**Prolapsing vaginal wall during post-partum perineal suturing; an atypical presentation of a Gartner's duct cyst**

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**Aim:**
To discuss an atypical presentation of a Gartner’s duct cyst and its management immediately post-partum.

**Methods Used:**
Retrospective review of patient’s case notes and review of existing literature.

**Results and Discussion:**
A 33-year-old primigravida patient underwent an instrumental delivery for prolonged second stage. This patient was allocated to Midwifery Led Care antenatally as she reported no significant past medical history. During labour, no abnormalities were noted during vaginal examinations. Post-delivery vaginal inspection revealed no specific abnormality other than a lateral vaginal wall tear. However, during suturing, an area of prolapsing vaginal wall began to obstruct the field from the right anterolateral aspect. The mass was palpated, examined and a haematoma was excluded. The patient was asked whether any previous diagnosis of vaginal wall cysts had been made. She confirmed that a Gartner’s duct cyst had been identified prior to pregnancy, enabling the clinical findings to be clearly diagnosed. With patient consent the cyst wall was incised and gelatinous-type material approximately 5cm in diameter was evacuated and sent for histological review. The cyst wall was sutured closed.

Upon retrospective review, Magnetic Resonance Imaging (MRI) had been used in the outpatient setting to characterise a vaginal wall cyst found incidentally when a cervical smear was taken. A diagnosis of Gartner’s duct cyst was made. The patient was discharged from clinic, as no intervention was required.

This information had not been disclosed in the antenatal hand-held maternity notes.

Gartner’s duct cysts arise from remnants of the mesonephric duct. The duct extends from the mesosalpinx via the broad ligament to the cervix, hence these cysts are typically located along the anterolateral vaginal wall. There are also documented associations with abnormalities of the mesonephric urinary system, which this patient does not have.

During review of existing literature there were no case reports of Gartner’s duct cyst obstructing a vaginal delivery. One case report suggested a cyst could be drained to facilitate a vaginal delivery\(^1\). Only one case report\(^2\) documented an antenatal complication – sepsis secondary to an infected Gartner’s duct cyst. However, successful treatment of sepsis and a post dates vaginal delivery were achieved.

**Conclusion:**
Despite a sizeable Gartner’s duct cyst, this patient had a relatively straightforward delivery. The presence of this patient’s cyst was an incidental finding during perineal suturing. Once the pathology was recognised it was managed quickly and efficiently. Evidence exists suggesting that large cysts can cause urinary tract obstruction but minimal obstetric-associated complications.

A differential diagnosis of Gartner’s duct cyst should be considered for appearances of an anterolateral vaginal wall ‘prolapse’.

**References**