Objective: The current database of medical articles rarely includes information about Giant Gartner’s duct cysts. This case study was developed to exhibit a varied clinical presentation of a Gartner’s duct cyst.

Case: During a routine vaginal speculum examination on a 21-year-old primigravida at 24 weeks’ gestation, a bulging membrane was visualized. Due to the patient’s uterine contractions and the possibility of rupturing the amniotic membrane, a vaginal exam was deferred. An amniotic sac appeared to funnel into a fluid collection within the vaginal vault. She was induced at term once a giant Gartner’s duct cyst was reduced.

Conclusion: When a fluid-filled membrane in the vaginal canal is encountered during pregnancy, non-obstetric sources such as a Gartner’s duct cyst should be considered in the differential diagnosis.

INTRODUCTION

- Gartner’s duct cysts are dilated Wolffian duct remnants found in the lower anterolateral aspect of the vagina. Gartner’s duct cysts mimicking pathologic conditions associated with pregnancy are rare.
- We describe a diagnostic complication of an antenatal course caused by a Gartner’s duct cyst.
- The purpose of this study is to present a varied clinical presentation of a Giant Gartner’s duct cyst.

CASE

- A 21-year-old primigravida presenting at 24 weeks’ gestation was transferred to a tertiary care facility with a diagnosis of "visible membranes" in the vaginal vault. The patient had presented to her primary obstetric care provider that day for a routine prenatal visit, during which time a test of cure for Chlamydia trachomatis was to be performed.
- At this time, a speculum was placed into the vagina and a large bulging bag of fluid was noted to be protruding. She had no complaints of pain, vaginal bleeding, contractions, or leakage of fluid.
- On our examination, the patient was found to be in no apparent distress with normal vital signs. Her abdomen was non-tender and soft. A sterile speculum exam revealed a bulging membrane at the hymen. A vaginal examination was deferred due to concerns about rupture of amniotic membranes.
- The fetal heart rate was 140 beats per minute and tocodynamometry did not record any contractions. The white blood count was 11.7 white blood cells per microliter with no left shift and all other laboratory findings were within normal limits.
- An abdominal ultrasound showed a vertex fetus with an estimated fetal weight of 677 grams and the amniotic fluid volume appeared normal. An amniotic sac appeared to funnel into a fluid collection within the vaginal vault (Figure 1).
- The patient was managed expectantly with strict bed rest. She was not deemed to be a candidate for a rescue cerclage due to her gestational age and subsequent development of symptomatic regular uterine contraction activity. She was placed on oral nifedipine for tocolysis and completed a course of intramuscular betamethasone as well as intravenous ampicillin and erythromycin.
- Several repeat sterile speculum examinations were performed and the presence of the “bulging bag of fluid” was noticed, but there was no evidence of ruptured membranes.
- The etiology of the “bulging bag of fluid” came into question as the patient approached term without delivery. Since the implication of unintentional amnioncensis was less significant near term, a more vigorous attempt was made to evaluate the sac and determine its origin, at which time it was diagnosed as a Gartner’s duct cyst.
- The Gartner’s duct cyst was 3 cm, fluid filled, thin walled, and originated from the right vaginal sidewall. The cervix was visualized as thick and tightly closed. The patient was eventually admitted for an induction at 41 weeks due to oligohydramnios.
- A spontaneous vaginal delivery of a healthy term male infant ensued. The mother and baby were discharged to home in good health. The cyst decreased in size following delivery and is asymptomatic at this time.

REFERENCES