BMUS Study Day: The good, The bad and The Ugly of Gynaecology Reporting to Primary Care

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BMUS

Aims

1. Review Gynaecology reporting in primary care based on my personal experience.
2. Highlight good practice.
3. Highlight how this could be fine tuned.

Disclaimer

- Consent has been given from my patients to use their scan reports for training purposes. All patient identifiable information is redacted.
- I am a GP who uses ultrasonography during my working week. My understanding of ultrasound nomenclature and reporting is greater that most GPs.
- Also means I am more aware of the limitations of each scan.
- Most GPs will probably just read the impression.
- Most patients now have the ability to access their records and reports.

Clinical | Administrative

- Patient Home
- (Home Visit Print)
- Special Notes
- Major Active Problems (4)
  - Cervical smear - recall delete (9O88.) (2)
  - Blepharoplasty of both eyelids (72130) (3)
  - Malignant melanoma of back (XaClv) (11)
  - Wide excision of skin lesion (7G055) (4)
- Minor Active Problems (2)
  - Cervical smear (Xa8PI) (7)
  - [redacted]
- Inactive Problems (22)
- Safeguarding Information
- Third Party Patient Record
- Summary & Family History (15)
- Quick Glance
- Appointments, Visits & Tasks
  - Attendance Counts
  - Appointments
  - Appointment Invitations (4)
  - Visits
  - Tasks
  - Scheduled Tasks
  - eWorkflows
  - Waiting Lists
- Tabbed Journal
- New Journal
- Read Code Journal (189)
- Medication
- Repeat Templates (1)
- Prescription Requests
- Prescription History (24)
- Sensitivities & Allergies
- Vaccinations (23)

Tabbed Journal

Searching in the journal shows results after any applied filtering. This does not include results from consultations in collapsed admissions. The search box only searches on patient data currently visible in the journal. This message can be hidden by going to User > User Preferences > Patient Record > New Journal and disabling the 'Show search warning' check box.

Custom Filter | Search

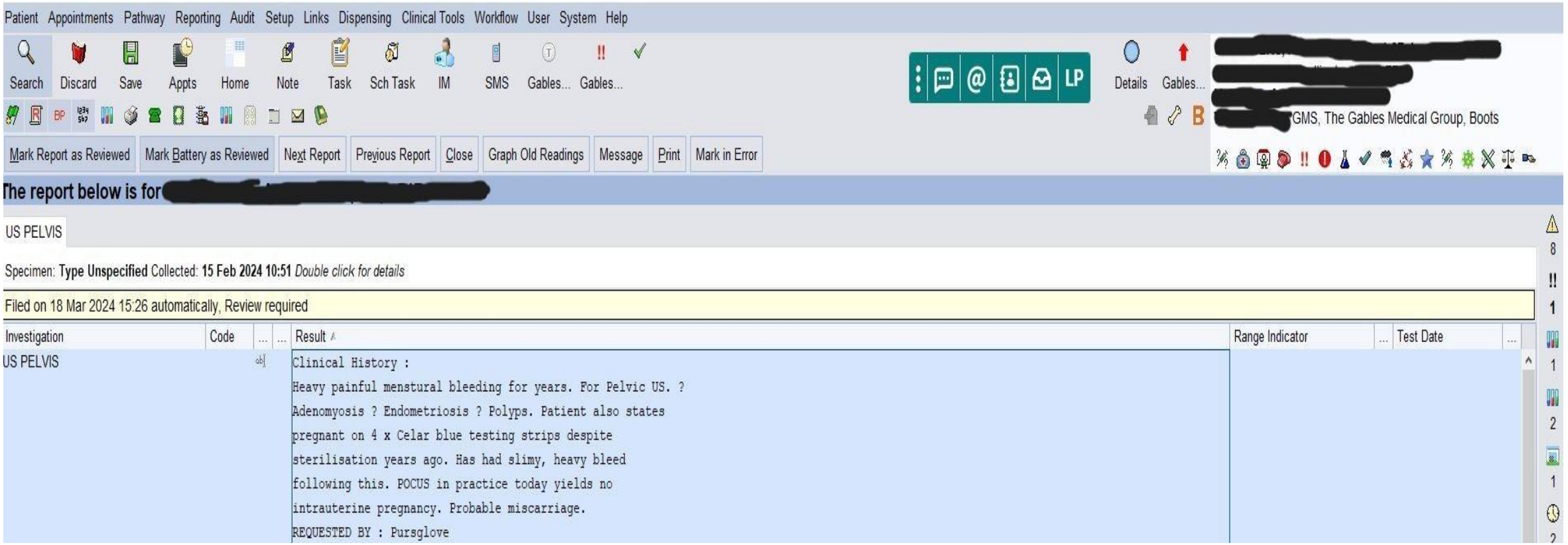
Local Data | GP Data | Community | Urgent Care | Everything | My Consults | +

Dr Parker	
27 Jan 2024 Auto-filed	14:08 - Surgery: Auto-filed US PELVIS: US Pelvis Clinical History : RIF pain, no feeling of urgnecy but sx presists depsite uti settling ?>? cause REQUESTED BY : [redacted] US Pelvis: Advanced Practitioner Report. Transabdominal and transvaginal scan performed with verbal consent. Chaperone present. LMP - Post menopausal, no bleeding. The anteverted atrophic uterus is heterogenous in echotexture measuring approx. 54mm x 23mm x 44mm with some distended peripheral myometrial varices noted. A 12mm focal fibroid is noted in the fundus abutting the endometrium. Endometrial thickness = 1.8mm, linear. Normal ultrasound appearance of both ovaries. No adnexal mass, cyst or free fluid identified. Prominent adnexal varices noted, more prominent on the right side. The known left angiomyolipoma has increased in size to 10mm on ultrasound today. A 20mm parapelvic left renal cyst noted. Subcentimetre right cortical renal cyst noted. Otherwise a normal appearance of both kidneys. Underfilled, but grossly normal bladder outline. Post micturition bladder volume of 23mls. Impression: Appearances are suggestive of a degree of pelvic congestion. Increase in size of the known left angiomyolipoma. [redacted] Advanced Ultrasound Practitioner HCPC Registration No: RA67831 (Reported in RIS) Reported by [redacted] / RAFWH: RIF pain, no feeling of urgnecy but sx presists depsite uti settling

100 Journal Entries

Items per page 100 | Page 8 of 8 | 16 Aug 2023 - 21 Feb 2024

Analysis – Example 1



POCUS Mandate

Any ultrasound scan that answers a YES or NO question or gives a definitive answer within 5 minutes.

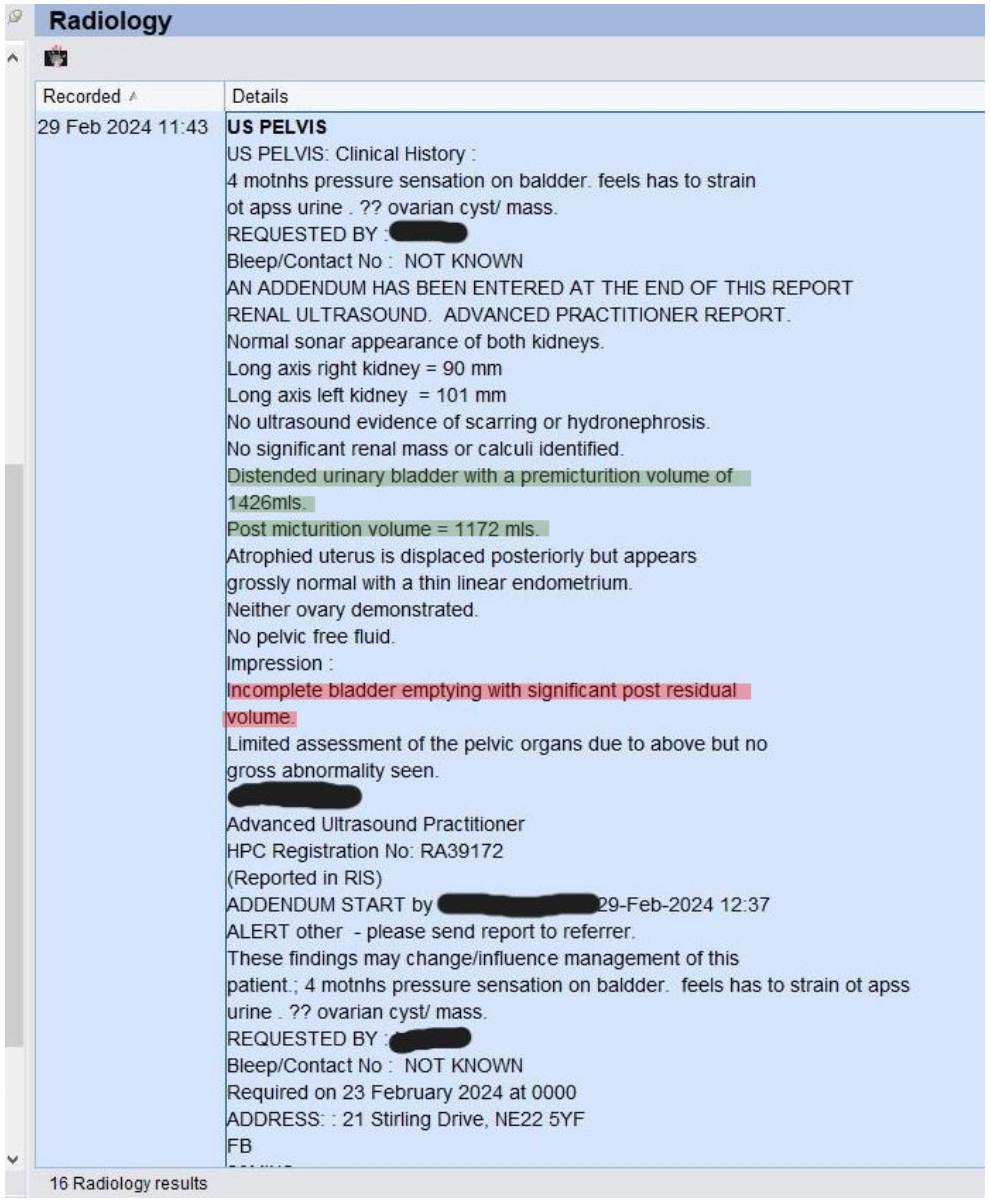
Analysis – Example 2

US Pelvis: Advanced Practitioner Report.
Transabdominal and transvaginal scan performed with verbal consent. Chaperone present.
LMP - 1-2 weeks ago.
Sub-optimal scan on a poor sonar subject.
The anteverted uterus is bulky, coarse and heterogenous in echotexture with a globular shape measuring approx. 110mm x 65mm x 61mm. The myometrium contains some small cystic areas throughout. Appearances of the uterus overall could be suggestive of possible adenomyosis. No focal fibroid identified.
Endometrial thickness = 10.6mm, grossly regular. No obvious polyp identified within.
The left ovary contains a 29mm thin walled cyst filled with echogenic debris suggestive of a haemorrhagic cyst.
Otherwise a grossly normal ultrasound appearance of both ovaries. No adnexal mass or free fluid identified.
Bladder underfilled and cannot be assessed.
Impression:
Appearances of the uterus overall may be suggestive of adenomyosis. Clinical correlation advised.
Small haemorrhagic cyst in the left ovary.
[redacted]
Advanced Ultrasound Practitioner

Analysis – Example 3

14:08 - Surgery: Auto-filed
US PELVIS: US Pelvis
Clinical History :
RIF pain, no feeling of urgnecy but sx presists depsite uti settling ?>? cause
REQUESTED BY : [redacted]
US Pelvis: Advanced Practitioner Report.
Transabdominal and transvaginal scan performed with verbal consent. Chaperone present.
LMP - Post menopausal, no bleeding.
The anteverted atrophic uterus is heterogenous in echotexture measuring approx. 54mm x 23mm x 44mm with some distended peripheral myometrial varices noted. A 12mm focal fibroid is noted in the fundus abutting the endometrium.
Endometrial thickness = 1.8mm, linear.
Normal ultrasound appearance of both ovaries. No adnexal mass, cyst or free fluid identified. Prominent adnexal varices noted, more prominent on the right side.
The known left angiomyolipoma has increased in size to 10mm on ultrasound today. A 20mm parapelvic left renal cyst noted. Subcentimetre right cortical renal cyst noted.
Otherwise a normal appearance of both kidneys. Underfilled, but grossly normal bladder outline. Post micturition bladder volume of 23mls.
Impression:
Appearances are suggestive of a degree of pelvic congestion.
Increase in size of the known left angiomyolipoma.
[redacted]
Advanced Ultrasound Practitioner
HCPC Registration No: RA67831
(Reported in RIS)
Reported by : [redacted] / RAFWH: RIF pain, no feeling of ur

Analysis - Example 4



Radiology

Recorded	Details
29 Feb 2024 11:43	**US PELVIS** US PELVIS: Clinical History : 4 motnhs pressure sensation on baldder. feels has to strain ot apss urine . ?? ovarian cyst/ mass. REQUESTED BY : [redacted] Bleep/Contact No : NOT KNOWN AN ADDENDUM HAS BEEN ENTERED AT THE END OF THIS REPORT RENAL ULTRASOUND. ADVANCED PRACTITIONER REPORT. Normal sonar appearance of both kidneys. Long axis right kidney = 90 mm Long axis left kidney = 101 mm No ultrasound evidence of scarring or hydronephrosis. No significant renal mass or calculi identified. Distended urinary bladder with a premicturition volume of 1426mls. Post micturition volume = 1172 mls. Atrophied uterus is displaced posteriorly but appears grossly normal with a thin linear endometrium. Neither ovary demonstrated. No pelvic free fluid. Impression : Incomplete bladder emptying with significant post residual volume. Limited assessment of the pelvic organs due to above but no gross abnormality seen. [redacted] Advanced Ultrasound Practitioner HPC Registration No: RA39172 (Reported in RIS) ADDENDUM START by [redacted] 29-Feb-2024 12:37 ALERT other - please send report to referrer. These findings may change/influence management of this patient.; 4 motnhs pressure sensation on baldder. feels has to strain ot apss urine . ?? ovarian cyst/ mass. REQUESTED BY : [redacted] Bleep/Contact No : NOT KNOWN Required on 23 February 2024 at 0000 ADDRESS: : 21 Stirling Drive, NE22 5YF FB

16 Radiology results

Key Learning Points

1. Gynaecology reporting in my area I would consider to be excellent.
2. Generally speaking, good clinical information with a question leads to a much more informative report.
3. GPs will struggle with terms and sizes used to describe ultrasound images.
4. Most GPs will only read the impression.
5. Patients read your reports.
6. Be confident in your impression.
7. Often GPs will not be aware of the significance of some ultrasound findings i.e Nabothian cysts, pelvic varices. If you work closely with gynaecology and are confident you know what happens with these patients make a comment.
8. Consider direct referral to SDEC if clear pathology that needs addressing urgently.