# ENDOMETRIOSIS PELVIC MRI ASSESSMENT > BR PROFORMA REPORT BLIND REVIEW

#### Uterus

1:

Absent

Present

### **Uterine** anatomy

Conventional

- Arcuate
- Septate
  - Full septum
  - b. Subseptate
- Bicornuate unicollis
- Bicornuate bicollis
- Didelphys
- Other (free text enabled).

## Uterine Lie (can be more than one selection)

- Anteverted
- Anteflexed
- Retroverted
- Retroflexed
- Axial
- Others (please specify) (Free text enabled)

Uterine Size (body + cervix - 3 planes in mm )

1. (Free text).

69 x 47 x 37 mm

### Endometrial thickness (sag plane in mm to nearest mm)

1. (Free text)

#### **Endometrial lesions**

Not identified.

2. Present. Polyp.

2b-1: No. of polyps (free text)

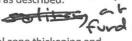
2b-2: Size of each polyp. (free text)

## Adenomyosis

1. No MRI supportive features

Supportive MRI features as described:

Submucosal cysts



2. Abnormal junctional zone thickening and measurement

Anterior (mm)

Fundal (mm)

Posterior (mm)

## Presence of an adenomyoma

## **Fibroids**

1:

No Yes

2b:

Number of fibroids: 2a:

Largest fibroids (location and size mm all

fibroids >10mm and/or impact on the cavity) - (Free text)

2h: Submucosal fibroids

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2b-1: Yes

2b-1-1: (description: free text)

## Left ovary

Absent (Branching logic - move to "Right ovary") 1:

Present

## Left ovary size (3 planes and volume)

1. NN x NN x NN mm 52 x 47 x 57 h

2. Volume (above x 0.52).

72.9ec

## Left ovary follicle measurements and count

1. N follicles between 2 and 9 mm in diameter

a. (Free text)

2. N follicles > 9 mm

a. (Free text)

10 25 na

3. Dominant follicle

b. N.

Left overy postton

2: High positioning in iliac fossa.

Tethered/ distorted appearances - (may be 3:

multiple options)

3a: Intimate relationship to the lateral uterus

3b Intimate relationship/tethering to adjacent bowel.

3c. Tethering to pelvic sidewall

3d:Tethering to the uterosacral ligament

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зе:

Other: (free text)

## Left ovarian endometrioma

No\_> 1:

Yes

1a: Size: NN in millimetres (mm)

> T2 shading (intermediate/low 1b: homogeneous T2 signal).

1b-0: No

1b-1: Yes

1c: T1 fat sat hyperintense

> 1c-0: Absent

1c-1: Present

1d: Internal nodularity, septation or other complexity.

> 1d-1: No

1d-2: Yes

1-d-2-1: (Free text)

## Left ovarian lesions/cysts other than suspected endometriomas

- 1: Not classifiable
- 2: Lesion features

2a: Unilocular cyst

38 mn Unilocular-solid cyst

2c: Multilocular cyst

2d: Multilocular-solid cyst

2e: Solid

3: Vascularity (post gadolinium enhancement).

> 3a: Present

3b: Absent

Fat component (T1/T2 hyperintense. Low signal on fat suppression).

4a: Present. 4b: Absent.

## Right ovary

Absent (Branching logic – move to "Adnexa")

2: Present

## Right ovary size (3 planes and volume)

1. NN×NN×NN mm 42 - 42 x 43 --

2. Volume (above x 0.52). 39.76

## Right ovary follicle measurements and count

- 1. N follicles between 2 and 9 mm in diameter
  - a. (Free text)
- 2. N follicles > 9 mm
  - a. (Free text)
- Dominant follicle



## Right ovary position

- 1: Lateral adnexa, Unremarkable,
- 2: High positioning in iliac fossa.
- 3: Tethered/distorted appearances - may be multiple options.

3a: Intimate relationship to the lateral uterus

3b Intimate relationship/ tethering to

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adiacent bowel.

- 3c. Tethering to pelvic sidewall
- 3d: Tethering to the uterosacral ligament

## Right ovarian endometrioma

2a:

1: No 2: Yes >

Size: NN in millimetres (mm)

2b: T2 shading (intermediate/low homogeneous T2 signal).

> 2b-0: No Yes 2b-1:

T1 fat sat hyperintense 2c:

> 2c-0: Absent Present 2c-1:

Internal nodularity, septation, complex. 2d:

> 2d-1: No 2d-2: Yes

## Right ovarian lesions/cysts other than suspected

# endometriomas

Not classifiable Lesion features

> 2a: Unilocular cyst

Unilocular-solid cyst 2b:

2c: Multilocular cyst

2d: Multilocular-solid cyst

2e: Solid

3: Vascularity (post gadolinium enhancement).

> 3a: Present

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3b:

Absent

4 Fat component (T1/T2 hyperintense. Low signal on fat suppression).

4a:

Present.

4b: Absent.

## Adnexa

1: Hydrosalpinx



2:

Hematosalpinx



3: Other (free text).

## Are both ovaries immediately approximated "kissing"?

1: No

## Urinary bladder nodule

Definition: Is there presence of a nodule in the bladder.

1: Absent
2: Present

2a:

Size: NN in millimetres (mm)

## **Uterovesical region**

Definition: Assessment of whether there is a visible preserved fat plane +/- physiologic fluid +/- absent distortion between the anterior uterine serosa and bladder.

1: Normal.

2: Abnormal.

2a: (free text if required)

# Ureteric nodule(s)?

1: Absent

2: Present

2a: Location (free text + distance to ureteric

orifice/ VUJ)

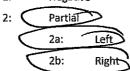
2b: Size (mm)

#### Pouch of Douglas obliteration

Definition: Assessment for abnormal loss of fat plane +/physiologic fluid and immediate approximation of
rectosigmoid and/or small bowel to the posterior uterine
serosa, cervix +/- vaginal wall.

Discrete linear bands may be visible ( $\sqrt{T1}$ ,  $\sqrt{T2}$ )

1: Negative



3: Complete

3a: Positive = obliteration.

3b: Positive = band adhesions.

## Nodules present on the posterior vaginal fornix?

Definition: Thickening of superior 1/3 of posterior vaginal wall +/- nodularity. Nodules: ↓ T2 ↑T1 (if active haemorrhagic deposits)

1: \_\_\_\_\_\_

2: Yes

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millimetres (mm).

Dimension of nodule to be measured in

2b1: Inactive.

2b2: Active

## Vaginal forniceal elevation?

Definition: Upper level of fornix on sagittal view is superior to the angle of the uterine isthmus with stretching of vaginal wall, and/or acute angulation of the fornix.

1: No Yes

2a: Left.

2b: Right

2c: Left and Right.

## Rectovaginal nodules present?

Definition: Presence of deep infiltrating endometriosis in the anterior rectal wall and posterior vaginal fornix, located below the peritoneum of the Pouch of Douglas. Inactive/ fibrotic disease characterised as  $\downarrow$  T1  $\downarrow$  T2 signal.

Active disease as 171, 1 to intermediate- T2 signal (hemorrhagic/ proteinaceous content + glandular deposits).

1: No

2a: Size (mm)

2b1: Inactive.

2b2: Active

Uterosacral ligament nodules or thickening?

Definition: Inactive/fibrotic disease nodules characterised as ↓ T1 ↓ T2 signal.

Active disease as ↑T1, ↑ to intermediate- T2 signal (hemorrhagic/proteinaceous content + glandular deposits).

1: No

2: Yes nodules 2a:

2b:

2a-1:

Right

Inactive

Active

Left

Size (mm) 2b-1:

Size (mm)

3:

Yes thickening.

Left. 3a: 3b: Right

> 3c: Both.

## Retrocervical nodule present?

Definition: Inactive/fibrotic disease characterised as \$\sqrt{T1}\$ ↓ T2 signal.

Active disease as 个T1, 个 to intermediate- T2 signal (hemorrhagic/proteinacous content + glandular deposits).

1: No

2:

2b2

2a: Size (mm)

2b1: Inactive.

Active.

Rectum and colon:

Is there bowel deep infiltrating endometriosis seen?

Definition: Inactive/ fibrotic disease characterised as \$\rightarrow\$ T1 ↓ T2 signal.

Active disease as ↑T1, ↑ to intermediate- T2 signal

(hemorrhagic/ proteinacous content + glandular deposits).

"Mushroom cap sign" is specific to severe invasive bowel endometriosis and is characterized as a plaque with  $\downarrow$  T2 at

its 'base' and 1 T2 at its 'cap'.

1: No 2: Yes

2c:

2a: Distance from the anal verge

Length (mm)

140 m

2b: Lesion type

> 2b-1: Isolated lesion

26-2: Multiple lesions

2b-3: Curved lesion

Straight lesion 2b-4:

Maximal depth layer of invasion each

leasion (muscularis, submucosa,

mucosa).

Lesion 1; (free text)

Lesion 2 (free text) - delete if (2c-2:

not relevant

(2c-3 etc.)

Is it stuck to any structures or free lying?

2d-1: Vagina

Uterus" 2d-2:

Uterosacral ligaments

rerrearvice nedule, full thickness

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2d-4: Ovary

FV

2d: Plaque thickness

2a: 1-5mm.

2b: 6-10mm.

2c: >11mm.

2e: Activity

> 2f1: Inactive.

Active.

2f: "Mushroom cap" appearance:

> 2g1: Present.

Absent.

Is there evidence of tethering of the bowel?

1: No

Yes, tethered to

Uterus 2a: 2b: L. ovary

2c: R. ovary

L. uterosacral ligament nodule 2d:

R. uterosacral ligament nodule 2e:

2f: L pelvic side wall.

2g: R pelvic side wall.

2h: Other.

Any other salient findings on the study:

2. Yes

a. (Free text).

Scan Photo/ Email: kate.cook@bensonradiology.com.au

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