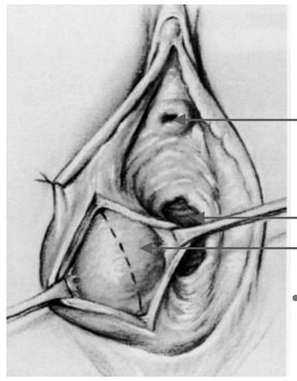
A RARE CASE OF BARTHOLIN'S AND PERI-URETHRAL ABSCESS

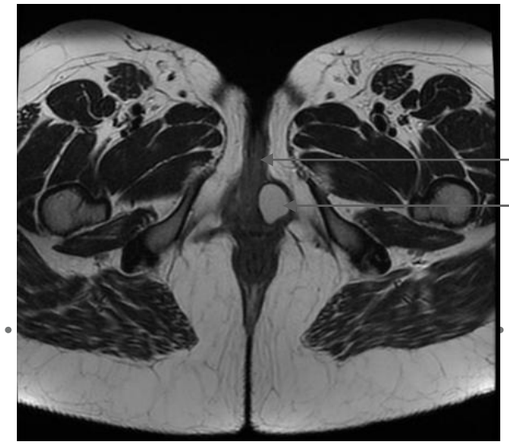
DR ADEEB KHAN O&G ST4, DR AISLING ARMSTRONG FY2, DR TOMMY TANG O&G CONSULTANT

Introduction

In the gynaecology outpatients setting, perineal infections are a common presenting complaint. Bartholin's glands provide lubrication to the vagina. They are prone to obstruction at the vestibule orifice and owing to this they are a common site for infection in the perineum. Secondary to outflow tract obstruction, cysts may develop. Lifetime incidence in women ranges from 2-7%.[1,3,4,6] If a cyst becomes infected, abscess formation may occur. Bartholin's abscesses (BA) may be asymptomatic or present with pain, dyspareunia, incontinence, obstructive voiding symptoms, discomfort mobilising and vulvar tumefaction.[1,5]

Scarcely reported in literature are cases of BA causing peri-urethral abscesses. Peri-urethral abscesses (PA) typically follow trauma caused by childbirth or surgical interventions and are rarely acquired.[2,7] PA like BA, may be asymptomatic or present with dyspareunia or dysuria.





Case Study

A 23 year old female presented to Emergency Department in acute urinary retention, saddle paraesthesia, leg pain and a reduction in power on lower limb assessment. She was given a working diagnosis of cauda equina and admitted to the regional Acute Spinal Unit in Belfast. Her MRI spine was unremarkable.

The patient experienced sustained pyrexia >38°C and tachycardia with markedly elevated inflammatory markers. Due to a history of dyspareunia a vaginal examination was conducted and an extensive right vulval cellulitis extending to the gluteal region and a right sided Bartholin's abscess was noted.

She was catheterised, commenced on intravenous antibiotics and referred to the gynaecology team who reviewed her and requested a CT abdomen and pelvis.

CT abdomen and pelvis confirmed a right sided Bartholins abscess and peri-urethral abscess deviating to the left side of the urethra. Consent was obtained to use images in this case report.

Treatment

The Bartholin's abscess was incised and drained on the ward under local anaesthetic. The patient was discussed with the urology team who advised a trial removal of catheter in one week. The patient was discharged with an indwelling catheter and oral antibiotics.

Outcome and Follow Up

The patient returned for removal of catheter one week later and was able to void successfully. She was clinically well and no further investigations were arranged.

Discussion

A concurrent Bartholin's abscess and peri-urethral abscess are rarely documented in literature. This report highlights a case in which a common gynaecological pathology presented in an atypical way. Although imaging modalities are useful to assist in diagnosis, good clinical history and examination findings are key.

References

1. A Clinical Approach to Vulvovaginal Cysts and Abscesses, A Review. Australian New Zealand Journal of Obstetrics and Gynaecology. 2018; 1-9. Bartoli J, Chowdary P, Nikpoor P, Readman E.

2. Experiences with Management of Pera-urethral Cysts in Adult Women. European Journal of Urology. 2013; 66(4): 477-480. Kose O, Ayedemire H, Metin O, Budak S, Sonbahar A, Adsan O.

3. Bartholins, Vulval and Perineal Abscesses. Best Practise & Research Clinical Obstetrics & Gynaecology. 23(5)2009; 661-666. Bora S, Condous G.

4 . Benign Vulvovaginal Cysts. Diagnositic Histopathology. 23(1):2017;14-18. Anderson S.

5. Unusual Presentation of a Bartholins Gland Duct Cysts: Anterior Expansions. BJOG. 112(8):2005; Rozier R, Azarian, M.

6. Benign Cystic Lesions of The Vagina: A Literature Review. The Journal of Urology. 170:2003;717-722. Eilber K. Raz S.

7. Lesions of the Skenes Gland and Periurethral Region: A review. Heller D.