Female Pelvis Ultrasound Protocol

The patient should be scanned either Trans abdominally (TA) with a full bladder or Trans vaginally (TV). The Sonographer has the authority to examine the patient by whichever mode they deem most appropriate however wherever possible a Trans-vaginal examination should be performed in addition to the Trans abdominal scan.
In addition, patients with significant pathology and/or being referred to Gynae outpatients, should have both a TA & TV scan undertaken, unless contra-indicated.

- The Sonographer or Clinical assistant must obtain verbal consent before performing a TV scan, as per consent policy.
- The Sonographer must aim to maintain patient dignity through out a transvaginal examination, and a clean sheet or paper towel must be used for each patient
- Individual probe cover should be used in the presence of the patient and removed immediately after the examination.
- The probe must be cleansed before application of the probe cover and after removal as per infection control policy.
- A TV scan should always be performed if examination of the endometrium is required.
- A trans-abdominal scan across the pelvis prior to a TV scan, to exclude any pelvic masses that may not be visible transvaginally, is advisable when the need to exclude a mass.
- A transvaginal scan should not be attempted on any patient who has never been sexually active.
- If a transvaginal scan is required, the male sonographer must ensure a chaperone is present during the examination.
- Non-latex probe covers, and gloves must be used in all cases of latex sensitivity.

The following observations/ measurements should be made/taken and recorded.

1. The lie of the uterus.
2. The measurements of the uterus in longitudinal and both short axis.
3. The AP diameter of the endometrium taken in the mid body of the uterus in the longitudinal plane.
4. The point in the patient's menstrual cycle, if appropriate.
5. Endometrial diameter measurement up to 20mm in menstrual cycle is normal
6. Endometrial diameter measurement up to 9mm in post-menopause is normal
7. Both ovaries should be identified and measured if appropriate again in 3 planes.
8. Measurements should be recorded for simple/complex/dermoid cysts.
9. Record on the ultrasound report when a non-latex cover is used.

Comments should be made on the following:

1. The presence of fibroids, size, position and type.
2. The appearances of the myometrium.
3. The appearances of the endometrium, please note that a rescan at the beginning of the patient's menstrual cycle may be useful in order to prove or exclude the presence of a polyp. The possibility of performing the scan on Day 5 of the cycle on all women who present with menstrual problems should be considered once the departmental waiting list has reached zero.
4. If the endometrium is difficult to image and measure, with no delineation between the myometrium and endometrium then this should be stated in the ultrasound report.
5. The appearance of the ovaries taking the point of the menstrual cycle into account, measurement of ovarian volume may be useful in the diagnosis of polycystic disease.
6. Any free pelvic fluid.
7. Endometrial hyperplasia can not be diagnosed from ultrasound.
8. When the scan is normal use "Normal ultrasound scan" or "No abnormality seen on ultrasound"

GYNAE PROTOCOL

Addition of Renal scan when the following exists:

- Where there is endometriosis or the clinician has '? Endometriosis'
- Large pelvic, ovarian mass or possible urinary obstruction.
- A renal ultrasound is indicated.
- Unusual uterine morphology

Reasons to arrange a rescan following the initial examination:

1. As previously mentioned a rescan at the beginning of the menstrual cycle may prove useful in order to exclude / prove the presence of an endometrial polyp.
2. In women who are menstruating a rescan should be arranged 6 weeks after the initial scan if a cyst measuring between 3.5-10cm is identified. In cases of a cyst measuring greater than 10 cm an urgent gynaecological review should be suggested.
3. If a complex cyst measuring less than 3.5cm is identified, the AP should consider the stage of the menstrual cycle before arranging a rescan i.e., a complex cyst on day 15 of a 28-day cycle might represent a collapsing corpus luteal.
4. In cases where a cyst is discovered in postmenopausal women a rescan in 3 months should be arranged if the cyst is simple and measures less than 5cm. If the cyst appears complex and or measures greater than 5cm than an urgent gynaecological review should be suggested.

Protocol to be followed for missing IUCD

The general protocol above should be followed; if the IUCD is not identified within the endometrial cavity then the Sonographer has the authority to request an abdominal X- ray (to include the symphysis and hemidiaphragms) in order to exclude mall positioning of the IUCD. If the IUCD is positioned low in the uterine cavity i.e., in the cervical canal then the Sonographer must inform the patient that she does not have contraceptive cover and she should see her GP as soon as possible for further review.

In the case of a Mirena coil, sonographers should only report the position of the 'body' of the coil, not the 'arms'.