THE OCCASIONAL

The Occasional Bartholin cyst management

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This article has been peer reviewed.

INTRODUCTION

Bartholin cysts and abscesses are common vulvovaginal conditions, affecting approximately 2% of individuals with vulvas at some point in their lives.[1] These typically occur after puberty when the Bartholin glands become functionally active. Infection can lead to a painful abscess requiring prompt drainage. In rural or resource-limited settings, access to specialist gynaecologic care may be limited. Rural generalists are well-positioned to manage these cases effectively when equipped with appropriate tools and procedural knowledge.[2]

ANATOMY AND FUNCTION

The Bartholin glands [Figure 1] are located in the vulvar vestibule at approximately the 5 and 7 o'clock positions.[2] Each gland is oval-shaped, averaging 0.5 cm in size.[2] They become functional after menarche and secrete mucoid lubrication during sexual activity via an efferent duct at the distal end of the vagina.[2] Obstruction of this duct may cause mucus accumulation, resulting in cyst formation. Secondary infection can lead to abscess formation.

DIAGNOSIS AND DIFFERENTIAL

A correct diagnosis is essential before intervention. Ultrasound can help distinguish solid from cystic lesions and confirm an abscess, but diagnosis is usually clinical.[2] The lack of a fluid-filled structure rules out a Bartholin cyst or abscess and should lead the provider to rethink their diagnosis.

TYPICAL PRESENTATION

- Cyst: Soft, non-tender mass near the 5 or 7 o'clock position of the vestibule
- Abscess: Tender, erythematous, fluctuant swelling, often painful with walking, sitting, or sexual intercourse.

Differential Diagnoses Include:

- Bartholin cyst–Over-accumulation of mucus due to duct occlusion; often sterile.[1] Figure 2
- Bartholin abscess – Infected cyst with pain, redness and swelling[1]
- Labial cyst – Typically non-tender, mobile[1] Figure 2
- Benign Bartholin gland tumour – Includes nodular hyperplasia, adenomas, hamartomas; usually mobile and well-circumscribed[3]
- Bartholin gland carcinoma – Very rare; consider in patients over age 40 or with firm, fixed, non-tender masses.[4]

INDICATIONS FOR DRAINAGE

Drainage should be considered when:

Received: 07-08-2025 **Revised:** 12-09-2025 **Accepted:** 13-09-2025 **Published:** 12-11-2025

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How to cite this article: Cross J, Soltys C, Giles S. The Occasional Bartholin cyst management. Can J Rural Med 2025;30:192-5.

Access this article online

Quick Response Code:

Website: https://journals.lww.com/cjrm

DOI: 10.4103/cjrm.cjrm_46_25

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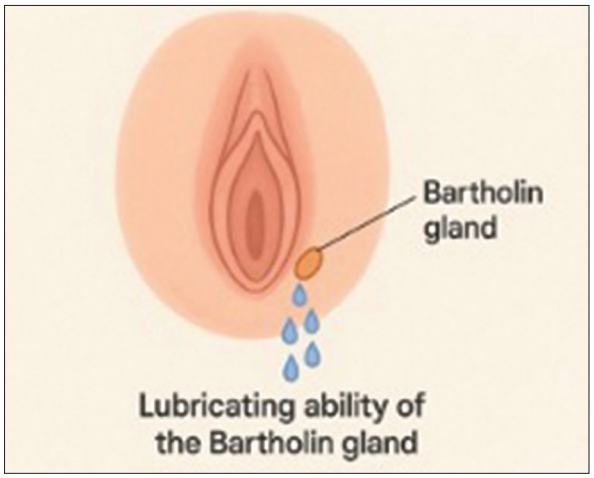


Figure 1: Anatomy of the Bartholin gland. Based on Lee *et al*. 2024.

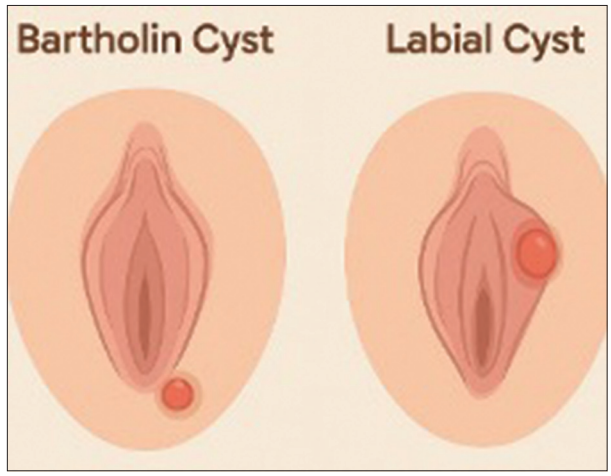


Figure 2: Typical Bartholin cyst versus labial cyst presentation. Based on Omole *et al*. 2019.

- Lesion is fluctuant and painful (suggestive of abscess) OR
- Rapid enlargement or suspected infection OR
- Conservative management has failed OR
- Patient is high risk (immunocompromised, diabetic and pregnant).

Note: It is important to avoid incising a non-fluctuant Bartholin lesion. Early cysts or indurated swellings should be managed conservatively with sitz baths and analgesia until the abscess points, as premature incision may increase the risk of complications.[1] Furthermore, simple lancing or incision and drainage is discouraged due to higher recurrence rates, potential creation of false tracts and the risk of complicating subsequent Word catheter or marsupialisation procedures.[1]

PAIN MANAGEMENT

- Local anaesthesia – Usually sufficient (lidocaine 1%–2%)
- Procedural sedation and general anaesthesia – May be required for severe pain and patient comfort.

MANAGEMENT

A. Conservative Treatment
   - Analgesia
   - Warm compresses
   - Sitz baths.[2]

B. Procedural Drainage.
   1. Word Catheter: Word catheter placement is effective, minimally invasive and well-suited for rural practice.[1] Contraindication to Word Catheter placement is latex allergy; if no Latex-Free Word catheters are available, the loop technique is preferred (see below).

Required equipment: Figure 3.
- Non-sterile gloves, eye protection
- Antiseptic solution (povidone iodine 10%)
- Local anaesthetic (1%–2% lidocaine with epinephrine)
- 30G needle with 5 mL syringe (lidocaine injection)
- Word catheter (or Penrose drain if unavailable)
- No. 11 scalpel
- Gauze pads, small forceps, haemostats
- Bacterial swabs (if indicated).

Steps:[1]
1. Test Word catheter balloon with 3 mL saline, then deflate but leave syringe attached [Figure 4]
2. Place the patient in the dorsal lithotomy position
3. Prep area with iodine
4. Infiltrate local anaesthetic at the planned incision site (5 or 7 o'clock position)
5. Make a 5 mm vertical incision into the cyst/abscess at the most fluctuant point [Figure 5]
   - *Tip*: Keep the incision small to reduce the risk of catheter falling out.
6. Insert deflated catheter into cyst cavity. Inflate balloon with 2–4 mL saline [Figure 6]

7. Tuck the catheter into the vagina for comfort[5]

2. Loop (Penrose) Drain: If Word catheter is unavailable or if patient has a latex allergy, a Penrose or Foley drain can be used [Figures 7 and 8].

   Steps:[1]

   1. Make two small (<1 cm) mucosal incisions within the abscess. One incision medially, over the point of fluctuance and the other slightly lateral. Stay within the soft tissue of the vaginal mucosa rather than venturing into the tougher external vaginal skin
   2. Pass the drain through the tunnel with haemostats
   3. Tie ends together or use suture to secure the ends and form a loop

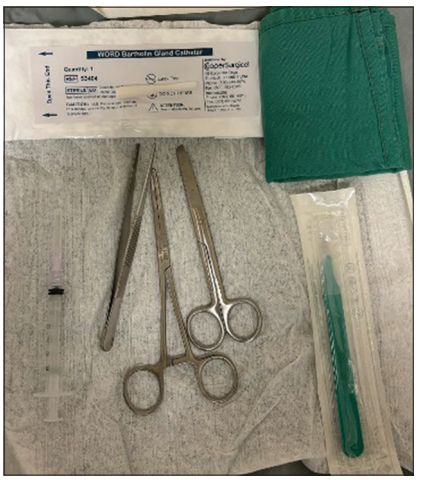


Figure 3: Bartholin drainage and Word catheter supplies.

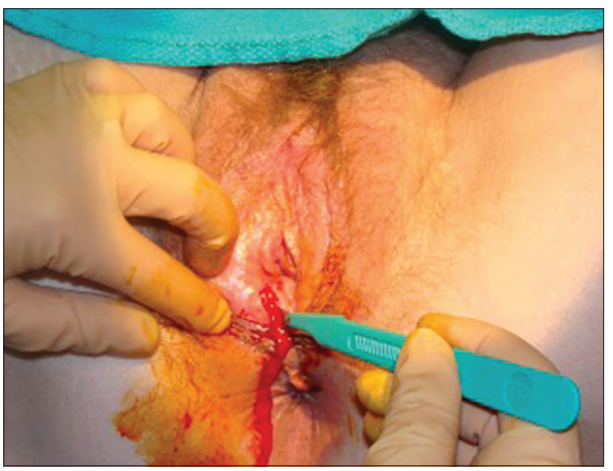


Figure 5: Vertical 5 mm incision into Bartholin gland abscess.

FOLLOW-UP AND AFTERCARE

- The catheter typically remains in place for approximately four weeks to allow for epithelialisation of the new tract.[1] Earlier expulsion is acceptable if it falls out on its own before this
- Avoid sexual activity until healed
- Return in 4 weeks for removal and assessment
- Monitor for cellulitis; antibiotics may be considered for Gram-negative and anaerobic coverage.[6,7]

ADDITIONAL CONSIDERATIONS

- Antibiotics – Not routinely required unless cellulitis, immunocompromise, methicillin-resistant *Staphylococcus aureus* risk factors or systemic symptoms present[6,7]



Figure 4: Testing the Word catheter.

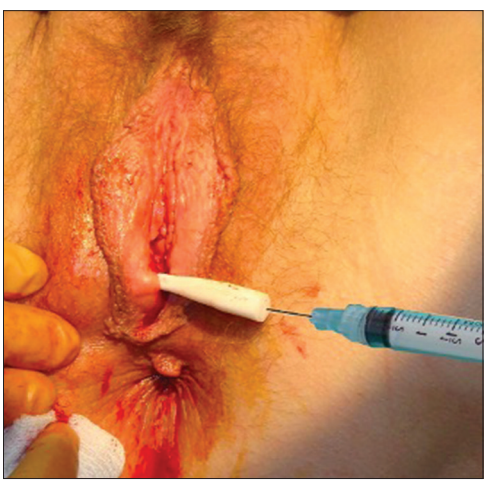


Figure 6: Word catheter placement and insertion.

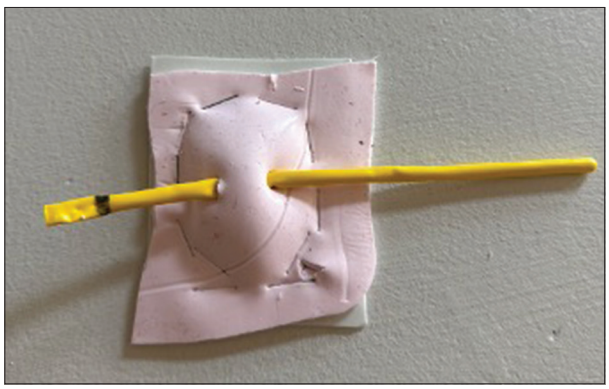


Figure 7: Insertion and placement of a Word catheter substitute.

- Sexually transmitted infection testing – Urine testing for gonorrhoea/chlamydia recommended
- Marsupialisation – For recurrent cases (≥3)
- Biopsy – If malignancy suspected (OB/GYN referral)
- Complete excision – For persistent or complicated cases[4]
- Pregnancy or antiplatelet agents – pregnant patients have increased vascularity and thus higher bleeding risk.[8] People on antiplatelet agents also have increased bleeding risk, and the provider should be equipped to deal with this before pursuing treatment.[9]

WHEN TO REFER (CRISP CRITERIA BY LEAD AUTHOR)

Refer to gynaecology or rural generalist surgeon when:

- Complicated: The case is complicated or non-resolving infection[3]
- Recurrences: Recurring ≥3 times[1,7]
- Intervention: Additional intervention (such as surgery/marsupialisation) is warranted[2,8]
- Suspicion: Suspicious of malignancy[1]
- Procedure: Procedure required that cannot be completed in the clinic/requires specialist care.[2,8]

CONCLUSION

This protocol highlights a cost-effective, evidence-based approach to Bartholin's abscess management that is particularly well-suited to rural and emergency care settings where resources may be limited. Word catheter placement remains one of the most effective methods for managing Bartholin abscesses in the short and long term.[1] When performed with proper technique and accompanied by appropriate patient education, this procedure significantly reduces recurrence. Empowering rural physicians with this practical skill not only ensures timely symptom relief but also decreases the need for specialist referral, ultimately providing care closer to home.

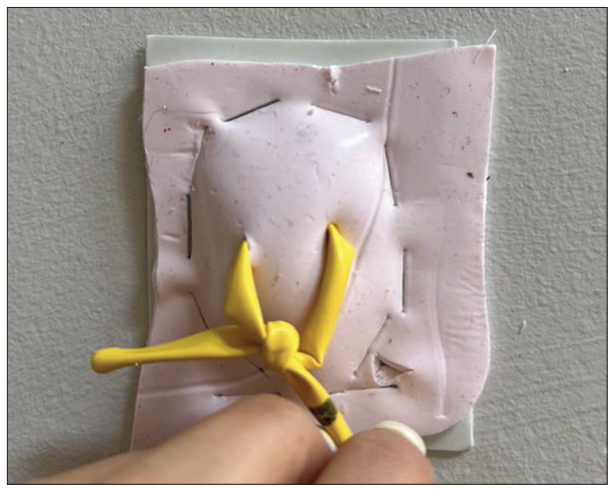


Figure 8: Closed ring and final placement of Word catheter substitute.

Acknowledgement: The authors would like to acknowledge the guidance, knowledge and expertise offered by Dr. Margaret Burnett, Professor of Obstetrics, Gynaecology and Reproductive Sciences at the University of Manitoba, during the preparation of this manuscript.

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

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