A Rare Case of Skene's Gland Abscess in Adolescence

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Background

Skene's glands are located on the distal urethral floor and homologs of the prostate gland, derived from the urogenital sinus. The incidence of skene cysts ranges from 1 in 2000-7000. There are few case reports for this under-recognised condition. As such, the gold-standard for clinical workup and management remains controversial.

Case

HISTORY

13yo girl

- 1/52 worsening vulval pain, left labial swelling, subjective fevers
- Denies discharge/bleeding/trauma/injury/shaving hx
- No nausea/vomiting/urinary/bowel symptoms

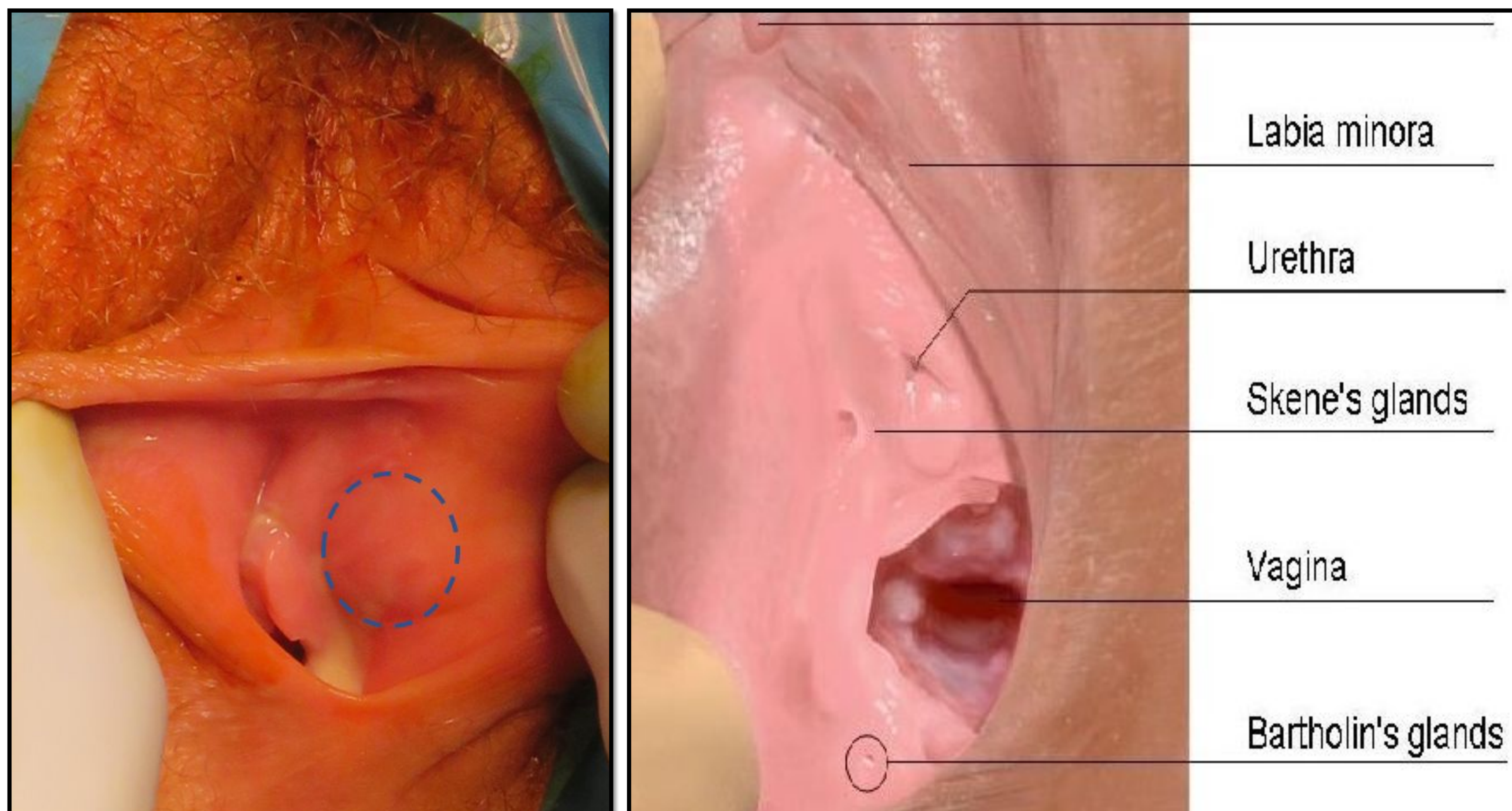
PMx: Nil. Wt 56kg.
SURGx: Marsupialisation of Left Bartholin's Cyst Dec '20
O&G: Menarche Oct '20, not sexually active

INVESTIGATIONS

- Hb 122 WCC 13 CRP 11
- Urine – no growth

EXAMINATION

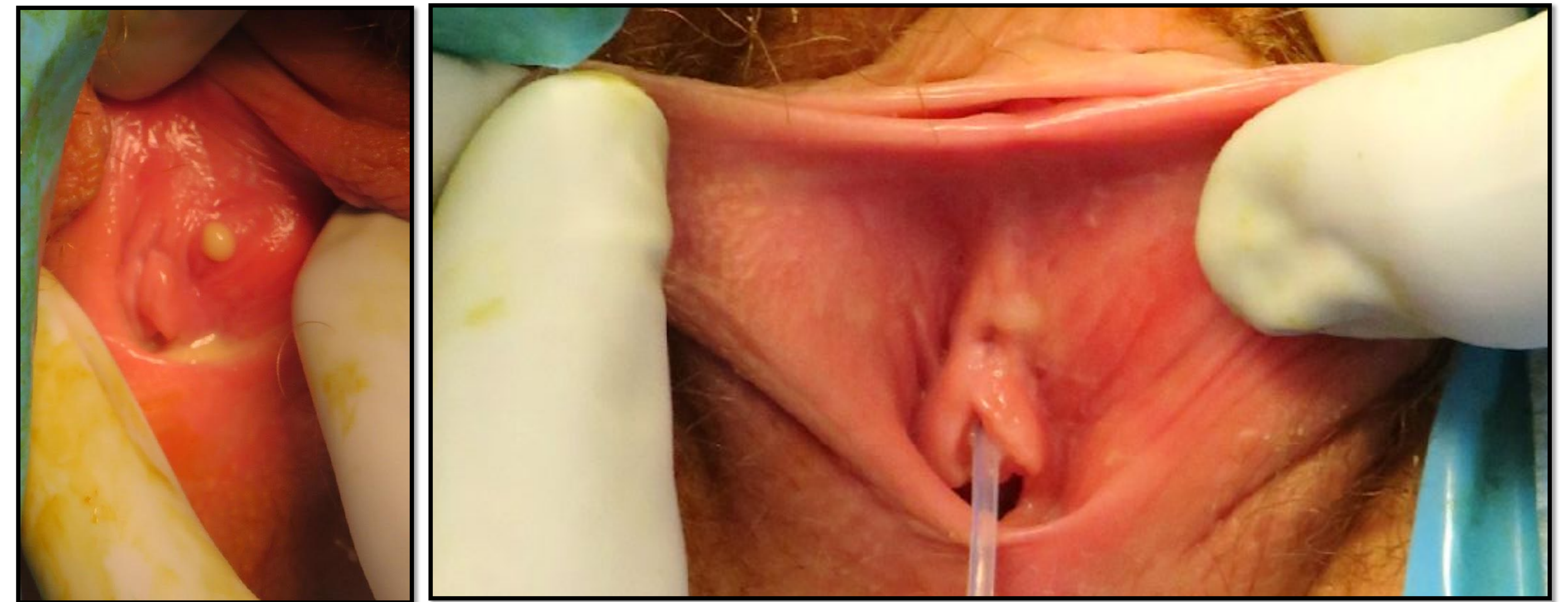
- 30mm ovoid cystic mass, left labial minora/majora swelling, oedematous, erythematous, tender



Case (*cont.*)

MANAGEMENT

- IV antibiotics
- Spontaneous rupture and drainage of pus from left anterior upper paraurethral abscess
- Vaginoscopy NAD, IDC inserted
- Discharged on day 2 post-op on PO antibiotics



- Swab – no growth
- Follow-up MRI – no paraurethral lesion, periurethral and peri-vaginal soft tissue within normal limits.
- Referred to Paediatric Adolescent Gynaecology

Discussion

Skene's glands were first discovered in 1880.
The aetiology of its cysts/abscesses remains unknown; hypotheses include oestrogen exposure, obstruction and inflammation of the duct, dislocation of the urothelium.[1]
Skene's glands secrete mucoid material with sexual stimulation.

Differential diagnoses for inter-labial masses in adolescent girls include the following:

- *Prolapsed ectopic ureterocele*
- *Prolapsed urethra*
- *Urethral diverticulum*
- *Bartholin's duct cyst*
- *Gartner duct cyst*
- *Urethral or vaginal neoplasm*
- *Periurethral fibrosis*
- *Epidermal inclusion cyst*

Patients with skene's gland abscesses may experience irritative urinary symptoms such as urgency, frequency, dysuria, obstructive voiding symptoms, or incontinence.[2]

Treatment options vary, depending on surgeon preference:

- *IV antibiotics alone (conservative management)*
- *Fine Needle Aspiration*
- *Surgical excision, incision & drainage*
- *Marsupialisation*

There is insufficient evidence to support one treatment option over another, however conservative management should always be considered first line.[3]

REFERENCES

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