

Giant Bartholin's Gland Cyst: A Case Report of An Uncommon Clinical Presentation

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ABSTRACT

Bartholin gland cysts are a common vulvar condition in women of reproductive age, usually presenting as small, asymptomatic lesions. Giant cysts are uncommon and may cause significant anatomical distortion, discomfort, functional impairment, and diagnostic challenges. Treatment should be individualized according to lesion size, recurrence, symptoms, age, and suspicion of malignancy.

A 35-year-old woman, gravida 2, para 0, with a history of recurrent left-sided Bartholinitis since the age of 18, previously managed with drainage, presented with a one-year history of progressive enlargement of a vulvar mass. On examination, a violaceous, painless lesion measuring approximately 12 × 8 cm was identified, associated with difficulty walking and performing daily activities. Ultrasonography revealed a large Bartholin gland cyst measuring 10 × 6 cm, while abdominal and pelvic computed tomography showed no other abnormalities. The patient underwent left Bartholin gland excision with left labial plasty. A 9 × 5 cm cystic lesion with an intact capsule was removed. Histopathological examination reported acute abscessed and chronic nonspecific fibrous Bartholinitis, with negative surgical margins. The postoperative course was favorable, without complications or recurrence during follow-up.

Giant and recurrent Bartholin gland cysts are uncommon and may significantly affect patients' quality of life. In cases of large, recurrent lesions or when malignancy cannot be excluded, complete surgical excision allows definitive treatment and histopathological evaluation. This case highlights the importance of individualized management based on lesion characteristics and clinical history.

KEYWORDS: Bartholin gland cyst; giant Bartholin cyst; Bartholinitis; vulvar mass; Bartholin gland excision; recurrent Bartholin cyst

ARTICLE DETAILS

Published On:
20 October 2026

Available on:
<https://ijmscrs.com>

I. INTRODUCTION

The Bartholin's glands, also known as the greater vestibular glands, are two glands located at the 4 o'clock and 8 o'clock positions of the vaginal introitus. In 1677, the anatomist Caspar Bartholin Secundus described these structures for the first time, which are oval-shaped and measure approximately 0.5 cm. Each gland connects to the posterolateral aspect of the vaginal opening, between the hymen and the labia minora, via an efferent duct 2 centimeters in length (1).

The urogenital sinus gives rise to the Bartholin's glands; the body of each Bartholin's gland is composed of mucinous acini lined by simple columnar epithelium. The efferent ducts of the glands are composed of transitional epithelium, which changes to squamous epithelium as the orifices open into the vagina (1).

The external pudendal artery provides the blood supply, and the pudendal nerve is responsible for innervating the Bartholin's glands (1).

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Their main function is the production of a mucous secretion that lubricates the distal part of the vagina during sexual intercourse. These glands become active after menarche and are normally non-palpable (1).

Obstruction of the duct leads to the accumulation of secretions, which can form a cyst, while a secondary infection can result in an abscess. Other causes of cysts include vulvovaginal trauma and surgical procedures, such as a mediolateral episiorrhaphy (1, 2).

Bartholin's gland cysts are common problems in women of reproductive age, with the highest incidence occurring between 20 and 29 years of age. It is estimated that 2% of women will experience an episode of a Bartholin's gland cyst or abscess during their lifetime (2).

The cyst usually ranges from 1 to 3 cm in diameter and is often asymptomatic, although larger cysts can be associated with pain and dyspareunia; one of the largest reported was 10 cm (3).

The diagnosis of a Bartholin's gland cyst or abscess is established through the clinical history and physical examination. Cysts are typically small and unilateral, grow slowly, drain spontaneously, and contain non-infected fluid. Women may occasionally experience dyspareunia, as well as discomfort or pain when walking or sitting. Abscesses grow rapidly, are larger and more painful, and display signs of inflammation such as warmth, tenderness, edema, erythema, and sometimes fever (4).

The formation of cysts and abscesses leads to atrophy of the gland, making its preservation unnecessary in many cases (2). Numerous treatment options exist for symptomatic Bartholin's cysts or abscesses. The most common interventions include incision and drainage with Word catheter placement, and marsupialization of the abscess (5).

Various types of surgical procedures have been described, such as: 1) fistulization or marsupialization, 2) Word catheter placement, 3) alcohol sclerotherapy, 4) simple incision and drainage, 5) silver nitrate application, 6) cyst ablation using carbon dioxide (CO_2) laser, and 7) gland excision (6). Radical Surgical Treatment (glandular excision) consists of performing the complete removal of the gland and its excretory duct, with a low recurrence rate (0–3%). It is performed when the cystic formation has replaced the Bartholin's gland, in patients with recurrence despite other treatments, and in cases of suspected neoplasm. Excision of the Bartholin's gland does not affect sexual response (7). Bartholin's gland malignancy is characterized by a painless mass, with an increased risk in women aged 40 and older, in whom a biopsy of the cyst wall and/or staging studies should be considered (8).

In current literature, few cases of giant Bartholin's gland cyst measuring over 10 cm in longitudinal diameter have

been reported. In 2008, the first case was reported in a 63-year-old woman with a vulvar mass in the left vulvar wall measuring 10.8×9.5 cm. The patient underwent magnetic resonance imaging (MRI), computed tomography (CT), and surgical excision due to suspected malignancy. Microscopic examination led to the diagnosis of a Bartholin's duct cyst. Two other cases of giant Bartholin's gland cyst were reported in 2017. Two perimenopausal patients presented with giant vulvar cysts measuring $10 \times 7 \times 3$ cm in diameter (a 68-year-old woman) and 23×11 cm and 6×6 cm (a 42-year-old woman). Pelvic MRI of the second patient provided information on the size, shape, and extent of the cyst. The MRI showed a connection between the two masses. In both cases, surgical removal of the cyst and histopathological examination were performed (4).

CLINICAL CASE

We present the case of a 35-year-old woman, gravida 2, para 2 (via cesarean section), with no chronic pathologies, a body mass index (BMI) of 37, and a history of cesarean sections 17 and 13 years ago, as well as an open cholecystectomy 22 years ago. She reports a first episode of bartholinitis at age 18, a second 5 years ago, and the last one 2 years ago, all treated with surgical drainage without complications; she denies gynecological follow-up. One year ago, she noticed an increase in glandular volume, color changes, and localized warmth. She denies spontaneous drainage and presented to our service 1 month prior to the procedure due to difficulty walking and performing daily activities. On gynecological physical examination, a tumor measuring approximately 12×8 cm is observed, with regular borders, purplish coloration, no drainage site, and no local warmth (Figures 1 and 2). She denies fever, weight loss, pain, or spontaneous drainage of the lesion.



Figure 1. Bartholin's gland cyst prior to surgery.

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Figure 2. Superolateral view of the Bartholin's gland cyst prior to surgery.

Given the size of the tumor, a diagnostic workup was initiated. An ultrasound reported the following findings: large Bartholin's cyst measuring 10×6 cm. Abdominopelvic computed tomography: normal / no abnormalities detected. Complete laboratory tests demonstrated an HbA_{1c} of 7%, with no other abnormalities. Surgical scheduling was arranged for a bartholinectomy + left labiaplasty. Upon hospital admission, the patient reported partial spontaneous drainage of the gland at home, resulting in a final presurgical dimension of 9×5 cm (Figure 3).



Figure 3. Bartholin's cyst, following partial drainage.

Performed on June 23, 2026, the following surgical findings were obtained: left Bartholin's gland measuring 9×5 cm, removed with an intact capsule (Figure 4); left labiaplasty was performed (Figure 5) without complications.

The surgical technique used was as follows: with the patient in the lithotomy position, asepsis and antisepsis of the genital region were performed, and a Foley catheter was placed for urinary diversion. A fusiform (spindle-shaped) incision was made over the medial aspect of the left labium majus, directly over the cyst. Blunt dissection was carried out using Kelly forceps, obtaining the cyst with an intact capsule. Hemostatic simple interrupted sutures were placed with 0 chromic gut. Redundant tissue was resected, followed by closure of the subcutaneous tissue using simple interrupted sutures with 2-0 Vicryl, and subsequent skin closure with 2-0 nylon.



Figure 4. Bartholinectomy.

The specimen was sent to pathology. After 24 hours of observation without complications, the patient was discharged with outpatient follow-up, during which no postoperative complications were reported.

The pathology report obtained on July 18, 2026, indicated a marginal bartholinectomy, acute abscessed and nonspecific chronic fibrous bartholinitis, with negative surgical margins.

Patient follow-up was concluded with an uncomplicated recovery.



Figure 5. Labiaplasty following surgical excision.

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DISCUSSION

Bartholin's cysts and abscesses account for approximately 2% of gynecological consultations per year and represent the most common vulvar cystic pathology in women of reproductive age. Various treatment modalities have been proposed, each associated with distinct rates of recurrence and complications (9).

Although the majority of cysts typically measure 1 to 4 cm, giant cysts (>5 cm) are rare and pose a therapeutic challenge due to pain, anatomical distortion, impairment of quality of life, and higher recurrence rates when conservative treatments are used (9).

Marsupialization is considered an appropriate method for treating Bartholin's gland cysts and abscesses because it is a simple, quick, minimally painful procedure that is very well tolerated by the patient. However, recurrence is highly probable, which may eventually necessitate surgical excision. Recurrence rates for Bartholin's cysts are estimated at 5% to 15% following marsupialization and 10% to 20% after Word catheter placement; in contrast, bartholinectomy demonstrates exceptionally low recurrence rates, although it is associated with higher postoperative morbidity (6).

As described in the current literature, treatment depends on the size, presence of infection, history of recurrence, and the patient's age. Bartholinectomy is considered the definitive treatment in patients with recurrent disease, large cysts, failure of previous treatments, suspected malignancy or uncertain diagnosis, and persistent abscesses (6).

In cases of giant cysts, such as the one presented here, anatomical distortion and tissue thinning complicate conservative procedures and favor disease persistence. Furthermore, complete resection provides a specimen suitable for histopathological examination (10).

From a histopathological standpoint, the reported findings align with the patient's clinical history and staging studies, supporting the benign nature of the submitted specimen (2).

Regarding the clinical case presented, the initial size of the Bartholin's gland cyst was estimated at 12 cm, making it an uncommon case and one of the largest reported in the literature when compared to those previously mentioned (23 and 10 cm). This suggests that, despite their benign nature, these cysts can reach considerable dimensions and significantly impact the patient's quality of life (2).

Considering the size of the lesion, the symptomatology, and the recurrence of the pathology—with up to 4 previous episodes—excisional management of the gland was justified as the optimal therapeutic choice in this clinical case (2). The favorable postoperative course and the absence of recurrence support the efficacy of this approach when patients are appropriately selected (6, 10).

This case reinforces the necessity of individualizing treatment based on the specific clinical context and medical history of each patient, aiming to reduce morbidity, recurrence, and chronicity, while ultimately improving the patient's quality of life.

CONCLUSION

Giant Bartholin's gland cysts and abscesses are uncommon entities for which treatment must be individualized. Although Word catheter placement and marsupialization remain the recommended initial options, bartholinectomy constitutes the definitive first-line treatment in giant, recurrent, or suspected malignant lesions. Under these circumstances, complete resection significantly reduces the likelihood of recurrence, eliminates pathological tissue, and enables histopathological analysis—aspects of particular relevance for optimizing the prognosis.

The experience gained from this case supports the use of bartholinectomy as an effective and safe strategy in patients with large lesions, provided that the indication is individualized and the risks and benefits are appropriately weighed.

A. Figures and Tables

Figures and tables must be centered in the column. Large figures and tables may span across both columns. Any table or figure that takes up more than 1 column width must be positioned either at the top or at the bottom of the page.

Informed Consent: Written informed consent was obtained from all participants or their legally authorized representatives prior to study participation and publication of clinical information and/or potentially identifiable images. Consent was obtained in accordance with applicable ethical and institutional requirements. The authors confirm that appropriate measures were taken to protect participant privacy and confidentiality and that any identifiable information or images published in this article were authorized for publication.

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