
**CYST OF THE SKENE’S GLAND: REPORT OF FOUR CASES AND BIBLIOGRAPHIC REVIEW**


Complejo Hospitalario Universitario La Coruña. Clínica Urológica Dr. Busto. La Coruña. Spain.

Summary.- OBJECTIVES: To show our experience with 4 cases of cysts of the Skene’s gland and a review of the published literature.

METHODS/RESULTS: Diagnosis and treatment of 4 cases of Skene’s gland cyst.

CONCLUSIONS: Skene’s gland cyst is a lesion that rarely is treated by Urologists, because it doesn’t usually have clinical repercussion, but when it’s derived to us we have to make a complete study of the urinary tract to exclude complications or different serious lesions. Surgery is the treatment of choice, making a complete excision of the lesion and repair of urethral injuries. All cases evolved well without recurrence or fistulous complications.

Keywords: Skene’s gland. Paraurethral glands. Skenitis. Cyst.

CORRESPONDENCE

Luis Busto Martín
Maestro Mateo 8, entr. izda.
La Coruña. (Spain)
lbm@urologiabusto.com

Accepted for publication: January 14th, 2010
Resumen.- OBJETIVOS: Presentar nuestra experiencia con cuatro casos de quistes de las glándulas de Skene de gran tamaño, realizar una revisión de la literatura publicada y conocer así los distintos diagnósticos diferenciales y el manejo a seguir.

MÉTODOS: Cuatro mujeres remitidas a nosotros desde su ginecólogo por presentar masas parauretrales refractarias a tratamiento conservador con posible afectación de la uretra distal.

CONCLUSIONES: El quiste de la glándula de Skene es una patología que raramente trata los urólogos debido a su escasa repercusión clínica pero cuando nos es remitida por los ginecólogos es importante realizar un estudio completo del aparato urinario para realizar así un diagnóstico diferencial certero que excluya patologías malignas o alteraciones del aparato urinario. El tratamiento de elección en los casos refractarios es quirúrgico, realizando una exéresis completa del quiste y reparando las posibles lesiones de la pared uretral. En todos los casos la evolución fue favorable sin presentar recidiva o complicaciones fistulosas.


INTRODUCTION

Skene’s gland’s, also known as periurethral glands or paraurethral feminine glands are small glands (usually 4) localized in the vagina’s dome, around the lower and distal edge of the urethra, and generally they pass unnoticed except in case of infection or obstruction. They drain in the external edge or the feminine urethra and they also lubricate it. They are considered to be the equivalent to the male prostate, being the main producers of “female PSA” and feminine eyaculation (1, 2). They are hormone-dependant, increasing their size during the pregnancy and atrophying during the menopause.

Paraurethral cysts from Skene’s glands are a very infrequent pathology, and sometimes it can appear since birth (1:2000-7000 live births) (3) being unnoticed most of the times, because they involve during the four first weeks, and presenting usually between 25 and 34 years old (4).

CASE REPORT

We present four patients 28, 31, 33 and 42 years old, one pregnant on her 26th week. Two consulted from dysuria during last 4 to 6 weeks, occasional dyspareunia and lately mass sensation located in the paraurethral area; the two left patients just came for the mass effect. All were sent to us by their gynecologist. Two of them previously to their gynecology practice had being treated by their MP with 875/125mg of Amoxicilline-Clavulana-

nate during one week, noticing an partial improvement of the clinic. We started a conservatory management with hygienic treatment, antibiotics and trying manual drainage with no success.

All were females sexually active, and neither they nor their partners reported any STD. None presented fever, diarrhea of weight loss.

Physical examination of all patients was totally anodyne, without inguinal nodes, lesions in external genitals or any vaginal secretion. In all we found a mass with variable sizes (between 1x1cm and 4, 1x4, 3 cm) with cystic aspect that compressed distal urethra. (Figures 1 and 2).

In all patients we made urine and vaginal secretion culture, being all negative for STD (N. Gonorrhoeae, Chlamydia...) and one having E. coli urine infection. We also ask in all cases for a retrograde urethrocystography (Figure 3) showing only in one case a small stenosis without clinic relevance. Urethra was integral in all cases and bladder was completely normal.

We started a conservatory management with hygienic treatment, antibiotics and trying manual drainage with no success.

We realized surgery using locoregional anesthesia, in two cases injecting methylene blue to distinguish the cysts, and in the other two cases with direct vision, placing in all an urethral catheter for conservative surgery and made a complete excision of the cysts with a Metzbaum scissor, with intraoperative opening in two cases which drained a purulent content (Figures 1, 2 and 3). We sent the specimens to the Department of Pathology and the containing to Microbiology. Results were cysts covered by a stratified squamous epithelium, with well formed basal lamina and prominent microvilli with browned-purulent content. Cultures were negative to STD.

Two patients stayed with a urethral catheter for one week to preserve urethral structure, because in two occasions the cysts were attached to the urethral wall and it was damaged during the surgery. After removing it and with a following period between 8 months and 4 years anyone presented any sign of recurrence or fistulous complications.

DISCUSSION

Skene’s gland disease are not usual, because in most of the cases they remain unnoticed, except when they present complications like obstruction or infection, in which they become inflamed and Skenitis shows up. This disease is usually diagnosed and treated by gynecologists, and only derived to the urologist when have a significant size that could compromise the urethra.
There are multiple causes that origin the cyst formation: mechanical traumatism, obstruction by strange body or repetitive infections that produce an increase of the diameter of the gland and ends ups forming a suburethral cyst or an abscess (1, 2).

Sometimes it communicates with the urethra. Symptoms are usually strange body sensation (100%), dysuria (78%), dyspareunia (26%), micturition difficulties (15%) and secretions.

Urethrocystoscopy and retrograde urethrocystographry (100% of sensibility) are needed explorations to discard communication between the urethra, the vagina and the bladder, and also to study the grade of obstruction (3, 4).

It’s important to make a differential diagnose with other masses of the anterior wall of the vagina as an urethrocele, an urethral diverticulum, Gardner’s cyst, epidermoid cyst, endometrial cyst and with urethral and paraurethral tumors (like adenocarcinomas, less than 0.003% of the total of genitourinary tract tumors in the female) (5, 6). For this we base in their localization and afterwards in their histology (7).

- Anterior vaginal wall: Gardner’s cyst (mesonephric rests), Mullerian cyst (paramesonephric rests).
- Anterior and posterior vaginal wall: urethrocele/ cystocele/ rectocele
- Distal urethra’s floor: Skene’s gland cyst.
- Posterior and lateral urethral wall: Urethral diverticulum.

We always have to think in the possibility of STD, as in gonorrhea this glands are usually affected. In this case the best treatment could be a single dose of 3º generation cephalosporine with 1 week of tetracyclines or azithromycin. Ciprofloxacin or ofloxacin in a single dose are also useful (3).
In newborns watchful waiting is recommended as this gland tends to decrease during the first 4 weeks and in most cases disappearing. In adolescents and adults when medical treatment is useless and mainly when cysts get big enough to produce symptoms, surgical excision seems to be the election treatment (7). We must avoid any urethral lesion (in 10% of the cases) and if it occurs the need of repairing it as soon as possible, leaving a urethral catheter during 1-2 weeks. Sometimes if it’s a small cyst a little incision and a complete drainage can be enough.

CONCLUSIONS

Clinic presentation of Skene’s gland cyst is something that an urologist doesn’t treat usually along his professional career, being probably an underestimated pathology caused by the different symptoms that usually are treated as urine infections with empiric antibiotics that solve the problem.

Only rarely, as we can notice in the small quantity of articles published in the literature, this pathology needs a surgical treatment, which if it is done with a urology complete examination, has really good results with little probabilities of recurrence and little complications.

If these are detected (10% distal urethral lesion) early reparation don’t worsen the outcome.

REFERENCES AND RECOMMENDED READINGS

(*of special interest, **of outstanding interest)