ENDOMETRIOSIS PELVIC MRI ASSESSMENT -BR PROPORIVIA REPORT BLIND REVIEW

Uterus

Present Absent

Uterine anatomy

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

Uterine Lie (can be more than one selection)

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

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

mm SS x09 x 8t

Endometrial thickness (sag plane in mm to nearest mm)

(Free text)

Zmy

Endometrial lesions

- Not identified
- Present, Polyp.
- No. of polyps (free text)
- 2b-2: Size of each polyp. (free text)

- No MRI supportive features
- Submucosal cysts.
- Abnormal junctional zone thickening and
- measurement

Presence of an adenomyoma

- No

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

- Supportive MRI features as described:

- Anterior (mm)
- Fundal (mm)
- Posterior (mm

- Yes

Fibroids

- Number of fibroids:

N

Largest fibroids (location and size mm all

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

Left ovary

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

Present

Left ovary size (3 planes and volume)

- NNXNNXNNmm 30 x 15 x 23 mm
- Volume (above x 0.52).

Left ovary follicle measurements and count

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



Left ovary position

- Lateral adnexa. Unremarkable.
- High positioning in Iliac fossa.
- multiple options) Tethered/ distorted appearances - (may be

3a: Intimate relationship to the lateral uterus

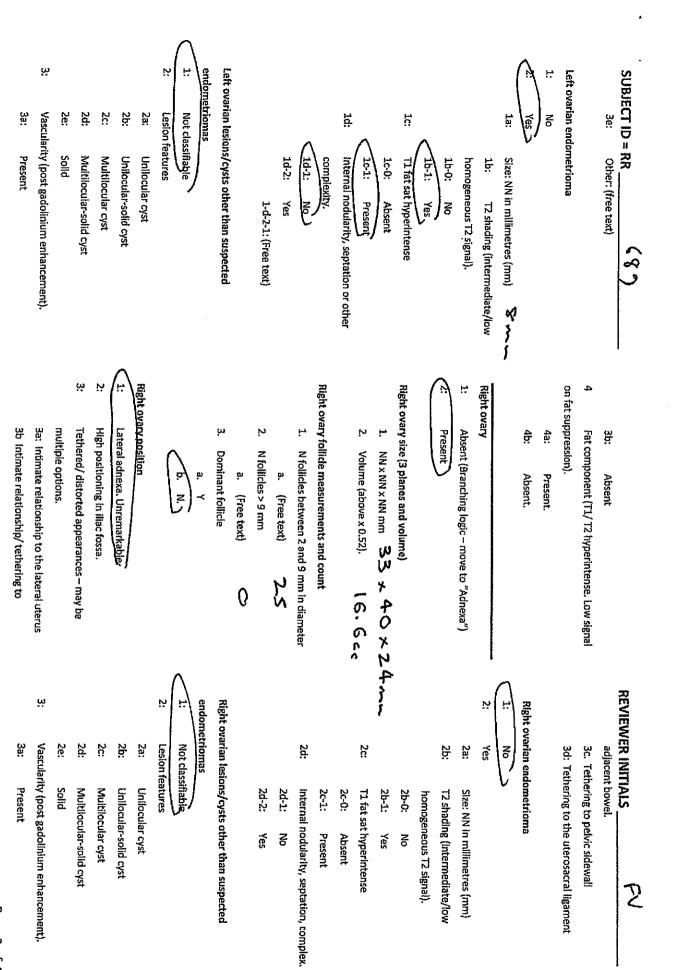
3b Intimate relationship/ tethering to adjacent

3c. Tethering to pelvic sidewall

3d:Tethering to the uterosacral ligament

Page 1 of 4

A3mu subserval > Joi. intramural paskin bods



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

Present.

4 Absent.

Adnexa

Hydrosalpinx 8

Hematosalpinx

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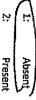
ψ Other (free text).

Are both ovaries immediately approximated "kissing"?



Urinary bladder nodule

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



5 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.

Normal.

- Ņ Abnormal.
- 2

Absent

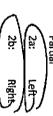
- Present
- orifice/VUJ)
- 26: Size (mm)

Pouch of Douglas obliteration

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

Discrete linear bands may be visible ($\sqrt{11}$, $\sqrt{12}$)

Negative



Complete

'n

- ä
- 끍 Positive = band adhesions.

Nodules present on the posterior vaginal fornix?

wall +/- nodularity. Nodules: ↓ T2 个T1 (if active haemorrhagic deposits)

(free text if required)

Ureteric nodule(s)

- Location (free text + distance to ureteric

- Ņ Partial
- Positive = obliteration.

Definition: Thickening of superior 1/3 of posterior vaginal

ĕ 2a:

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Dimension of nodule to be measured in

Z

millimetres (mm).

2b1: Active fnactive.

Vaginal forniceal elevation?

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



2a: Left,

2b: Right

2c: Left and Right.

Rectovaginal nodules present?

fibrotic disease characterised as \downarrow T1 \downarrow T2 signal. the anterior rectal wall and posterior vaginal fornix, located Active disease as \uparrow T1, \uparrow to intermediate- T2 signal below the peritoneum of the Pouch of Douglas, inactive/ Definition: Presence of deep infiltrating endometriosis in (hemorrhagic/proteinaceous content + glandular deposits).

- 20
- Size (mm
- 2b1: Inactive.
- Active

Uterosacral ligament nodules or thickening?

Definition: Inactive/fibrotic disease nodules characterised

as ↓ T1 ↓ T2 signal.

Active disease as \T1, \T to Intermediate- T2 signal

(hemorrhagic/ proteinaceous content + glandular deposits).

8

Yes nodules

2a: Left

2a-1: Size (mm)

25 Right

25-1: Size (mm)

2c1: Inactive.

ដ Active

Yes thickening.

ώ

a Left.

쁈 Right

35 Both.

Retrocervical nodule present?

Definition: Inactive/ fibrotic disease characterised as ↓ T1

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

(hemorrhagic/ proteinacous content + glandular deposits)

8

Size (mm)

2b1: Inactive.

262: Active

Rectum and colon:

is there bowel deep infiltrating endometriosis seen?

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

(hemorrhagic/ proteinacous content + glandular deposits)

"Mushroom cap sign" is specific to severe invasive bowel

endometriosis and is characterized as a plaque with ψ T2 at

Its 'base' and ↑ T2 at its 'cap'.

2 Distance from the anal verge

Length (mm)

2b: Lesion type

26-1: Isolated lesion

2b-2: Multiple lesions

Curved lesion

Straight lesion

20 Maximal depth layer of invasion each leasion (muscularis, submucosa,

mucosa).

2c-1: Lesion 1: (free text)

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

not relevant

2c: is it stuck to any structures or free lying?

Vagina

Uterus

2d-3: Uterosacral ligaments

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2d-4: Ovary

2d: Plaque thickness

2b: 6-10mm. 2a: 1-5mm.

2c: >11mm.

Activity

2e:

262 Inactive. Active.

"Mushroom cap" appearance:

2

2g1: Present.

Absent.

Is there evidence of tethering of the bowel? 8

Yes, tethered to

2a. Uterus

<u> 2</u>b: L ovary

R. ovary

2e: R. uterosacral ligament nodule L. uterosacral ligament nodule

4 L pelvic side wall.

R pelvic side wall.

Any other salient findings on the study:



(Free text)

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