**O&G:**

**CASE 1:**

CASE SEVEN

PROLONGED PREGNANCY: THE ROLE FAMILY PHYSICIAN IN PROMPT INTERVENTION

NAME: B. J AGE: 31 years HOSPITAL NUMBER: 402516

SEX: Female OCCUPATION: Teacher RELIGION: Christian

MARITAL STATUS: Married ADDRESS: Ikorodu, Lagos ETHNICITY: Yoruba

PARITY: G2P1+0 LMP: 4/02/2021 EGA: 40+weeks

INFORMANT: Patient EST DOD: 02/06/2022? DOA: 14/07/ 2022

MANAGED AT: Lagos Island Maternity.

PRESENTING COMPLAIN: presentation in a post-dated pregnancy.

B. J presented for routine ante natal visit and was admitted for cervical ripening and induction of labour following post dated pregnancy of 40+6 wks. : B.J had not experienced labour pains or drained liquor or seen show she had no history of abdominal pain, no drainage of liquor or bleeding per vaginum and she perceived adequate fetal movement admitted for cervical ripening and induction of labourdue to post-datism at ega of 40+6 weeks

`History of index pregnancy: The pregnancy was booked for antenatal care at gestational age of 27 weeks. This pregnancy was planned, desired and spontaneously conceived. She tested positive to a urine pregnancy test and confirmed the pregnancy with a pelvic ultrasound scan done at 12weeks gestation. The antenatal period was uneventful; she had regular antenatal attendance and made a total visit of eight visits to the clinic. Her booking blood pressure was 118/71mmHg and it remained within normal limits till her last visit. Her weight gain was satisfactory and appropriate for gestational age. Her booking weight was 70 kg which increased to 82 kg by the last visit. Routine antenatal investigations done remained within normal limits. She received two doses of tetanus toxoid at 29 and 34 weeks respectively, two doses of intermittent sulphadoxine-pyrimethamine (1500/75mg) combination for malaria chemoprophylaxis at 29 and 33 weeks respectively and was on routine haematinics.

Obstetrics History: In 2018, she had spontaneous vaginal delivery of a live female baby in a private hospital at term. Pregnancy, labour and puerperium were uneventful. She weighed 3.55kg and was exclusively breastfed. She was also fully immunized. She is alive and well.

Gynaecological History: She attained menarche at 12 years of age. She menstruated for 3 days in a 28-day regular menstrual cycle. Her menstrual flow was moderate and she had no dysmenorrhea. She was aware of contraceptives but did not use any. She was aware of Papanicolaou’s smear and her last screening was in 2019, the result was negative for intraepithelial lesion and malignancy.

Past Medical and Surgical History: She was not a known hypertensive, diabetic, asthmatic, or sickle cell disease patient. She has no history of hospital admission

Drugs and Allergy History: She was using astyfer one tablet daily. She had no known drug allergy.

Family and social history: She was married to a 44-year-old man in a monogamous setting, they had child who was years old. The family was an emerging family according to the Stevenson’s family model. She worked as a teacher and made ₦80,000 monthly. Her husband worked as a sales representative and made about ₦100,000 monthly. She neither drank alcoholic beverages nor smoked cigarette. She had no family history of diabetes mellitus or hypertension and no history of multiple gestation in her or her husband’s family. They lived in a two-bedroom apartment which was well-ventilated, and their source of waste disposal was closet

Review of other system: Not contributory.

General examination: B. J was a healthy-looking young woman. She was 1.55 m tall and weighed 82kg. She was not in any obvious painful distress, afebrile (T0C of 36.50C), not pale, anicteric, acyanosed and not dehydrated. She had no pedal oedema, varicose veins or generalized lymphadenopathy.

Breasts: Her breasts were well developed and symmetrical bilaterally. Her nipples were everted and there were no palpable lumps.

Respiratory system: Her respiratory rate was 18 cycles per minute. Her tactile fremitus was equal and her percussion note was resonant.

Cardiovascular system: Her pulse rate was 80 beats per minute; her blood pressure was 110/60mmHg. The first and second heart sounds were heard.

Abdomen The abdomen was gravid She was not febrile, pale or icteric and had no pedal edema. There was no area of tenderness. The liver, spleen and kidneys were not palpably enlarged. The symphysio-fundal height was 40cm which was compatible with her gestational age of 41 weeks 2days. The fetus was in longitudinal lie and cephalic presentation. The fetal head was 4/5 palpable per abdomen. The fetal heart rate was 144 beats per minute.

Vaginal examination revealed a normal vulva/perineum, a posterior cervix of medium consistency and about 2cm long. The cervical os was 2cm dilated and the presenting part was at station -2, making a Bishop’s score of 4/13(an unfavorable cervix).

Assessment of prolonged pregnancy in a multigravida with unfavorable cervix was made. Her anxiety was allayed and she was re-counselled on the diagnosis and the need for cervical ripening and induction of labour, for which she gave verbal consent. Blood sample was taken for PCV and two units of compatible blood were cross-matched and made available in the blood bank.

Summary of results of investigations: PCV -36% Blood group: O rhesus D. Genotype: AA. Urinalysis: Negative for glucose and albumin. HIV: Negative I and II. VDRL: Non-reactive. Blood was negative for Hepatitis B and C and syphilis. The liquor volume was adequate. Obstetric Ultrasound Scan (11/07/22) showed Single viable intra-uterine fetus in longitudinal lie, cephalic presentation with good cardiac activity at gestational age of 40weeks 2days. Antero-fundally located placenta. Adequate liquor and estimated foetal weight of 3961g. Fetal biophysical profile (excluding non-stress test) score was 8/8.

The maternal vital signs and fetal heart rate were monitored closely. She was reassured and observed in the labour ward

Labour ward admission (15/07/22): She was admitted into the labour ward for cervical ripening using Foley’s catheter. She had no complaint. Fetal movement was satisfactory. Her general condition was satisfactory. At 18.00 hrs. cervical ripening was done using extra-amniotic trans-cervical balloon catheter insertion was done using a size 20 FG Foley’s catheter. Under aseptic conditions. She was placed in lithotomy position. The lower abdomen, vulva and vagina were cleaned with dilute antiseptic solution. The cervix was exposed using a sterile Cusco’s speculum. The anterior lip of the cervix was grasped with a sponge holding forceps. A size 20 FG Foley’s catheter was inserted into the extra- amniotic space through the cervix using a sponge holding forceps. The balloon of the catheter was inflated with 50ml of sterile water and the catheter was strapped to the inner aspect of the right thigh under mild tension. The procedure was well tolerated by the patient and she was observed in the labor for two hours after which she was transferred to the antenatal ward and scheduled for induction of labor.

The next day(16/07/2023): She complained of mild, intermittent, lower abdominal and back pain of 2hours duration. The balloon of the catheter had fallen off. There was no liquor drainage or bleeding per vagina. Fetal movement was satisfactory. The abdomen was uniformly enlarged. The symphysio-fundal height was 40cm. The fetus was in longitudinal lie and cephalic presentation. Descent was 2/5th palpable and she had two contractions in 10minutes lasting 30-40seconds.The fetal heart rate was 130 beats per minute and regular.

Vaginal examination: The vulva and vagina were normal. The cervix was soft, central, and about 0.5cm long. The cervical os was 5cm dilated. The presenting part was vertex at station 0. There was no moulding nor caput and the membranes were intact. Her Bishop score was 10/13. (Favorable cervix)

Induction of labour: At 6:00hours, she had fore-water amniotomy done under strict aseptic conditions. Two hundred milliliters of clear amniotic fluid was drained slowly. Fetal heart rate was 144 beats per minute after amniotomy. She was also administered intramuscular Pentazocine 30mg and 25mg Promethazine for analgesia. She was nursed in the left lateral position. The fetal heart rate was monitored every 30 minutes, and the uterine contractions were monitored for 10 minutes every 30minutes. Also her pulse rate and her blood pressure were closely monitored.A partograph was used to monitor her labour. Theanaesthetist and paediatrician were informed to be present at the delivery.

At 10:00hours: She had 4 contractions in 10 minutes lasting about 40-60seconds each. Her general condition was satisfactory. Her blood pressure was 120/70 mmHg. Fetal heart rate was 148 beats per minute and regular. Her vaginal examination revealed that the cervix was soft, central, fully effaced and 8cm dilated. The presenting part was at station 0 in left occipito-posterior position, liquor was clear and there was no caput or moulding.

At 11:05 hours, she expressed the urge to bear down. Her vital signs were satisfactory. The fetal heart beat rate was 144 beats per minute and regular. Vaginal examination revealed a fully dilated cervix and the presenting part was at station +1. There was no caput or moulding. She was encouraged to bear down with each contraction. She had a spontaneous vaginal delivery of a live male neonate at 11:25that weighed 3.9kg, with Apgar score of and 10 in 1 and 5 minutes respectively. Intramuscular oxytocin 10i.u was administered following delivery of the baby. The placenta was delivered by controlled cord traction at 11:35hours, it was grossly normal and weighed 850g. Estimated blood loss was 150ml

THE PUERPERIUM: She was monitored in the labour ward for the first two hours post-partum and administered 40i.u oxytocin in 5% dextrose water over 4 hours. Her pulse rate was 86 beats per minute, her blood pressure was 120/70 mmHg, her respiratory rate was 18 cycles per minute and her temperature was 36.5oC. Her lochia was normal and she had no complaints. She was transferred to the postnatal ward and was administered oral paracetamol 1gm thrice daily for three days, ferrous gluconate 300mg thrice daily, vitamin C 100mg thrice daily and folic acid 5mg daily. She established lactation and the uterus involuted normally. Her packed cell volume was 35%. She was discharged home with a six-week appointment to the post-natal clinic and was offered family planning.

SUMMARY: BJ was 31-year-old woman who had cervical ripening and induction of labour for a post-dated pregnancy. It was successful and she had an uneventful postnatal period.

Discussion: The duration of pregnancy varies between 40+0 and 41+3 weeks. Conventionally, and essentially arbitrarily, a pregnancy is considered to be “prolonged” after 41+0 weeks, but the infant is not considered “post-term” until 42+0 weeks. A term birth thus occurs during the period from 37+0 to 41+6 weeks.1 Mrs. B J, is a 31-year-old now Para 2+0` (2 Alive) woman who presented aqt EGA of…and had successful cervical ripening and induction of labour. The terms prolonged pregnancy, postdates and postdatism are synonymously used to describe the same condition.2 The frequency of postterm pregnancies is very heterogeneous: in Europe and the United States, it ranges from 0.5% to 10% according to country. In Netherlands for instance its prevalence is 7%.1,3 The prevalence of prolonged pregnancy in Nigeria is in the range of 4.9-13.1%.2 This percentage varies depending on population characteristics (i.e incidence of risk factors in the population) and local management practices/policy.3 Post-datism is associated with obstetrical, maternal, perinatal complications and long term effects on the offspring.4 It is also associated with increased costs of antenatal foetal monitoring, induction of labour and is a source of significant anxiety for the pregnant woman and her family.3 The perinatal mortality rate is increased by 2-folds, 4-folds and 5-7folds at 42, 43 and 44 weeks respectively with utero-placental insufficiency, meconium aspiration and intrauterine infection been the implicated clinical conditions adduced for this increase.3  B.J did not have any of the above complications because of prompt intervention.The most common aetiology of postterm pregnancies is inaccurate dating.3 The use of standard clinical criteria to determine the estimated delivery date (EDD) tends to overestimate gestational age and consequently increases the incidence of postterm pregnancy. Clinical criteria which are commonly used to confirm gestational age include last menstrual period (LMP), the size of the uterus as estimated by bimanual examination in the first trimester, the perception of fetal movements, auscultation of fetal heart tones, and fundal height in a singleton pregnancy.3 In B.J’s case LMP was used.

Genetic and/or epigenetic factors, environmental factors along with nulliparity, previous post-term pregnancy, congenital malformation foetuses (fetal adrenal hypoplasia/insufficiency, male gender of the fetus, and trisomy have been implicated as possible risk factors for the development of prolonged labour.5,6 The observed risk factor in Mrs. B J was foetal male sex. The most common means of management of low risk postdate pregnancy is either expectant management or via induction of labour. Expectant management entails antenatal foetal surveillance which includes use of foetal movement counting, non-stress test, biophysical profile, contraction stress test, with or without weekly monitoring of Doppler velocimetry of the umbilical artery.7 These surveillance tools were not used for Mrs B.J due to availability, hospital policy and practice. Expectant management is associated with increased cost and poor compliance in developing Nations like Nigeria.8 The decision to intervene with induction of labor requires the consideration of multiple factors, including antepartum fetal assessment, favorability of the cervix, gestational age, maternal risk factors, and maternal preferen/ce.7  B.J’s informed consent was obtained. Induction of labour is defined as the planned initiation of uterine contractions after the 28th week of gestation and before the onset of natural labour by medical and or surgical means for the purpose of achieving normal vaginal delivery. It involves a complex set of interventions that may defy routines and presents numerous choices and challenges to clinicians and parturient.9 The induction of labour rate in Nigeria is 11.5% and post term pregnancy is the commonest indication which contributed 45.8% of all cases.8 It is more likely to be successful if the body has initiated some of the physiologic mechanics of labour as seen in the case of Mrs. B.J. Various methods exist for the induction of labour: manual nipple stimulation, membrane sweeping, passage of intracervical extra amniotic Foley’s catheter, passage of misoprostol and use of oxytocin infusion are some of these methods.8 Mrs. B J’s had cervical ripening with Foley’s catheter followed by induction with amniotomy. A choice informed by her multiparous status because the other available option- misoprostol had been associated with increased risk of uterine rupture in multiparous women although a low dose misoprostol may be helpful if there was no other option.1 The Foley’s catheter concomitantly ripened the cervix and induced labour in her, this was further enhanced with amniotomy. The induction-delivery interval was 7hours and was faster than that reported by Lawani et al at 12 ± 3.6hours.8 Intermittent auscultation with hand-held doppler (sonic aid) was used for fetal monitoring in Mrs. B J due to unavailability of cardiotocograph machine for continuous labour monitoring at that time. Mrs. B J had a successful induction of labour which resulted in vaginal delivery as was seen in 82.2% of similar patients.9 Maternal complications of induction of labour are excessive uterine activity, cephalo-pelvic disproportion, labor dystocia, operative vaginal delivery, severe perineal injury, caesarean birth, postpartum haemorrhage, uterine rupture, maternal water intoxication, puerperal infection and psychological problems.8 Fetal complications of post-datism are intrauterine growth restriction, abnormal fetal heart rate patterns, fetal distress, macrosomia, shoulder dystocia, low Apgar scores, meconium aspiration etc.10 Mrs. B J and her neonate had no complications.

Lesson Learnt: family physicians as Frontline doctors should accurately identify post dated pregnancies and offer appropriate intervention. Advocacy for training of midwives should be done.

References

1. Christopher Vayssière, Jean-Baptiste Haumonte, Anne Chantry, FrédéricCoatleven, Marie Pascal Debord, Conchita Gomez et al., Prolonged and post-term pregnancies: guidelines for clinical practice from the French College of Gynecologists and Obstetricians (CNGOF). Volume 169, ISSUE 1, P10-16, July 01, 2013
2. Garba I, Muhammed AS, Muhammad Z, Galadanci HS, Ayyuba R, Abubakar IS. Induction to delivery interval using transcervicalfoley catheter plus oxytocin and vaginal misoprostol: A comparative study at Aminu Kano Teaching Hospital, Kano, Nigeria. Annals of African Medicine.2016; 15(3):114-119
3. Galal M, Symonds I, Murray H, Petraglia F, Smith R. Postterm pregnancy. Facts Views Vis Obgyn. 2012;4(3):175-87.
4. Schierding W, O’Sullivan JM, Derraik JGB, Cutfield WS. Genes and post-term birth. BMC Research Notes. 2014;7:720. Available from <http://biomedcentral.com/17560500/7/72>0. Assessed on 23rd March 2023
5. Oberg AS, Frisell T, Svensson AC, Iliadou AN. Maternal and fetal genetic contributions to postterm birth: familial clustering in a population-based sample of 475,429 Swedish births. Am J Epidemiol. 2013 Mar 15. 177(6):531-7
6. Practice bulletin no. 146: Management of late-term and postterm pregnancies. Obstet Gynecol. 2014 Aug. 124 (2 Pt 1):390-6
7. Vitale SG, Marilli I, Rapisarda AM, Iapichino V, Stancanelli F, Cianci A. Diagnosis, antenatal surveillance and management of prolonged pregnancy: current perspectives. Minerva Ginecol. 2015 Aug. 67(4):365-73.
8. Lawani LO, Onyebuchi AK, Iyoke CA, Okafo CN, Ajah LO. Obstetric Outcome and Significance of Labour Induction in a Health Resource Poor Setting. Obstetrics and Gynecology International.Hindawi Publishing Corporation.2014
9. Oyebode TA, Toma BO, Shambe LH, Kahansim ML, Embu HY, Daru PH, et al. Induction of labour at Jos University teaching, hospital, Jos, Nigeria: a four year review. International Journal of Research in Medical Sciences.2015; 3(8):1942-1948.
10. Chantry A. Lopez E. Fetal and neonatal complications related to prolonged pregnancy. Journal de Gynecologie, Obstetrique et Biologie de la Reproduction. 2011; 40: 717-725

**CASE 2:**

BARTHOLIN’S CYST IN A YEAR 41-OLD HAIR DRESSER

Name: O.O Age: 36 years Hospital number: 435467

Domicile: Bariga, Lagos State Sex: Female Date of Consultation: 07/07/2022

Religion: Christianity Tribe: Yoruba LMP: 22/06/ 2022

Marital status: Married Occupation: Hair Dresser Parity: P3+ 0 (3 alive)

Managed at: Gbagada General Hospital

Presenting Complaint: Painful mass on her private part of three weeks’ duration

History of Presenting Complaint – OO noticed a mass in her private part about 2 weeks prior to presentation. It started initially as a small mass located on her left labium, which progressively increased in size, she first assumed it was a boil. It wasn’t painful but associated with mild discomfort. There was no history of vaginal bleeding or fever. There were no other masses on her body. There was associated history of painful micturition, but no frequency, urgency or incontinence.She had no history of recent travel. She took diclofenac, amoxicillin/clavulanic acid and metronidazole tablets but decided to present when the swelling did not improve. OO feared her private part will become disfigured thus might result into a serious condition. She had no idea of the cause of the swelling on her labia. She was embarrassed by it and this has made her to perform her marital duties below expectations. She hoped to get a relief from this discomfort.

Review of Systems: OO had no headaches, neck stiffness or blurring of vision. She had no cough, chest pain, dyspnoea on exertion, orthopnoea, paroxysmal nocturnal dyspnoea or leg swelling. She had no abdominal pains, weight loss, nausea/vomiting nor change in bowel habit.

Past Medical and Surgical History -She was not hypertensive, diabetic, asthmatic, epileptic or a sickle cell patient. Nil any history of previous surgery.

Drug and Allergy History - She is not on medications and had no known drug allergies.

Obstetrics and Gynaecology History - She attained menarche at the age of twelve. She menstruated for three days in a regular monthly cycle. She had no history of dysmenorrhoea or menorrhagia. Coitarche was at 18years. She had no history of dyspareunia. She uses oral contraceptive pills (OCP) and is comfortable with it. She had no history of multiple sexual partners and no history of sexually transmitted infections. OO had three spontaneous vertex deliveries of two females and a male child, no complications all are alive and well; aged were nine and six and 3.

Family and Social History: O.O was married to a 45-year old Tiler in a monogamous setting with three children aged 9,6, and 1. Her family was at the family with schoolchildren stage of the Duvall’s family cycle model. She was hair dresser her shop was recently demolished; she’s hoping to rent another one soon. OO and her husband both had senior secondary school leaving certificates. Their family income was about N140, 000 per month and healthcare cost was borne by her (out of pocket payment). They lived in a ventilated one bedroom rented apartment with shared toilet, bathroom and kitchen. They ate home cooked meals (usually healthy diet) and drank borehole water. Sewage disposal was by water closet. She had adequate sleep (at least 8 hours) and watched movies on her phone during her spare time. She attends church regularly. She did not smoke cigarette, take alcohol or use recreational drugs. She had no family history of chronic illness, masses or cancers.

Physical examination: O.O was calm and not in any form of distress. She was not pale, anicteric, acyanosed, afebrile (T-36.20C) and not dehydrated. She had no peripheral lymph node enlargement and no pedal oedema. Her weight was 65kg, height was 1.64m and BMI was 24.2kg/m2 (normal).

Abdomen: Her abdomen was full, moved with respiration and she had the female-pattern hair distribution. There was no area of tenderness. The liver and spleen were not palpably enlarged, and the kidneys were not ballotable. Bowel sounds were normal. Digital rectal examination revealed good perianal hygiene, normal sphincteric tone, and smooth, mobile mucosa. The examining gloved finger stained with a well-formed brownish faecal matter.

Vaginal examination revealed a swelling on her left labia majora. It measured 6.5cm by 4cm by 3cm. There was no differential warmth. It was non-tender, soft and fluctuant. Aspiration yielded 4mls of fluid. The cervix was firm, posterior and the os was closed. Cervical excitation test was negative. The pouch of Douglas was empty and there was no palpable adnexa mass. The uterus was not bulky.

Cardiovascular System: The PR was 78 bpm, full volume and regular. Her BP was 120/87mmHg. The JVP was not raised. The apex beat was in the left 5th intercostal space, mid-clavicular line. Only the first and second heart sounds were heard.

Respiratory System: Her RR was 20cpm. Trachea was central and chest expansion was equal bilaterally. Percussion, tactile and vocal fremitus were normal. Breath sounds were vesicular.

Central nervous system: She was conscious and alert. There was no neck stiffness. Examination of her motor and sensory modalities showed no abnormalities.

Diagnosis –Left Bartholin’s cyst

Differential diagnosis was left labial lipoma, vulva cancer, left sided inguinolabial hernia.

MANAGEMENT – O.O was counselled on the diagnosis and management. She was also counselled on chances of possible recurrence with simple incision and drainage. Her fears were allayed. She was told to do some investigationsand an appointment fixed for next week.

Next follow up (13/07/22): O.O was seen the following week, her results were reviewed and she was book for surgery the following day.

Surgery: An informed consent was taken for an incision and drainage with marsupialization. She was given IM diclofenac 75mg stat. O.O was taken to the minor theatre for the procedure. She was put in lithotomy position. The perineum was cleaned with chlorhexidine solution. Draping was done to expose the and perineum. Local anaesthesia (5mls of 1% lidocaine) was used to infiltrate the region of the mass. A 2cm vertical incision was made on the mucocutaneous junction of the swelling about 8mls of fluid was drained. An artery forcep was used to break loculi and more fluid was let out. The cavity was irrigated with normal saline. The wall of the cyst was everted and sutured medially to the vaginal wall and laterally to the vulva with chromic 2/0 interrupted sutures. The sample of the fluid was sent to the laboratory for microscopy, culture and sensitivity. The procedure was well tolerated.

The post operation instructions were as follows: Amoxicillin/Clavulanic acid tablets 1g twice daily for five days. Metronidazole tablets 400mg three times a day for five days. Diclofenac tablets 50mg twice daily for three days. Oral Vitamin C 200mg three times a day for a week. Sitz bath (tepid water with chlorhexidine solution or salt) to be done for 10 minutes morning and evening. She was counselled to abstain from vaginal sexual intercourse until the wound was completely healed. She was given a week’s appointment.

22/07/2022 – One week post operation: O.O came with her test result. She complained of boredom, headache and poor sleep had minimal pain at op site. She had completed her antibiotics. Vaginal examination revealed a clean wound with evidence of reepithelialisation. She was encouraged to continue the sitz bath and abstain from sexual intercourse until the wound was totally healed. She reported that her husband had been supportive. Result of microscopy, culture and sensitivity revealed Staphylococcus aureus sensitive to Ciprofloxacin, Cefuroxime, Meropenem, Ceftriaxone and Amoxicillin/Clavulanic acid. She was counselled that for the mean time she can be doing petty trading to keep her busy before her shop was ready. She was given a two-week appointment.

5 / 8 / 2022 – Three weeks post operation: OO had no complaints. Her wound had healed completely. She had started supply business, headache has ssubsided and she was now sleeping well. She asked when she could resume sexual intercourse. She was told she could and was counselled on healthy living- adequate diet, exercise, rest, hygeine and immunization against tetanus, cervical cancer and HBV. She was also counselled on monthly SBE and PAP smear and maintaining a positive mental health amidst adverse situation. She was subsequently discharged from the clinic.

Summary: O.O was a 36-year-old Hairdresser who presented with a three-week history of a mass on her left labia. A diagnosis of a Bartholin’s Cyst was made, and she was managed with an incision and drainage with marsupialization and oral antibiotics. She recovered well following surgery and her need for finding financial relevance and worth was met.

Discussion: A Bartholin cyst is a benign blockage of the Bartholin gland that is usually unilateral, asymptomatic, and maybe incidentally found during a pelvic exam or imaging studies.1 The Bartholin's glands are located symmetrically at the posterior region of the vaginal opening and play an important role in the female reproductive system. These two pea-sized glands are involved in mucus secretion and vaginal lubrication. Cyst formation in the glands is common and results from mucus build-up in gland ducts.2 Approximately 2% of women, mostly in their reproductive age would develop Bartholin’s gland cyst or abscess at some point in their life.3 O.O is a 36-year-old female. Anozie et al in a four-year retrospective study of cases of Bartholin’s gland cysts in Federal Teaching Hospital, Abakaliki, South-East Nigeria found a prevalence of 1.78% among 1015 respondents.4 This is similar to the incidence of 2% quoted by another study.5 John et al. reported an incidence of 1.4% in Port-Harcourt while Yuk et al. found an incidence of 0.55%.6 Some of the risk factors for Bartholin’s cyst/abscess include previous history of Bartholin’s gland cyst/abscess, multiple sexual partners, sexually transmitted infection, mediolateral episiotomy and vulva trauma.7 O.O had no previous history of Bartholin cyst, vulva trauma nor any sexually transmitted infections, she however, fell within the high risk age group of people susceptible to contracting the disease. Bartholin glands can form a cyst and an abscess in women of reproductive age. Both are difficult to differentiate on a physical exam. The cyst is usually 2-4 cm in diameter and may cause dyspareunia, urinary irritation, and vague pelvic pain.1 O.O presented with vaginal pain during micturition and during sexual intercourse with her husband. Bartholin cyst is usually filled with non-purulent fluid that contains staphylococcus, streptococcus, and E. coli.1 Result of microscopy done on the purulent discharge taken from the excision of the mass on O.O revealed Staphylococcus aureus sensitive to Ciprofloxacin. When examining a patient with a suspected Bartholin gland cyst/abscess, it is important to inquire about the duration of symptoms; tenderness with activities such as walking, sitting, standing, or sexual intercourse; purulent drainage; and history of previous Bartholin gland cyst/abscess, vaginal bleeding/discharge, or sexually transmitted infections.1,2 Bartholin cysts often have a protracted course as they are mainly asymptomatic. Take into consideration the patient's age because malignancy, while rare, may have a similar presentation. The physical exam will often reveal asymmetry with a protrusion of one side (left or right) of the inferior aspect of the vulva. Bartholin gland abscesses, unlike Bartholin cysts, are very painful. While both are primarily unilateral, Bartholin abscesses are often tender to palpation, erythematous, indurated, and may have an area of fluctuance and/or purulent drainage. Physical examination, history and presenting symptoms of O.O helped guide our choice of diagnosis, there was however, need to also consider a differential diagnosis of left labial lipoma, vulva cancer, and left sided inguinolabial hernia as a result of her age and similarities in symptoms with the aforementioned cases. Asymptomatic Bartholin cysts do not require further treatment. Bartholin cysts that are spontaneously draining may be managed conservatively with sitz baths and analgesics. Although no modality of treatment, surgical or conservative, is superior to any other in terms of recurrence rate.8 first-time Bartholin cyst may be treated with incision and drainage with Word catheter placement due to ease and effectiveness of treatment,1,8 incision and drainage with marsupialization was the preferred choice of management for O.O in a poor resource setting as ours as the recurrence rate is low.

Lesson Learnt: Bartholin’s gland cyst is a clinical gynaecological condition which make women present to the gynaecology clinic. It is important to educate the public especially the rural areas of this pathology. It is also important clinicians keep themselves updated about the ideal, safe and effective definite treatment options to improve quality of life, reduce morbidity, avoid complication and reoccurrence.9,10

References

1. Lee WA, Wittler M. Bartholin Gland Cyst. Available from: https://www.ncbi.nlm.nih.gov/books/NBK532271/ cited on 16th March 2023

2. Lee MY, Dalpiaz A, Schwamb R, Miao Y, Waltzer W, Khan A. Clinical Pathology of Bartholin's Glands: A Review of the Literature. Curr Urol. 2015;8(1):22-5.

3. John, C.O., Enyinda, C.E. and Okonya, O. Bartholin’s Cyst and Abscesses in a Tertiary Health Facility in Port Harcourt, South-South Nigeria. Journal of Medical and Biological Science Research, 2015;1:107-111

4. Anozie, O. ,Esike, C. , Anozie, R. , Mamah, E. , Eze, J. and Onoh, R. Incidence, Presentation and Management of Bartholin’s Gland Cysts/Abscesses: A Four-Year Review in Federal Teaching Hospital, Abakaliki, South-East Nigeria. Open Journal of Obstetrics and Gynecology, 2016;6: 299-305

5. Saeed, K.N. and Al-Jufauri, Z.A. Bartholin’s Gland Abscesses Caused by Streptococcus pneumonia in a Primigravida. Journal of Laboratory Physicians, 2013;5:130-132

6. Yuk, J.S., Kim, Y.J., Hur, J.Y. and Shin, J.H. Incidence of Bartholin’s Duct Cysts and Abscesses in the Republic of Korea. International Journal of Gynecology & Obstetrics, 2013;2:122, 62-64

7. Basheer S, Paul M, Jose V. An unusual case of huge vulva swelling. BrueiInt Med J., 2013; 9(4): 264-65

8. Kroese JA, van der Velde M, Morssink LP, Zafarmand MH, Geomini P, van Kesteren P Word catheter and marsupialisation in women with a cyst or abscess of the Bartholin gland (WoMan-trial): a randomized clinical trial. BJOG. 2017;124(2):243-249

9. Donatov D, Bellati F, Casorelli A, Giorgini M, Perniola G, Marchetti .Carbon dioxide laser treatment for Bartholin’s gland abscess Ultrasound evaluation of risk recurrence. J. Minim. Invasive Gynaecol.2013;20(3):346-52.

10. Shaheen B, Mary P, Vijay J. An unusual case of a huge vulva swelling. Brunei Int. Med. J. 2013;9(4): 262-265