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Patient Name:	RRI127	**Accession Number:**	BR-4891290-MR
Patient ID:		**Requested Date:**	February 7, 2020 09:07
Gender:		**Report Status:**	Final
Date of Birth:		**Requested Procedure:**	5098047
Home Phone:		**Procedure Description:**	MRI PELVIS
Referring Physician:	KNIGHT, PAUL	**Modality:**	MR
Organization:	City West		

Findings

Radiologist: KNOX, STEVEN

MRI PELVIS

Summary:

Deep obliterative posterior cul-de-sac endometriosis/ fibrosis. There is a dense plaque which is contiguous between the posterior uterine body/ fundus and the upper rectum. There is haemorrhagic signal seen deep to the muscularis propria within the rectal wall in this location which would reflect invasive mural involvement. It does not appear to extend to rectal mucosal surface. There is more lateral disease also present within the deep posterior cul-de-sac, slightly more prominent on the right.

Mild ovarian distortion and some nodularity/ thickening on the right uterosacral ligament. No further separate areas of significant bowel disease are identified. No hydrosalpinx.

Clinical:

Grade IV endometriosis. Pouch of Douglas adhesions. Surgical planning.

Technique:

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

Findings:

Uterus:

Size & morphology: Retroverted anteflexed at uterine body, retroflexed at uterine fundus. Distortion related to posterior cul-de-sac endometriosis/ fibrosis. Size: 91 x 40 x 56mm. Conventional uterine anatomy without septum or duplication.

Endometrial thickness: ET = 5mm. No endocavitary pathology.

Junctional zone: Small submucosal microcysts at left cornua supportive of regional superficial adenomyosis. There is no evidence of gross junctional zone expansion or adenomyoma formation. The functional zone measures 4mm anteriorly, 4mm at fundus and 5mm posteriorly.

Uterine lesions: No myometrial primary lesion. There is invasive serosal posterior uterine body endometriosis/ fibrosis.

Cervix & vagina:

No cervical or vaginal lesions of note.

Left ovary:

Position:&#0;Left adnexa tethered medially.

Size:&#0;24 x 8 x 10mm (1ml).

Follicle(s): small present.

Lesions and/or endometrioma: Elliptoid left ovarian or para ovarian endometrioma at 12mm.

Right ovary:

Position:&#0;Anterior/ lateral right adnexa.

Size:&#0;20 x 12 x 14mm (1.7mls).

Follicle(s): small present.

Lesions and/or endometrioma: Present. Two small endometriotic cysts at 9 and 6mm.

Adnexa: Deep posterior cul-de-sac central obliteration by endometriosis/ fibrosis. Multiple bands extend between the uterine serosa and the junction of the mid to upper rectum. This effaces the cul-de-sac.

There is absent regional physiologic fluid. The cul-de-sac is predominantly obliterated from the mid posterior uterine body level. There is a dense plaque seen measuring 21mm in craniocaudal length and to a thickness of 11mm between the posterior uterine body serosa and the upper rectum. The high resolution rectal images show this to penetrate the mesorectal fascia and obliterate the mesorectal fat. This marginates the upper rectal serosa with the dedicated axial views showing intramural hemorrhagic signal, supporting rectal wall invasion vs. superficial contact. It does not appear to extend to the mucosal surface. The dense plaque shows small punctate micro haemorrhagic activity although the dominant disease is dense old fibrosis.

There is a further band eccentric to the right of uterine serosa endometriosis which puckers the adjacent mesorectal fascia with multiple linear adhesions present. This has a thickness of around 5mm but spares the bowel in this location. There is some distortion to the right uterosacral ligament as a result of this.

No hydrosalpinx. No further bowel disease is identified.

Other findings:

Degenerate lower lumbar spine.

Dr Steven Knox **Dr Frank Voyvodic**

Electronically signed 11/02/2020 09:33