bensonradiology.com.au
support@bensonconnect.com.au

Patient Name:	RRI139	**Accession Number:**	BR-4801319-MR
Patient ID:		**Requested Date:**	December 3, 2019 08:46
Gender:		**Report Status:**	Final
Date of Birth:		**Requested Procedure:**	4994973
Home Phone:		**Procedure Description:**	MRI PELVIS
Referring Physician:	LEONG, YEN	**Modality:**	MR
Organization:	Morphett Vale		

Findings

Radiologist: KNOX, STEVEN

MRI OF THE PELVIS

Summary:

Supportive features of multicompartmental pelvic endometriosis/fibrosis. This is mostly present within the posterior cul-de-sac extending out laterally to the left and right adnexa. A band of mixed fibrotic and active haemorrhagic plaque is over the uterine serosa and tethers adjacent ovaries and small bowel. There are also further bands of more dense fibrosis extending from the mid uterine body to the parietal peritoneum. Suspicion for bladder dome surface involvement although not able to be confirmed given the collapsed nature of the bladder.

No hydrosalpinx. No endocavitary pathology. No adenomyosis.

Clinical:

History of endometriosis. Last lap 2014/15 ? left endometrioma ? fundal endometriosis. Retroflexed uterus, increasing pain.

Technique:

Multi-parametric pelvic MRI fertility protocol including Volumetric 3D Coronal T2 plus reconstructions. Recall for T1 axial pre/post fat saturation.

Findings:

Uterus:

Size & morphology: Anteverted retroflexed. Retroflexion appears pathologic related to posterior cul-de-sac endometriosis/fibrosis. Small active glandular foci are seen. Uterus size 78 x 38 x 48mm. Assumed LSCS niche with around 2mm scar thickness.

Endometrial thickness: ET = 4mm. No endocavitary pathology.

Junctional zone: Junctional zone thickness is appropriate throughout at 4mm diffusely. There are no submucosal microcysts or supportive features of adenomyosis.

Uterine lesions: There are no discrete uterine lesions.

There are multifocal lesions of surface serosal endometriosis/fibrosis. The mid uterine body there is a band tethering to the anterior peritoneum. No clear active haemorrhagic foci. There are multifocal areas containing small microhaemorrhagic cysts over the posterior uterine serosa from fundus extending to the uterine body/cervix junction. This tethers to the medialised ovaries and there is also regional tethering to the adjacent small bowel loops.

Cervix & vagina:

Uncomplicated nabothian cysts. No cervical or vaginal pathology of note.

Left ovary:

Position: Posterior and medialised left adnexa.

Size: 41 x 44 x 39mm (37ml).

Follicle(s): Tiny present.

Lesions and/or endometrioma: 36mm diameter left ovarian endometrioma showing hemoconcentration. No fat component or complexity.

Right ovary:

Position: Medialised slightly tethered right adnexa.

Size: 38 x 27 x 35mm (19ml). Enlargement related to complex cyst.

Follicle(s): Present. Approximately four subcentimetre follicles are noted.

Lesions and/or endometrioma: Complex hemorrhagic cyst at 26mm. No established endometrioma based on T1 characteristics.

Adnexa:

Supportive features of multicompartmental endometriosis/fibrosis. This is present within the posterior cul-de-sac obliterating it centrally with active haemorrhagic surface serosal deposits, medialised ovaries, tethered small bowel and effaced fascial planes. There is nodularity extending laterally along the uterosacral ligaments on both sides. Vaginal fornices do not appear elevated. Similarly within the anterior cul-de-sac there is a band adhesion which extends to the anterior peritoneum. There appears to be some focal thickening of the bladder dome which is further suspicious for some bladder serosal disease however unfortunately the bladder is largely collapsed this is difficult to confirm.

No clear hydrosalpinx. No peritoneal inclusion cyst. No additional bowel findings of concern.

Dr Steven Knox **Dr Yen-Lee Leong**

Electronically signed 06/12/2019 12:47