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RRI053

Accession Number: BR-4936355-MR
Requested Date: March 6, 2020 12:05
Report Status: Final
Requested Procedure: 5149714
Procedure Description: MRI PELVIS
Modality: MR

Home Phone:
Referring Physician: YOONG, RAY
Organization: City West

Findings

Radiologist: KNOX, STEVEN

MRI PELVIS

Summary :

Obliterative posterior cul-de-sac endometriosis/fibrosis. Large ovarian endometriomas, bridging across the posterior cul-de-sac, are associated with significant posterior cul-de-sac architectural distortion. There is tethering of the ovaries medially which are adherent to the posterior uterine serosal surface with posterior uterine serosal fibrosis. No deep myometrial invasive disease is identified. There is a moderate size superficial plaque at the serosal surface of the rectosigmoid anteriorly spanning 33mm. No extension to mucosal surface is identified. Similarly there is deep anterior cul-de-sac multifocal endometriosis/fibrosis including internal microhaemorrhagic foci supporting ongoing activity. This partially involves the posterior aspect of the bladder dome with bladder serosal involvement although without clear bladder mucosal surface involvement.

No adenomyosis or uterine endocavitary pathology.

Clinical:

Grade 4 endo on ultrasound for surgery check extent of bowel involvement.

Technique:

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

Findings:

Uterus:

Size & morphology: Retroverted antiflexed. Size (uterine body and cervix) 89 x 40 x 49mm. Conventional anatomy without septum or duplication.

Endometrial thickness: ET=3mm. There is no endocavitary pathology.

Junctional zone: Normal junctional zone thickness throughout. No submucosal microcyst or supportive features of adenomyosis. Junctional zone measures 4mm diffusely.

Uterine lesions: Not identified.

Cervix & vagina:

No cervical or vaginal lesions of note identified.

Ovaries:

Distorted, medialised with multifocal endometrioma formation.

Left ovary:

Position: Medialised left posterior adnexa.

Size: 60 x 53 x 63mm (104ml). Enlargement related to multifocal endometrioma formation.

Follicle(s): Small follicles are present, definable inferiorly and laterally within the stroma although distorted related to the endometrioma formation. Approximately three subcentimetre follicles.

Lesions and/or endometrioma: Multifocal endometrioma formation. The largest measures 70mm in diameter. A further three endometriomas present, second largest anteriorly at 20mm. No obvious internal solid component.

Right ovary:

Position: Medialised, tethered right posterior adnexa. Associated with a serosal rectosigmoid bowel plaque. Multifocal endometrioma formation.

Size: 56 x 47 x 50mm (68ml). Enlargement related to multifocal or endometrioma formation.

Follicle(s): A few small follicles are present <10mm.

Lesions and/or endometrioma: Multifocal endometrioma formation. There is a septated or multiple communicating endometrioma forming most of the ovarian volume at 57 x 34 x 49mm. No obvious solid component.

Adnexa:

Complex endometriosis/fibrosis. There is obliteration of the deep posterior cul-de-sac with the ovaries adherent to the posterior uterine serosa and particularly the right ovary adherent to the rectosigmoid with a serosal rectosigmoid plaque. The plaque overlies the anterior aspect of the rectosigmoid spanning 33 x 8mm. It does not appear to extend to the mucosal surface. There are multifocal small haemorrhagic endometriotic foci through the plaque although the dominant signal is fibrosis. There is further endometriosis/fibrosis within the anterior cul-de-sac tethering the uterus anteriorly with associated uterine anteflexion. The plaque measures 40 x 16mm. There is also further plaque overlying the posterior aspect of the bladder dome with bladder surface involvement. 16mm in diameter. It does not appear to extend through to bladder mucosal surface. Disease at the uterosacral ligaments is more notable on the right with regional architectural distortion. There is bridging haemorrhagic product between the left and right dominant endometriotic cysts at the posterior lower uterine/ cervical junction. This material spans 23mm in diameter. A discrete serpiginous hydrosalpinx is not identified however tubular distortion given the degree of endometriosis is anticipated. There is no definable small bowel disease. Related to the posterior cul-de-sac obliteration, the physiologic fluid is predominantly within the anterior cul-de-sac.

Other findings:

Nil significant.

Dr Steven Knox **Dr Melissa Jenkins**

Electronically signed 11/03/2020 09:04