

Bartholin Cyst & Abscess

Blocked duct → trapped mucus → painless cyst; add bacteria → abscess (hot, swollen, incredibly tender). Small and quiet = warm sitz baths and time. Infected = drain it AND keep the tract open with a Word catheter (a tiny soft tube), because a hole that closes too soon just refills. Over 40 with a new gland lump = biopsy to rule out a rare cancer.

THE ONE-LINE TRUTH

A Bartholin cyst forms when the tiny drainage tube of a lubricating gland at the vaginal opening gets blocked and fluid backs up — and it becomes a painful abscess when bacteria grow inside the trapped fluid.

The chain — how it unfolds

1. Duct blockage occurs — why: Mucus production continues against a closed drain — the gland keeps making fluid but it has nowhere to go
2. Painless cyst forms (1 to 3 cm) — why: Slow swelling stretches tissue gradually — often noticed only as a soft lump or one side looking bigger than the other
3. Bacteria move into the trapped fluid — why: Standing fluid plus warm body temperature equals a perfect incubator for germs to multiply
4. Abscess forms — fast growth over 2 to 4 days — why: Pus generation outpaces the pocket's ability to stretch, so pressure and pain climb fast
5. Severe focused pain, difficulty sitting and walking — why: The vulva is packed with nerve endings; a pressurized pocket pushes on those nerves with every step
6. Overlying skin thins and may rupture on its own — why: Pressure finds the weakest exit — brief relief, but tracts that seal shut refill and the cycle starts again
7. Untreated spread: vulvar cellulitis (spreading skin infection), rarely bloodstream infection — why: Bacteria escaping the pocket invade surrounding soft tissue; fever and spreading redness are the alarm signals
8. Recurrence after incomplete drainage — why: Any drainage method that does not keep the tract open — like needle aspiration or a cut that closes too soon — lets the cycle restart. This is why the Word catheter (a tiny soft tube left in place for weeks) exists: it holds the drainage hole open while it heals into a permanent channel.

Spot it — what you see, and why

- Soft, painless lump beside the vaginal opening (cyst stage): The duct draining the Bartholin gland (a pea-sized gland deep in the lower vaginal lip that makes lubricating fluid) gets blocked—often by thick mucus or a tiny flap of tissue. Mucus keeps being made but can't escape, so it slowly collects in a pocket and stretches the gland like a water balloon filling drop by drop. Because it grows slowly and doesn't have bacteria in it yet, there's no infection and no pain—just a smooth bump you can feel or see on one side.
- Rapidly growing, very painful lump on one side of the vaginal opening (abscess stage): Bacteria (commonly normal skin germs like *Staphylococcus* or *Streptococcus*, sometimes sexually transmitted bacteria like gonorrhea or chlamydia) get into the trapped fluid and multiply fast, turning clear mucus into thick pus. The pocket fills faster than it can stretch, so pressure builds quickly. The vulva (the outer genital skin) is packed with nerve endings, so even a small pressure spike causes sharp, throbbing pain. Your immune system rushes white blood cells to the spot, adding more fluid and swelling—like a blister filling under high pressure.
- Pain with sitting, walking, or sex: The swollen, pressurized pocket sits right where your legs meet your pelvis. Every time you sit down, take a step, or have penetrative sex, your body weight or movement squeezes the lump against the bone and nerve-rich tissue around it—like pressing on a bruise over and over. The pressure wave inside the pocket triggers pain signals every time.
- Redness and warmth on one side of the lower vaginal lip: When bacteria invade, your immune system opens up blood vessels near the infection to flood the area with white blood cells and antibodies. More blood flow means the skin looks red (like a blush) and feels warm to the touch. This is inflammation doing its job—trying to wall off and kill the bacteria—but it shows you there's an active infection, not just a harmless fluid-filled cyst.
- Sudden gush of fluid and instant relief of pain: The abscess pocket builds up so much pressure that the thinnest part of its wall tears open, and pus drains out all at once—usually onto underwear or a pad. The instant the pressure drops, the pain disappears, like letting air out of an over-inflated balloon. Relief is real, but often temporary: the tear can seal itself shut within hours or days, the duct stays blocked, and fluid starts collecting again, so the lump and pain can come back.
- Pus or thick yellow-white fluid draining from the lump or vaginal opening: If the abscess ruptures on its own or is drained by a doctor, the infected fluid inside—a mix of dead bacteria, white blood cells, and tissue debris—flows out through the opening. Drainage is a good sign that pressure is relieving, but you need to watch the site: if it re-seals before the infection is fully gone, the pocket can refill.

Red flags — act now

- Fever, chills, or rapidly spreading redness beyond the lump — bacteria are escaping the pocket into surrounding tissue (cellulitis) or the bloodstream (sepsis), and you need urgent antibiotics and possibly hospital admission.
- New Bartholin-area lump in anyone over age 40 — cancer of the Bartholin gland is rare but possible, so biopsy the tissue before assuming it's just a cyst.
- Hard, fixed, or irregular mass at any age — a solid, anchored lump doesn't behave like a fluid-filled cyst and raises concern for cancer; biopsy is mandatory.
- Severe pain out of proportion to the size of the lump, or skin turning dusky, gray, or breaking down — rare but life-threatening necrotizing soft-tissue infection (flesh-eating bacteria) is possible; call 911 or go to the ER immediately.
- Abscess keeps coming back in the same spot after drainage — simple lancing won't fix a duct that keeps re-sealing; you need definitive surgery (marsupialization or gland removal), and tissue should be biopsied in older women.

Treat it — in this order

1. Warm sitz baths and warm compresses (for a small, minimally painful cyst) → Heat opens blood vessels in the area, softens the overlying skin, and encourages the cyst to open and drain on its own. Soak the area in warm water for 10 to 15 minutes, three to four times a day.
2. Incision and drainage (I&D) with Word catheter placement → A small cut lets the pus out (immediate pain relief). Then you place a tiny balloon catheter (Word catheter) into the opening and inflate it with 2 to 3 mL of saline. The catheter stays in for 4 weeks, keeping the new drainage tract open so it can form a permanent lining (epithelialize) and stop the cyst from refilling.
3. Marsupialization (stitching the cyst wall open, for cysts that keep coming back) → The surgeon cuts open the cyst, drains it, and then sews the cyst wall edges to the surrounding skin, creating a permanent new opening for the gland. This stops the refill cycle for good. Usually done after the infection has cooled down.
4. Antibiotics (ONLY for specific reasons: spreading redness, fever, pregnancy, weak immune system, STI, or recurrent abscess) → Covers the infection when it's spreading beyond the abscess pocket or when the patient is at higher risk. Common regimens: trimethoprim-sulfamethoxazole 160/800 mg twice daily for 7 days (covers MRSA, a common skin bug), OR cephalexin 500 mg four times daily for 7 days, OR amoxicillin-clavulanate 875/125 mg twice daily for 7 days (covers gut bugs and skin bugs). If gonorrhea or chlamydia is suspected or confirmed, give ceftriaxone 500 mg IM once PLUS doxycycline 100 mg twice daily for 7 days.

5. Pain control — NSAIDs and local anesthetic injection for the procedure → Ibuprofen or naproxen eases throbbing pain from pressure and inflammation. During drainage, injecting lidocaine 1% around the abscess numbs the area so the patient can tolerate the small cut and catheter placement at the bedside.

Your top priorities at the bedside

1. Position and comfort: side-lying, pressure off the perineum, ice early / sitz baths as ordered — why: A pressurized vulvar abscess makes sitting agony; simple positioning is high-impact comfort care.
2. Prepare for and assist with I&D; label and send cultures correctly — why: Drainage is the definitive treatment — a clean setup and properly collected culture guide any antibiotic decisions.
3. Word catheter teaching: it stays ~4 weeks, pelvic rest while in place, report early fallout — why: The catheter only prevents recurrence if the tract heals open around it — early loss is the number-one failure mode.