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Case Report

A rare case report of anterior vaginal wall cyst

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ABSTRACT

Background: Vaginal wall mucinous cyst is very rare benign condition, and it is non-invasive in nature, it can be mistaken as urethral diverticulum, inclusion cyst, Gartner cyst. Cyst may cause symptoms if it increase in size then cyst excision is the treatment of choice.

Case Report: 35 yrs old woman presented with chief complaints of mass per vaginum since 6yrs, white discharge per vaginum since 6yrs, difficulty in micturation since 6 months, dysparunia since 3 months, on examination diagnosis is second degree UV prolapsed with cervicitis with cystocele and rectocele with anterior vaginal wall cyst, vaginal hysterectomy with cystocele and rectocele repair with excision of anterior vaginal wall cyst specimen sent for HPR and shows uterus with cervicitis with ulceration, secretory endometrium and benign mucinous cyst of ant vaginal wall.

Conclusion: Vaginal wall mucinous cyst is rare condition, cyst is completely excised but long term surveillance to be done for recurrence.

1. Introduction

Vaginal cysts are rare and diagnosed incidentally, cystic lesion may arise from all the vaginal walls, usually from lateral vaginal walls and rarely may extended into fornix. Depending upon histopathology cyst are classified into squamous inclusion cyst, mesonephric or gartners duct cyst, mullerian or paramesonephric cyst, bartholian cyst. [1,2] The cyst may present with different sign and variety of symptoms. Here we are presenting a rare case report of anterior vaginal wall cyst.

2. Case Report

A patient of 35 years old woman presented to OPD with complaining of mass per vaginum since 6yrs, white discharge per vaginum since 6yrs, difficulty in micturation since 6 months, dyspareunia sine 3months. Patient had no previous medical disorders and surgical operations. attain menarche at the age of 13 yrs, with regular menstrual cycle and LMP 45 days back, she is para 3 living 3, with marital life 15 yrs, and her last child birth 8 yrs back.

On General physical examination vitals signs are normal, cardiac and respiratory system is normal. On per abdomen examination –abdomen is soft, non tender, no palpable mass is palpated. On per speculum examination-white discharge is seen, uterine prolapse is seen.

On per vaginal examination-UV prolapse of 2^{nd} degree is noted, with a cyst of size 5*4cm is palpated at left anterior and left lateral wall of the vagina at the level of mid vagina, which is cystic in nature and non tender.

2.1. Diagnosis

Second degree UV prolapse with cervisitis with cystocele and rectocele with anterior vaginal wall cyst.

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2.2. Management

All the investigation of the patients are with in normal limit and posted for surgery vaginal hysterectomy with urethrocele and rectocele repair with cyst excision.

Intra operative-on dissection of cyst- thick, chocolate colour mucinous secretions are seen.

There are no post-operative complications.

2.3. Histo-pathology report

Gross Morphology- Uterus measure 7*4*4cm, Cervix is congested, Cyst wall of size 5cm is seen Microscopy-cervix –Chronic cervicitis, Noatypia seen Endomertrium – Secretory, no malignancy CYST WALL-Shows columnar epithelium over fibrocollagenous wall.

2.4. Impression

Chronic cervicitis with ulceraton, Secretory endometrium (hysterectomy specimen).

Anterior vaginal wall- Benign mucinous cyst.

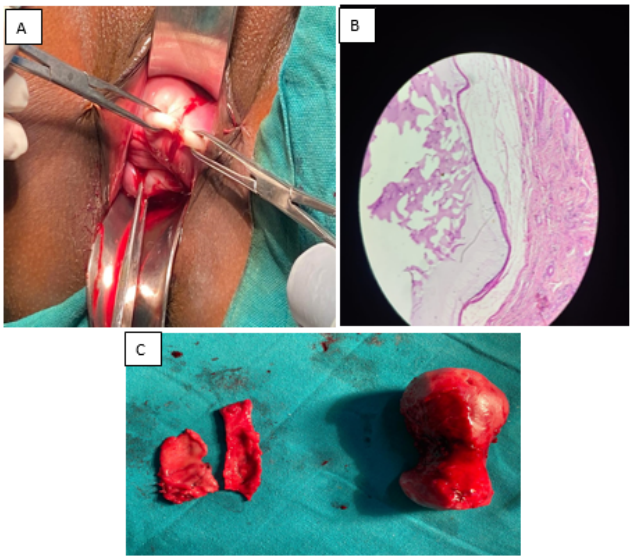

Fig. 1: A: Intraoperative image of vaginal wall cyst; **B:** Microscopic section of vaginal wall cyst; **C:** Cut section of vaginal wall cyst

3. Discussion & Conclusion

Most of the vaginal cyst are asymptomatic and treatment is not needed prevalence is 1 in 200[3] patient may complain of mass per vaginum, vaginal discomfort, dysparunia, vaginal pain. The vaginal wall cyst should be differentiated from cystocoele and rectocoele by examination location of the cyst excludes from bartholian cyst endometriotic cyst should be ruled out by absence of cyclical abdominal pain during menstrual cycle.

Mullariancyst are the most common cyst seen in the vaginal wall, mostly they are located anteriolaterally, usually single sometimes multifocal.[4,5] During embryonic development paramesonephric duct (mullarian duct) fuses distally and forms uterus, cervix and upper part of vagina, these are lined by pseudostratified coloumar epithelium mesonephric duct (wolffian duct) regress in females the derivaties of these ducts seen with in the vaginal walls.

Gartners cyst is lesscommon, most common;y sen anteriolateral vaginal walls and it is associated with abnormalites of metanephricduct like ectopic ureter, unilateral ureter and renal hypoplasia.[6,7]

Gartners cyst contain basement membrane and smooth muscle layer. Clear distinguish from mesonephric and paramesonephric duct by histo chemical staining paramesonephric cyst mucin and periodic acid schiff positive, mesonephric duct are devoid of they are negative.[6]

Transvaginal ultrasound and magnetic resonance imaging is done to see exact location, number and its extension,[8] MRI is imaging modality of choice to know characteristic of the tumour[6] treatment includes surgical excision of the cyst it may include incision and drainage or marsupilization of the cyst, during surgery injury should be avoided to urethra and bladder usage of laser reduces complication like post-operative pain, dyspareunia and hemorrhage.

This is a rare case of benign muscinous cyst of anterior vaginal wall.

4. Source of Funding

None.

5. Conflict of Interest

The authors declare no conflict of interest.

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