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Abdominal ultrasound worksheet

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Full Abdomen Worksheet \$3.00 Editable Word Document Abdomen Limited/RUQ Worksheet \$3.00 Editable Word Kidney Ultrasound Document Working Sheet \$3.00 Editable Word Document Renal Artery Doppler Sheet work \$3.00 Editable Word Document Aorta Duplex Ultrasound Worksheet \$3.00 Editable Word Document Ultrasound Sheet \$3.00 Editable Word Document 1st Cuts Worksheet Ultrasonics OB \$3.00 Editable Word Document 2nd-3rd Quarter OB Worksheet \$3.00 Editable Word Document Breast Ultrasound Spreadsheet \$3.00 Editable Word Document Ultrasound Combined Package includes: All general/surface ultrasonic worksheets shown above. Available for immediate download and editing. Save more than 50% compared to individual prices. Save up to now! Below is a list of available listings for members. They are a great resource to make reporting faster, easier and more uniform across staff. They can be inserted directly into the patient's notes. Isn't he a member? Click on the highlighted samples below for examples. Unable to open document? You may need an adobe reader. Click on this link for the official soft download site. An ultrasound report can be defined as recording and interpreting observations from an ultrasound examination. The ultrasound report must be written and by the sonographer performing the ultrasound examination and seen as an integral part of the entire exam The report must be written as soon as possible after completing the exam The name and state of the sonograph issued by the report must be recorded in the report The sonographer must assume responsibility for accuracy of the report and ensure that the report is communicated to the appropriate staff The sonographer must be aware of its limitations and, consequently, seek clinical advice when necessary. Report Style The style of the report must be concise, clear and easily understood standard reports that are understood and accepted by staff within a hospital may need to be modified for external references The potentially ambiguous phraseology should not be used Short paragraphs should be used and the burial of important avoided comments Abnormal and related findings should be grouped Irrelevant information should be avoided Technical findings should be avoided : There is a simple right of adnexal cyst present of 7.6 cm in maximum diameter, derived from the right ovary A well defined mass with mixed echoes is present in the left rectum kist. The injury is exquisitely tender The massive measures 5.2 x 4.6 x 3.6cm Acoustic or technical language should be used when significantly aiding in diagnosis. 'Ecogenic' is often used inappropriately to indicate greater reflectivity. It should be avoided unless it is qualified with a comparison such as the abbreviations increase of ecogenicity It should only be used when the user is sure that the content of the exam will be clearly interpreted And the techniques used should be documented For example: There is a large left side varicocele and, in view of this, the kidneys were examined The placenta edge could not be identified trans-abdominally and a vaginal scan Action taken should be reported For example : I have informed the patient that they have an ovarian cyst and that a follow-up scan is arranged in six weeks' time in view of the results I have personally discussed these results with Dr**** by phone A succinct conclusion should be included at the beginning or end of the Clinical Content report The report should address the clinical issue and, in general, , for the reason of the bypass. For example: Gallbladder is very tender and cholecystitis is the likely cause of right upper quadrant pain The scan confirms the clinical impression of oligohydrams. There is significant dilation of fetal bladder and bilateral hydronephrosis in accordance with bladder output obstruction The report should be conclusive when possible, indicating when appearances are consistent with a specific diagnosis. When there is no conclusion it is possible alternative explanations for ultrasonic appearances can be offered. The report should guide the referral doctor into greater management. For example: Although a calculation of the distal bile duct has not been shown, appearances agree with a distal bile obstruction and further research is advised to assess the cause of jaundice There is evidence of a significant defect of the ventricular septum and a further investigation is advised detailed cardiac anatomy Any limitation must be and, if a relevant body has not been fully examined, the reasons must be indicated. For example: the pancreas obscured by the gallbladder of intestinal gas contracts, patient not fasting The presence/absence of ascites, lymphadenopathy or distant metastases should be noted in cases of known primary carcinomas. It may be appropriate, depending on local practice, to suggest new research that may clarify the diagnosis. These include other imaging modalities such as a flat X-ray, CT scan, MRI or invasive procedures. For example: There is a poorly defined mass of 7 cm, mainly solid adjacent and separated from the left kidney. This can be the intestine or a mass of lymph nodes. Suggest CT or MRI to clarify The value of exclusion and the importance of ultrasonic appearances should be indicated when relevant. The sonographer must be aware at all times of the implications for the patient of the contents of the report and act in accordance with local guidelines. Pro forma Report / Spreadsheet When using a pro forma report, for example, in obstetric reports , should include a clear definition of what a positive, negative or lost response means. It is imperative to ensure that the precise meaning of statements made about the pro forma is clearly understood. It is recommended that a free text installation be available on the report form and used when appropriate The use of worksheets, when used in conjunction with departmental work schemes, it is useful as help memories for training purposes (Examples of obstetric ultrasonic spreadsheets can be found in the Appendix) Guidance to complete patient notes / Hospital records A provisional report written in patient notes should always be written in black ink. If the handwriting is unreadable, the report must be printed. The report must be written in an appropriate part of the notes, dated, signed and the name and status of the printed abbreviations of the reporter must be avoided and the words always written in full must be avoided, for example, DVT should be written as deep vein thrombosis, or SPV, superficial femoral vein, since it cannot be assumed that the person reading the report will be familiar with the abbreviations of the writer Fluid Corrections or sticky labels should not be used to cover errors. Any mistake that is made must have a single horizontal line through the words or phrase and initial. If the incorrect patient report is entered in the notes, then the entire report must be deleted by a single horizontal line punctuated across each line of text and signed with an explanation note, for example, mistakenly written If additional details should be included, it is advised that a continuation sheet of the case note and a patient label placed in the addresser area should be used. If a the patient's hospital number, full name, address and date of birth must be clearly admitted The provisional report must be followed by a verified printed report as soon as possible. If a second opinion has been requested for the examination or report, the person opinion should also be noted in the report and its status given Examples of examination specific reports listed in this section are common examples of report formats suitable for use with several specific references. These are not intended to be complete or prescriptive. 3.2 Breast ultrasound The report should include the following information: clinical indication for breast examination under examination location within the areas examined differential diagnostics in order of probability recommendations for more images and / or investigations The report should describe any pathology in terms of: clinical and / or radial location of mammographic correlation using the face of the standard clock annotation and distance of the size and extent of nipple lesions including the greater diameter and/or tumor volume definition of the inner margin of posterior eco-texture through the characteristics of vascular transmission of adjacent structures It should be remembered that breast ultrasound is not appropriate as a cancer screening research and has a limited capacity to demonstrate morphological changes associated with the disease in situ. Therefore, the terms are recommended no anomaly is detected and there is no anatomical alteration when no pathology has been shown. Abnormal ultrasound appearances Reference for the palpable mass of the left breast The palpable lump at the position of 30mm of the 12 at point is a well defined aneopic mass of 24mm that shows a subsequent /augmented acoustic improvement through transmission. Appearances are those of a simple cyst. Reference for examination of the right breast and Axilla: The palpable lump at the position of 4 in point 30mm is an irregular solid mass of 14 mm poorly defined that shows subsequent acoustic shadows. Internal arterial vessels show a high-speed resistance flow. Axillary lymph nodes are enlarged, round and evenly hypocoacal. Appearances are those of malignancy with the participation of LN. Biopsy of the nucleus of the needle necessary for confirmation. Reference for the examination of the left breast: The injury detected mammographically in the UOQ is a well defined solid mass of 12 mm with rear acoustic improvement and border shading. Internal arterial vessels show low resistance to low-speed flow. Appearances are those of a fibroadenoma. Histological confirmation is suggested. (There is a wide spectrum of diffuse proliferative benign diseases that can be described several times as a benign breast change (BBC), benign breast disease (BBD), fibrocystic change (FCC) or fibrocystic disease (FCD.) 3.3 General Medical Ultrasound It may be useful to have a standardized information format for normal abdominal scans that includes all organs routinely examined and which is acceptable to the imaging department and referral doctors. Various formats may be required in accordance with the reason for the in order to answer the relevant clinical questions. Below is an example of a simple factual abdominal ultrasound report: Technique: Fasting patient, fasting. Liver: Nodular appearance consistent with cirrhosis. No focal injury. Portal vein patent with forward flow. Spleen: Enlarged - 17cm (< 12cm). Gallbladder: Normal. Common bile duct: Normal - 5mm. Kidneys: 5cm simple cyst upper right kidney. Otherwise normal. Right 11.2cm. Left: 10.5cm. Aorta: Normal.Other Findings: Abdominal wall varices.Comment: The findings are consistent with cirrhosis and hypertension of the portal with a patent portal of vein and abdominal wall varicose veins. Reference for suspected bile disease Normal occurrence of ultrasonication of the liver. The gallbladder is clear. There is no evidence of dilation of bile ducts. The pancreas, spleen, both the kidneys and the aorta are normal. Reference for urological symptoms Normal occurrence of ultrasonication of both kidneys, bladder and prostate. There is no evidence of ultrasound of kidney stones, mass or obstruction. Normal ultrasound aspects of both the kidneys and the bladder. Award volume ... Mls. Rear urination volume ... Mls. Reference for the known primary carcinoma Normal occurrences of ultrasound of liver, gallbladder, CBD, pancreas, spleen, both kidneys and adrenal glands. There is no evidence of abdominal lymphopathy or ascites. Reference for the palpable rug mass Normal occurrences of ultrasound of liver, gallbladder, CBD, pancreas, spleen and both kidneys. Reidel's lobe prominently pointed out. No RUQ mass has been identified. Reference for fat intolerance The gallbladder contains several calculations. Normal common duct without dilation of the intrathatic duct. Ultrasound appearances of the liver, pancreas, spleen, both the kidneys and the aorta are normal. Reference for ruq pain The liver has increased ecogenicity with a decrease in the prominence of the portal pathways an appearance consistent with fat change. There is a highly reflective focal injury of 3 cm in segment 6 of the liver. Appearances are typical of a haemangioma, but if there is clinical suspicion of malignancy, then metastasis cannot be excluded. Normal appearances of the gallbladder, pancreas, spleen, both kidneys and aorta. Reference for bleeding varices Shrunken nodular liver. Enlarged spleen (16 cm) with varicose veins around the hilum. Reverse flow is present in the vein of the portal and intrathatic liver blood flow is increased. Patent of the right and middle liver veins – left technically difficult to prove. The paraumbilical vein of patents was anued. There are dirty ascites. Conclusion: Ultrasound appearances are compatible with advanced liver disease with portal hypertension. Reference for improved contrast ultrasound The sonographer should make sure that the report describes: - the behavior of lesions in the arterial, portal and late stages if the behavior is benign or malignant and if it is possible to conclude with the nature of the injury, for example, cases of haemangioma where the characterization of small (<1cm) are difficult or larger injuries that are atypical are referred for other technically suboptimal imaging research when a reference for more images is desirable 3.4 Gynecological Gynecological The report must contain the following information: method of examination, i.e. vaginal and/or abdominal named person as chaperone if current date of the last menstrual period (LMP) duration of the menstrual cycle Various standard report formats may be required according to the reason of the reference in order to answer the relevant clinical questions(s): pathological findings organ size internal reflectivity - cystic, solid, complex, septata, rear solid foci across transmission boundaries - definition of other associated occurrences, e.g. ascites Reference for pelvic pain Vaginal scan Day 23 of 29-31 regular cycle. Anteverted uterus - normal in size and echo pattern with a cystic structure of 5 mm in the cervical canal. Ultrasound appearances are consistent with a nabothian cyst. Xmm endometrial thickness with some fluid that has been noticed in endometrial cavity. Ultrasound appearances of both ovaries are normal for the lute phase of the cycle. Not too much pelvic or liquid has been shown. Vaginal examination with the consent of the patient. Day 18 of 28 days of cycle. Clomid 50 mg days 2-6. Reversed uterus with thickened endometrial (Xmm). Ultrasound appearances of both ovaries are normal. Lute cyst corpus 25mm in the right ovary. No other adnexal masses have been seen. There is no liquid in Douglas's bag. Ultrasound appearances are compatible with the lute phase. Reference for transabdominal examination of postmenopausal bleeding. Approximately 3 years after menopause. Ultrasound appearances are of a normal antevrte uterus with thin endometrium (Xmm) and right ovarian volume of Ymls. The left ovary was obscured by intestinal gas. There are no obvious adnexal masses although the left side is difficult to visualize. There is no liquid in Douglas's bag. Reference for minor vaginal scans with the patient's consent. 25 days after LMP. Irregular cycle 4-6 weeks. Reversed uterus containing several submucosal fibroids on the front wall, the largest of which is Xmm in diameter. Ultrasound appearances of both ovaries are normal with a luteum corpus in the left ovary. Reference for deep disparity Patient declined a vaginal scan. Irregular cycle. Anteverted uterus with thick endometrial Xmm. Ultrasound appearances of the left dnaexa are normal but the left ovary is not proven - ?absent (patient unsure of it when questioned). The right ovary demonstrates normal ultrasound appearances. Next to this ovary is a complex structure that measures YxYxYmm containing low-level echoes. Small amount of liquid pointed to Douglas's bag. These ultrasonic appearances are consistent with pyrosalpinx, tubo-ovarian abscess or ectopic pregnancy. Reference for suspected transabdominal exploration of pelvic mass. Patient says he had a partial abdominal hysterectomy in December 1986. There is a mass irregular emerging from the pelvis 15 cm in diameter. It contains several highly vascular solid areas. Uns proven ovaries. Ultrasound Appearances of the Liver Are Normal, but There Are Bilateral Bilaterals and ascites is present. These ultrasonic appearances are consistent with ovarian malignancy. In view of these findings, a CT exam can be useful for staging purposes. Reference for the Hy-Co-Sy exam: Examination carried out in accordance with departmental guidelines. Day 6 of 30 days of cycle. Transabdominal and vaginal scans performed prior to the procedure. Uterus is normal in size, shape and texture. Endometrial measures ... mms, preliminary in appearance. Endometrial measures where A ... mm; C..... mm; E..... Mm. Ovary RT (3-dimensional state); Ovary Lt (3-dimensional state) contains a dominant follicle of ... cm in diameter. HycoSy - Contrast agent xmls used. The spontaneous flow was demonstrated, with spillage over both ovaries. Bilateral tubal pathology. 3.5 Musculo-Skeletal Medical History of the shoulder: Pain in the left shoulder ?tendinitis of the cuff. There is a lower focus of tendinitis in the supraspinat tendon, but there is no tear. There is no significant bursal thickening. No normal long biceps, subscapularis and infraspinatus tendons. Normal AC joint. Medical history of the Achilles tendon: The right Achilles tendon was slightly thick and hypocoacal approximately 5 cms from its calcaneal insertion which can represent a focal tendonosis. Normal calcaneal insertion. There is no evidence of tears. 3.6 Obstetric ultrasound First Trimester - Early pregnancy • Pregnancy from unknown location 1 Transabdominal scan, EVS declined. Single gestation sac present inside the uterus. Gestation sac volume 0.4mls, equivalent to 5 + weeks. No embryos or sacks of yolk have been seen. Normal appearances with measurms in accordance with the recent positive pregnancy test. Appointment made with rescan in 10 days to evaluate the presence of embryonic, heart beats and therefore an ongoing pregnancy. • Pregnancy of the unknown location 2 Vaginal examination performed with consent. Chaperone present. Positive pregnancy test 8 days ago. Anteverted uterus with thickened endometrium. No gestation bag has been identified. Normal ovaries. Corpus luteum pointed to the left ovary. There's not too much dna to see. There is no free liquid present. Ultrasound findings in isolation do not indicate an ectopic pregnancy. However, in view of the clinical symptoms of mild right side and vaginal spotting, it is recommended greater management, for example, hCG serum monitoring. • Pregnancy of uncertain result Vaginal examination performed with consent. Chaperone is present as requested. Ms X reports a positive pregnancy test six weeks ago with some vaginal spotting. Average diameter of the gestation sac 12mm = 5 + weeks. No embryos or heart beats have yet been seen. Ms X is aware of the discrepancy between her menstrual history and today's ultrasound results. We have agreed to re-explore the findings and exclude a miscarriage. • Miscarriage 1 Vaginal examination performed with consent. Chaperone present. Average diameter of the gestation bag 40mm, equivalent to 9 + size of the week. The gestation sac was empty, with no evidence of an embryo or sack of yolk seen. The findings of an ongoing pregnancy of this gestational era would include a living embryo, 22-30mm in length and sack of yolk. These were not present. Conclusion: appearances indicate a miscarriage. • Miscarriage lost 2 Vaginal examination performed with consent. Chaperone declined. Irregular gestation sac present inside the uterus. Embryo of 10 mm seen (equivalent to 7 + weeks) but no heart beats were shown. I discussed these findings with Ms X and referred her to the gynae on-call team. Conclusion: appearances indicate a miscarriage. • DOUBLE PREGNANCY MCDA, nuchal translucency - increased transabdominal risk scan carried out. Maternal age 37 years. A single posterior placenta together with the appearance 'T sign' of the membrane intertwined in the placental interface confirm a diamiotic dichorionic pregnancy (DCDA). Twin 1, the lower twin, is on the maternal left. Twin 2, the upper twin, is on the maternal right. Twin 2, the upper twin, is on the maternal right. Gestational age = 12 weeks and 5 days Twin 1 CRL 60mm NT 1.7mm, Twin 2 CRL 64mm NT 1.5mm Trisomy Risk 21 based on maternal age = 1:242 Adjusted risk of Trisomometa 21 for Twin 1 = 1:1066 Adjusted Risk of Trisomy 21 for Twin 2 = 1:1298 Ms X is aware that nuchal translucency measures have resulted in a reduced risk for Down syndrome for both fetuses. The routine appointment of scanning anomalies has been arranged. We have also arranged 4 weekly (monthly) scans from 24 weeks, to evaluate fetal growth according to our protocol. • DOUBLE PREGNANCY MCDA, nuchal translucency - increased transabdominal risk scan carried out. Maternal age 37 years. A single posterior placenta together with the appearance 'T sign' of the membrane intertwined in the placental interface confirm a monochoromatic diamiotic pregnancy (MCDA). Twin 1, the lower twin, is on the maternal left. Twin 2, the upper twin, is on the maternal right. Gestational age = 12 weeks and 0 days. Twin 1 CRL 56mm NT 1.5mm, Twin 2 CRL 56mm NT 3.5mm Risk of Trisomy 21 based on maternal age = 1:100 Adjusted risk of Trisomy 21 for pregnancy = 1:7 Ms X is aware that nuchal translucency measures have led to an increased risk for Down syndrome for pregnancy. It is also aware that the increase in nuchal translucency has been reported as an early sign of TTTS. We briefly discussed diagnostic tests and 2nd trimester ultrasonic screening including detailed fetal heart assessment. Ms X understands there is a risk of miscarriage, in Singleton pregnancies, of about 1%, associated with both CVS and amniocentesis. We made an appointment for Ms X and her partner with our screening midwife later today to discuss the scan results and their management options. Second trimester • Singleton pregnancy, 2nd trimester dating from a single living pregnancy. HC = 130mm AC = 105mm FL = previous placenta of 22mm, not low. Gestational age, based on HC and FL dating parameters = 16 weeks and 4 days. USAT = XX. Yy. ZZZZ Ms X has already discussed screening for Down syndrome you want to do it. She understands that pregnancy is too advanced for combined screening of serum and nuchal translucency. We have her form of detection of triple test serum and sent her to take her blood today. Exploration of routine abnormalities reserved for 4 weeks. • Screening of routine abnormalities, low placenta The appearance of fetal anatomy is normal. The speed of fetal growth is normal. Normal volume of amniotic fluid. The previous placenta is low at present, but does not extend through the internal system. There is no evidence of vasa praevia as evaluated with color doppler. We have arranged to review the placental site at 32 weeks according to protocol. Ms X is aware that vaginal imaging may be necessary in this examination. • Completion of the analysis of anomalies 1 Repetition exam at 22 weeks + 4 days due to the initial poor visualization in the analysis of routine anomalies at 20 weeks + 4 days. Normal place. Normal appearance of the view of four chambers of the heart. The exit roads and fetal face could not be seen properly. Ms X is aware that we have been unable to conduct a full fetal anatomy survey and that this has been due to poor viewing due to a BMI of 36. In accordance with our guidelines we have not arranged further scans to review fetal anatomy, but since this is Mrs X's first pregnancy, we have arranged to rescan for growth at 32 and 36 weeks. • Suspected abnormal spina bifida, banana-shaped cerebellum. Cerebellum trans diameter 15mm. Dilated ventricles noted, both would be 11mm. Lumbar and upper vertebrae and skin that cover abnormal in appearance. Conclusion: appearances indicate spina bifida (L3-S2) with meningoceole and hydrocephalus. I discussed these findings with Mr X who will see the parents later this morning. I explained my findings to the parents. • Mild renal pelvic dilation Mild dilation of both kidney hairs noted. AP diameter of left pelvis 6mm, right pelvis AP 7mm. No other markers of abnormal cariotype were seen. I take into

account the low-risk Down detection result. I discussed these findings with Miss X. Re-scanning arranged at 32 weeks to control kidney hair. Third trimester fetal growth • Growth rate within normal limits, singleton pregnancy, BPD = 84mm HC = 310mm AC = 260mm FL = 65mm The fetal growth rate is within normal limits, with the head and femur measurements in the 50 centimeter and the abdominal circumference in the 10th centile. Estimated fetal weight = Xgm. Normal volume of amniotic fluid, AFI 15.5 cm. Ms X reports good fetal movements that were also observed during the examination. We have arranged a new appointment in 2 weeks to evaluate fetal growth. • Asymmetric growth restriction, singleton pregnancy BPD = 84mm HC = 310mm AC = 260mm FL = 65mm The circumference of the head is in the 40th centimeter, while that of the abdomen has fallen below 5 centimeter. Estimated fetal weight = Xgm. Umbilical artery Doppler traces with positive end diastolic flow. Average brain artery PI below 5th centimeter. Reduced amniotic fluid volume, AFI 8.5cm. Ms X reports a decrease in fetal movements in recent days. Fetal movements were seen today the exam, but the fetus was quiescent for most of the exam. These findings suggest an asymmetrical restriction of intrauterine growth with redistribution. The obstetric squad has been contacted - for review into the ANC today. We will review fetal growth in 2 weeks if it is not delivered. • Placental location, cephalic presentation of 36 weeks, BPD = 89mm HC = 325mm AC = 300mm FL = 69mm Normal growth rate. Estimated fetal weight = Normal volume of amniotic fluid Xgm, AFI = 15.0cm Ms X reports good fetal movements that were also observed during the examination. Vaginal scan performed with Ms. X's consent. The front edge of the anterior placenta is 15 mm of the internal operating system as it is evaluated vaginally. There was no evidence of vasa praevia - no ships were seen near or crossing the internal operating system as evaluated with color doppler. We have made Ms X an ANC appointment with her consultant to discuss her additional management. 3.7 Paediatric and neonatal ultrasound Clinical history of neonatal cranial ultrasound: 30 weeks premature, ?intracranial bleeding. Normal intracranial appearances. Normal ventricular size. No evidence of bleeding has been shown. Neonatal cranial ultrasound. Medical history: 28 weeks premature, ?intracranial bleeding. Peri-ventricular sclerling was demonstrated. There is an average change in the ventricular system due to an extensive area of bleeding lower than the third ventricle and that extends to the temporal cortex. Color Doppler demonstrates an active flow within this area that suggests a continuous enlargement of this bleeding area. Pediatric hips Normal ultrasonic appearance of both hips, which are in joint. (The right hip angle is x degrees, the left hip angle is x degrees). Pediatric hips Both hips are immature and the left hip is in a dislocated position. Alpha angle of the right hip is xx degrees, beta angle x degrees, Graff x rating; Alpha angle of the left hip is xx degrees, beta angle x degrees, Graff x rating. Renal ultrasound Reference for recurrent urinary tract infections. Both kidneys are normal in size and structure. There is no evidence of mass or obstruction. The urinary bladder is clear and completely empty on the urination. Reference renal ultrasound for recurrent urinary tract infections. The right kidney is markedly hydronephric with significant cortical loss. There is no apparent ureteric distress. Normal left kidney, without evidence of obstruction. The urinary bladder is clear and emptied into urination. Appearances of the right kidney are probably due to PUJ obstruction. Confirmation of a MAG3 Renogram is advised. Abdominal ultrasound Reference for palpable epistric mass. There is a large mass of mixed ecogenicity in the epigastric region of 8.7 x 9.5 x 10 cms. This is possibly related to the left of the liver, but this was difficult to differentiate. Liver texture otherwise seems normal. Pancreas, spleen and kidneys are normal. No apparent abs Differential diagnoses include hepatoblastoma, neuroblastoma and lymphoma. Further research is required for CT and biopsy. 3.8 Surface ultrasound thyroid ultrasound reference for ?goitre. Normal tests of thyroid function. The thyroid gland is normal in size and ecogenicity. There are no obvious discreet nodules. There is no lower cervical lymphadenopathy. Conclusion - normal exam. Thyroid ultrasonic reference for retrosternal goitre. This confirms a great diffuse goitre that is of altered ecogenicity in everything. There are nodules discreet. There is evidence of bilateral retrosternal extension, the most prominent on the left side. There is no lower cervical lymphadenopathy. Parotid Ultrasound Reference for swelling of the left parotid gland ?cause. There is a well-defined hypocopic mass of 1.5 cm superficially in the tail of the left parotid gland. It contains a small central cystic area. This could represent a small pleomorphic adenoma or possibly a Warthin tumor. Normal submandibular salivary glands. There is no lower cervical lymphadenopathy. Ultrasonic-guided FNA is advised. Reference of testicular ultrasonication for palpable mass. There is a well-defined mass of 2.5 cm of mixed ecogenicity in the left testis. In view of the patient's age, it is more likely to be a teratoma. Proper tests and epidymis are normal. 3.9 Caroton vascular ultrasound The report should indicate the presence of the disease including location and extension. When a significant disease is found i.e. >50% stenosis, the report should include: the psychic systolic speed peak and final diastolic speed EDV in the distal CCA (i.e. 1-2 cm below the fork) you can calculate the highest PSV and EDV that can be obtained around stenosis From these speeds, you can calculate the PSV ratio (ICAPSV/CCAPSV or St Mary's Ratio (ICAPSV/CCAEDV), but the original speed measurements should always be cited in the report. In the case of a large plate in a large bulb measure and report the diameter of the bulb and the thickness of the plate (residual lum) Qualitative note any calcification and irregular plate surface Length of the plate Record the distance of the fork underneath the mastoid process (cm) Record presence or otherwise clear lumen distal Note if the lumen of the distal ICA is clear with the filling of color and the nature of the flow i.i. pulsatile, turbulent or wet. It is necessary to point out the presence of calcification, low ecogenic plaque and any ulceration seen. Percentage of stenosis NASCET ICA Systolic Peak Speed cm/sec ICA PSV to CCA PSV ICA ratio to CCA EDV <50%ratio 125 <2%<2%<8 50-59=>125 2-4 8-10 60-6 >125 2-4 11-13 70-79 >2 30 >4 14-21 80-89 >89 >4 22-34 >90 but less than near occlusion >400 >5 >35 Near High Occlusion, low or variable chain Variable Occlusion No flow not applicable for vertebral arteries, flow direction and wave type, when pathological, should be recorded, i.e. antegrade/retrograde and transient or complete subclavian steel wave shape. Where abnormal vertebral</8> </50> </50> the maximum PSV in the proximal subclave artery should be measured <1.50 m/s).= caution= should= should= exercised= in= interpreting= velocities= when= there= is= severe= bilateral= disease= (arteriosclerosis)= or= when= there= is= concurrent= aortic= valve= disease.= where= there= is= poor= visualization= due= to= patient= habitus.= calcified= vessels.= or= a= firm= conclusion= is= otherwise= difficult= or= ambiguous.= the= report= should= note= this= and= indicate= that= further= imaging= is= required= for= a= definitive= diagnosis.= location= and= extent= of=disease= should= reported= including= start= of= occlusion= and= point= of= reconstitution.= velocities= at= discrete= should= should= measured= when= there= is= a= greater= than= two= fold= increase= in= psv= at= the= stenosis= relative= to= the= proximal= psv.= indicating= a=> (normal 50% stenosis. Measured values should be cited in the report, for example(from 1.2 to 4.7 m/s). It may be appropriate to summarize the observations, for example: Widespread narrowing throughout the SFA-popliteal segment or uneven lumen throughout or SFA was ecstatic. Indicate the quality of the distal wave shape, for example, the wet flow below the knee or Flow remained good and pulsating at ankle level. Note that the quality of the distal run-off i.e. are the vessels of normal/narrow caliber in the ankle, are patent of rear and earlier tibial arteries. Ultrasonic Research for Deep Vein Thrombosis (DVT) Note which veins have been evaluated and record their compressibility and presence / absence of color filling Note the presence /absence of fasmal flow with breath or Valsalva in proximal veins Note whether vigorous/slow enhanced flow is seen in manual distal compression Where the trombone is identified, record your location and extension and if there is any pathetic through ultrasonic research trombe for the varicose occurrence Vein Note and the location of reflux in the LSV and SSV distributions. Includes anterior thigh vein and giacomini vein when you see Note the presence of incompetence in SFJ and SPJ Note occurrence of reflux at mid-thigh and large calf piercings Note any incompetence in distal popliteal vein (reflux >1 second) and gastrocnemius vein (when seen, usually runs to a puncher in the calf) In the case of recurrent varicose veins, veins, determine and report the source of any incompetence seen with reference to milestones: Example: Absent LSV, Incompetent anterior thigh vein runs from SFJ to lateral knee border, incompetent surface vein runs from mid-thigh piercing 10 cm above the knee, LSV present and incompetent from 6 cm below the SFJ with communicative vein to incompetent SFJ , large incompetent piercing 8 cm above medial malleolus. Vein marking for harvesting or other pre-surgery ultrasound With the patient standing or sitting to ensure determine the location and measure the diameter of the vein (it must be greater than 3-4 mm for use as graft). The marking is done with a water-colored pencil and is then marked with a permanent marker, as the gel is removed from the skin. The report must take into account the vein <1.50> </1.50> and the location of the right vein, for example, good LSV at 8 cm below the knee – more than 4 mm throughout. Marked vein. Marked.

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