



ISSN:2456-9739

Available Online at <http://www.bjbmr.org>

BRITISH JOURNAL OF BIO-MEDICAL RESEARCH

Cross Ref DOI: <https://doi.org/10.24942/bjbmr.2018.369>

Volume 02, Issue 05, Sept -October 2018

Case Study

An Unusually Large Gartner's Duct Cyst: A Rare Case

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ARTICLE INFO

ABSTRACT

Article History:

Received on 06th Sept 2018

Peer Reviewed on 21th Sept 2018

Revised on 11th October 2018

Published on 29th October 2018

Keywords:

Gartners cyst, Wolffian duct, Marsupialisation, Excision

Gartner's duct cyst are cystic dilatation of remnants of Wolffian duct which are found in around 25 % of women. Its most commonly found at the antero-lateral wall of proximal third of vagina. Here we present a case of 23 year lady incidentally diagnosed with a huge 6*7 cm gartner's cyst. The patient was asymptomatic and the diagnosed by ultrasound. Patient underwent excision of the cyst and had an uneventful post-operative period. In cases with huge gartner's duct cyst like this special care should be taken to define the extent of the lesion and associated anomalies of urinary system. Surgeons may be required to employ an abdominopelvic approach to access such huge mass extending into the retroperic space.

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INTRODUCTION

Gartner's ducts are remnant of mesonephric duct which are known to persist in about 25% of women. They in nearly 1% cases develop a secretory mechanism, cause dilation and result in formation Gartner's duct cyst. Characteristically, the cyst is solitary, situated in the anterolateral wall of proximal third of the vagina, unilateral and less than 2 cm in diameter.[1] These cysts are usually asymptomatic and diagnosed accidentally on routine gynecologic examination. However patient's complaints can comprise that of pelvic pain, skin tag, urinary problems, pressure symptoms, itching. here we describing a huge gartner's cyst which accidently diagnosed during ultrasonographic examination.

CASE REPORT

A 23 year P0L0A1 lady with no prior significant medical or surgical history reported with incidental finding of a gartner's cyst found on ultrasonography. It was not associated with pain, abnormal vaginal bleeding, urinary complaints or

difficulty during intercourse. Her menstruation was regular, normal in flow and without any pain. On examination her vitals were stable, abdomen was soft, nontender. On local examination a 7*6 cm fluctuant, nontender, mobile, cystic-appearing mass was noted arising from left anterolateral aspect of vagina extending up to the introitus. Ultrasound showed the single cystic, fluid-like, avascular area, of approximately 8 cm, independent from bowel or bladder (cystocele or enterocele excluded) arising from superolateral aspect of vagina. As the uterus size and shape were normal, ovaries apparently normal, There was no abnormality noted in the genitourinary and abdominal systems. Diagnosis of gartner cyst was confirmed. After confirming the diagnosis of Gartner's cyst patient was prepared for excision of the cyst. Cyst was extended 4cm inside retropubically. The cyst wall (Figure-1) was sent for biopsy which was consistent with the diagnosis of gartner's cyst.(Figure-2) Patient had an uneventful post operative period and was followed in OPD after 2 weeks

Figure1-Excised Gartner's Cyst

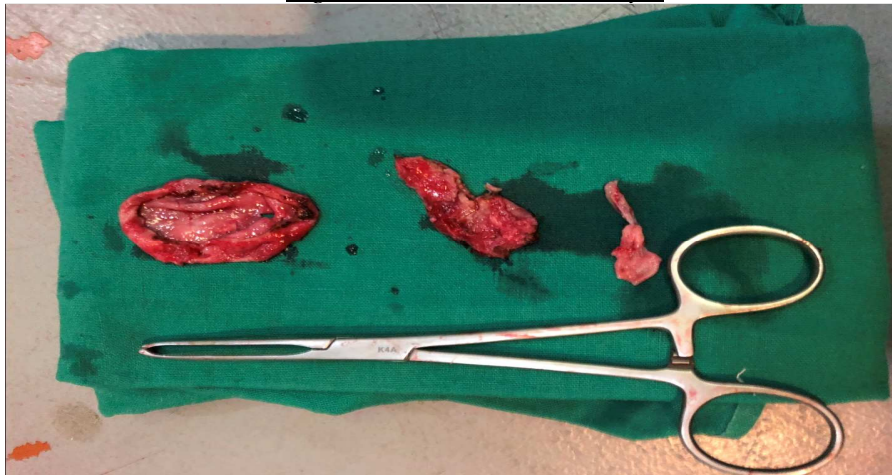
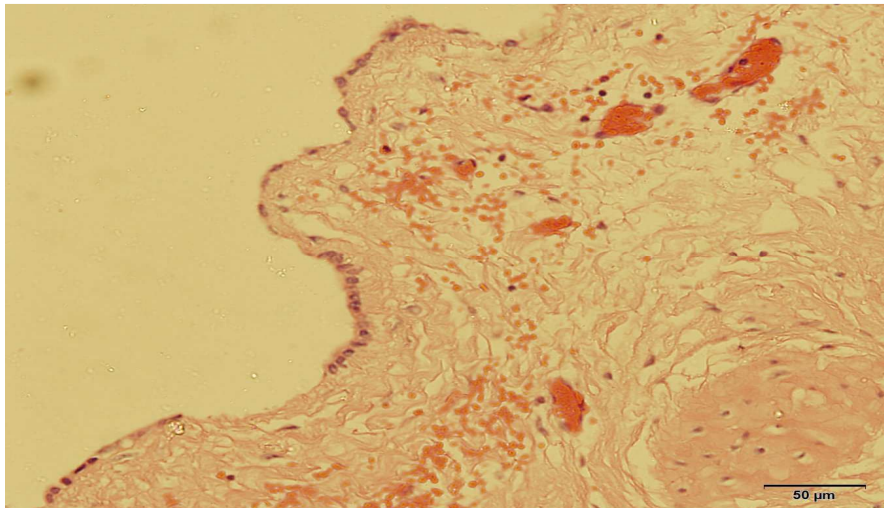


Figure2-20 x Columnar Epithelium of Gartner Cyst wall

DISCUSSION

The urogenital tract is derived from the Wolffian ducts (mesonephric) and the Müllerian ducts (paramesonephric) which are present in both sexes. Through the eighth week of embryologic development in females, the Müllerian ducts fuse distally and form uterus, cervix, and upper vagina while the Wolffian ducts undergo regression. These ducts may persist as vestigial structure and form Gartner's cysts. The cysts are primarily situated in the right anterolateral wall of proximal third of the vagina but can rarely be found along the course of wolffian duct such as the lateral walls of uterus [2,3]. Abnormal development of Wolffian duct can be associated with malformations of metanephric urinary system such as the ectopic ureter, unilateral renal dysgenesis, and renal hypoplasia [2, 4, 5]. Symptoms include palpable mass, voiding disturbances, dyspareunia, pain and vaginal discharge. [6] Although majority of them are asymptomatic, they can be complicated with infections, bladder dysfunction and urinary incontinence due to compression of the bladder neck [4]. Gartner's cysts even though are typically small but large cyst are also reported which can be confused with other differentials such as cystocele rectocele, enterocele, uterine prolapse, Bartholin's gland cyst or

abscess, urethral diverticulum, endometriosis, Skeine's gland cyst, or abscess and ureterocele. and malignant growth among others. [7]. About 1 to 2 % of women are diagnosed with vaginal cysts, out of which around 10 % are gartner's cyst. [2, 8] Transvaginal ultrasound is recommended to confirm the diagnosis. Intravenous pyelography and computed tomography can be helpful to exclude other urogenital anomalies [2]. Treatment depends on the symptoms and desire of the patient. In symptomatic patient treatment of choice is excision or marsupialization. Cyst drainage or intra-cystic tetracycline injection can be attempted in selected cases [9]. Marsupialization is minimally invasive, creates least surgical scarring and prevents recurrence. It also provides pathological diagnosis which shows cellular remnants comprising of nonmucin secreting low columnar or cuboidal epithelium. For recurrent cyst management include periodic surveillance, sclerotherapy, marsupialization and excision [10]. Even though malignant transformation of Gartner's cysts is exceptionally rare, in elderly patients, a mass wall biopsy is mandatory in order to exclude neoplasia.[11].

CONCLUSION

A gartner's cyst is usually small cyst (~2-3cm) located in anterolateral vaginal wall, however in exceptional cases the cyst can grow upto enormous sizes like elaborated in the given case. In such cases carefull evaluation regarding the extent and nature of cyst should be contemplated before taking up the patient for surgery. In cases with extension into the pelvic or abdominal cavity an abdomino-pelvic approach can be used to access and completely remove the mass.

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How to cite this article:

Khan Dina Aisha, Sharma Nalini, Jethani Roma, Jaya Mishra. *An Unusually Large Gartner's Duct Cyst: A Rare Case.* Br J Bio Med Res, Vol.02, Issue 05, Pg.559 - 562, September - October 2018. ISSN:2456-9739 Cross Ref DOI : <https://doi.org/10.24942/bjbr.2018.369>

Source of Support: Nil

Conflict of Interest: None declared.

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