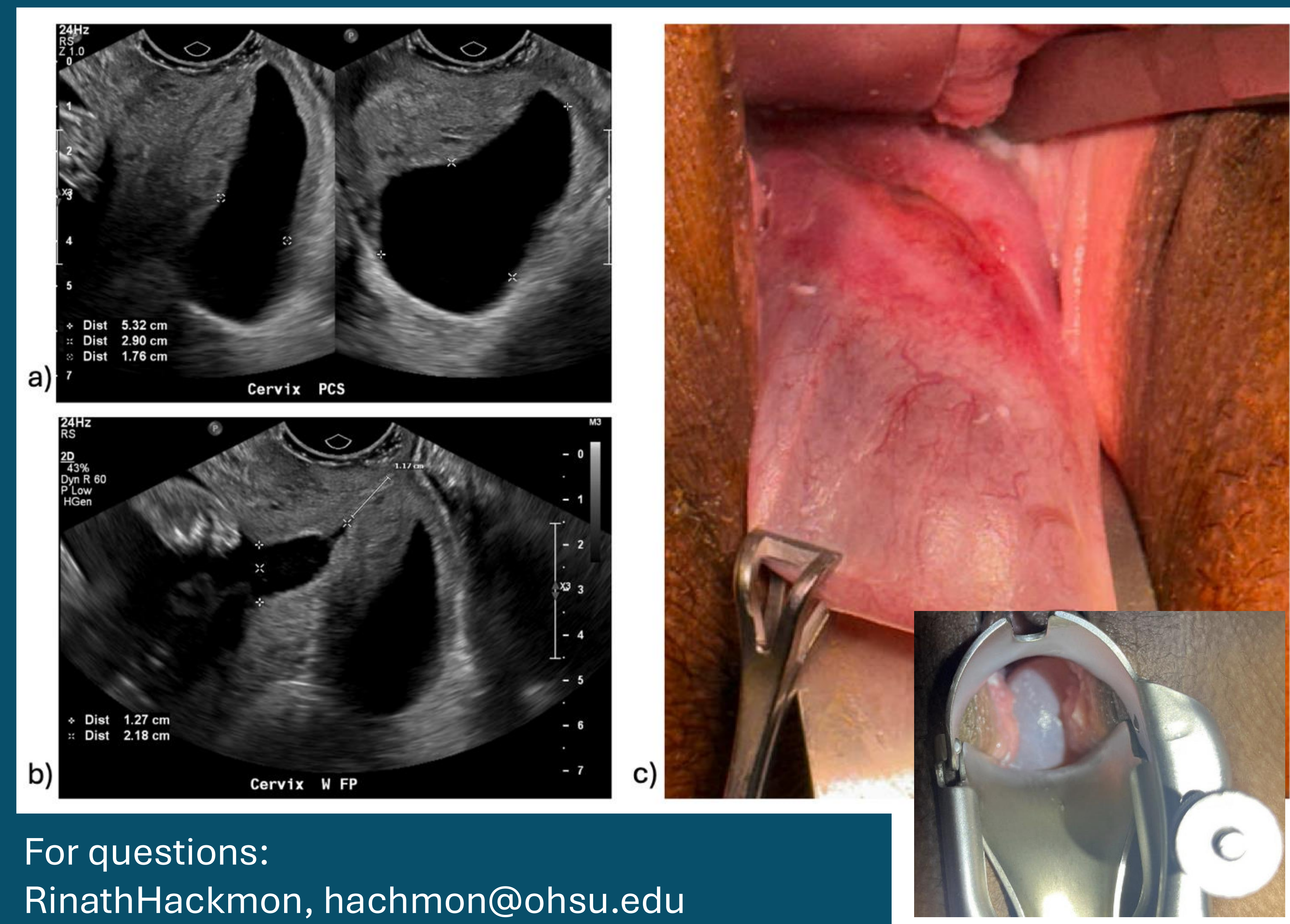


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Introduction

Large vaginal cysts first noted in pregnancy are uncommon and usually do not require intervention during pregnancy. However, there is a scarcity of published data on the association between large cysts and cervical insufficiency, characterized by a short cervix on transvaginal US (TVUS), and no studies have examined management strategies when a cerclage is indicated.

Figure 1a) Cyst dimensions. 1b) Cyst in relation to short cervix. 1c) Cyst originating from posterior lip of cervix. 1d & 1e) Cyst appearance on MRI.



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Case presentation

The patient is a 29-year-old G3P2002 presenting to a routine fetal anatomical survey at 20 weeks of gestation and found to have a posterior fornix cystic mass measuring 5.3 x 2.9 x 1.8cm and a short TVCL at 1.1 cm. The patient complained of a bulging cyst throughout the pregnancy with Valsalva, which resolved when lying down (Figure 1). Physical exam noted cervical dilation of 1cm, and a vaginal cyst appeared to be originating from the posterior cervix. Given the concern that cerclage placement would not be possible without penetrating the cyst of unknown origin and organs, such as the bowel or urinary tract, she was admitted to our hospital. She underwent further pre-operative imaging with pelvic MRI and urogynecology consultation. MRI findings were most consistent with Gartner's duct cyst (4.6 x 3.1 x 3.7cm). In the operating room, pelvic exam findings were notable for a 5cm fluid-filled vaginal cyst confluent with the posterior cervix and vagina with drainage of clear, serous-appearing fluid upon opening of the cyst wall. She underwent partial cyst wall resection and marsupialization of the cyst by the urogynecology team. A McDonald's cerclage was then placed using the standard technique by the MFM team. There were no apparent complications at the time of the procedure. The patient's cerclage was removed at 36 weeks of gestation, and she went on to have an uneventful spontaneous vaginal delivery at 39 weeks of gestation, without complications.

Conclusion

We present a unique case of a patient with a vaginal cyst and cervical insufficiency, requiring a multidisciplinary team who underwent MRI evaluation and successful marsupialization of the cyst with subsequent cerclage placement. She delivered at term via spontaneous vaginal delivery without complications. This finding was summarized as most likely Gartner cyst (Table 1), though further urogynecology follow-up and imaging are recommended.

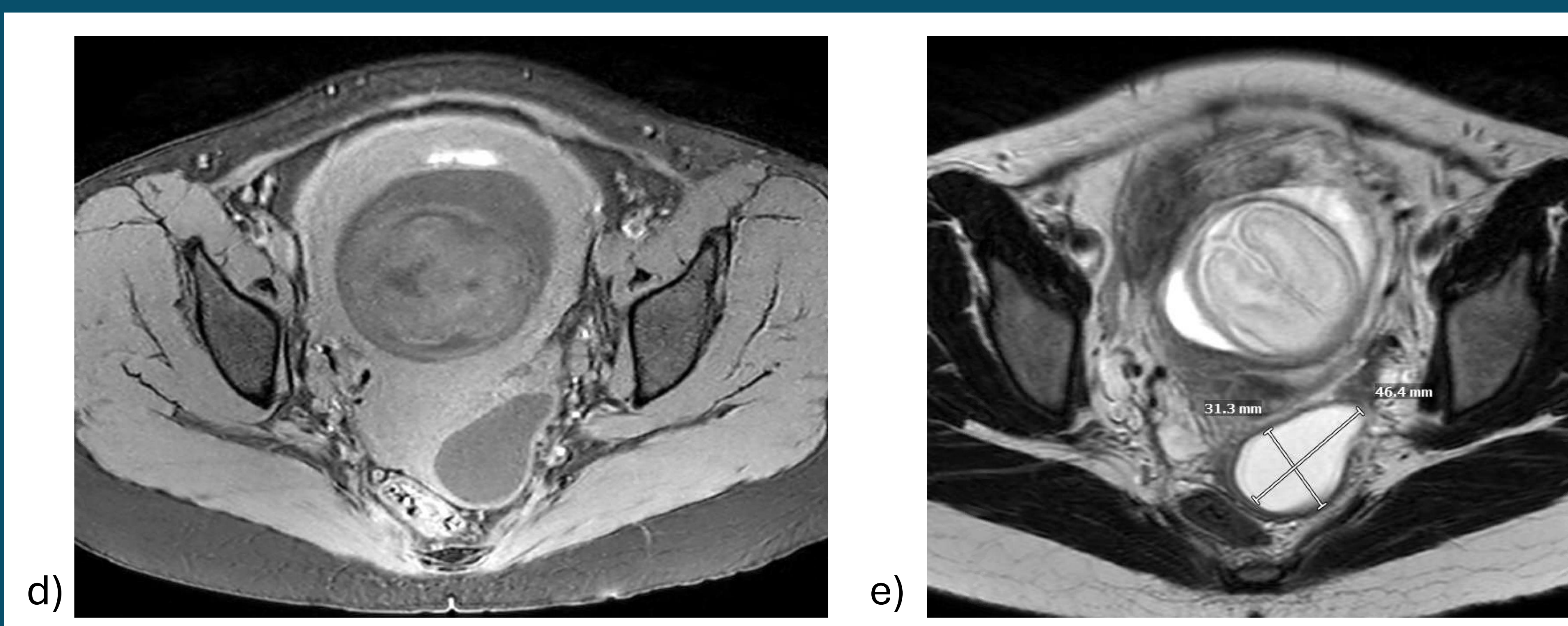


Table 1. Differential diagnosis for vaginal cyst during pregnancy

Mullerian duct cyst	Gartner duct cyst
Epidermal inclusion cyst	Bartholin duct cyst
Skene duct cyst	Nabothian cyst
Ureterocele	Urethral diverticulum
Rectal prolapse	