SPECIALIZED ULTRASOUND IN GYNECOLOGY & OBSTETRICS
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[redacted]

PELVIC ULTRASOUND

INDICATION: Pelvic pain and spotting 3 weeks, in post menopausal woman with hx of endometriosis.

LMP: N/A

RELEVANT CLINICAL HISTORY: Yes
Subtotal hysterectomy, left tube, right tube and left ovary removed.

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

UTERUS: Hysterectomy.

OVARIES/ADNEXA:

Right Ovary: Not Visualized

Left Ovary: Oophorectomy

Adnexa: Normal

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: Abnormal with evidence of deep endometriosis measuring 15.6 x 19.4 x 7.7 mm.

M. Leonardi, MD, PhD, FRCSC
Date of transcription: 19 Dec 2024

Sonographer: L. Yu

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Rectouterine pouch (cul de sac): Sliding sign: Negative, representing an obliterated (i.e. **abnormal**) 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:
Abnormal complete pelvic ultrasound today.

Cervix noted measuring 26 x 30 x 33 with blood within with low-level echoes measuring 17 x 16 x 5 mm.

This is highly likely the source of the spotting. There is bowel endometriosis, which is adherent to the cervix, resulting in obliteration of the rectouterine pouch. In the event the cervix will need to be removed, this would be a complex/challenging surgery and referral to MIGS would be necessary.

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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