

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: Pelvic pain NYD. ? endometriosis but onset was very sudden. Treated for PID with ongoing pelvic pain/burning symptoms entire pelvis.

CLINICAL INFORMATION: Patient complains of severe back pain with periods. Majority of painful symptoms occur around ovulation. The patient feels a fluctuant mass in the RLQ, most prominent at ovulation. The patient has also been told on previous ultrasounds that ovaries have a polycystic appearance. Patient states blood work has been normal.

Re: indication of PID - the patient states antibiotic treatment was given, but diagnosis of PID was not conclusively proven. STI panel was negative per patient. No history of pelvic surgery.

FINDINGS:**UTERUS:**

The uterus was well visualized, anteverted in orientation and size measuring 85 x 47 x 31 mm. Volume 64 ml.

Myometrium: The myometrium appeared normal.

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

Endometrium: Endometrial thickness measured: 5.8 mm. Endometrial cavity pathology: None.

OVARIES/ADNEXA:

Right Ovary: the right ovary appeared normal in appearance and echogenicity, measuring 32 x 18 x 20 mm. Volume 6.0 ml.

Right Ovary Mobility: Mobile

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Date of transcription: 18 Jul 2024
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Left Ovary: the left ovary appeared normal in appearance and echogenicity, measuring 30 x 25 x 20 mm. Volume 7.6 ml.

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

Right uterosacral ligament: Normal with no evidence of deep endometriosis or other gross pathology.

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-obiterated (i.e. normal) rectouterine pouch.

Superficial endometriosis: Evaluation for superficial endometriosis today was not 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:

Normal limited abdominal and full pelvic ultrasound today. A limited assessment of the RLQ for palpable mass was performed, although at this stage of cycle patient cannot palpate. There is no obvious mass or sign of inflammation in the RLQ. No lymphadenopathy is noted.

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No evidence of deep or ovarian endometriosis or endometriosis-associated adhesions. While we can safely rule these out based on evidence-based diagnostic test accuracy studies, it is important to note that the absence of superficial endometriosis does not rule out superficial endometriosis.

It is important to note that a normal ultrasound does not signify the patient is normal; rather, it simply means we have not visualized anatomical abnormalities in the structures evaluated on today's ultrasound.

Today's ultrasound was a **sonographer-led endometriosis ultrasound**. Whilst we did not identify endometriosis, 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, even though these were not identified today.

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