SPECIALIZED ULTRASOUND IN GYNECOLOGY & OBSTETRICS
200 JAMES ST. SOUTH, SUITE 305 HAMILTON, ON L8P 3A9 | PHONE: (905) 522-2220
FAX: (905) 522-2280 | WWW.SUGOCLINIC.COM

[redacted]

PELVIC ULTRASOUND

INDICATION: Dysmenorrhea, for 1.5 years. Associated with presyncope, nausea, vomiting.

LMP: 19-Aug-2024

RELEVANT CLINICAL HISTORY: No

Our patient consented to a complete pelvic ultrasound examination using real-time transabdominal and transvaginal ultrasound.

UTERUS: Normal. The uterus was well visualized.

Measurements: 60 x 48 x 41 mm; Volume: 61.5 ml.

Orientation: Retroverted

Adenomyosis: Evaluation for adenomyosis revealed: Nil.

Fibroids: No fibroids are visualized

Congenital anomaly: No

Endometrium:
Thickness 5.9mm. Endometrial pathology:

OVARIES/ADNEXA:

Right Ovary: Normal
was adequately visualized and measured 30 x 19 x 19 mm; Volume: 5.8 ml.

Left Ovary: Normal
was well visualized and measured 31 x 25 x 15 mm; Volume: 6.2 ml.
Multifollicular

Adnexa: Abnormal
Right paratubal cyst noted

M. Leonardi, MD, PhD, FRCSC
Date of transcription: 30 Aug 2024

Sonographer: L. Yu

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FREE FLUID: Absent
ANTERIOR COMPARTMENT:

Bladder: Normal with no evidence of deep endometriosis or other gross pathology.
Ureters: Normal bilaterally with no evidence of hydroureter.

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-obliterated (i.e. normal) rectouterine pouch.
Triangle sign: Negative.

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:
Overall normal complete pelvic ultrasound today.

There is a benign right paratubal cyst of no clinical significance.

Though no endometriosis was noted, there was one suspicious area on the review of images in the right uterosacral ligament region, worth of reassessment. This would IDEALLY be planned for post-ovulation

As per the latest guidelines on the assessment of PCOS, ultrasound is *no* longer appropriate to use in adolescent individuals to assess the ovaries for follicle number or volume. Today's patient falls into this adolescent period (within 8 years of menarche), so the appearance of their ovaries is irrelevant to the potential PCOS diagnosis. PCOS may still be diagnosed using the other criteria. If there is ongoing concern for PCOS beyond adolescents or in the case of multifollicular appearing ovaries today, a repeat scan can be considered then.

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Please see:
Recommendations from the 2023 International Evidence-based Guideline for the Assessment and Management of Polycystic Ovary Syndrome
DOI: 10.1016/j.fertnstert.2023.07.025

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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