United Kingdom Collaborative Trial of Ovarian Cancer Screening

PELVIC ULTRASOUND SCAN RESULTS

First Name _____ **Surname** _____ **Volunteer Ref No** _____

Date _____/_____/_____ **Ultrasonographer** _____

Please tick the relevant box

Mode of scan ☐ TRANSABDOMINAL ☐ TRANSVAGINAL ☐ BOTH **Latex allergy** ☐ YES ☐ NO

Period in last year ☐ YES ☐ NO **Date of last period (if within the last year)** _____/_____/_____

Type of HRT if used ☐ ESTROGEN ☐ PROGESTOGEN ☐ COMBINED CYCLICAL (CONVENTIONAL)
☐ COMBINED CONTINUOUS (NO BLEED) ☐ TIBOLONE ☐ OTHER

Hysterectomy ☐ **Previous oophorectomy** ☐ NONE ☐ LEFT OOPHORECTOMY ☐ RIGHT OOOPHORECTOMY

DETAILS OF OVARIAN SCAN

	LEFT OVARY / ADNEXA	RIGHT OVARY / ADNEXA
VISUALISATION MUST BE COMPLETED	☐ SEEN ☐ NOT SEEN / GOOD VIEW ☐ NOT SEEN / POOR VIEW ☐ NOT SEEN / PREVIOUS OOPHERECTOMY	☐ SEEN ☐ NOT SEEN / GOOD VIEW ☐ NOT SEEN / POOR VIEW ☐ NOT SEEN/ PREVIOUS OOPHERECTOMY
If ovary not seen, reason	☐ BOWEL ☐ FIBROIDS ☐ PELVIC VARICOSITIES ☐ OTHER	☐ BOWEL ☐ FIBROIDS ☐ PELVIC VARICOSITIES ☐ OTHER
OVARIAN DIMENSIONS	mm mm mm	mm mm mm
Morphology MUST BE COMPLETED IF OVARY SEEN (If COMPLEX please write description of findings in abnormalities notes box & complete other side of this form. Also enter reference number at top of page)	☐ NORMAL ☐ SIMPLE CYST ☐ COMPLEX MORPHOLOGY	☐ NORMAL ☐ SIMPLE CYST ☐ COMPLEX MORPHOLOGY
	If <u>midline mass</u>, please enter under left or right adnexa and describe below If <u>longstanding UNCHANGED complex morphology</u> which has been previously investigated on UKCTOCS screening and is being managed conservatively, please fax form to Susan Davies on 0207 380 6929 for data entry	
Number of Cysts **(more than 1 cyst = complex morphology)**		
Ovary mobile?	☐ YES ☐ NO	☐ YES ☐ NO

Max double endometrial thickness _____ **mms** **Fluid POD or ascites (max vertical diameter)** _____ **mms**

Details of abnormalities: **Referred in view of incidental findings** ☐ YES ☐ NO

Type of Image Record ☐ NONE ☐ DISK ☐ PHOTO ONLY ☐ BOTH DISK AND PHOTO

***Result Classification /Recommended Action <u>Must Be Completed</u> At Time Of Scan**

☐ NORMAL hence ROUTINE SCREENING ☐ UNSATISFACTORY hence REPEAT LEVEL 1 SCAN

☐ ABNORMAL therefore LEVEL 2 / SURGERY **(If any other option required, contact Susan Davies on 0207 380 6913)**

- **As defined by protocol.**

Entered Signature Date

Checked Signature Date

Signature_____ Date _____

DETAILS OF ANY OVARIAN / ADNEXAL LESION DETECTED **VOLUNTEER REF (Please enter)**_____

	LEFT OVARY/ADNEXA	RIGHT OVARY/ADNEXA
Cyst dimensions	mm mm mm	mm mm mm
Cyst wall thickness	mm	mm
Cyst wall structure	☐ SMOOTH ☐ IRREGULAR	☐ SMOOTH ☐ IRREGULAR
Fluid in cyst	☐ ANECHOIC ☐ RANDOM ECHOGENICITY ☐ UNIFORM ECHOGENICITY	☐ ANECHOIC ☐ RANDOM ECHOGENICITY ☐ UNIFORM ECHOGENICITY
Cyst structures	☐ SEPTAE ☐ PAPILLATIONS	☐ SEPTAE ☐ PAPILLATIONS
Maximum septa thickness	mm	mm
Size of largest papillation	mm	mm
Solid areas	☐ Yes ☐ No	☐ Yes ☐ No
Overall impression of lesion (Classification using International Ovarian Tumour Analysis criteria) **MUST BE COMPLETED IN THE PRESENCE OF AN OVARIAN LESION**	☐  Unilocular cvst ☐  Unilocular solid ☐  Multilocular cvst ☐  Multilocular solid ☐  Solid	☐  Unilocular cvst ☐  Unilocular solid ☐  Multilocular cvst ☐  Multilocular solid ☐  Solid

DOPPLER STUDY OF ABNORMAL AREA

Doppler performed	☐ YES ☐ NO
Presence of colour signal	☐ YES ☐ NO
Location of colour signal	☐ SEPTAE ☐ WALL ☐ SOLID AREA ☐ PAPILLATIONS ☐ OTHER
Lowest RI measured	
Lowest PI measured	
Peak systolic velocity	

Findings suggestive of ☐ DERMOID CYST ☐ ENDOMETRIOTIC CYST

Were scan images reviewed at CC? ☐ YES ☐ NO

Person at CC with whom results discussed _____

Suggested management ☐ AS RECOMMENDED ☐ OTHER **(if other, please enter details in notes)**

NOTES