

Rare Case of Prolapsing Vaginal Cyst

Shalini Mahana Valecha, Neha Shah, Manisha Gandhewar, Prajakta Shende

ABSTRACT

Müllerian cysts typically are <2 cm in size and asymptomatic. Our patient presented with big mass coming out per vaginum and intermittent vaginal discharge. A provisional diagnosis of first degree uterovaginal descent with cystoectocele with small right lateral vaginal wall cyst was made. The patient was posted for vaginal hysterectomy with anteroposterior colporrhaphy with excision of the cyst. What we thought was a routine vaginal hysterectomy for prolapse allotting another few minutes for a small cyst removal, turned out to be a complicated procedure, requiring additional time and expertise. Not all patients presenting with mass coming out per vaginum, necessarily, are a case of prolapse. One should not minimize the importance of vaginal wall cysts, irrespective of their size. A detailed evaluation, using MRI scan is indicated, prior to proceeding with their removal.

Keywords: Müllerian, Uterovaginal descent, Vaginal discharge, Cyst excision, Magnetic resonance imaging.

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INTRODUCTION

Cysts of the vaginal wall are relatively uncommon and often an incidental finding.¹ Vaginal cysts can be histologically classified as epithelial, inclusion, Müllerian, mesonephric and urothelial in addition to other rare types.² Müllerian cysts typically are <2 cm³ in size and asymptomatic. If at all they are symptomatic they present as a visible or palpable mass, dyspareunia, voiding problem, vaginal discharge and pain.⁴ Müllerian duct cysts are remnants of embryologic paramesonephric ducts.³

CASE REPORT

A 42-year-old lady para 2 came to the gynecological service of Employees State Insurance Postgraduate Institute of Medical Sciences and Research and Model Hospital, Mumbai, India complaining of a big mass coming out per vaginum since 9 years. As per history the mass was reducible. She also complained of excessive vaginal discharge intermittently. Patient had no bowel, bladder or menstrual complaints. On examination, her vitals were stable and systemic examination was within normal limits. On per speculum, first degree uterovaginal descent with minimal cystoectocele was noted. A 3 × 3 cm cystic swelling under the mucosa of the right lateral vaginal wall protruding out of the introitus was present. There was no visible punctum. On bimanual examination, uterus was retroverted, bulky, freely mobile with both fornices clear. Cyst

was tense, nontender. A provisional diagnosis of first degree uterovaginal descent with cystoectocele with small right lateral vaginal wall cyst was made. The patient was posted for vaginal hysterectomy with anteroposterior colporrhaphy with excision of the cyst.

Operative Procedure and Intraoperative Findings

Vaginal hysterectomy with anteroposterior colporrhaphy was completed under spinal anesthesia. Incision was given over the tense cyst wall. Mucinous material of approximately 50 cc was drained and sent for culture sensitivity. Dissection of the cyst wall from adjacent vaginal wall was started. We found that the cyst was a unilocular blind sac. A finger was inserted in the cavity to determine its extent. To our utter surprise, the cyst was extending deeply along the right lateral vaginal wall nearly up to the right fornix. Only with extensive sharp dissection⁵ could the cyst wall be separated from the vaginal wall and the cyst was removed *in toto* with difficulty. A large cavity, whose upper extent could not be visualized, remained. Since, there was no active hemorrhage within this enormous dead space, no sutures were taken. An absorbable gelatine sponge was kept within the cavity and the vaginal mucosa at the introitus closed with interrupted delayed absorbable sutures. Vagina was packed tightly for 24 hours. Postoperative course was uneventful. Histopathological examination showed Müllerian cyst of vaginal wall with mucin secreting, tall columnar epithelium of endocervical type.^{1,5} Culture sensitivity of the cyst contents showed pus cells ++, *Streptococcus* +, *Enterococcus* + both sensitive to amoxicillin + clavulanic acid. Postoperatively patient was given course of this antibiotic for 7 days. Patient followed up in OPD after 6 weeks. Vaginal mucosa healed well and patient had no complaints.

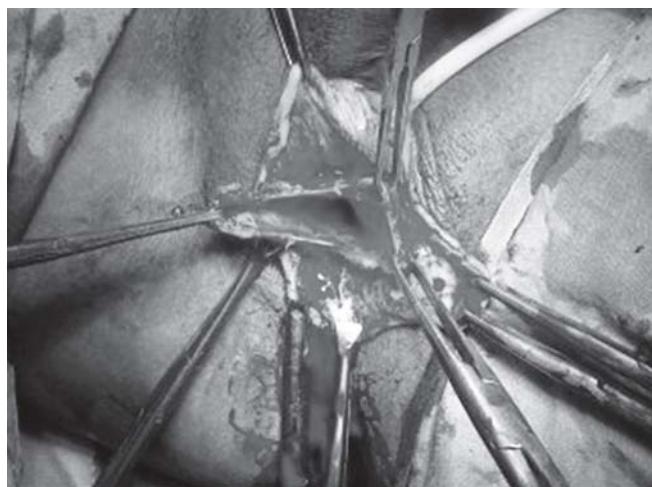


Fig. 1: Vaginal cyst dissected before resection

DISCUSSION

Müllerian cysts typically present in the child-bearing age,^{5,6} unusually, this patient presented in the perimenopausal age. Large cysts are almost always symptomatic and patient presents with complaints of dyspareunia, difficulty in micturition or defecation, vaginal discharge and pain.⁴ Our patient presented with big mass coming out per vaginum and intermittent vaginal discharge. Preoperatively, we were misled by the small size of the cyst and attributed her symptoms only to the uterovaginal descent with minimal cystocele. Retrospectively, we concluded that the huge Müllerian cyst was probably filling up, repeatedly with mucinous material discharging intermittently, with the patient interpreting it as leukorrhoea. The main complaint of the patient, then, was really the cyst coming out per vaginum and with its penchant for filling and discharging on its own. What we thought was a routine vaginal hysterectomy for prolapse allotting another few minutes for a small cyst removal, turned out to be a complicated procedure, requiring additional time and expertise. Had we correctly evaluated the cyst preoperatively by MRI we would have been better prepared to remove this enormous cyst. Perhaps, the uterus may have then be left *in situ* after discussing the same with the patient. Ultrasound though an acceptable modality, MRI, with its better resolution for pelvic and perineal pathology is a superior diagnostic tool for all cysts along the vaginal walls irrespective of their size.⁷⁻⁹ One must not minimize the importance of a vaginal wall cyst, even if they clinically appear small and inconsequential. Thorough radiographic evaluation is advised before proceeding for removal.¹⁰

CONCLUSION

Not all patients presenting with mass coming out per vaginum, necessarily, are a case of prolapse.^{3,9} One should not minimize the importance of vaginal wall cysts, irrespective of their size. A detailed evaluation, using MRI scan is indicated, prior to proceeding with their removal.

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