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Case Report

Vaginal mullerian cyst presenting as enterocele

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Introduction

Cysts of vaginal wall are relatively uncommon and are often an incidental finding. Vaginal cysts have been classified according to the histology of their lining as epithelial inclusion, mullerian, mesonephric and urothelial in addition to other rare types[1]. Mullerian cysts may be symptomatic sometimes presenting as a visible or palpable mass, dyspareunia, voiding problem, vaginal discharge and pain. This report describes an unusual presentation of a vaginal cyst.

Case report

A 22 year old Muslim primiparous woman came to our outpatient department in October, 2002. Her complaints started in September 2001 during her 3rd month of pregnancy when she noticed a mass prolapsing through her introitus. The mass used to increase in size on straining and was completely reducible. There had been no increase in the size of the mass over the time. It was not associated with any bowel or bladder complaints. She underwent cesarean section on 12th February, 2002 because this vaginal mass was expected to cause obstruction to delivery. Her past medical and surgical history was not significant.

General and abdominal examinations were normal. A 5x5 cm tense cystic swelling covered by vaginal mucosa was seen at the introitus. Overlying mucosa had decreased rugosities. On speculum examination done after reducing the mass, the cervix was to be normal without any descent. A bulge was seen in the posterolateral vaginal wall extending from the fourchette to the posterior fornix. On straining another 4x3cm sized smaller bulge appeared at lower end of the swelling 4x3cm (Figure 1). Vaginal examination revealed a 4x4cm

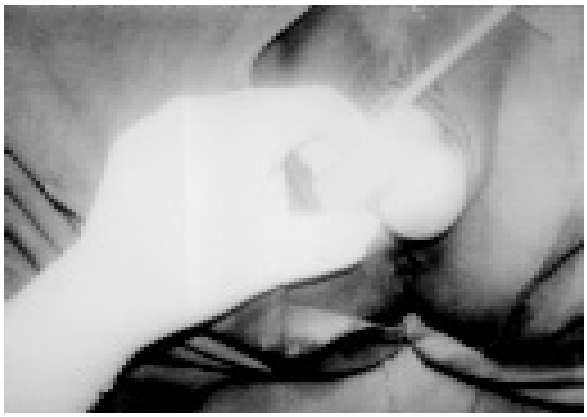

Figure 1. Vaginal cyst with daughter cyst. Urethra is catheterized to show posterior location of cyst

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cyst which was reduced completely through a constriction ring. After reducing the cyst, a bulge remained in the upper half of posterior vaginal wall. Uterus was small, retroverted and both the fornices were normal. On rectovaginal examination rectal mucosa was free and no mass was felt in the rectovaginal septum. A provisional clinical diagnosis of enterocele was made.

On investigations, blood biochemistry was essentially normal. Transvaginal sonography revealed normal uterus and ovaries. A unilocular cystic mass (6x5 cm) was seen posterior to the upper half of the vagina with haustrations suggesting the possibility of intestine X-ray of lumbosacral spine was normal and ruled out the remote possibility of anterior meningocele. Computed tomography demonstrated a well defined 6.6 x 4.2 x 5.8 cm hypodense lesion of fluid intensity seen in the region of vagina protruding through introitus and extending to posterior fornix with appearance of internal septation and without any mural nodule or contrast enhancement (Figures 2 and 3). Rectum was normal. Provisional diagnosis suggested was duplication cyst of rectum or vaginal cyst. No evidence of enterocele was demonstrated.

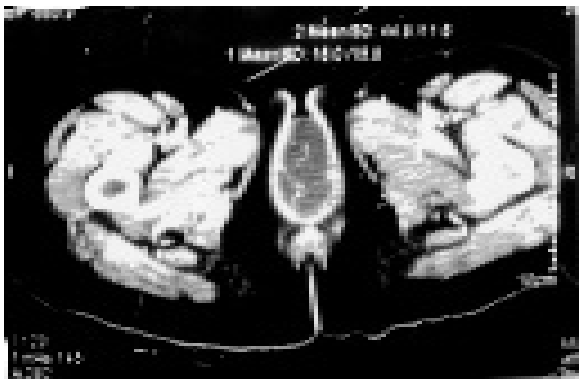

Figure 2. Transverse CT scan showing the cysts.

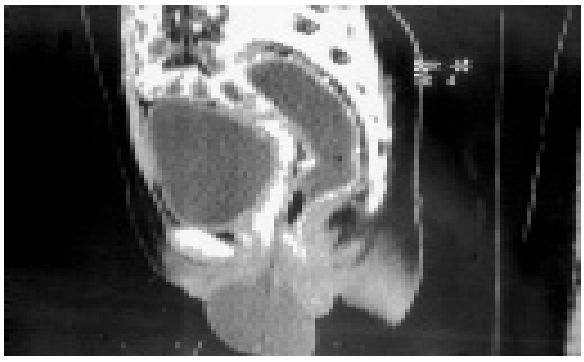

Figure 3. Sagittal CT Scan showing the cysts.

Patient was taken up for surgical excision of the cyst under anesthesia. Incision was given at the left mucocutaneous junction. Vaginal wall was separated from the cyst. Cyst got accidentally ruptured and mucinous material (200 mL) drained out. The cyst was a unilocular blind sac without any communication with the peritoneal cavity. There was a weakness in the cyst wall through which a daughter cyst was prolapsing which could be reduced into the parent cyst. The margin of the cyst wall through which the daughter cyst was prolapsing appeared as constriction ring. The cyst wall was stripped away from vaginal wall and the cyst removed in toto. Histological evaluation of the specimen showed the cyst lining to be of mucin secreting tall columnar cells characteristic of mullerian cyst (Figure 4). Postoperative period was uneventful.

Patient was followed up for 6 months. She had no complaints, was using barrier contraception and showed no abnormality on examination.

Figure 4. Histology. Microphotograph showing the cyst wall lined with mucus secreting tall columnar cells. HE stain : 100x.

Discussion

Vaginal wall cysts have been reported predominantly in women of child bearing age but also seen in infants, children and postmenopausal women[2]. The reported

incidence is 1 in 200. Some reviews found epithelial cysts[2,3] to be the commonest vaginal cysts while others reported mullerian cysts[3]. Commonest congenital cysts are mullerian cysts[2,3]. Though they may occur anywhere but are usually in anterolateral vaginal wall[1]. Their size varies between 1.4 to 7 cm. Rarely a symptomatic congenital cyst may be as large as 16 cm[4]. Cysts that occur at the level of cervix usually extend anteriorly lying in relation to bladder and may present as cystocele. Rarely a large mullerian cyst may present as anterior enterocele[5]. Our case was rare that the cyst presented in posterolateral wall. Also the presence of daughter cyst completely reducible inside parent cyst was the most confusing clinical finding.

References

1. Sahnidt WN. Pathology of the vagina - Vaginal cysts. In : Fox H, Wella M (eds). Haines and Taylor Obstetrical and Gynecological Pathology, *Vol. 1 5th edn*. New York : Churchill Livingstone, 2003:180-3.
2. Junaid TA, Thomas SM. Cysts of the vulva and vagina: A comparative study. Int J Gynaecol Obstet 1981;19:239-43.
3. Pradhan J, Tobon H. Vaginal cysts: a clinicopathological study of 41 cases. Int J Gynecol Pathol. 1986;5:35-46.
4. Hagspiel KD. Giant gartner duct cyst: Magnetic resonance imaging findings. Abdom Imaging. 1995;20:566-8.
5. Lucente V, Benson JT. Vaginal mullerian cyst presenting as an anterior enterocele: A case report. Obstet Gynecol. 1990;76:906-8.