SPECIALIZED ULTRASOUND IN GYNECOLOGY & OBSTETRICS
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ADVANCED GYNECOLOGY ULTRASOUND (ENDOMETRIOSIS SONOGRAPHER-LED):

Our patient consented to a full pelvic ultrasound examination using real-time transabdominal scan and transvaginal scan technique. Due to the **indication of endometriosis on the requisition**, advanced dynamic techniques, including limited abdominal ultrasound, were performed.

INDICATION: Dysmenorrhea and menorrhagia. 6 months of AUB - likely secondary to Movisse, however, would like to r/o endometrial cause.

FINDINGS:

UTERUS:

The uterus was well visualized, anteverted in orientation and size measuring 75 x 65 x 53 mm. Volume 134 ml. The cervix measures 36 mm in length.

Myometrium: The myometrium appeared **abnormal**.

- **Adenomyosis**: Evaluation for adenomyosis revealed:
  Present. The following MUSA (Morphologic Uterine Sonographic Assessment) group features are identified:

1. Asymmetrical thickening
2. Echogenic sub-endometrial lines and buds
3. Fan-shaped shadowing
4. Irregular junctional zone

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

Endometrium: Endometrial thickness measured: 5.5 mm. Endometrial cavity pathology: None.

OVARIES/ADNEXA:

Right Ovary: the right ovary appeared normal in appearance and echogenicity, measuring 21 x 25 x 16 mm. Volume 4.3 ml.
Right Ovary Mobility: Mobility is difficult to assess due to the high position of the ovary in the pelvis. Some mobility with transducer pressure is noted.

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Date of transcription: 18 Dec 2024
Signed

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Left Ovary: the left ovary appeared **abnormal** in appearance and echogenicity, measuring 70 x 70 x 65 mm. Volume 166 ml. There is a cystic lesion measuring 66 x 62 x 58 mm with anechoic contents, cyst-within-a-cyst appearance (i.e multilocular two locules), smooth and thin walls, no solid components, and no abnormal Doppler vascularity. This is benign as per IOTA Simple Rules.
Left Ovary Mobility: Mobile

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: No hydronephrosis 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 measuring 14.4 x 3.2 x 16.2 mm.
Right uterosacral ligament: ****Abnormal** with evidence of deep endometriosis measuring 10.0 x 4.0 x 8.8 mm. Possible adherence of the rectum to this region. The patient experienced tenderness with transducer pressure.
Torus uterinus: Normal with no evidence of deep endometriosis or other gross pathology.

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

Rectouterine pouch (cul de sac): Sliding sign: Positive, representing a non-obliterated (i.e. normal) rectouterine pouch. Some resistance to sliding is noted at the level of the cervix - ? due to presence of large left ovary in the rectouterine space?

Superficial endometriosis: Evaluation for superficial endometriosis today was *somewhat* aided by the presence of peritoneal fluid. We did not identify superficial endometriosis. It is important to note that the absence of superficial endometriosis does not rule out superficial endometriosis.

IMPRESSION:

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Abnormal limited abdominal and full pelvic ultrasound today.

Findings include:

- Features of adenomyosis.
- Deep endometriosis of the uterosacral ligaments.
- Left ovarian cyst, benign. Repeat scan in 3 months recommended as this will likely reoslve - likely follicular.

Today's ultrasound was a **sonographer-led endometriosis ultrasound**. Whilst endometriosis was identified, we are still at the infancy of sonographer-led endometriosis ultrasound. If surgery is going to be considered for this patient, I would recommend a **sonologist-led endometriosis ultrasound** to ensure optimal accuracy, enhancing surgical outcomes, particularly for the domains of bowel/bladder/ureter endometriosis and severe endometriosis-associated adhesions.

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