SPECIALIZED ULTRASOUND IN GYNECOLOGY & OBSTETRICS
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[redacted]

**ENDOMETRIOSIS ULTRASOUND:**

Our patient consented to a limited abdominal and full pelvic ultrasound examination using real-time transabdominal scan and transvaginal scan technique.

**INDICATION:** 29 F with endometriosis suspected on previous US, please provide designated endometriosis US.

**FINDINGS:**

**UTERUS:**

The uterus was well visualized, retroverted in orientation and size measuring 63 x 36 x 39 mm.

**Myometrium**: The myometrium appeared normal.

- **Adenomyosis**: Evaluation for adenomyosis revealed: Nil.
- **Fibroids**: Evaluation for fibroids revealed: Nil.
- **Congenital anomaly**: Nil.

**Endometrium**: Endometrial thickness measured: 9.5 mm. Endometrial cavity pathology: None.

**OVARIES/ADNEXA:**

**Right Ovary:** the right ovary appeared **abnormal** in appearance and echogenicity, measuring 54 x 35 x 50 mm. Volume 50.0 ml. There is a unilocular cystic lesion encompassing the entirety of the ovary with ground glass echogenic contents, smooth and thin walls, no solid components, and no abnormal Doppler vascularity. This is benign as per the IOTA Simple Rules. This is an endometrioma as per IOTA Easy Descriptors.

**Right Ovary Mobility:** Fixed inferiorly to the ipsilateral USL and medially to the uterus.

**Left Ovary:** the left ovary appeared **abnormal** in appearance and echogenicity, measuring 53 x 36 x 39 mm. Volume 38.5 ml. There is a unilocular cystic lesion measuring 32 x 29 x 37 mm with ground glass echogenic contents, smooth and thin walls, no solid components, and no abnormal Doppler vascularity. This is benign as per the IOTA Simple Rules. This is an endometrioma as per IOTA Easy Descriptors.

M. Leonardi, MD, PhD, FRCSC
Date of transcription: 01 Apr 2024
Signed


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There is another unilocular cystic lesion measuring 38 x 32 x 42 mm with some internal echoes (reticular/web-like), smooth and thin walls, no solid components, and no abnormal Doppler vascularity/with peripheral 'ring of fire'. Due to its persistence since February 2024, this may be consistent with a hemorrhagic endometrioma.

**Left Ovary Mobility:** Fixed inferiorly to the ipsilateral USL and laterally to the sidewall.

**Adnexa:** Normal bilaterally.

**ANTERIOR COMPARTMENT:**

**Bladder:** Normal with no evidence of deep endometriosis or other gross pathology.
**Ureters:** Normal bilaterally with no evidence of hydroureter.
**Kidneys:** Normal bilaterally.

**POSTERIOR COMPARTMENT:**

**Posterior vaginal fornix:** Normal with no evidence of deep endometriosis or other gross pathology.
**Rectovaginal septum:** Normal with no evidence of deep endometriosis or other gross pathology.
**Left uterosacral ligament:Abnormal** with evidence of deep endometriosis nodule measuring 10.0 x 10.4 x 4.3 mm.
**Right uterosacral ligament: Abnormal** with evidence of deep endometriosis nodule measuring 9.0 x 3.5 x 13.7 mm.
**Torus uterinus: Abnormal** with evidence of deep endometriosis nodule measuring 9.2 x 4.6 x 9.3 mm.

The USL nodules are continuous with each other creating a horseshoe lesion through the torus uterinus.

**Bowel:** Normal with no evidence of deep endometriosis or other gross pathology.

**Rectouterine pouch (cul de sac):** Normal with no evidence of deep endometriosis or other gross pathology.
Sliding sign: Positive. Triangle sign: Negative, representing an obliterated (i.e. **abnormal**) rectouterine pouch with preservation of the bowel.

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**Superficial endometriosis**: Evaluation for superficial endometriosis today was not aided by the presence of peritoneal fluid. We did not identify superficial endometriosis.

**IMPRESSION:**

Abnormal limited abdominal and full pelvic ultrasound today with main findings including severe endometriosis involving USL + torus uterinus, bilateral ovaries. Obliteration of the rectouterie pouch is noted.

During and following the ultrasound performed today, I provided real-time feedback regarding the ultrasound findings to the patient. I provided some basic information about the findings. I validated the patient's experiences. I advised them to follow up with you, their referring doctor, to discuss management strategies going forward. In the event surgery is desired/clinically relevant, referral to minimally invasive gynecologic surgeon is indicated.

It was a pleasure to be involved in their care. Thank you for the opportunity to contribute to your patient's diagnostic journey.

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