Reference Number: Version Number: 2	Date of Next Review: 2025 CAV Trust/LHB Reference Number:

Management of Bartholin Gland Cyst and Abscess

Introduction and Aim

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, usually in the reproductive age group[1]. As a result, they are a common presentation to the Emergency Gynaecology Assessment Unit (EGAU).

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 – erythema, swelling, pain and heat. Symptoms can be severe and are usually localised, systemic symptoms of infection may also be present.

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	List all documents the reader is advised to read alongside / in support of this document
Approved by	Gynae Professional Forum Obstetrics and Gynaecology Directorate. Dr Anju Sinha, Consultant Gynaecologist.

Accountable Executive or Clinical Board Director	*Dr Abraham Theron. Clinical Director, Obstetrics and Gynaecology*
Author(s)	*Miss Sioned Powell SSpR O&G*
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
2	TBA	TBA	Revised document

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Introduction

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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 pregnant women. While one should be aware of a potentially increased vulval blood flow, management is no different.

The most commonly implicated microbes are *E.coli* and *Streptococcus sp*.[2] *N.gonorrhoeae* is found in 1-17% of Bartholin's abscesses and cases associated with *Chlamydia trachomatis* have been reported[3].

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[4]. 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

Obtain a swab of discharge from a Bartholin's abscess (whether spontaneously discharging or at surgical drainage) for microscopy, cultures and sensitivities (charcoal swab). If risk factors for STIs are present, take triple swabs too (HVS, endocervical and Chlamydia/Gonorrhoea PCR).

Medical

Oral antibiotics are recommended if the abscess has started to drain spontaneously.

- Flucloxacillin 500mg-1g QDS PO
- OR if penicillin allergy: Doxycycline 200mg stat followed by 100mg BD PO

Treatment should be for 5-7 days with a review on day 3.

However, the abscess should be managed surgically if not spontaneously draining.

Surgical

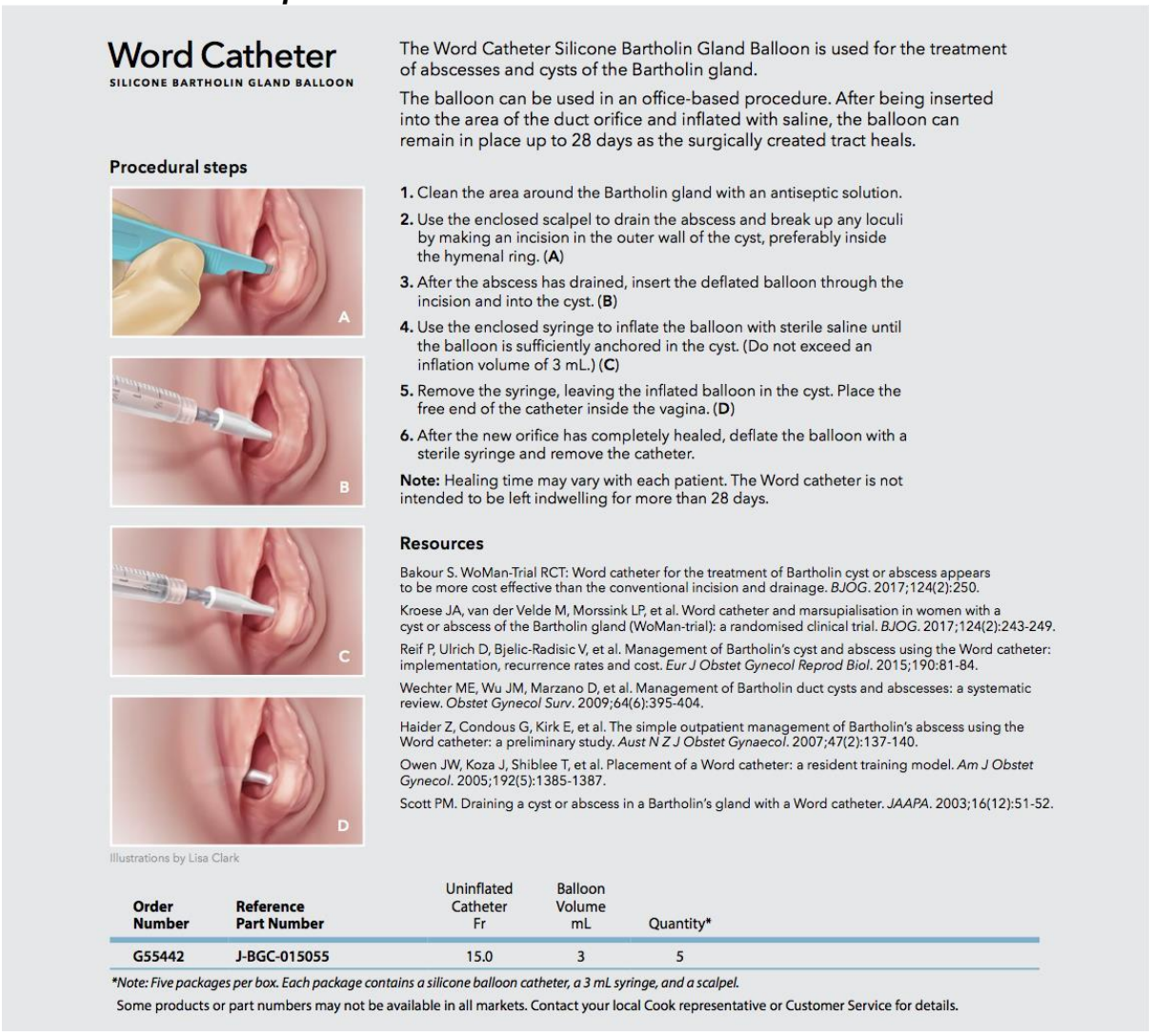
Clinical judgement, and the woman's preferences will inform the decision regarding the choice of approach including the choice of anaesthetic required. Current evidence doesn't demonstrate a significant improvement in outcomes with any single surgical intervention[5].
Consent should be obtained and documented. Written consent is required for cases undertaken in theatre.

	Location / anaesthetic options	**Pros**	**Cons**	**Reported recurrence rates**
Incision and drainage	Can be performed in the EGAU with local anaesthetic OR In CEPOD theatre under general or regional anaesthetic	Quick and cheap intervention If performed in EGAU will avoid need for admission and CEPOD time Acceptable to many patients	Considered inferior to other options due to significantly higher recurrence rates	39.6% recurrence within 12 months in one study[6] If silver nitrate inserted following drainage - 18.9% [5]
Incision, drainage and Word catheter insertion	Appropriate for EGAU setting with local anaesthetic Consider using in patients requiring regional or general anaesthetic too	Quick procedure that can be performed in the EGAU Acceptable to many patients	Not suitable for patients with LATEX allergy Word catheter needs to remain in situ for 4 weeks The catheters can fall out spontaneously	2-17% [7,8]
Marsupialisation	Usually performed under regional or general anaesthetic in the	Gives opportunity to explore cavity and break down any loculations	Requires significantly more resources, especially if	3-25% [9]

	CEPOD theatre Can be performed under local anaesthetic	Suitable for patients with latex allergy Often recommended in recurrent cases	requiring CEPOD theatre time and therefore hospital admission Significant delays may occur if awaiting CEPOD	

Following surgical management, it is reasonable not to use antibiotics as spontaneous healing will begin. If clinical concerns or signs of severe infection, antibiotics can be considered according to the microbiology guidance above.

The Word Catheter procedure



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

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.

Illustrations by Lisa Clark

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.

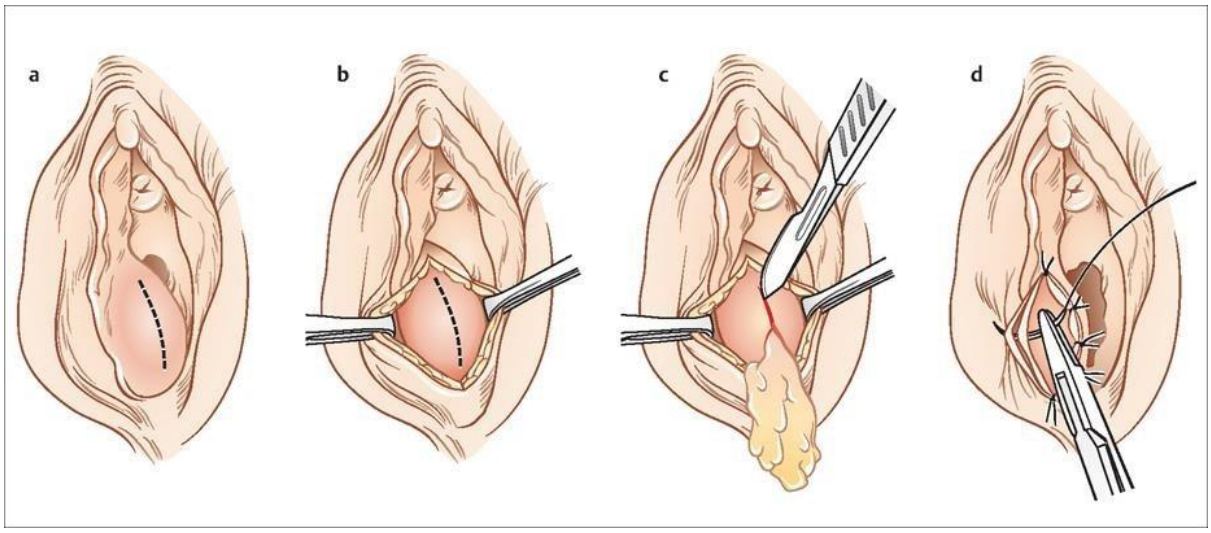
Make the incision just inside the introitus, as this gives a more anatomically correct neo-duct, and allows the catheter to be tucked inside the vagina painlessly. There need not be any specific restrictions to leisure, hygiene or sexual activities[10].

The catheter is designed to be used for 4 weeks then removed, this is done by deflating the balloon. Some catheters will fall out spontaneously during the 4-week period. If this is the case and the patient is well, no follow up is required.

Marsupialisation

The cyst / abscess is opened and drained with an incision of 1.5-2cm just inside the introitus. Any loculations can be broken down digitally, and the cavity debrided with a gauze swab.

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 whilst healing begins. The packing is usually removed after 12-24hrs, before discharge.



Discharge and Follow Up

All women should be given the phone number of the EGAU and advised to contact this number if any complications arise. A typed discharge summary should be completed on Welsh Clinical Portal.

Simple analgesia (paracetamol +/- NSAID) can be recommended.

If medical treatment is instigated and the abscess has not ruptured or been incised, a follow up enquiry should be made in 3 days. This could be patient driven, by phone-call from EGAU, or by attendance at EGAU for review. Surgical treatment may be necessary if not resolving.

Most women can be discharged on the same day following marsupialisation or incision and drainage. No specific follow up is required.

If a Word catheter is in situ, patient contact details should be kept and telephone contact made after 1 week. If the catheter is still in situ, arrangements for removal should be made at 4 weeks. If the catheter has fallen out and the patient is well, no further follow up is required.

Appointments for telephone follow up should be put in the ward diary, and notes kept on the ward until completion of treatment.

Recurrence / Postmenopausal women

If there are multiple recurrences of the lesion is slow to heal (particularly in postmenopausal women), consider the need for a tissue biopsy from the base of the abscess cavity to exclude adenocarcinoma of the Bartholin's gland.

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5. Illingworth BJG, Stocking K, Showell M, Kirk E, Duffy JMN. Evaluation of treatments for Bartholin's cyst or abscess: a systematic review. BJOG 2020;127:671–678.

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