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Patient Name:	RRI151	**Accession Number:**	BR-2850010-MR
Patient ID:		**Requested Date:**	December 7, 2015 12:44
Gender:		**Report Status:**	Final
Date of Birth:		**Requested Procedure:**	2763124
Home Phone:		**Procedure Description:**	MRI PELVIS
Referring Physician:	THALLURI, VAMSEE	**Modality:**	MR
Organization:	Salisbury		

Findings

Radiologist: KNOX, STEVEN

MRI PELVIS

Summary :

Features support pelvic endometriosis. There is uterine retroflexion present related to deep posterior cul-de-sac invasive endometriosis involving predominantly the torus uterinus. There is associated elevation of the vaginal fornices and tethering medially of both ovaries. Nodular thickening particularly on the left of the uterosacral ligament and several small endometriotic regional foci are noted. Left sided hydrosalpinx. No evidence of haematosalpinx.

Diffuse uterine adenomyosis. No endocavitary pathology.

Clinical:

Had laparoscopy with significant adhesions. Surgeon unsure if endometriosis or due to previous pelvic infection ? adenomyosis.

Work sheet = day 11. G2 P1. Appendicectomy age 12. Laparoscopy 6 weeks 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 retroflexed. This appears related to deep posterior cul-de-sac adhesions and subsequent uterine distortion. Size (uterine body and cervix) 86 x 50 x 46mm. Conventional uterine anatomy with no septum or duplication.

Endometrial thickness: ET = 7mm. There is no endocavitary pathology.

Junctional zone: No submucosal microcysts. Acknowledging the early point in the cycle there remains an indistinct expanded junctional zone measuring average 12mm. This is indirect evidence of background adenomyosis. Appearances are more prominent at posterior uterine body and fundus.

Uterine lesions: Not identified.

Cervix & Vagina:

Small Bartholin gland cysts bilaterally. No significant cervical or vaginal lesions. The vaginal fornices are, however, elevated related to the posterior cul-de-sac fibrosis and in addition to this there are haemorrhagic foci seen at the level of the torus uterinus and vaginal vault consistent with regional deep posterior cul-de-sac endometriosis. Plaque measures approximately 14mm.

Left Ovary:

Position: Left lateral adnexa.

Size: 32 x 25 x 33mm (13.8ml). Distortion related to regional adhesions.

Follicle(s): Present. Approximately 8 subcentimetre follicles are noted.

Lesions and/or endometrioma: Posterior thinly septated cystic structure closely applied to the ovary is probably a regional peritoneal inclusion cyst noting the regional adhesions and endometrial deposits. Size 46 x 28mm. There are discrete small endometriotic cysts within the left ovary with at least three measures <5mm.

Right Ovary:

Position: Medialised right adnexa.

Size: 31 x 13 x 35mm (7.4ml).

Follicle(s): Present. Approximately 5 subcentimetre follicles.

Lesions and/or endometrioma: Not identified.

Adnexa:

Uterine retroflexion related to the posterior cul-de-sac fibrosis and obliteration. The physiologic fluid is bound by this. There is a left sided hydrosalpinx. Left sided peritoneal inclusion cyst. There is nodular thickening and fibrosis along the uterosacral ligaments more prominent on the left and with regional anatomic distortion. There are no bowel serosal deposits. There are discrete small endometriotic foci seen along the lateral aspect of the left uterosacral ligament.

Other Findings:

No significant bony findings. The remainder of the pelvis is unremarkable.

Radiologist: Dr S. Knox

Second Reader: Dr J. Cowie