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Patient Name:	RRI078	**Accession Number:**	BR-4510005-MR
Patient ID:		**Requested Date:**	May 22, 2019 08:15
Gender:		**Report Status:**	Final
Date of Birth:		**Requested Procedure:**	4661360
Home Phone:		**Procedure Description:**	MRI PELVIS
Referring Physician:	WOOLCOCK, JANE	**Modality:**	MR
Organization:	North Adelaide		

Findings

Radiologist: JENKINS, MELISSA

MRI PELVIS

Summary :

57mm endometrioma associated with the left ovary. This abuts the sigmoid, however without convincing findings of bowel invasive disease.

No deep/infiltrating endometriotic deposit identified elsewhere.

Posterior JZ appearance is favoured to reflect persistent uterine contraction rather than adenomyosis.

15mm right anterior pedunculated fibroid.

Clinical:

Ultrasound shows 5.5cm endometrioma. Planned laparoscopy ? rectal nodule.

Technique:

Multi-parametric pelvic MRI fertility protocol including Volumetric 3D Coronal T2 plus reconstructions, T1 axial pre/post fat saturation.

No menstrual cycles, G0P0.

Findings:

Uterus:

Size & morphology: Anteverted uterus measures 76 x 49 x 65mm.

Endometrial thickness: 10mm thickness. No uterine lesion.

Junctional zone: There is persistent thickening at the junctional zone, which morphologically is favoured as uterine contraction rather than adenomyosis. This measures approximately 9mm. 5mm JZ thickness anteriorly, with thin JZ at the fundus.

Uterine lesions: 15mm subserosal/pedunculated anterior right fibroid. Non-degenerate/ non-suspicious. No submucosal lesion.

Cervix & vagina:

NAD.

Left ovary:

Position: Left adnexa.

Size: 76cc (5.1 x 5.3 x 5.4cm).

Follicle(s): Two tiny follicles lateral margin.

Lesions and/or endometrioma: Ovarian volume largely determined by 57cm high T1, low T2 structure consistent with endometrioma.

Right ovary:

Position: Right adnexa.

Size: 4cc (2.3 x 1.4 x 2.1cm).

Follicle(s): 12 follicles at 9mm or<.

Lesions and/or endometrioma: None identified.

Adnexa:

Sigmoid colon is seen to drape over the left endometrioma, which is in the posterior adnexa. Despite this there is no gross regional distortion or serosal thickening to support invasive disease.

Physiological small volume of fluid within the pouch of Douglas, without deep/infiltrating endometriotic deposit elsewhere. No gross effacement/ obliteration.

No hydrosalpinx.

Dr Melissa Jenkins **Dr Steven Knox**

Electronically signed 23/05/2019 08:33