



Research Article

A RARE CASE OF HUGE BILATERAL GARTNER DUCT CYSTS : A CASE REPORT

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ABSTRACT

Gartners duct cysts are cystically dilated mesonephric(wolffian) duct remnants found in the anterolateral part of the vagina. They represent 11% of vaginal cysts [1]. A 40 year old premenopausal women presented to gynaecology OPD with chief complaint of something protruding from her vagina since 7 – 8 years. She had no other particular complaint. On per speculum and per vaginal examination a 5x4cm and a 6x5cm cystic masses arising from right and left lateral vaginal wall respectively were noted. Bilateral cyst removal was done after complete examination , investigations along with the consent.

KEYWORDS : Anterolateral part of vagina, wolffian duct remnants.

INTRODUCTION

Gartners ducts are identified in approximately 25% of all adult women and nearly 1% evolve into gartners duct cysts [2].During embryological development around 8th week the mesonephric (wolffian) duct develop from their predetermined structures and later regress.Remnants often remain as gartners ducts , epoophoron and paraophoron. Sometimes they might develop a secretory mechanism that may cause dilatation of surrounding cells and due to its occlusion can result in a gartners duct cyst. Classically these cysts are solitary, asymptomatic and unilateral. They are usually less than 2cms in diameter and are located in the anterolateral wall of proximal third of vagina [3].

CASE

A 40 year old premenopausal women presented to gynaecology OPD with complaint of that she has noticed something protruding from her vagina since 7-8 years.It was painless and gradually increasing in size and was causing discomfort to the patient even at rest. She had no history of vaginal bleeding ,urinary retention ,incontinence ,fever ,injury and pain abdomen [4]. Her obstetric history, menstrual history and past surgical and medical history were not significant. After proper history taking, thorough

general physical examination was done.On per abdomen examination nothing significant was noted.Per speculum and per vaginal examination revealed two cystic masses measuring 5x4cm and 6x5cm arising from right and left lateral vaginal wall respectively.They were nontender ,cystic and irreducible.Cervix was downwards and backwards with an anteverted anteflexed uterus of normal size and bilateral fornices free.Investigations were done and after proper consent patient was posted for surgical removal. Bilateral cystectomy was performed and the tissue was sent for HPE. Post- operative period went uneventful. Microscopy:Vaginal cyst-biopsy submitted showed cyst wall predominantly lined by few cuboidal epithelium at places showing squamous metaplasia.Overall morphology was in favour of benign cyst suggestive of gartners duct cyst.

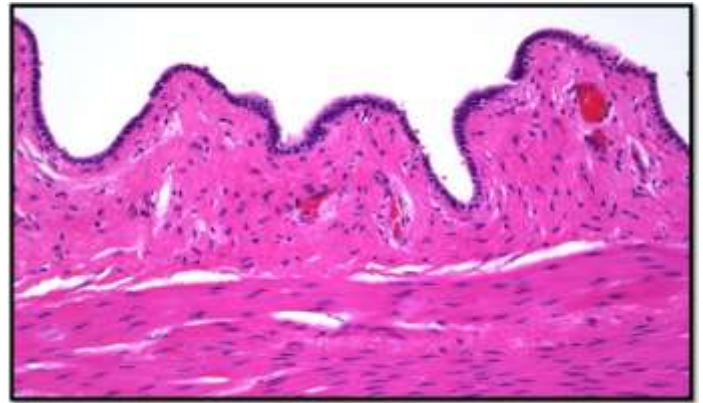
Fig 1: Pre –operative picture of gartner duct cyst



Fig 2: Intra operative picture.



Fig 3: Histopathology report



DISCUSSION

Gartner duct cysts can be associated with abnormalities of the metanephric urinary system. Such abnormalities usually present in childhood. Ectopic ureters, besides having direct communications with the vagina and introitus, have been reported to communicate with Gartner duct cysts and cause urinary incontinence[5]. The Gartner duct cyst can present as ipsilateral blind vagina. Differential diagnosis of a cyst in lateral aspect of female genital tract includes bartholins gland cyst or abscess , prolapsed urethra, prolapsed uterus, vaginal wall inclusion cyst, endometriosis, leiomyoma, malignant mass, skenes gland cyst , nabothian cyst and broad ligament cyst [6] .

CONCLUSION

MRI is a useful tool to define the course of the Gartner's duct cyst and differentiate it from other pathologic considerations for making a differential diagnosis [7] .Confirmation by histo- pathologic examination may be employed to correctly identify the cellular remnants composed of non-mucin secreting low columnar or cuboidal epithelium. Rarely a malignant transformation can be identified [8] . Recurrences of giant cysts are generally multiloculated [9] . Management strategies for multiloculated recurrences include periodic surveillance, sclerotherapy and marsupialization into the peritoneal cavity.

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