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Identifying Risk Factors for Bartholin's Gland Cyst and Abscess Formation: A Retrospective Case Series

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ABSTRACT

Bartholin's glands are paired vestibular glands essential to vulvovaginal lubrication. Bartholin's gland cysts and abscesses (C&As) affect approximately 2% of females and are associated with significant pain, dyspareunia, and impaired quality of life. Recurrence rates approach 40%, yet risk factors and preventive strategies remain poorly defined. Although hormonal influences, sexual activity, and vaginal infections have been proposed as contributing factors, supporting evidence is limited. This study aims to identify behaviors that may promote C&A occurrence and recurrence through descriptive analysis of survey data. 132 participants with a history of C&A recruited through an online forum completed a 45-item electronic survey assessing demographics, potential exposures, and clinical characteristics. Out of 132 participants, 77.3% reported abscesses, and 93.2%, cysts. Median onset was 19-30 years. 15.2% had not engaged in intercourse before onset of their first C&A. 12.9% reported menstrual cup or disc use; 21.2%, vaginal delivery; 77.3%, hormonal birth control use. 32.6% reported abnormal PAP results, with 44.2% ASCUS, 48.8% HPV and 14.0% cervical intraepithelial neoplasia. 24.2% reported positive STI tests. 50% reported vaginal infections; 69.7%, UTIs. 49.6% routinely bathe after intercourse. 12.1% reported vaginal douching at least once. Abscess episodes ranged from 1–10. Findings should be interpreted cautiously given potential biases and study-design limitations. Bartholin's gland C&As remain underrepresented in literature despite high recurrence rates. Our findings underscore the multifactorial nature of disease development and highlight the need for wider-ranging studies to clearly define a risk profile and inform preventive strategies.

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Manuscript Introduction

The greater vestibular glands, also known as Bartholin's glands, are a pair of small glands located bilaterally at the vaginal introitus at the 4-5 and 7-8 o'clock positions, which measure approximately 0.5cm in diameter, and play a crucial role in sexual physiology [1-4]. Each gland's duct measures 2.0-2.5 cm and drains into the vestibule of the vagina [2,3]. Supported by the contraction of the bulbospongiosus muscle, the glands secrete alkaline fluid during sexual arousal, which facilitates lubrication [1-3].

Bartholin's gland cysts (BGC) are sac-like structures that develop when the ducts become obstructed, leading to the retention and subsequent accumulation of fluid within the glands [2,4]. A Bartholin's gland abscess (BGA) is a collection of pus caused by bacterial infection [2-4]. BGAs can present with significant discomfort, including vulvar pain while sitting, standing, or walking, and dyspareunia [1-4]. They may even progress to provoke systemic symptoms such as fever [1,3]. Symptom severity is correlated with the size and depth of the abscess, as swelling can provoke medial protrusion of the labia [3]. If left untreated, BGAs can lead to severe complications, including serious infection, sepsis, and rectovaginal fistulas [4].

The prevalence of Bartholin's gland cysts and abscesses (C&As) is estimated to be around 2%, with a reported recurrence rate of 38% as of 2024 [2-5]. These statistics are likely underestimations, as many patients are seen in Emergency Departments instead of OB-GYN clinics [5].

The proposed risk profile for C&As includes hormonal influences and sexual activity, where friction and microtrauma are theorized to contribute to glandular swelling and consequent obstruction [1-4]. Additionally, some literature has implicated Sexually Transmitted Infections (STIs) by *Neisseria gonorrhoeae* and *Chlamydia trachomatis* as causative pathogens, but was limited by statistically insignificant results [2,5-8]. Other studies have found opportunistic constituents of the vaginal microbiota in abscesses, most commonly *Escherichia coli* and *Staphylococcus aureus* [3,4]. However, all of these proposed associations remain insufficiently supported by evidence.

Management strategies vary and are guided by patient age, abscess size, severity of symptoms, and recurrence history [3]. Unfortunately, all available options are unable to prevent recurrence [1,4]. This causes further uncertainty in Emergency Department management of C&As, increasing disease burden [5].

Preventative measures might be key determinants since recurrence currently cannot be limited through treatment. However, despite

some advancements in microbial etiology, the risk profile for C&As remains uncertain. This study aims to identify behaviors that influence C&A's occurrence and recurrence through survey data collection.

Methods

This case series includes 132 participants with a history of at least one Bartholin's glands cyst or abscess. Participants were recruited through an online forum on reddit.com denoted "r/BartholinCyst" (subreddit) between 09/07/2024 to 12/01/2024. Eligibility criteria included a history of Bartholin's gland cysts or abscess. Disqualifying factors included no history of Bartholin's glands cyst or abscess. Data was collected using a survey administered electronically through Google Forms, consisting of 45 questions inquiring about demographic characteristics (age, height, weight), potential exposures (sexual activity, vaginal infection history), and clinical features (recurrence of cysts/abscesses, treatments used). Labeling to avoid answer duplication while maintaining anonymity was achieved by using first and last initials with two-digit birth month and birth year. (ex: AS1600) Participants were informed that their participation was both voluntary and anonymous; no identifiable information was collected. Participating in the survey implied consent. A full list of the survey questions is available in Figure 1. Data from open-ended questions has been omitted from this manuscript as it was not relevant to our primary objective. Data was analyzed using descriptive statistics to summarize counts, means, and percentages for categorical values. For follow-up questions requiring an answer to previous questions, percentages were calculated using the subgroup of participants who answered 'yes' as the denominator (instead of the total study population). No inferential statistical tests were conducted due to the descriptive nature of the study design.

Bartholin's gland cyst and abscess survey looking for correlations	Bartholin's gland cyst and abscess survey looking for correlations – continuation
1. How old are you? (<18, 18-21, 22-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80+)	29. Have you ever been diagnosed with a Urinary Tract Infection (UTI)? (Yes, more than 5 times; Yes, less than 5 times; Yes, only once; No)
2. What is your height in feet and inches?	30. How often do you get tested for Sexually Transmitted Infections (STI)? (I have never gotten tested for STIs, I have been tested in the past, but have not had a check-up in the past 5 years, After each new partner, Once a month, Once every 6 months, Once a year, More than 10 years ago)
3. What is your weight in pounds?	31. Have you ever been diagnosed with an Sexually Transmitted Disease (STD)? (Gonorrhea, Chlamydia, Herpes (HSV), Syphilis, HIV, HPV, No)
4. Please select your race/ethnicity? (American Indian or Alaska Native, Asian, Black or African American, Hispanic/Latino, Native Hawaiian or Other Pacific Islander, White, Unknown, Two or more)	32. Have you ever been diagnosed with a vaginal infection? (Yes, I do not remember which type; Yes, BV; Yes, candidiasis; Yes, trichomonas; No)
5. Where were your grandparents born? (City, State, Country) (open-ended question)	33. Have you ever had a Bartholin's Gland Cyst? (Non-painful lump) (Yes, No)
6. What do you do for a living? (student, job, athlete) (open-ended question)	34. Have you ever had a Bartholin's Gland Abscess? (painful, infected lump) (Yes, No)
7. Do you have any medical conditions? (open-ended question)	35. At what age did you get your first Bartholin's Gland Cyst/Abscess? (Before menstruation, 14-18, 19-24, 25-30, 31-35, Other)
8. Have you ever been diagnosed with Hidradenitis Suppurativa? (Yes, No)	36. At the moment of your first Bartholin's Gland Cyst/Abscess, had you already had penetrative vaginal sex before? (Yes, No, I don't know)
9. Do you get abscesses in other parts of your body besides your vagina? (Yes, No)	37. How many Bartholin's Gland Cyst/Abscess have you had?
10. Describe your menstrual cycles. (Every 25-32 day, Once every 2-3 months, Irregular, Menopause, No periods due to contraceptive use)	38. What treatments/remedies have you TRIED? Check all that apply (Topical Witch Hazel, Topical Tea Tree Oil, Topical PRID, Topical Manuka Honey, Topical Onion Slices, Oral Mucinex, Oral Silica, Oral Probiotics, Oral Horsetail, Hot Sitz Baths, Cold Sitz Baths, Incision & Drainage, Catheter placements, Marsupialization, CO2 laser, Gland Removal)
11. Describe your menstrual symptoms. Select all that apply. (Abdominal or pelvic cramping, Lower back pain, Bloating and sore breasts, Food cravings, Mood swings and irritability, Headaches, Fatigue)	39. What treatments/remedies have WORKED? Check all that apply (Topical Witch Hazel, Topical Tea Tree Oil, Topical PRID, Topical Manuka Honey, Topical Onion Slices, Oral Mucinex, Oral Silica, Oral Probiotics, Oral Horsetail, Hot Sitz Baths, Cold Sitz Baths, Incision & Drainage, Catheter placements, Marsupialization, CO2 laser, Gland Removal)
12. What menstrual products do you use? (Pads, Tampons, Cups, Discs, Period underwear, Other)	40. Do you notice any lymph node inflammation with your Bartholin Gland Cyst/Abscess? (Yes, No)
13. Do you perform vaginal douching? With what frequency? (Never, Once, Once a year, Once a month, Once a week, Daily)	41. Have you tried lymph drainage/cleanse for your Bartholin's Gland Cyst/Abscess? (Yes, No)
14. Do you CURRENTLY use any type of hormonal or barrier birth control? Select all that apply. (Progestrone Only Contraceptive Pill (POCP), Combined Oral Contraceptive Pills (COC), Implant (Nexplanon), Intrauterine Device (IUD), Depo Shot, Vaginal Ring, Transdermal Patch, Condoms, Diaphragm, Cervical Cap, No type of birth control)	42. History of first Bartholin's Gland Cyst/Abscess: internal/external, labia majora or minora, how did it develop, describe lesion (red, hot, painful, white head), evolution of lesion, how many days did it last, how did it resolve? (open-ended question)
15. Have you used any type of hormonal or barrier birth control IN THE PAST? Select all that apply. (Progestrone Only Contraceptive Pill (POCP), Combined Oral Contraceptive Pills (COC), Implant (Nexplanon), Intrauterine Device (IUD), Depo Shot, Vaginal Ring, Transdermal Patch, Condoms, Diaphragm, Cervical Cap, No type of birth control)	43. Describe any subsequent episodes and any history you want to add. (open-ended question)
16. How many sexual partners have you had total? (0, 1-2, 1-5, 5-10, 10-20, 20-30, 30-40, 40-50, More than 50, More than 100, I don't know)	44. Have you noticed any trend related to Bartholin's Gland Cyst/Abscess occurrence? (after vaginal sex, after beach/lake/river/pool day, with concomitant STI/UTI/BV infection) (open-ended question)
17. Are you sexually active? If so, how often do you have sexual activity? (No, Once a month, Less than 5 times a month, Less than 10 times a month, Over 15 days of the month, I don't know)	45. How would you describe sex before vs after your first Bartholin Gland Cyst/Abscess? (This does not mean sex during an active abscess, but could include during a non-infected cyst) (new need for lubrication, painful, etc) (open-ended question)
18. What type of sexual activity do you perform? (Not sexually active, Penetrative vaginal sex, Non-penetrative sex)	
19. Do you usually shower after sex? (Yes, immediately after; Yes, a few minutes after; No)	
20. How many pregnancies have you had total?	
21. How many times have you given birth total?	
22. How many miscarriages have you had total?	
23. Have you ever gone through In Vitro Fertilization (IVF)? (Yes, No, Other ART)	
24. Do you take estrogen/hormone replacement therapy (HRT/ERT)? (Yes, No)	
25. What type of underwear do you wear? (Cotton, Polyester, Thongs/G-strings, Bikinis, Hipster/Briefs, Boxers, I don't wear underwear, I don't know)	
26. How often do you get PAP smears (Papanicolaou test)? (Annually, Every 3 years, I have never gotten a PAP smear)	
27. Have you ever had an abnormal PAP smear result? (Yes, ASCUS; Yes, ASC-H; Yes, ASC-HIL, Yes, I don't know what the results were specifically; No)	
28. Have you ever been diagnosed with any cervical neoplasia? (CIN I, CIN II, CIN III, No)	

Figure 1: Survey consisting of 45 questions inquiring about demographic characteristics (age, height, weight), potential exposures (sexual activity, vaginal infection history), and clinical features (recurrence of cysts/abscesses, treatments used).

Results

Demographics

A total of 132 patients with C&As were included in the study. The mean age was 31.1 years (SD, 8.0 years). The modal BMI category was 18.6–24.9 (Healthy Weight), observed in 53.1% (69/132) of participants. The modal age range for the onset of Bartholin's gland C&A was 19-30 years old, observed in 66.7% (88/132) of participants.

Potential Exposures

Hormonal birth control use, including COCP, POCP, Nexaplon implant, transdermal patch, IUD, vaginal rings, and the Depo-Provera shot, was reported by 77.3% of participants (102/132), while 22.7% (30/132) have never used any form of hormonal birth control. Additional hormonal exposures included assistive reproductive technology procedures (ART) in 1.5% (2/132) of participants and hormone replacement therapy (HRT) in 3.0% (4/132) of participants.

Among respondents, 34.1% (45/132) reported having between one and five pregnancies; of those individuals, 60.0% (27/45) underwent a vaginal delivery.

Regarding menstrual products which are inserted into the vaginal canal, 53.8% (71/132) of participants reported the use of tampons; 9.1% (12/132), cups; and 3.8% (5/132), discs. As for vaginal douching, 12.1% (16/132) reported having engaged in vaginal douching at least once, while 87.9% (116/132) reported never engaging in vaginal douching.

Before the onset of their first C&A, 15.2% (20/132) of participants had never had penetrative vaginal intercourse. At the time of the survey, 5.3% (7/132) reported never engaging in sexual activity. Of the 125 who had, 8.8% (11/125) do not engage in penetrative vaginal intercourse.

Triennial PAP smear screening was reported by 40.9% (54/132) of participants, along with 18 abnormal PAP smear results (Table 1). Among those participants, 38.9% (7/18) recalled their cytology as ASCUS, 38.9% (7/18) had positive HPV results, 16.7% (3/18) had a diagnosis of cervical intraepithelial neoplasia II (CIN II), and 5.6% (1/18) had a diagnosis of cervical intraepithelial neoplasia III (CIN III).

Annual PAP smear screening was reported by 29.5% (39/132) of participants, along with 21 abnormal PAP smear results (Table 1). Among those participants, 47.6% (10/21) recalled their cytology as ASCUS, 57.1% (12/21) had positive HPV results, and 4.8% (1/21) had a diagnosis of CIN III. An additional CIN III diagnosis was found in the “once” PAP smear screening category 33.3% (1/3).

Table 1: Descriptive Analysis of Respondent’s Pap Smear Results Relating to Cytology, Hpv Positivity, and Cin Ii/Iii Diagnoses

PAP smear frequency	count	Abnormal results	ASCUS	(+) HPV	CIN II	CIN III
Quinquennial	3	2	1	0	0	0
Triennially	54	18	7	7	3	1
Annually	38	21	10	13	0	1
Once	4	2	1	1	0	1
Never	33	-	-	-	-	-
Totals	132	43	19	21	3	3

30.3% (40/132) of participants get tested for Sexually Transmitted Infections (STIs) “after every new partner”, and 28.0% (37/132) have never undergone STI testing. Out of the participants who had undergone STI testing at least once, 25.3% (24/95) reported a positive test result. These included 19 cases of Chlamydia trachomatis, 6 Trichomonas vaginalis, 6 Herpes Simplex Virus (HSV), and 1 Neisseria gonorrhoeae. Some of these positive results co-occurred in a single participant.

50% (66/132) reported a history of vaginal infections, divided as Gardnerella vaginalis (BV) only (47.0%; 31/66), Candida vaginitis (candidiasis) only (20.0%; 13/66), and both BV and candidiasis (33.3%; 22/66). Regarding hygiene practices, 49.6% (62/125) routinely bathe after engaging in sexual activity.

Urinary tract infections (UTIs) were reported in 30.3% as “never” (40/132), 17.4% as “once” (23/132), 28.8% as “occasionally” (38/132) and 23.5% as “frequently” (31/132).

Clinical Features Relating to Cysts or Abscesses

Of 132 participants, 93.2% (123/132) reported history of a BGC. Out of these, 24.4% (30/123) never had a BGA. Within this subgroup of participants who have had a cyst but not an abscess, 40% (12/30) reported abnormal PAP smear results, 30% (9/30) reported positive HPV results, and 10% (3/10) have a diagnosis of CIN II. Reported history of STIs include 16.7% Chlamydia trachomatis (5/30), 10% Trichomonas vaginalis (3/30), and 10% HSV (3/30). Reported history of vaginal infections include 46.7% BV (14/30), and 30% candidiasis (9/30). Frequent UTIs were reported in 30% (10/30), while 26.7% (8/30) reported “occasional” UTIs. The total occurrence rate for cysts ranges from 1 to 4, with a modal frequency of 1 occurrence.

In contrast, 77.3% (102/132) of participants reported a history of a BGA. Among these, 6.8% (9/132) never had a BGC. In this subgroup of participants who have had an abscess but not a cyst, 33.3% (3/9) reported abnormal PAP smear results, while no one reported positive HPV results or a diagnosis of CIN II/III. Reported STIs include 11.1 % Chlamydia trachomatis (1/9). Reported history of vaginal infections include 44.4% BV (4/9), and 22.2% candidiasis (2/9). History of frequent UTIs were reported by 11.1% (1/9). The total occurrence rate for abscesses ranged from 1 to 10, with a modal frequency of 2.5 occurrences.

Discussion

This study’s findings offer hypothesis-generating insights into patient-reported exposures, clinical characteristics, and outcomes related to Bartholin’s gland C&As.

Main findings

Prior studies established that C&As occur in reproductive age patients and implicate sexual activity, secondary to friction and microtrauma, as a risk factor [1-4]. However, a subset of our participants were not of reproductive age (i.e., before menarche and after menopause) on the onset of their first C&A. Others reported their first C&A occurring before engaging in penetrative vaginal intercourse. Although these only account for a handful of cases, they challenge the assumption that reproductive age and penetrative vaginal intercourse are necessary conditions for disease development.

Evaluating the theory that physical trauma could contribute to the development of C&As, our survey inquired about internal menstrual product use. Only a small number of participants reported use of

menstrual cups or discs. Although a majority reported tampon use, this cannot be correlated to C&A development because of low occurrence rates in tampon users in the general population.

Previous literature has also suggested that vaginal dysbiosis is implicated in C&A development [1,7,10]. Engaging in practices like vaginal douching can disrupt the vaginal pH balance and increase the risk of bacteria and yeast infections, and has therefore been implicated in C&A development [10]. Nonetheless, this practice was extremely uncommon among our participants, suggesting that it is unlikely to represent a primary driver in our cohort. Broader hygiene practices, including routine bathing after intercourse and underwear habits, did not demonstrate clear patterns suggestive of causality either.

Notably, a majority of participants reported a history of BV or candidiasis, and recurrent UTIs. Vaginitis was more common among participants with cysts without abscess, supporting the theory of a multifactorial etiology. While this may indicate shared susceptibility to glandular obstruction, the absence of vaginitis in half of participants, and the high baseline prevalence of these infections in the general population, limit causal interpretation.

While some STIs were observed in the results, primarily Chlamydia trachomatis, our results paralleled prior studies demonstrating low rates of *Neisseria gonorrhoeae* and Chlamydia trachomatis isolation from abscesses [2,5]. These organisms are likely an incidental finding rather than the primary pathogenesis responsible for C&A development, in comparison to prior suggestions that STIs may be causative agents of C&As [5,6]. Reports of HSV were also present in low quantities.

In attempting to find associations with hormonal influences, questions relating hormonal contraceptives, ART, HRT, and pregnancies were inquired. Over three-quarters of participants used various forms of hormonal contraception. However, the presence of C&A development across participants that do not use hormonal contraception limits conclusions. Participation in HRT and ART was minimal. One third reported prior pregnancies. Hormone influence data is insufficient to identify any protective or causative roles.

Abnormal cervical cytology (ASCUS), HPV positivity, and CIN were reported among some participants; however, no consistent pattern suggested a direct relationship between cervical dysplasia and C&A occurrence. These findings likely reflect overlapping population risk factors rather than shared pathophysiology.

Lastly, the presence of abscesses development without a preceding cyst challenges the dual-pathway model of disease development that states an obstruction (cyst) leads to infection of the gland (abscess). This is limited by self-reporting bias, as some participants may have had an asymptomatic cyst prior to developing an abscess.

Strengths and Limitations

Our patient-centered survey design allowed participants to express how C&As cause undue stress, increase health burden and significantly decrease their quality of life, issues which are not frequently explored in literature. Through this recruitment method, we were able to appreciate valuable insight into different perspectives which may have otherwise been hard to collect.

This study has several limitations that affect interpretation of its findings. The observational and descriptive design of this study

limits its internal validity. Participants were recruited from a defined subgroup during a specific timeframe and provided self-reported answers, introducing the potential for selection bias, recall bias, and information bias. Reporting may have been further influenced by the retrospective nature of questioning. Due to the lack of a control group, confounding variables cannot be accounted for; therefore, unmeasured factors could have also influenced results.

The external validity of this study is similarly limited by recruitment of participants from a single online forum and a relatively small sample size. Additionally, since participants were selected from a specific forum about C&As, this population may disproportionately represent patients with more mild or severe cases. This study population may also be an inaccurate representation of the general population. For example, some inquired exposures may not be applicable to some cultural or generational groups, and conversely, some exposures relevant to these subgroups may have been inadvertently omitted in this study.

Finally, random variation may have contributed to the observed distribution of results. Accordingly, these findings should be interpreted as descriptive and used to generate hypotheses rather than to infer causality.

Strengths and Limitations Compared to Other Studies

Although we have not found another case series reporting practices as extensive as ours, other manuscripts have attempted to establish causality through microbe populations, including commensal skin flora such as *Escherichia coli* and *Staphylococcus aureus*, and STIs such as *Neisseria gonorrhoeae* and Chlamydia trachomatis. Our study lacks culture-based microbiology or molecular pathogen identification and restricts our ability to define any microbial profile associated with disease episodes, limiting comparisons with studies that included direct microbial sampling [9].

Clinical Implication

In summary, no clinically significant correlation was found with C&A development and reproductive age, sexual activity, penetrative menstrual products, hygiene practices, underwear model or fabric, vaginal douching, vaginitis/vaginosis, UTIs, STIs, hormonal birth control, ART/HRT, obesity, abnormal PAP results, positive HPV results or CIN diagnoses. Collectively, these findings suggest a multi-factorial pathogenesis that may include intrinsic factors, such as ductal anatomy and unmeasured hormonal influences, combined with extrinsic triggers such as infection or microtrauma, to contribute to C&A formation in varying degrees across patients.

Notably, many participants reported not seeking medical care for subsequent abscesses, a factor that significantly impacts the reported recurrence rate of 38% across literature and highlights existing gaps between clinical data and real patient experience. This underscores the need for identifying causative factors, establishing a defined risk profile, and developing management strategies aimed at reducing recurrence rates.

Although generalizability is limited, this survey-based approach provides preliminary, hypothesis-generating data to inform future prospective studies with larger, more diverse cohorts and controlled variables.

Unanswered Questions and Future Research

Large-scale prospective studies with a diverse cohort and set control group are warranted to strengthen validity and improve

generalizability. Our data leads to two different focus points: microbiological confirmation in a large group and exploring possible changes in anatomy that may predispose to recurrence once a C&A has formed.

Conclusion

Bartholin's gland cysts and abscesses remain clinically significant yet comparatively understudied conditions with high recurrence rates, unclear risk profiles, and inconsistent management. Our findings challenge previously suggested causative factors, emphasize the multifactorial nature of disease development, and highlight the critical importance of listening to patients' perspectives. Future studies with larger, more diverse populations and standardized outcome measurements are needed to clearly define risk factors, refine management, and guide the development of preventive strategies.

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Contributors

JTM conceptualized the study, created the study design and survey, and collected and interpreted data. JTM and JF wrote and edited the manuscript, with JTM leading the draft. Both JTM and JF finalized the published version.

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Conflicts of Interest

All authors declare no conflicts of interest, whether financial, personal, political, intellectual, or religious.

Ethical Approval

No ethical approval was necessary for this study.

Data Sharing

Shared survey data is available in this manuscript. Labeling used is omitted to ensure anonymity without a shadow of a doubt.

Authors affirm that the manuscript is an honest, accurate, and transparent account of the study being reported, no important aspects of the study have been omitted, and any discrepancies from the study as planned have been explained.

The Use of Generative Artificial Intelligence (AI) was Not Included in any Part of This Study, Including but Not Limited to: Conceptualization, Survey Drafting, Manuscript Write-Up or Editing Process.

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