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Patient Name:	RRI103	**Accession Number:**	BR-4188582-MR
Patient ID:		**Requested Date:**	October 4, 2018 08:27
Gender:		**Report Status:**	Final
Date of Birth:		**Requested Procedure:**	4293868
Home Phone:		**Procedure Description:**	MRI PELVIS
Referring Physician:	TREMELLEN, KELTON	**Modality:**	MR
Organization:	North Adelaide		

Findings

Radiologist: KNOX, STEVEN

MRI PELVIS

Summary :

Bulky fibroid uterus. There are no submucosal fibroids or fibroids with significant mass effect on the cavity. A moderate to large posterior right uterine body subserosal fibroid predominantly fills the right posterior cul-de-sac.

No endocavitary pathology. There is a small region of submucosal cystic change at the junctional zone near the fundus which would support anterior regional adenomyosis.

Right sided ovarian endometriotic cysts. Potential small focus of endometriosis within the anterior cul-de-sac. No gross pelvic distortion.

Clinical:

Fibroid on ultrasound. Pain suggests adenomyosis. Please assess prior to IVF.

Worksheet = DAY 18. G1P0. No prior section. Prior LEEP 15 years ago.

Technique:

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

Findings:

Uterus:

Size & morphology: Anteverted minimally anteflexed. Size: (96 x 100 x 85mm). Enlargement related to multi focal fibroids. No septum or duplication is definable. Arcuate morphology.

Endometrial thickness: ET = 6mm. No endocavitary pathology.

Junctional zone: Small region of submucosal cystic change at the fundal JZ which supports regional adenomyosis. No complexity. The anterior junctional zone measures 5mm. Fundal junctional zone 3mm. Posterior junctional zone: - 5mm.

Uterine lesions:

Multiple intra mural to subserosal fibroids. All fibroids are non-degenerate and non-suspicious. There are no endocavitary fibroids identified. None with haemorrhagic signal or diffusion restriction. The largest fibroid is characterised as follows:

1. Exophytic left lower anterior uterus. Subserosal. Base of attachment 13mm. Size: 35 x 29 x 31mm.

2. Anterior mid uterine body entirely intramural. 4mm from mucosal surface. 6mm from serosal surface. Size: 21mm.

3. Right intramural to subserosal. Approximately 25% exophytic. Mid uterine body. Size: 13mm.

4. Right anterior uterine body /fundus. Entirely intramural. 4mm from serosal surface. 2mm from mucosal surface. Size: 13mm.

5. Entirely intramural anterior midline uterine body/ fundus. Size: 13mm. 7mm from mucosal surface. 4mm from serosal surface.

6. Subserosal exophytic posterior right uterine body. Base of attachment approximately 61mm. Partially filling the posterior right cul-de-sac. Size: 79 x 75 x 78mm.

Cervix & vagina:

There is a moderate size left sided Bartholin gland cyst. This measures 45mm. There is some layering internal proteinaceous material. No definable solid component or overt complexity. No cervical or vaginal lesion of concern.

Left ovary:

Position:&#0;Left lateral adnexa.

Size: 30 x 21 x 21mm (9.9mls) Enlargement related to dominant follicular activity.

Follicle(s): Present. Approximately four subcentimetre follicles. Dominant follicle 16 x 10mm.

Lesions and/or endometrioma: Not identified.

Right ovary:

Position: Anterior right superior adnexa.

Size: 52 x 35 x 47mm (44mls). Enlargement related to moderate sized follicle/ cyst. Size: 42mm x 38mm. Simple features.

Follicle(s): Approx 5 subcm follicles.

Lesions and/or endometrioma: Present. Posterior endometriotic cyst at 16mm. Right lateral cyst showing haemoconcentration and high T1 signal measures 11mm.

Adnexa:

No hydrosalpinx. In the anterior cul-de-sac at the level of the mid uterine body is an ovoid cystic focus showing high T1 signal which would suggest a small haemorrhagic deposit and could reflect uncomplicated anterior cul-de-sac endometriosis. There is no associated bladder wall thickening or gross anatomic distortion. The posterior cul-de-sac is distorted related to the large posterior fibroid however allowing for this, no evidence of gross posterior cul-de-sac endometriosis/ fibrosis is seen.

Other findings:

No other significant intrapelvic pathology. There is some fibrocystic change at the right femoral head-neck junction region with loss of concavity to the femoral head-neck junction. Slightly less marked features on the left. This would support chronic femoroacetabular impingement, predominantly CAM type. No definable para labral cyst or other features of concern on this study.

Dr Steven Knox **Dr Parineet Takhar**

Electronically signed 04/10/2018 16:50