The Word catheter is not intended to be left indwelling for more than 28 days.

Resources

Bakour S. WoMan-Trial RCT: Word catheter for the treatment of Bartholin cyst or abscess appears to be more cost effective than the conventional incision and drainage. *BJOG*. 2017;124(2):250.

Kroese JA, van der Velde M, Morssink LP, et al. Word catheter and marsupialisation in women with a cyst or abscess of the Bartholin gland (WoMan-trial): a randomised clinical trial. *BJOG*. 2017;124(2):243-249.

Reif P, Ulrich D, Bjelic-Radisic V, et al. Management of Bartholin's cyst and abscess using the Word catheter: implementation, recurrence rates and cost. *Eur J Obstet Gynecol Reprod Biol*. 2015;190:81-84.

Wechter ME, Wu JM, Marzano D, et al. Management of Bartholin duct cysts and abscesses: a systematic review. *Obstet Gynecol Surv*. 2009;64(6):395-404.

Haider Z, Condous G, Kirk E, et al. The simple outpatient management of Bartholin's abscess using the Word catheter: a preliminary study. *Aust N Z J Obstet Gynaecol*. 2007;47(2):137-140.

Owen JW, Koza J, Shiblee T, et al. Placement of a Word catheter: a resident training model. *Am J Obstet Gynecol*. 2005;192(5):1385-1387.

Scott PM. Draining a cyst or abscess in a Bartholin's gland with a Word catheter. *JAAPA*. 2003;16(12):51-52.

Order Number	Reference Part Number	Uninflated Catheter Fr	Balloon Volume mL	Quantity*
G55442	J-BGC-015055	15.0	3	5

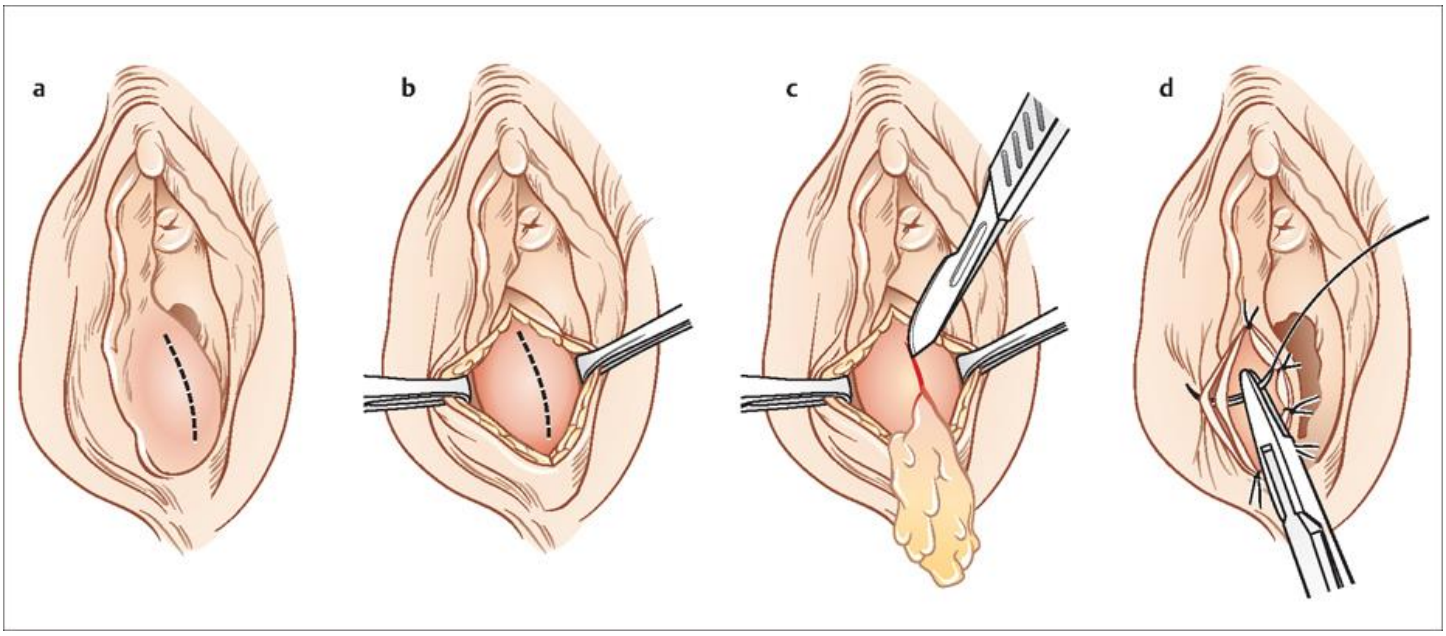
**Note: Five packages per box. Each package contains a silicone balloon catheter, a 3 mL syringe, and a scalpel.*

Some products or part numbers may not be available in all markets. Contact your local Cook representative or Customer Service for details.

Marsupialisation -

The cyst / abscess cavity is opened and drained, any loculations can be broken down digitally and the cavity debrided with a gauze swab. The incision should be just inside the introitus, in line with the anatomical position of the duct and to maximise healing potential.

The inside edges of the cavity are then sutured to the outside edges of the skin incision with interrupted rapidly absorbable fine sutures (such as 2/0 Vicryl Rapide). If a large cavity is left it can be packed with gauze or alginate ribbon (sorbsan / kaltostat) to keep it open while healing begins. The packing is usually removed after 12-24 hours, before discharge. This has traditionally been the gold standard and is associated with the lowest recurrence rate (10.3% needing repeat surgery within 1 year, vs 12.3% Word catheter) [4].



Discharge and Follow Up

SOS “safety net” phone number to Gynae Assessment ward / EGAU should always be provided. A typed discharge summary should be made available to the GP on Welsh Clinical Portal outlining treatment, recommendations and follow up.

Simple analgesia (paracetamol +/- NSAID) can be recommended and if absolutely necessary, prescribed.

If medical treatment is instigated, especially if the abscess has not ruptured or been incised, a follow up enquiry should be made in 3 days (Microguide CAV). This could be patient driven, a phone call from EGAU or an appointment / attendance. If evolving or not resolving surgical treatment may be offered.

Most women can be discharged the same day after marsupialisation or I&D treatment, and no specific follow up is required.

If a Word catheter is in situ patient contact details should be kept and a follow up phone call made after 1 week. If the catheter is still in situ, arrangements for its removal should be made at 4 weeks. If the catheter has fallen out and the patient is well, no further follow up is required. Concerns can be discussed with the patient and followed up with the EGAU or GP as appropriate.

Appointments for telephone follow up should be put in the ward diary, and notes kept on ward until completion of treatment. It is reasonable for doctors or nurses to undertake telephone follow up and seek advice as required. If patient un-contactable then attempt should be made the following day. If after 3 days no contact has been made a letter should be set to the patient, to remind them to contact or attend for follow up and the GP should be notified.

Recurrence / Postmenopausal Women -

If multiple recurrences or slow to heal (particularly in postmenopausal women), consider taking a tissue biopsy from the base of the abscess cavity to exclude adenocarcinoma of Bartholin's gland.

Word Catheter Checklist

1. Definitive diagnosis of Bartholin's abscess made.
2. Abscess not already ruptured or discharging.
3. Patient competent, consenting and cooperative for treatment.
4. Patient understanding of limitations of local anaesthetic procedure and availability of general anaesthesia option.
5. Patient able and willing to return for follow up.

6. Patients contact details recorded for telephone follow up at 1 week, and put in ward diary.
7. Unit contact details in case of query or complication given to patient.
8. Word catheter inserted successfully - abscess cavity drained, catheter inserted into cavity, balloon inflated and catheter retained, presence of catheter tolerated.
9. Prescription, or advice for analgesia or antibiotics as deemed necessary.
10. Information leaflet given.(* *Information Leaflet not yet written or approved*)

Telephone follow up at 1 week.

- Is patient well?
- Have symptoms improved? Swab results can be discussed.
- Is catheter still in situ? - If catheter has fallen out and patient is well, further follow up is not required.
- Any concerns from patient? If significant concern, symptoms worsening or systemically unwell arrange face to face review in EGAU.
- If all well reinforce face to face visit at 4 weeks from insertion to remove catheter.
- If catheter falls out in meantime, patient should contact ward regarding follow up appointment. If no other concerns 4-week follow up can be cancelled, at patient's request.

4-Week Follow Up Appointment

- General health check.
- Symptoms better?
- Examination and removal of catheter.

- Acknowledgement of any remaining patient concerns.
- Referral for GOPD follow up if continuing problems.

References

1. Omole, F, Simmons, DJ, Hacker, Y. Management of Bartholin's duct cyst and gland abscess. *Am Fam Physician* 2003; **68**: 135– 40.
2. Wechter, ME, Wu, JM, Marzano, D, Haefner, H. Management of Bartholin duct cysts and abcesses. A systematic review. *Obstet Gynecol Surv* 2009; **64**: 395– 404.
3. Philipp Reif, Daniela Ulrich, Vesna Bjelic-Radisic, Martin Häusler, Elke Schnedl-Lamprecht and Karl Tamussino. Management of Bartholin's cyst and abscess using the Word catheter: implementation, recurrence rates and costs. European Journal of Obstetrics & Gynecology and Reproductive Biology, 2015-07-01, Volume 190, Pages 81-84
4.Kroese JA, van der Velde M, Morssink LP, Zafarmand MH, Geomini P, van Kesteren PJM, Radder CM, van der Voet LF, Roovers JPWR, Graziosi GCM, van Baal WM, van Bavel J,

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5. Philipp Reif, Hend Elsayed, Daniela Ulrich, Vesna Bjelic-Radisic, Martin Häusler, Elfriede Greimel and Karl Tamussino. European Journal of Obstetrics & Gynecology and Reproductive Biology, 2015-07-01, Volume 190, Pages 76-80.