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|---|---|---|---|
| **Patient Name:** | RRI130 | **Accession Number:** | BR-4400810-MR |
| **Patient ID:** | | **Requested Date:** | March 6, 2019 08:35 |
| **Gender:** | | **Report Status:** | Final |
| **Date of Birth:** | | **Requested Procedure:** | 4536922 |
| **Home Phone:** | | **Procedure Description:** | MRI PELVIS |
| **Referring Physician:** | SEMMLER, JODIE | **Modality:** | MR |
| **Organization:** | City West | | |

## Findings

**Radiologist:** KNOX, STEVEN

**MRI PELVIS**

**Summary :**

**The boundaries of the posterior cul-de-sac are significantly improved post surgery and the posterior fibrosis has been divided, with the depth of the cul-de-sac increased. The fluid through this area contains multiple thin internal septations. It is without mass effect but does suggest a further evolving peritoneal inclusion cyst in the posterior cul de sac.**

**There are no active haemorrhagic endometriotic foci identified within the pelvis. There are no discrete ovarian endometriomas. There is no bowel disease or further evidence of architectural distortion.**

**On the right side there is suspicion for a progressive hydrosalpinx since the previous study.**

**Clinical:**

Follow up regarding endometriosis and adenomyosis.

Has had previous extensive surgery. Last MRI inclusion cyst left side ?haemorrhagic side right side.

**Technique:**

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

**Comparison Study:**

MRI pelvis 19/08/2016.

**Findings:**

**Uterus:**

Size Morphology: 8cm x 4.8cm x 5cm, 100cc. Enlarged. The lie of the uterus has changed since the prior surgery. The previous deep posterior cul-de-sac fibrosis has been resected and physiologic fluid now extends appropriately through this area. The uterus shows some very mild retroflexion. Improved mobilisation of the posterior cul-de-sac post surgically is noted although the fluid in this area does contain some thin internal septations/loculations. *

Endometrial Thickness: 7.4mm. No endocavitary pathology.

Junctional Zone: Normal junctional zone thickness throughout. Average JZ 5mm. No submucosal microcysts identified to support adenomyosis.

Uterine Lesions: Nil significant. No subserosal, intramural or submucosal fibroid.

**Cervix and Vagina:**

Incidental Nabothian cysts.

**Left Ovary:**

Position: Left adnexa.

Size: 39 x 23 x 29mm (14ml).

Follicles: Present. Dominant follicle 31mm. Approximately six subcentimetre follicles are noted.

Lesions and/or Endometrioma: Not identified.

**Right Ovary:**

Position: Right adnexa slightly medialised.

Size: 22 x 13 x 18mm (2.7ml).

Follicles: Present. Approximately eight subcentimetre follicles.

Lesions and/or Endometrioma: Not identified.

**Adnexa:**

The surgery has improved the posterior cul-de-sac with the prior effacement no longer identified and fluid now insinuating through this region. There are multiple thin internal loculations through the posterior cul-de-sac fluid however and quite close relationship of this fluid to the left ovary. Morphologic appearances supports an additional evolving peritoneal inclusion cyst given its loculation.

A tubular serpiginous region adjacent the right ovary is more notable on today's study than previously and has imaging features most suggestive of an evolving right sided hydrosalpinx. There are no definite haemorrhagic foci identified on the T1 weighted sequences to support active haemorrhagic endometrial deposits. No bowel disease is seen.

**Other Findings:**

The levator plate, obturator internus, anal canal with internal and external sphincter all are unremarkable.

**Dr Steven Knox** **Dr Jatinder Shekhawat**

Electronically signed 14/03/2019 10:35