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RESEARCH ARTICLE

MANAGEMENT OF A BIG GARTNER'S CYST

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ABSTRACT

Gartner cyst is usually found during routine gynaecological examination. Very rarely, they may increase in size because of mucus production. We diagnosed a case of a large Gartner cyst of approximately 10cm in a 35-year-old woman, multiparous, who came to outpatient department of Gynaecology, with a complaint of intermittent dragging pain in right lower abdomen. Apart from routine investigations, Ultrasonography abdomen and pelvis done I. Uterus normal size, Left adnexae showed single cyst 5cmswith wall3mm II. Non visualization of left kidney, confirmed by computerized tomography.

Trans vaginal sonography: Showed a Well defined cyst with Internal echoes with deviation of uterus to right lateral vaginal wall is indistinct S/o 1. GARTNER CYST
Left Adnexal cyst size 8.5x7.5x7.8 cms,
Treated by Marsupalization and documented.

INTRODUCTION

Gartner's duct cysts and metanephric urinary anomalies, such as ectopic ureter & ipsilateral renal hypoplasia. Discovered and described in 1822 by Hermann Treschow Gartner. Gartner duct cysts are vestigial remnants of the wolffian ducts, and these mesonephric cysts are most commonly found on the cephalad, lateral wall of the vagina. The cysts are usually 1 to 5 cm in size and are typically found only incidentally during pelvic examination. A small asymptomatic Gartner duct cyst may be followed conservatively. Deppisch (1975) described 25 cases of symptomatic vaginal cysts. They reported a wide range of symptoms, including dyspareunia, vaginal pain, difficulty with tampon use, urinary symptoms, and palpable mass. Symptomatic cysts may be treated by operative excision. Occasionally, these cysts may become infected, and if intervention is required during the acute phase, marsupialization of the cyst is preferred. Excision of vaginal cysts may be much more difficult and time consuming than anticipated, as some may extend up into the broad ligament and anatomically approximate the distal course of the ureter (Williams). The prognosis of Gartner Duct Cyst of Vagina is excellent with adequate treatment. Deppisch (1975) described 25 cases of symptomatic vaginal cysts. Case of Double gartner duct cyst of vagina was described in literature.

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Clinical presentation: A 35-years aged multiparous woman came to Gynaec out-patient department with a complaint of intermittent dragging pain in right lower abdomen. Her M.H regular 2/30, normal flow. She underwent myomectomy 25 yrs back and tubectomy 18 yrs back. She never had urinary or bowel complaints. This woman only referred mild dyspareunia. General condition good, moderately built and well nourished.

B.P. 110/70mm of Hg. Pulse 80/mt. Heart and lungs normal

Local Examination: EGH, (External Genital Healthy), P/S – Cervix healthy and high up, there is fullness on left side in the lateral wall of vagina, Mass at upper 1/3rd, Vaginal rugaee lost P/V – Cervix ↓ high up, UT undersized, mid position fixed (deflected to right), Right fornix free, Left fornix full, Anterior fornix on right free and was detected having a large tumefaction, soft, cystic, non-tender, non mobile, fluctuant seeming to have origin on the anterio- lateral left vaginal wall in the upper 1/3rd. On examination P/A sub umbilical mid line incision Scar present soft, no organomegaly, no masses felt and no tenderness. Patient was admitted in Gynaec ward for further management with Inpatient registration number ……134000

Local Examination

EGH (External Genital Healthy)
P/S – Cervix healthy and high up, there is fullness on left side in the lateral wall of vagina, Mass at upper 1/3rd, Vaginal rugae lost P/V – Cervix ↓ high up, UT undersized, mid position fixed

(deflected to right), Right fornix free, Left fornix full, Anterior and posterior fornices free and was detected having a large tumefaction, soft, cystic, non-tender, non mobile, fluctuant seeming to have origin on the anterio- lateral left vaginal wall in the upper 1/3rd. of size 8-9cms

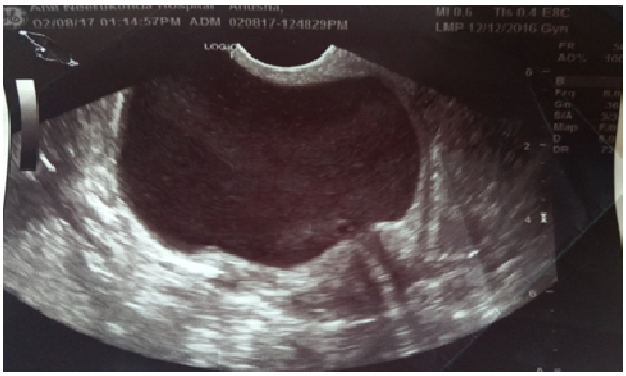
Basic analytical blood test, urinalysis and urine culture were normal.

USG ABDOMEN & PELVIS

S/o 1. Left Adnexal cyst 2. Non visualized left kidney (ref1) suggested CT KUB/pelvis

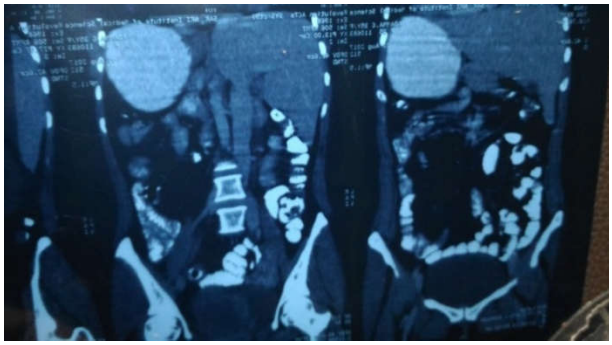
TVS

Well defined cyst with Internal echoes with deviation of uterus to right Lateral vaginal wall is indistinct S/o 1. GARTNER CYST (Fig –G) 2. Left Adnexal cyst size 8.5×7.5x7.8cms



CT SCAN :(FIG-B):CYST

C.T. PELVIS - CYSTIC MASS, (Fig. g1)



C.T. SCAN: Absent left kidney (Fig-A)

DISCUSSION

Differential diagnosis: Bartholin's gland cyst, uterine prolapse, cystocele, rectocele, enterocele, urethral diverticulum, endometriosis and malignant growth. Age of the patient, location of mass, lack of inflammatory signs examination clinical findings excludes the possibility of uterine or vaginal walls prolapse, Bartholin's gland cyst and malignant growth. Though it is a very large without any urinary complaints or history of urinary tract infections, the possibility of urinary bladder descent and urethral diverticulum are excluded. By the investigation we carried out transvaginal and abdominal ultrasound (Fig a). We identified a single cystic, fluid-like, a vascular area, of approximately 10cms, independent from bowel or bladder (cystocele or enterocele excluded).Neither the patient's complaint nor the clinical findings are fitting in to endometriosis as uterus size and shape were normal, ovaries apparently normal, sac of Douglas was free and the mass in not tender. So the final conclusion of Gartner's cyst was made. Gartner duct cysts can also be associated with abnormalities of the metanephric urinary system. A reno-vesical ultrasound was performed, looking for urinary tract malformations, the left kidney is absent (C.T. SCAN: Absent left kidney (FIG-A). The patient was proposed for surgery—drainage and marsupialisation of the cyst—which was performed without any complications.

Operation Notes

Major operation No:-895/17: Notes…..Patient is draped under sterile conditions in lithatomy position .Under spinal anesthesia the cyst of 10cms was opened by a transverse incision at dependent portion. Thick mucus secretions drained. The cyst base was very deep up to Broad ligament. Care was taken to avoid injury to contents of broad ligament. Marsupalization was done. Douching of cyst was done with betadine solution. The treatment could be expectant or surgical. Given the large size of the cyst and the young age of the patient we did not decide in favour of expectant management. Regarding the surgical treatment, it could be by vaginal or abdominal approach. We chose vaginal surgery because it seemed more accessible, less invasive and simpler.

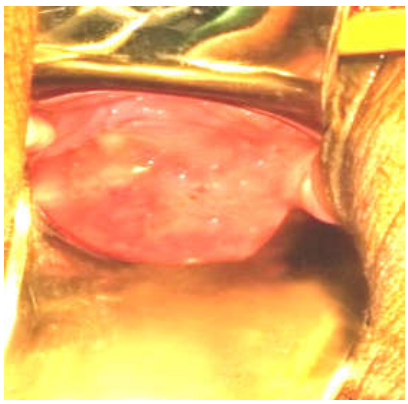


Fig. 1. Gartner's cyst (Before surgery)

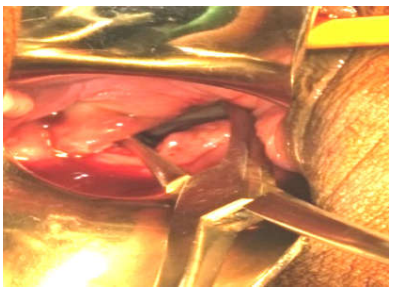


Fig. 2. After drainage

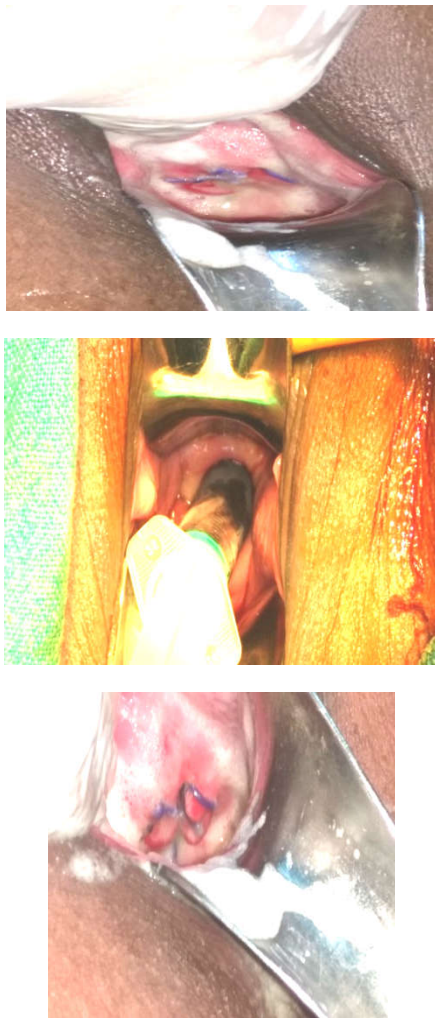


Fig. 3. Betadine Doushing Review after 20 days

Learning points

1. Clinical examination of patient is importment.
2. This big size Is very rare (ref –4) as it is mentioned in literature.
3. 3.confirmation by T.V.S.(REF-2)

REFERENCES

Dwyer, P.L., Rosamilia, A. 2006. Congenital urogenital anomalies that are associated with the persistence of Gartner's duct: a review. *Am J Obstet Gynecol*., 195:354–9 [PubMed]

Li, Y.W., Sheih, C.P., Chen, W.J. 1992. MR imaging and sonography of Gartner's duct cyst and single ectopic ureter with ipsilateral renal dysplasia. *Pediatr Radiol.,* 2:472–3 [PubMed

Siegelman, E.S., Outwater, E.K., Banner, M.P., et al. 1997. High-resolution MR imaging of the vagina. Radiographics. Radiographics., 17:1183–203 [PubMed]

Case Rep. BMJ 2013; 2013: bcr2012007996.Published online 2013 Feb doi: 10.1136/bcr-2012-007996 PMCID: PMC3604159 Case Report.

Midlife Health. J 2015 Oct-Dec; 6(4): 187–190. doi: 10.4103/0976-7800.172354.

PMCID: PMC4743283, Posterior vaginal wall Gartner's duct cyst. Ripan

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