SUBJECT ID = RR

ENDOMETRIOSIS PELVIC MRI ASSESSMENT -

BR PROFORMA REPORT BLIND REVIEW

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Absent

Present

Uterine anatomy

Conventional

Arcuate

Septate

a Full septum

b Subseptate

Bicornuate unicoflis

Bicornuate bicollis

Didelphys

Other (free text enabled)

Uteride Lie (can be more than one selection)

Anteverted

Anteflexed

Retroverted Retroflexed

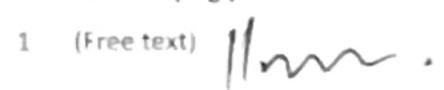
Axial

Otners (please specify) (Free text enabled)

Uterine Size (body + cervix - 3 planes in mm.)



Endometrial thickness (sag plane in mm to nearest mm)



Endometrial lesions



Not identified.

2b-1. No of polyps (free text)

Size of each polyp. (free text)

Adenomyosis

No MRI supportive features

Supportive MRI features as described:

Submucosal cysts.

Abnormal junctional zone thickening and measurement

Anterior (mm)

Fundal (mm)

Posterior (mm)

Presence of an adenomyoma

Yes

Fibroids

No

Yes

Number of fibroids 2a.

Largest fibroids (location and size mm all-

fibroids >10mm and/or impact on the cavity) - (Free text)

Submucosal fibroids

2b-0 No

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2b 1

2b-1-1. (description: free text)

Left ovary

Absent (Branching logic - move to "Right ovary")

Present

Left ovary size (3 planes and volume)

1. NN x NN x NN mm

Volume (above x 0.52)

Left ovary follicle measurements and count

N follicles between 2 and 9 mm in diameter

a (Free text)

2. N follicles > 9 mm

a. (Free text)

Dominant follicle



Left ovary position

Lateral adnexa: Unremarkable.

High positioning in iliac fossa.

Tethered/ distorted appearances - (may be

artifuple options)

3a Intimate relationship to the lateral interus-

3b Intimate relationship/ tethoring to adjacent

obwel.

3c. Tethering to pelvic sidewall

2d Tethering to the uterosacral ligament

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CLIBIECT	426		REVIEWER INITIALS
SUBJECT		3b: Absent	adjacent bowel.
	10) and makelly	4 Fat component (T1/ T2 hyperintense. Low signal	3c. Tethering to pelvic sidewall
	- A. J. A. III P M	on fat suppression).	3d:) Tethering to the uterosacral ligament
Left ovaria	n endometrioma		Je: (C) orby ordhesms.
N	ia .	4a: Present.	Right ovarian endometrioma
/ 2·) Y	es de co-	4b: Absent.	
1	a. Size: NN in millimetres (mm) 2 30		No
	1b: T2 shading (intermediate/low	Right ovary	(2) Yes 20
	homogeneous T2 signal).	1: Absent (Branching logic – move to "Adnexa")	2a: Size NN in millimetres (mm) 5 mm
	1b-0: No	2 Present	2b: T2 shading (intermediate/low
	1b-12 Yes		homogeneous T2 signal).
1	c I fat sat hyperintense	Right ovary size (3 planes and volume)	2b-0: No
	1c-0: Absent	1. NN X NN X NN mm USX43X43	76-1.) Yes
		2. Volume (above x 0.52).	2c: Fa fat sat hyperintense
	1c-1 Present	45ml.	2c-0; Absent
	ld: Internal nodularity, septation or other		2c-1) Present
	complexity.	Right ovary follicle measurements and count	2d: Internal nodularity, septation, complex.
	1d-1: No	 N follicles between 2 and 9 mm in diameter 	2d-1.) No
	A:0-2) Yes	a. (Free text)	2d-2. Yes
	1-d-2 1: (Free text)	2. N follicles > 9 mm	20.5. 162
	in lesions/cysts other than suspected adjace	a. (Free text)	
Left ovaria	in lesions/cysts other than suspected adjace	3. Dominant follicle	Right ovarian lesions/cysts other than suspected
endometri			endometriomas /
1 1	Not classifiable	b. N.	1: Not classifiable
2	esion features		2: Lesion features
	a: Unilocular cyst	Right ovary position	2a: Unilocular eyst
	b. Unilocular solid cyst	Lateral adnexa. Unremarkable.	2b: Unilocyrar-solid cyst
		 High positioning in iliac fossa. 	2c. Multilocular cyst
2		3 Tethered/ distorted appearances – may be	2d: Multilocular-solid cyst
	d- Multilocular-solid cyst	multiple options.	Ze. Solid
	le: Solid	3a: Intimate relationship to the lateral uterus	3: Vascularity (post gadolinium enhancement)
3/ V	ascularity (post gadolinium enhancement).		3a: Present
3	a Present	30 letimate relationship/ tethering to	
/			Page 2 of 4

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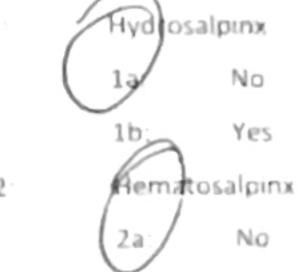
3b:

Absent

- 4 Fat component (T1/T2 hyperintense. Low signal on fat suppression).
 - 4a Present
 - 4b: Absent.

Adnexa

1



3: Other (free text)

Are both ovaries immediately approximated "kissing"?

Yes

(2)

Yes

No

Urinary bladder nodule

1 Absent

Present

2.a Size: NN in millimetres (mm)

Uterovesical region

Normal

Definition. Assessment of whether there is a visible preserved fat plane +/- physiologic fluid +/- absent stortion between the antenur uterine serosa and biadder

- Abnormal
 - 2a: (free text if required)

(Ureteric nodule(s)?

- I: Absent.
- 2: Present

2a: Location (free text + distance to ureteric orifice/ VUJ)

2b: Size (mm)

Pouch of Douglas obliteration

Definition: Assessment for abnormal loss of fat plane +/physiologic fluid and immediate approximation of
rectosigmoid and/or small bowel to the posterior uterine
serosa, cervix +/- vaginal wall.

Discrete linear bands may be visible (\$\square\$ T1, \$\square\$ T2)

1: Negative

Yes

Partial

la. Left fb Right

3 2b 3a.

a. Positive = obliteration

3b. Positive = band adhesions.

Nodules present on the posterior vaginal fornix?

Defavition: Thickening of superior 1/3 of posterior vaginal vall */- nodularity: Nodules: ↓ T2 ↑T1 (if active haemorthagic deposits)

1. No.

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2a: Dimension of nodule to be measured in millimetres (mm).

2b1. Inactive.

2b2 Active

Vaginal forniceal elevation?

Definition: Upper level of fornix on sagittal view is superior to the angle of the uterine isthmus with stretching of

Waginal wall, and/or acute angulation of the fornix.

No Yes

2a Left.

2b: Right

2c: Left and Right.

Rectovaginal nodules present?

Definition: Presence of deep infiltrating endometriosis in the anterior rectal wall and posterior vaginal formix, located below the peritoneum of the Pouch of Douglas. Inactive/fibrotic disease characterised as \$\psi\$ T1 \$\psi\$ T2 signal.

No

Yes

2.a Size (mm)

2b1 Inactive

2h2. Active

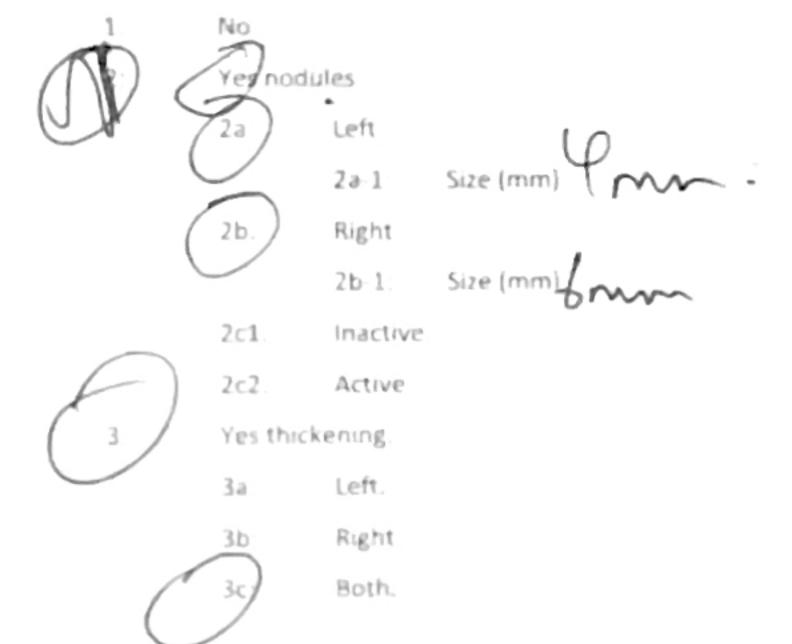
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Uterosacral ligament nodules or thickening?

Definition. Inactive/ fibrotic disease nodules characterised as \downarrow T1 \downarrow T2 signal

Active disease as \uparrow T1, \uparrow to intermediate-T2 signal (hemorrhagic/ proteinaceous content + glandular deposits).



Retrocervical nodule present?

2b1

2b2:

Definition Inactive/ fibrotic disease characterised as ↓ T1 ↓ T2 signal.

Active disease as TT1, T to intermediate-T2 signal (hemogrhagic/proteinacous content + glandular deposits)

1. No

2. Yes

2a. Size (mm)

inactive

Active

Rectum and colon

Is there bowel deep infiltrating endometriosis seen?

Definition: Inactive/ fibrotic disease characterised as ↓ T1 ↓ T2 signal.

Active disease as \uparrow T1, \uparrow to intermediate-T2 signal (hemorrhagic/ proteinacous content + glandular deposits). "Mushroom cap sign" is specific to severe invasive bowel endometriosis and is characterized as a plaque with \downarrow T2 at its 'base' and \uparrow T2 at its 'cap'.



No

Yes

- 2a: Distance from the anal verge
 - 2a-1: Length (mm)
- 2b: Lesion type
 - 2b-1: Isolated lesion
 - 2b-2: Multiple lesions
 - 2b-3: Curved lesion
 - 2b-4. Straight lesion
- 2c: Maximal depth layer of invasion each leasion (muscularis, submucosa, mucosa)
 - 2c-1. Lesion 1: (free text)
 - (2c-2. Lesion 2 (free text) delete if not relevant

(2c-3 etc.)

- 2c: is it stuck to any structures or free lying?
 - 2d-1. Vagina
 - 2d-2. Uterus
 - 2d-3: Uterosacral ligaments

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2d-4 Ovary

2d Plaque thickness

2a 1-5mm

2b. 6-10mm

2c: >11mm.

2e: Activity

2f1: Inactive

2f2: - Active.

2f: "Mushroom cap" appearance:

2g1: Present.

2g2. Absent.

Is there evidence of tethering of the bowel?

I No

Yes, tethered to

2a Uterus

L ovary

R. ovary

L uterosacral ligament nodule

R uterosacral ligament nodule

2f: L pelvic side wall:

2g: R pelvic side wall.

2h: Other.

Any other salient findings on the study:

1 No

. Yes

a. (Free text).

Scart/ Photo/ Email: kate cook@bersonradiology.com.au.