Bartholin Cysts: A Mini Review of Etiology, Diagnosis, And Modern Treatment Modalities

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ABSTRACT

The Bartholin glands, also known as the larger vestibular glands, are two small structures located bilaterally at the 4 and 8 o'clock positions near the vaginal introitus. They play a critical role in vaginal lubrication during sexual arousal. Bartholin cysts, affecting approximately 2% of reproductive-aged women, result from obstruction of the gland's ducts due to inflammation, infection, or trauma. Hormonal influences contribute to their prevalence, particularly after puberty until menopause. Bartholin cysts form when fluid accumulates within the blocked duct, typically remaining asymptomatic. However, some may cause pain, discomfort, or infection, leading to a Bartholin abscess characterized by redness, warmth, and pus. These conditions are classified as infectious or non-infectious and require thorough gynaecological examination to exclude other pathologies such as tumours or severe infections. Diagnosis is primarily clinical, with imaging used in uncertain cases. Treatment strategies vary based on cyst size, symptoms, and infection status. Asymptomatic cysts often resolve without intervention, while symptomatic cases may require procedures such as incision and drainage, needle aspiration, marsupialization, or fistulisation for recurrent issues. Education about symptoms and timely care is vital, as is monitoring recurrent cases to prevent complications. Advances in treatment aim to enhance management options, focusing on effectiveness and minimizing invasiveness. Regular follow-ups ensure better outcomes for affected women, with healthcare providers playing a key role in improving awareness and care for this common gynaecological condition.

Keywords: Bartholin cyst, Bartholin abscess, Vestibular gland, Marsupialization, Word catheter, Cauterization.

INTRODUCTION

Among women who have reached of reproductive age, Bartholin's gland cysts and abscesses have become common gynecological issues. Two percent of all gynecological visits are related to Bartholin's cysts each year. An uncomplicated surgical operation needs to be done to treat the Bartholin's cyst and abscess, but there is additionally a significant possibility of morbidity, including scarring, dyspareunia, and most importantly recurrence (Riche et al., 2020).

The Bartholin glands, frequently referred to as the bigger vestibular glands, are two 0.5 cm glands situated in the lower right and left regions of the vaginal introitus, at the 4 and 8 o'clock positions. A gland which secretes mucus, the Bartholin gland contributes to lubrication of the vaginal area. Mucus droplets are drained into a 2.5 cm long duct by each Bartholin gland, which is around 0.5 cm in size (W. A. Lee & Wittler, 2023).

The main objective of the organs in the female reproductive system is to create mucus, which lubricates the vulva and vagina, especially while sexual activity. Removal of a Bartholin's gland does not appear to impair the vestibular epithelium or sexual function because the gland's secretions give the vulva some moisture but are not mandatory for sexual lubrication (Oksuzoglu & Evliyaoglu, 2022)

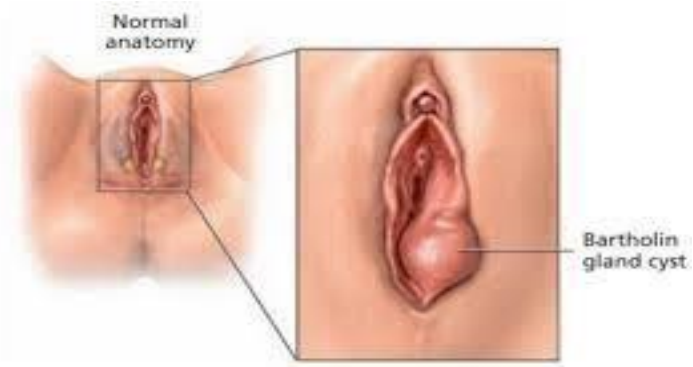
When unobstructed, Bartholin glands generally not perceptible. After puberty, cysts and abscesses are frequently found, with a decline in frequency following menopause. The majority of cases of Bartholin cysts/abscesses are observed in women who are fertile. Bartholin cysts are more common as puberty proceeds and continue to rise in frequency until menopause. The cyst frequently reaches a diameter of 2-4 cm, can trigger vague pelvic pain, generate dyspareunia, and irritate the bladder. E. Coli, streptococcus, and staphylococcus bacteria can be identified in the fluid inside the cyst, which can frequently non-purulent in

nature. A Bartholin cyst originates when the lining of the Bartholin duct becomes clogged and mucous discharge from the gland accumulates, whereas a Bartholin abscess is brought on by an infection of either the primary gland or a Bartholin cyst. (W. A. Lee & Wittler, 2023)

Congenital duct narrowing, vestibular impairment, iatrogenic occlusion from surgical sutures, inflammation after infection, and mucus inspissation that causes plugging are among the causes of duct blockage. Bartholin cysts usually not cause discomfort much and don't display any symptoms. They may get enlarged and cause discomfort, especially during sitting, ambulating and Sexual intercourse (Tadesse, 2023).

Subsequent laboratory or radiographic examinations are typically not required for Bartholin cyst abscesses; however, during the incision and draining of the abscess, wound cultures and biopsies may be conducted. Bartholin cysts that don't hurt don't need to be managed further. Conservative therapy for spontaneously draining Bartholin cysts or abscesses may require sitz baths and painkillers. The basic protocol for treating a Bartholin abscess entails providing sufficient analgesia, surgical drainage, analyzing the retrieved specimen bacteriologically, and administering the right antibiotics. (Bhalerao-Gandhi et al., 2023) Surgery is the only effective treatment for Bartholin cysts and abscess. These involves gland removal, marsupialization, aspiration, basic incision and drainage, rupturing the cyst or abscess and inserting a word catheter (done as a straightforward office surgery), and cauterization using a carbon dioxide laser and silver nitrate (Karabük & Aygün, 2022). Aspiration, incision, and drainage comprise a high recurrence rate, which is the biggest drawback (Zhou et al., 2023). The removal of the gland, which has been suggested in scenarios that linked to severe bleeding, the development of hematomas, soreness during surgery, infection, and dyspareunia due to dryness and scarring in the vagina (J. C. Jackson & Adelstein, 2023).

For women who are of reproductive age, Bartholin's gland cysts and abscesses frequently cause gynecological issues. 2% of gynecological visits are related to Bartholin's cysts annually (Elkins et al., 2021a). Women of reproductive age frequently develop Bartholin gland cysts and abscesses, which decrease following menopause. A prior Bartholin cyst or abscess increases the likelihood of another one developing (W. A. Lee & Wittler, 2023). Bartholin's cysts and abscesses can impair one's quality of life or result in aesthetic issues including pain and discomfort during sitting, walking, and sexual activities. There are no official methods in managing Bartholin's cysts and abscesses. Abscesses are almost three times more common than cysts (Elkins et al., 2021b; Wiśniewska-Ś lepaczuk et al., 2022)



(Fig 1. Bartholin cyst representation) **(Das et al., 2024)**

PATHOPHYSIOLOGY

At the point when they enter the vestibule, the Bartholin's ducts are vulnerable to obstruction. The ostium of the duct may become clogged by non-infectious closure, or the duct may get compressed by infection and oedema. This blockage leads secretion to build up and the duct to dilate cystically as a result. An untreated Bartholin's cyst includes transparent, translucent, mucoid, sterile material. typically, the neighboring tissue undergoes a slight inflammatory response (Das et al., 2024). An acute inflammation of the Bartholin's gland is called Bartholinitis (Martini, 2021). The gland and the duct are both affected and exhibit the typical inflammatory response. The duct's lining swells, and a tiny, clogged red macula appears at the orifice. The duct's lining swells, and a tiny, clogged red macula appears at the orifice. Either way, it can go away completely, but more often than not, an abscess develops and eventually bursts through the lower vaginal wall. An abscess may form and the infection may occasionally persist in a chronic form with recurrent exacerbations. The duct may close by fibrosis, which causes the opening to close and causes cyst formation to follow (Elkins et al., 2021; Zhang et al., 2023).

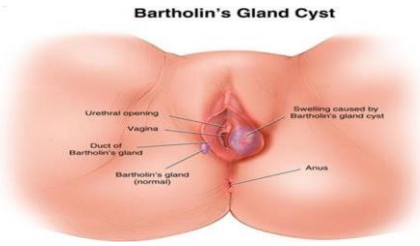
MICROBIOLOGY

Although it is now widely recognized that the infection is polymicrobial in origin, it was once thought to be always gonococcal. The facultative and anaerobic aerobes are the most frequently isolated bacteria from these abscesses. Pepto-streptococcus and Bacteroides species are the most common anaerobic microbes. Staphylococcus aureus, Streptococcus faecalis, Neisseria gonorrhea, Escherichia coli, and Chlamydia trachomatis are the most common facultative and aerobic bacteria (Oriji et al., 2022a).

There is little evidence linking Chlamydia trachomatis and Neisseria gonorrhea to Bartholin's duct abscess. It is no longer believed that the STI is the only cause of Bartholin's abscess. For the patient and her contacts to receive proper antibiotic treatment, it is recommended that an STD that infects the cervix or the abscess be ruled out *(Elkins JM et al., 2021)*

ETIOLOGY

It primarily occurs as a result of infection occurring in the perineal area's fluid-accumulated region inside the blocked duct. Most of Bartholin's gland cysts are brought on by perineal infection-causing microorganisms (Oriji et al., 2022a). A benign blockage in the Bartholin gland, a Bartholin gland cyst is most likely asymptomatic and only detectable by imaging examinations or pelvic exams (Bhalerao-Gandhi et al., 2023). The main trigger of the blockage that results in the formation of an abscess is the immune system's reaction to the bacterial pathogenic pathogens. These agents include, for instance: Gonorrhea is a sexually transmitted disease that is caused by Neisseria gonorrhoeae. Escherichia coli can cause hemorrhagic colitis by interfering with the water supply. The underlying cause of chlamydia is Chlamydia trachomatis. pneumonia is caused by streptococcus pneumonia, which also middle ear infections Hemophilus influenza, which causes ear infections and respiratory diseases (Das et al., 2024).



(FIGURE 2. Anatomy of Bartholin gland cyst*) *(Joseph, 2021)

RISK FACTORS:

Potential Causes

- Infections: Infections are an important variable in the emergence of cysts by inhibiting the ducts of Bartholin's glands. The blockages may be brought about by microbial pathogens, bacterial infections, or illnesses that are transmitted through sexual contact.
- Injury: Blockages that obstruct the normal flow of fluid and resulting in the formation of cysts can also be caused by trauma or injury to the region underlying the Bartholin's glands. Contributing factors might include accidents, serious traumatic experiences, or physical damage sustained during childbirth (Lilungulu et al., 2017)*(Das S et al 2024).*

Discussion of Risk Factors

- Sexual Activity: Having more sex, particularly with several partners or doing things that could infect the vaginal area with bacteria, can increase the chance of Bartholin's cysts.
- Those who have previously experienced Bartholin's cysts are more likely to experience recurring bouts. The chance of recurrence can be decreased with effective care and preventative actions.
- Age-Specific Considerations: Bartholin's cysts may develop as a result of ageing. Understanding and managing postmenopausal women requires taking age-specific aspects into account, as they may have distinct risk factors from younger women (*Das S et al 2024)*.

Bartholin's cyst most likely affects women of childbearing age that are nulliparous. But significant risk factors are listed below:

1. History of Bartholin’s cyst.
2. History of any vaginal or vulval surgery.
3. A physical trauma in that affected area.
4. Being sexually active *(Lee WA 2023).*

In postmenopausal women, cancer should be considered if a Bartholin abscess or cyst is detected. There is a higher probability of duct obstruction in prepubertal women due to the gland's increased and more viscous mucus output. Since the Bartholin gland starts to grow and function, it is very uncommon for a cyst and abscess develop in prepubertal women (Y.-R. Li & Ding, 2023).

REPRODUCTIVE AGE:

Other researchers additionally verified the low socioeconomic position, single, nulliparous, and predominantly reproductive age group characteristics of our study cohort has been more affected by Bartholin cyst. Over half of the participants were women between the ages of 21 and 30. Sexually active women in their 20s and 30s are usually impacted by Bartholin cysts and infections, which have a 2% lifetime risk and decline after menopause. This is due to the fact that beyond age 30, the Bartholin glands gradually begin to involute. Because oedema from friction during sexual contact often blocks the Bartholin gland orifice's entrance into the vestibule, which leads to the formation of the Bartholin gland cyst, the Bartholin gland cyst and abscess occur most often in sexually active women. (Oriji et al., 2022a). Women who engage in multiple sexual partners are more inclined to develop this Bartholin gland cyst[2]. The typical age range for Bartholin gland cysts to occur is between the ages of 20 and 30 years old, mostly affecting sexually active women. *(Oriji PC 2022)*

CLINICAL MANIFESTATIONS:

- Bartholin gland cysts tend to be asymptomatic. The extent of the Bartholin's cyst or abscess impacts the symptoms. In besides causing vulvar pain predominantly when walking and sitting, the big Bartholin cyst may also result in dyspareunia, or pain during coitus (M. Y. Lee et al., 2015a).
- Oedema and/or a big mass area inside the vulva are signs of an infected cyst.
- The prevalent signs of Bartholin's abscess are intense discomfort that starts suddenly and trouble urinating. There may be fever, chills, redness, cyst discharge, and cyst expansion (Jones, 2024) (Lilungulu et al., 2017)
- This cyst can be uncomfortable and painful as it develops larger and becomes infected. Leakage and rupture are other potential signs.
- Erythema may also result from the cysts growing into big mass forms. (M. Y. Lee et al., 2015)

DIAGNOSIS:

Bartholin cysts are primarily diagnosed as: The physician could inquire about prior medical conditions. A pelvic exam from the patient is required. To screen for sexually transmitted diseases, a sample of secretions from the cervix or vagina must be obtained. A biopsy is required to look for malignant cells if the patient is postmenopausal or older than 40. Depending on the kind of polyp that forms, the cyst in the Bartholin gland can be diagnosed. Generally speaking, women over 40 are advised to get a biopsy in order to prevent the development of carcinomas, as well as to have the polyp drained. A biopsy is advised because it is extremely uncommon for malignant cells to grow in the Bartholin's gland (M. Y. Lee et al., 2015a)

The evaluation standard for Bartholin's cancer are as follows: The tumor ought to primarily be found in the labia, in which there should be a little the amount of glandular epithelium and no harm to the surrounding tissue *(Lilungulu A 2017).* Endocervical and high-vaginal swabs must be done if there are any signs of a sexually transmitted infection (Oriji et al., 2022b) This comprises warts, the cyst originating from the Bartholin gland, an abscess, malignancy, and several cyst types (Sebaceous, Skene's, Vestibular mucosa, and Female Hydrocele) (M. Y. Lee et al., 2015b).

DIFFERENTIAL DIAGNOSIS:

Since many vaginal and labial lesions resemble Bartholin gland disorders, differential diagnosis is taken into consideration. This includes abscesses, cancer, warts, the Bartholin gland cyst, and several cyst types (Skene's, sebaceous gland, vestibular mucosa, and canal of nuck) (Dole & Nypaver, 2019a).

CHARACTERISTICS	BARTHOLIN CYST
Onset	Gradual
Location	Position of the vulvar vestibule at 4 or 8 o'clock
Duration	Weeks
Character	✓ 1-3 cm in diameter ✓ Constant or intermittent pain ✓ Normal color to slight erythema ✓ Absence of fever ✓ Serous to mucoid drainage
Aggravating Factor	Vaginal intercourse and sitting
Relieving Factor	Fluid loss and moderate analgesia
Radiation	Localized and non-invading

(Table 1. Characteristics of Bartholin cyst) **(Reif et al., 2015a)**

RADIOLOGY

Along with a physical examination, big Bartholin's duct cysts may be examined with computed tomography and magnetic resonance imaging. Magnetic resonance imaging scans are another method for examining asymptomatic cysts (Chang et al., 2020). The existence of Bartholin's cyst is also detected by high resolution ultrasound imaging (Shariff et al., 2022).

TREATMENT

The treatment plan is determined by the patient's symptoms. The only treatment for a spontaneously erupted Bartholin's abscess may be soaks in warm water, antibiotics, and analgesics. A patient under 40 years of age may not want any treatment for a small, asymptomatic cyst. Conservative management of a non-fluctuant infected cyst is possible. Surgery is necessary to treat a large, symptomatic abscess and cysts (M. Y. Lee et al., 2015b).

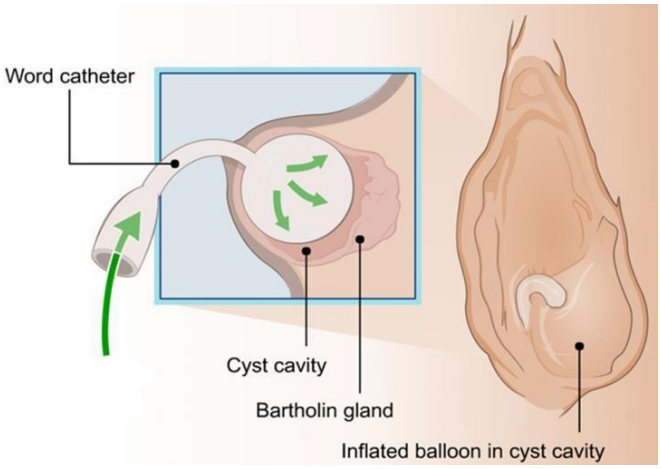
MEDICAL MANAGEMENT

Moderate complaints of a non-fluctuant infected gland or small cysts, like vulvar irritation or pain when sitting or walking, can be relieved with warm baths, painkillers, rest, and broad spectrum antibiotics. Unless cellulitis is present, antibiotic treatment won't be required. Wide-spectrum antibiotics should be provided as treatment if cellulitis is found (Panuciak et al., 2022).

Patients with systemic symptoms, such as fever, suspected sepsis, those who have failed initial I&D (incision and drainage) with Word catheter placement, and those deemed to be at high risk for recurrence should all be evaluated for antibiotic therapy. Cefixime plus clindamycin, amoxicillin-clavulanate plus clindamycin, or trimethoprim-sulfamethoxazole alone are available antibiotic options. *(Lee WA, Wittler M. 2023)*

SURGICAL PROCEDURES

1. Although incision and drainage are a straightforward procedure that may be executed effortlessly while offering the patient with immediate comfort, it should be discouraged considering its high recurrence tendency.
2. Word Catheterization: Bartholin's cyst and abscess can be treated conservatively and frequently with a "Word" catheter, which helps to prevent recurrence. An inflatable balloon tip loaded with saline solution sets up the catheter. The procedure entails making a tiny incision at the site of infection and inserting a Word catheter balloon into the cavity of the cyst or abscess. In order to guarantee epithelialization, the catheter is left in place for four to six weeks. Sitz baths will be recommended to facilitate the healing process. Deep cysts and abscesses are not recommended to be treated with catheters *(Abduljabbar et al., 2018; Long et al., 2021a).* The Jacobi ring and the Foley catheter are further fistulization techniques that could be employed *(Long et al., 2021a).*



(Figure 4. Word Catheter) (Reif. P et al 2015).

3. Fistulization: After a stab wound, if a foreign body has been introduced into the cyst cavity and left there for a longer duration of time, the wound will entirely epithelialize, creating a permanent new opening for the duct. *(Word B 1968; Haider Z et al 2007).*

(Figure 3. Fistulization) (Reif et al., 2015a).

4. Marsupialization: The primary line of treatment for Bartholin cysts or abscesses should be marsupialization *(Das S 2024).* However, a suitable therapy, such as marsupialization or cystectomy, may be considered *(Li HY 2023)* based on the patient's condition. The alternatives for this treatment are local anaesthetic or pudendal nerve block. In order to drain the cyst, a 1.5–2 cm incision must be made into the cyst *(Li HY 2023)*. Next, utilizing interrupted, the cyst wall is everted and approximately aligned with the margin of the vestibular skin*. (Bakouei F et al 2024; Omole F et al 2019;* H.-Y. Li & Ding, 2023)*.*
5. The Window procedure, is modified version of the marsupialization process. Local anesthesia is used throughout the procedure. A tiny oval-shaped section of skin, measuring 2-3 cm in length and 1-1.5 cm in breadth, is removed, and the excised margins are sutured *(Bakouei F et al 2024; Erdoğan & Şimşir, 2022).*
6. Excision: To alleviate the symptoms of Bartholin's cysts, women who have abscesses or Bartholin's cysts are recommended to have an excision treatment. The ailment can be treated and future recurrence of similar problems can be avoided when the operation is carried out thoroughly. The gland and surrounding tissue are significantly removed during this treatment. It is employed merely in cases of probable Bartholin's cancer and recurring cysts. It is preferable to execute out the procedure when there isn't a current infection. It gets done under general anesthesia and bears a risk of substantial bleeding, hemorrhage, secondary infection, protracted healing, and scarring-related dyspareunia. Physical deformity, dyspareunia, and persistent pain in the affected area are potential outcomes**.** *(Kelsey, 2019; Nwogu, n.d.-a; Purohit et al., 2021).*
7. CO2 laser vaporization: The cyst wall has been entirely vaporized as well as a new drainage channel created with the CO2 laser. It was initially performed under general anesthesia and subsequently under local anesthesia *(Speck et al., 2016a).* It is used to incise the vaginal mucosa enclosing the cyst for the purpose to drain it and then evaporate the cyst lining. There are not any additional packs or drains used. The procedure goes quickly and without any issues. The patient recovers without noticeable scarring, without ongoing drainage, and without enduring any sexual function impairment. In four weeks, healing is done. *(Cardaillac et al., 2019).* Although CO2 laser surgery is more involved, there is a decreased risk of intraoperative complications. Specifically, bleeding occurs less frequently due to CO2 laser. Surgery offers low thermal reactivity to nearby tissue and instant hemostasis as tissue is vaporized *(Speck et al., 2016b).*
8. **SITZ BATH:** For Bartholin cysts, a sitz bath is a popular and affordable at-home remedy. All you need is warm water and a bathtub *(Oriji PC., Allagoa DO., Ubom AE., Oriji VK 2022).* Prepare the sitz bath by filling a bathtub with warm water that is two to three inches deep enough to cover the vulva. Only when the impacted region is completely submerged in water does it function effectively. Furthermore, the warm water will accelerate the healing process by increasing local blood flow. Salt and baking soda can be added to the water to stop bacteria from growing and reduce the chance of infection. Every ten to fifteen minutes, soak in the sitz bath and let it drain naturally for best results. Acetaminophen, can be given at that point to alleviate the discomfort *(David Ghozland M. D 2023).*

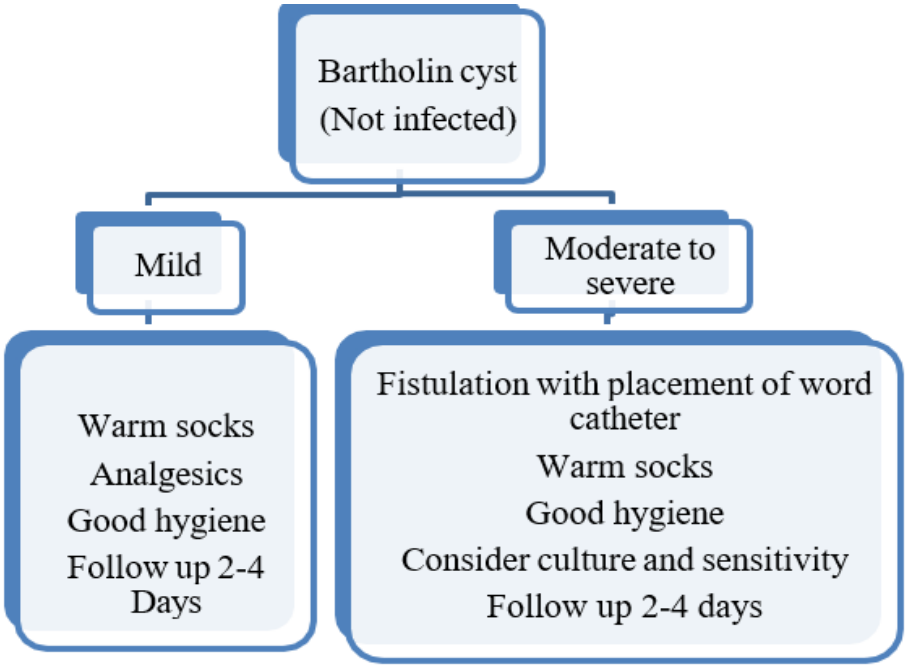
SCLEROTHERAPY

Sclerotherapy involving alcohol. The location of greatest fluctuation is where an 18- to 20-gauge needle is put into the cyst. Aspirating the contents causes the walls of the cyst to collapse. The cyst is injected with a comparable volume of 70% alcohol, allowed to sit for five minutes, and then aspirated. Usually, healing takes place in a week *(Illingworth et al., 2020).* Sclerotherapy involving silver nitrate. The patient is placed in a lithotomy position *(Goklu et al., 2021)*. After inserting a clamp into the cyst or abscess, the contents are completely drained. The cavity is filled with a 5- mm diameter silver nitrate stick that has been cut to a 5-mm length. To keep the stick in the cavity and enable ongoing drainage, one stitch is put to the incision site*(A. Jackson et al., 2017).* After three days, the stick is
taken out with the necrotized tissue using a clamp. It takes around two weeks to heal *(Abduljabbar et al., 2018; Erdoğan & Şimşir, 2022b; Long et al., 2021b; Ramesh, 2020).*

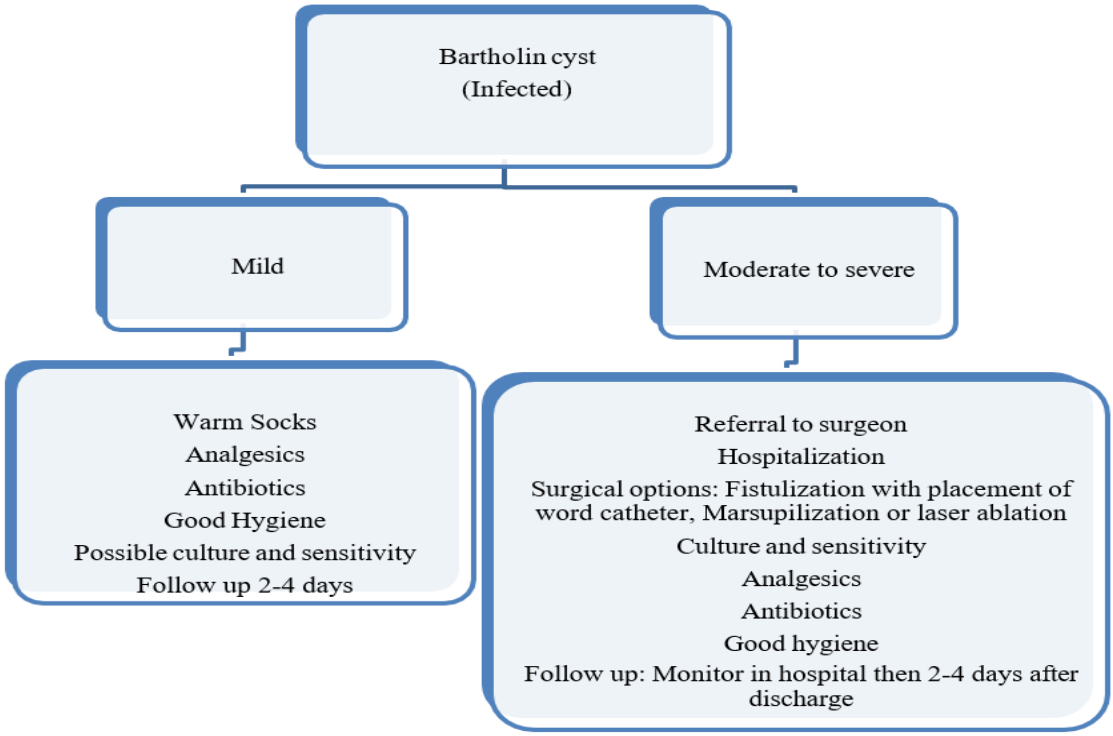
ACTIONS NOT SUGGESTED

Despite being straightforward procedures, incision and drainage as well as needle aspiration are not advised due to their greater recurrence rates when compared to the previously stated office procedures *(AP et al., 2024; M. Y. Lee et al., 2015b).*

TREATMENT ALGORITHM



(Table 2. Treatment algorithm for Non-infected Bartholin cyst) (Abduljabbar et al., 2018; Dole & Nypaver, 2019b; M. Y. Lee et al., 2015b).



(Table 3. Treatment algorithm for Infected Bartholin cyst) (Abduljabbar et al., 2018; Ashraf Muhammed et al., 2022; M. Y. Lee et al., 2015c; Reif et al., 2015b).

COMPARISON OF TREATMENT

PROCEDURE	ADVANTAGE	DISADVANTAGE	REOCCURENCE
Alcohol Scelrotherapy	• Faster healing • Brief duration of treatment	• Elevated blood sugar • Hematoma • Scarring from necrosis of the tissue	• After seven months, 8% to 7%.
Drainage and incision only	• Short duration of therapy	• Elevated incidence of recurrence	• 13%
Fistulization	• Simple to accomplish • Low price • Low rate of recurrence • There is greater patient satisfaction	• Two sites of incision are needed.	• 0% after six months • 4% after a year
Marsupialization	• Low rate of recurrence	• Prolonged healing	• 0% at six months • 10% at 12 months
Needle Aspiration	• Short treatment time	• High recurrence rate	• Upto 38%
Silver Nitrate Sclerotherapy	• Less scar tissue than alcohol sclerotherapy • Short treatment time	• Scarring • Vulvar burning • Chemical burns • Labial edema • Hematoma	• 3.8% at 12 months
Word Catheter Fistulization	• Easy to perform • Low cost • Low rate of recurrence	• Catheter may expel prematurely if incision is too large • Pain at site of balloon is overinflated	• 3% at six months • 12% at 12 months
		• Contraindicated in patients with latex allergy	

*(**Table 4. Different treatment strategies of Bartholin cyst) (Dole & Nypaver, 2019b, 2019b; Kallam et al., 2017; Kroese et al., 2017).***

RECUPERATION ADVICE FOLLOWING BARTHOLIN CYST SURGERY

- Wash solely with simple water to clean the genital area. Never use chemicals or soap. It could aggravate the skin and lead to an infection.
- Wear only cotton, soft underwear until you're fully recovered.
- Drink a lot of water and eat salads and fresh fruits. It should make your bowel movements more fluid.
- Do not strain if you feel constipated. Make use of a moderate laxative instead.
- Steer clear of anything that is really hot, spicy, or could make you bloat. It might put undue strain on them.
- Whether or not you experience symptoms, finish the entire course of your medications.
- Be sure to follow up within seven days.
- Do not engage in penetrative intercourse for 15 days following *surgery (Boama & Horton, 2016).*

STRATEGIES TO PREVENT AND PREVENT BARTHOLIN CYST RECURRENCE

- Preserve the vaginal region from harm: harm to the Bartholin gland may result in bodily harm and obstruct the gland's flow. Thus, the Bartholin cyst is formed. So, be careful not to get hurt when you work, play, or engage in other physical activity.
- Maintain proper hygiene by avoiding unsanitary touch and keeping the vaginal area clean. Abscesses can be caused by infections.
- Adopt safe sexual practices: To prevent STIs, you should only have sex with a partner who has had routine STI testing or use condoms during intercourse.
- Cautionary Penetration: Use caution when you or your companion puncture. The skin around the labia may tear as a result of careless penetration or rough or dry sex *(Boama & Horton, 2016).*

POST TREATMENT CARE:

- Until the region has healed, you should use a sanitary pad rather than tampons to absorb discharge. The surgical site might exhibit some bleeding or discharge. This is only going to last for a week or so.
- Make sure that the area is as dry as clean as you can.
- Every time you urinate, bathe the affected area with warm water to do this. Steer clear of body washes and soaps.
- After every washing, pat the area dry or use a hair dryer set to a cold setting. For approximately six to eight weeks, stay away from swimming pools, spas, and baths.
- While the Word catheter is in place or any incision is healing, you should keep your pelvis at rest, meaning

nothing should be in the vagina.
- All of the discomfort should be alleviated with simple medications like paracetamol.

CONCLUSION

Bartholin cysts, typically small, valvular masses, usually resolve spontaneously within four weeks. However, in some cases, they can grow larger, particularly due to polymicrobial infections, which may be sexually transmitted, often as a result of unprotected sexual activity. Treatment options for these cysts vary in complexity and effectiveness. While simpler procedures like incision and drainage or needle aspiration are often sufficient for smaller, uncomplicated cysts, more involved techniques like alcohol sclerotherapy, fistulization, and marsupialization may be necessary in cases of recurrent or persistent cysts, or those that are significantly larger or infected. Surgical intervention, often performed under local anesthesia, is a common approach, especially for larger cysts or those that have failed to respond to less invasive treatments. However, the prevalence of general anesthesia procedures for Bartholin cyst treatment in the UK raises questions about the optimal management strategy, especially given the lack of definitive evidence from randomized controlled trials. Further research is needed to determine the most effective and least invasive treatment approach for Bartholin cyst.

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