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Abdominal ultrasound is a safe and painless test using sound waves to make images of the abdomen (belly). During the test, the ultrasonic device sends a sound wave to the abdomen and the image is recorded on the computer. Black and white images show the internal structure of the abdomen, such as appendix, intestine, liver, gallbladder, pancreas, spleen, kidney, urinary bladder. Full ultrasound of the abdomen evaluates all of the organs of the abdomen. Limited ultrasound of the abdomen evaluates one or more organs, but not all. The doctor orders abdominal ultrasound when you are concerned about symptoms such as abdominal pain, repeated vomiting, abnormal liver or kidney function tests, or swollen belly. Abdominal ultrasound shows the size of the abdominal organs and helps to assess the injury or disease of the organs of the abdomen. Certain conditions that help with ultrasound diagnosis include: appendicitis (inflammation of the appendix) pyloric stenosis (narrowing of the lower part of the stomach, blocking the passage of food from the stomach to the intestine, stones of the kidney or gallbladder abdominal mass such as abdominal tumors, cysts, or abscesses can be used to guide procedures such as needle biopsy or catheter insertion (needle or catheter). Abdominal ultrasound is also used to monitor the growth and development of babies in the uterus during pregnancy. Preparation In everyday cases, children often need to be prepared before abdominal ultrasound, and doctors may ask them not to eat or drink anything a few hours before the test. However, in an emergency, abdominal ultrasound may be performed without preparation. Before the test begins, you need to tell the technician about the medication your child is taking. Procedure Abdominal ultrasound is usually performed at a radiology department or radiation center in a hospital. Parents can usually accompany their children to provide peace of mind and support. Your child will be asked to change into a cloth gown and lie on the table. The room is usually dark, so the picture can be clearly seen on the computer screen. A technician trained in ultrasound imaging (sonographer) spreads a transparent and warm gel on the skin of the abdomen. This gel helps to transmit sound waves. The technician moves a small wand (transducer) over the gel. The transducer emits high-frequency sound waves, and the computer measures how the sound waves bounce off the body. The computer will change those sound waves to the image to be analyzed. Sometimes the doctor comes in at the end of the test to meet your child and take some more pictures. Typically, this procedure is less than 30 minutes. What to expect is that abdominal ultrasound is painless. Your child may feel a slight pressure on his belly. It may move over the body and make the gel wet or cold. You need to tell the child to lie still during the procedure so that the sound waves can effectively reach the area. The technician may ask your child to lie in a different position or hold his or her breath for a short time. Babies may cry in the ultrasound chamber, especially if they are restrained, but this does not interfere with the procedure. Radiologists who get results (doctors who are specially trained in reading and interpreting X-rays and ultrasound images) interpret the results of ultrasound and give information to your doctor to review the results with you. If the test results look abnormal, a doctor may order further tests. In an emergency, ultrasonic results can be ready immediately. Otherwise, you will usually be ready after 1-2 days. In most cases, the results cannot be given directly to the patient or family during the test. Risks are not associated with abdominal ultrasound. Unlike X-rays, radiation is not involved in this test. Some young kids who help your child may be afraid of the machines used for ultrasound. A brief explanation of how abdominal ultrasound is performed and why it is done can help relieve any fear. You can encourage him or her to tell your child that the equipment will take pictures of the belly and ask the technician questions. Tell your child to try to relax during the procedure because strained muscles can make it more difficult to get accurate results. If you have any questions about abdominal ultrasound, please talk to your doctor. You can also talk to a technician before the exam. Review: Do Kids Health Medical Professionals Work Off Campus? Many sonographers have already regularly compiled formal reports, but others are transitioning to the role of clinical ultrasound, which is expected to be reported. This article summarizes best practices for reporting ultrasound based on international literature and discusses key topics such as reporting structure, clinical content, style, and language. A number of examples and sample phrases are provided, and common pitfalls are discussed. Continued advances in ultrasonic technology, combined with the wide availability of ultrasound and its excellent safety track record, have resulted in an increase in the clinical usefulness of ultrasound technology across all medical disciplines and a dramatic increase in clinical demand for ultrasound 1. In this changing medical environment, sonographers have long been recognized as experts in ultrasound imaging and are given considerable professional respect, autonomy and responsibility. All sub-specialty studies have shown in many studies.3-11 For this reason, sonographers are now expected to run as well as more and morePerform an inspection, but make a 2,12, formal written report to provide diagnostic interpretation. 14 Some countries, such as the UK, have a long tradition of sonographer practices, including the official reports 13 and 15 offers in Australia and New Zealand, but the practice of sonographer reporting differs greatly between individual sonographers and between different departments. The formal tiering of 17 sonographers, 2, who formally tier the ultrasonic profession into a minimal competent sonographer and an advanced or professional sonographer, has not yet occurred. A study conducted by the AsUM branch of New Zealand in July 2011 found that 48 percent of sonographers had already prepared a formal report, and 20 percent of sonographers routinely prepared a formal report that radiologists would not have seen before they were reported to a reference clinician. Indeed, the reporting responsibility of sonographers has been recognized for years in New Zealand employment contracts under the titles Reporting Sonographers, Professional Sonographers, and Clinical Specialists Sonographers. The purpose of this article is to provide a detailed overview of best practices in the formal reporting of ultrasound tests supported by comprehensive literature reviews. A wide range of healthcare professionals who perform ultrasound are involved in providing diagnostic reports. This includes sonographers, radiologists, and point-of-care practitioners (emergency physicians, general practitioners, sub-specialists, midwives, nurses, physiotherapists, and other ultrasound-trained healthcare professionals). Specific instructions in practice, peer review and audit.23, 25 formal report writing, directed practice and audit must be part of the training of sonographers. Academic and professional institutions that provide ultrasound training programs must ensure that formal written reports are incorporated into the academic curriculum. Curriculum (September 2017, E-mail from Dr. Armour Aziz of CQ University) 28 The University of Auckland plans to introduce it in the future (e-mail from Associate Professor Jenny Sim, September 2017). Monash University, University of South Australia and Queensland Institute of Technology are not going to work on curriculum reporting in the short term (e-mail from Paul Lombard, course combiner master of medical ultrasound, e-mail from Associate Professor Kelly Twar in September 2017, and e-mail from course coordinator Medical Ultrasound in September 2017). There is a good agreement with the literature on the structure of the ultrasonic report.13, 22, 23, 25, 29-31 In general, the ultrasound report should include the following sections: (1) Title (2) Patient Identification, Demographics, Date, Recipient, Provider Details (3) Indications: History and Clinical Information (4) Technical and Procedural Explanations (if Necessary) (5) Observations (a) Normal and Abnormal Observation (c) Diagnostic Comments (6) Impressions/Conclusions (7) Names of Individuals Involved in Inspection (8) The types of reference criteria to include reference criteria in footnotes (if necessary) must be clearly identified. Abdominal ultrasound is targeted at targeted hepatobiliary ultrasound in the right inguinal portion, since the evaluation of implantability test ultrasound patients in ICU often exceeds a simple scanning procedure, the term scan should be avoided. Unlike other radiation scans, ultrasound includes important elements of clinical interaction between sonographers and patients, for example, historical photography, observation, palpation, dynamic evaluation using various maneuvers, sonopation and evaluation in different body positions. It's not a scan, it's a comprehensive inspection. It is important that the report is correctly identified by the patient's name, date of birth, and one of the following: address, national health identifier, patient clinic identifier, clinic attendance code or other similar identifier. 30 The date and time of the inspection (if appropriate) must be clearly stated. The sonographer must verify the referer and recipient and verify that there are steps in place to receive the report, whether the recipient is in electronic or hard-copy format. For external reports, the facility name and contact details must be clearly stated. Patient history and clinical information may come from a number of sources, including historical and clinical information provided by the referer. History and clinical information from other medical records; Clinical observation by sonographers; The patient's relevant clinical history should be copied from to include it in the report. Many patients have a thorough medical history, including multiple joint morbidity, continuous investigation, complex interventions, detailed management plans, and extensive medication regimes. It may not be practical (or desirable) to include all of this information in the body of the report. In these cases, the sonographer must exercise sound clinical judgment and select clinical information specifically related to ultrasound and clinical problems. Sonographers working in community or third-grade centers may be able to obtain valuable medical records (hospitalization and discharge summaries, clinic letters, surgical reports, laboratory tests, past imaging tests) as well as valuable medical history from other sources, including hardcopy notes. Access to medical records may become more universally available in the near future as more patients choose cloud-based medical records storage. To encourage sonographers to access all available clinical information during ultrasound examination, some departments have systematized such practices in the ultrasound protocol manual: 33 Before starting ultrasound, the sonographer should check the referral letters from the patient: laboratory and PACS images (if necessary) All relevant medical records, including Clinic documentation, should be reviewed. Complaint of the patient's presentation has changed, or the patient can reveal undiscovered public information that may help the patient evaluate the patient and interpret the test. If appropriate, the sonographer should also evaluate the patient clinically before starting ultrasound. 34 Visual evaluation and palpation of specific areas of interest can create important clinical clues to ambiguous ultrasonic appearances with a wide range of differences. For example, surface mass, anatomical position, size, shape, number, firmness, compressive, variation, smooth or irregular boundary, related skin changes, decoloration, erythema, heat, duration, edema, pain or tenderness, packing, exclusion, mobile, skin pulling, packing, closing, it can be evaluated clinically for parameters such as other features. When engaging a patient in clinical examination or piloting performance, such as during ultrasound examination, the test and its results should be noted: the patient experiences pain and movement restrictions with the abduction of the arm more than 45 degrees. All relevant observations should be noted in the report and included in the source of the confirmed information. Examinations such as abdominal or small partial ultrasounds are useful for professional examinations such as transvaginal ultrasound, specific vascular examinations, contrast-enhanced ultrasound, marking for bedside drainage, etc. Contrast-enhanced ultrasound was performed using a picture-defining @ perflutren microcol (IV borus injections: X, total volume of contrast: Xml). High-resolution ultrasonic evaluation of cranial sutures was performed. The resting ankle-arm pressure index (ABPI) was 1.0 between the two countries. The patient was challenged to walk for 5 minutes on a treadmill set at a slope of 10 degrees and a speed of 3.5 km/h. A typical report should present the findings in a logical order, in the order in which the tests were performed or in the order of clinical priorities. Comprehensive structured testing allows you to list specific organs and test sites to clearly communicate to the subjects what they have and what is not (Figure 1). Example of an itemized reporting template for normal upper abdominal ultrasound. For the subject test, a brief explanation may be more appropriate: the right pleural exudation fluid simply (not sepsis) appears to be suitable for transdermal bedside drainage. Suitable sites are marked on the patient's skin with permanent markers. The Report End report should itemize and describe normal and unusual observations and provide relevant interpretation comments. Any abnormality should be modified by its exact anatomical position, image characteristics and measurements. 13,22,30,31 segment 8 of the liver includes irregular thick collection 4.5x3.5x2.8cm of size containing particulate contents of the liquid level. Clinical history and image discovery are in agreement with liver abscesses. Classic, obvious abnormalities with the appearance of the lesion can be directly referenced and do not require a long technical explanation. (Not: The ovaries contain a single, round, thin wall, anechoic, fluid filling, vascular structure with admirable acoustic enhancement, vascular structure that matches a simple cyst.) Some gallstones were pointed out to be up to 3-6 mm in size (Not: the gallbladder measures the size of 3-6 mm and contains several highly echo-sourced, rounded, moving float lesions with the back acoustic shadowing properties of gallstones.) Accidental findings are 37 recognized and should be addressed. For example, accidental detection of polycystic solid cystic mass in postmenstrual women exhibiting upper abdominal ultrasound ensures extending the examination to include detailed transvascular and vaginal scans of the pelvis. Normal anatomical variants should be reported even if they are not clinically significant at the time of testing. Some variants (uterine anatomical variants and uterine anatomical variants) may become clinically relevant in the future. Replication of the femoral vein attracted attention. This is a common normal anatomical variety. Uterus: size: 7.2x4.2x5.0, volume: 79ccs (normal) orientation: extrathelmal form: If the examination is extended or reduced within the anesthetic range, this reason should be recognized and justified. The test was extended to include Doppler evaluation of the mesomal, portal vein and hepatic vascular system. The findings are in agreement with the right testicular new organism. Tests were extended to evaluate the splenic code, local lymph nodes and kidneys. I informed Mrs. Smith about the benefits of transvaginal ultrasound to assess the thickness of the endometrium, but she declined. When measurements are provided, it is important to make sure that the units of measure are used consistently. For example, in an obstetrics report that shows various measurements, measurements in centimeters and millimeters should not be mixed. Sonographers should consider rounding the measurement to a realistic degree of accuracy, as necessarily directed by a given clinical scenario, in the same format that they are provided on the ultrasound system. For large structures such as organ size measurement and mid-trimester fetal biometry, it is appropriate to round to the nearest millimeter. However, in finer structures (newcal translucent, bile ducts, etc.), it is necessary to round to the nearest one-tenth millimeter. Fetal biometry: BPD . . . . . ± . . . . . For example, if the fetal middle cerebral artery pulsation index is above the 95th percentile of the reference chart, it may seem to be outside the normal limits. However, the type of study and its date should be noted when compared to previous studies.39 is defined as abnormal only if the measurement falls below the 5th percentile. Small indeterminate lesions described in segment 7 represent a simple cyst measuring a diameter of 6 mm. Direct comparison is particularly important when monitoring sonographers are investigating patients for the presence of interval changes. The presence or absence of changes should be clearly stated. The previous 4.5 cm AAA is not changed. Monitoring of the time of 12 months is arranged according to the guidelines of the department. Conversely, it is necessary to acknowledge the lack of research for comparison, especially if clinicians require repeated testing at another facility and previous image records are not available. Previous ultrasound tests performed at [Clinics, Cities] in dd/mm/yyyy are not available for direct comparison. You can't comment on changing the interval. Apart from the performance of ultrasound scanning, the sonographer clinically inspects the patient with a transducer (sonopalpate), has the ability to observe important physiological or pathological changes in various clinical maneuvers or different patient positions. These observations can provide further clinical information. It is worth including these findings in the body of the report: the left ovary and the left adnexa are not friendly to the application of transducer pressure. The area of pain in which protrusions of the upper spinal muscles are seen beyond the abduction of 45 degrees corresponds directly to retic clusters, but morphologically normal indural nodes. This finding is in agreement with lymphadenosis. It is debatable to see how useful the image quality comments will be to the responders of the diagnostic report, but significant technical drawbacks that may affect the interpretation of the test need to be recognized. On the other hand, excessive hedging is generally considered useless because, on the other hand, clinicians may not understand how dependent the results can be. These considerations should be disclosed if the quality of the test significantly impairs the confidence of the sonographer's diagnosis, or if the test is non-diagnostic. Whenever possible, you should provide suggestions on how to achieve diagnostic results. Evaluation of the liver with ultrasound is non-diagnosis due to technical limitations associated with high BMI. Considering the background of the rise of hepatitis B and AFP, it is necessary to consider other cross-sectional imaging. The anatomy of the fetus' heart and face cannot be assessed due to the unfavorable fetal position. In order to complete the fetal morphology evaluation, it is recommended to repeat the ultrasound in a week's time. Sufficient transvaginal and vaginal ultrasound of the pelvis cannot be achieved because the patient is experienced severe pain and the examination cannot be tolerated. The exam was canceled. Transvaginal pelvic ultrasound may be achievable in light subsides. Contact x team at extension 1234Discuss. Like all medical professionals who use ultrasound (radiologists, point-of-care practitioners, emergency physicians, etc.), sonographers may not have a full spectrum of expertise in all subspecialties of ultrasound. For this reason, sonographers must resist the temptation to provide specific diagnoses in areas outside their field of expertise. For example, a sonographer working in a private center may be very skilled in performing fetal morphology scans, but may not be skilled in the performance and interpretation of fetal echocardiography. In the case of accidental detection of complex congenital heart failure, (a) it is more appropriate to withhold certain diagnostic comments, (b) testing the fetus' heart causes suspicion of congenital heart failure, (c) A complete range of relevant diagnostic comments will be introduced to a third-level fetal medical unit for formal echocardiography that can be rendered in the format required by the sub-specialized Pediatric Cardiology Team. Fortunately, sonographers most often work as part of a team in a clinic or hospital environment. These environments provide a wealth of opportunities to consult with colleagues to solve complex imaging problems. The final summary should include final interpretation comments, recommendations (if necessary), and additional actions. New information should not be introduced into conclusions that do not exist in the Survey Results section of the report. 30, 32, 43 Urgent or important findings should be prioritized and listed first in non-critical findings 25, 32, 44Impression:1 Acute calcareous cholecystitis 2 simple cysts of the left loba of the liver 4 liver without biliary dirlitis: discovery strongly suggests an extrauterine pregnancy of the ruptured right side. The incidental note was made with a simple left ovarian cyst. The patient was immediately transferred to an emergency room after the examination. The terms impression, conclusion, and summary are preferable to diagnosis as a problem of read efficiency, but many clinicians tend to skip the body of the report and refer to the conclusion immediately. With regular inspection, the summary can be easy. Normal abdominal ultrasound. The cause of RUQ pain was not identified. The growth of the fetus was normal. Prominent ultrasound examination of the right shoulder. In other cases, it may be appropriate to state whether the findings are good or related. Occasionally, premature atrial contractions were pointed out. These usually represent a good fetal arrhythmia that resolves spontaneously. If CTG or bedside Doppler tests do not increase the likelihood of upper chamber tachycardia, no further imaging is required. The presence of multiple target lesions in the right loba of the liver is of great concern of the transition. A simple report is acceptable if you do not have a conclusion .25, 30, 31 interpretation and diagnostic comments can be made within the survey results section or concluded according to the length and style of the report. The size of the fetus is normal. The mother does not report loss of fluid, but early rupture of the membrane is the most likely cause of anesthetic hydrothermal failure. Interpretation should put the founding of ultrasound in clinical context. Sonographers should consider all information (image discovery, patient history, clinical presentations, laboratory findings, past imaging and other sources) when make rigorous clinical decisions and formulate diagnostic opinions. Whenever possible, diagnostic comments should be direct and conclusive.32,42 tactile scrotum mass corresponds to simple testicular cysts. There is no mass of testes. If this is not possible, it is necessary to provide a clinically realistic difference and be properly ranked in terms of probability or clinical priority (Figure 2), the cause of 22 biliary expansion is not visualized. Given the acute presentation combining pain and jaundice and the presence of gallstones in the gallbladder, cholethermia is considered very likely. The pancreas is well visualized and looks normal. Although ampoule-level pathology is unlikely to be excluded by ultrasound alone, an extensive list of differential diagnostics is generally not useful and should be avoided. If 44 findings are clear or uncertain properties, the sonographer can still narrow the difference to the processes that may cause (inflammatory, novel, ischemic, hemorrhagic or other), appearance may indicate the possibility of representing a good or ominous process it may be able to indicate. Palpable mass, loss of normal hiller pattern, rounded shape, asymmetry of normality thickness, enlarged showing a plurality of features, including microvascular margins and low perfusion zones, morphologically it represents abnormal lymph nodes. Clinically unrealistic differences should not be included or rejected. Right testes: length: 4.5 cm, volume: 14.5ccs (normal), color Doppler perfusion: normal normal recurring torsions were excluded. Any found that has any or less clinical significance should be recognized as such in an appropriate and qualified comment. 32, 41, 45 two small gallbladder polyps were pointed out by measuring sizes 2 and 3 mm. These are not clinically important and do not require further follow-up. In separation, choroidal cysts represent the discovery of goodness, and no further evaluation is required. Sonographers should make sure that the report deals directly with all clinical issues raised in the referral. In addition, sonographers should also predict clinical questions that are not explicitly listed in the referral. In some cases, mentioning the lack of specific finds can reassure clinicians by emphasizing that sufficient attention is paid to the area of concern. The cause of RIF pain was not identified by intraperitoneal or transvaginal ultrasound. Specifically, there is no evidence of gynecological abnormalities, appendicitis, or urolithritis. The anatomical cause of menstrual hagia was not identified. Specifically, endometrial thickening, polyps or fibroids were not detected. Occasionally, sonographers may need to ignore misleading clinical information that may have led the referer to suspect disease processes other than those that ultrasound convincingly indicates. The patient reports an acute onset of left testicular pain after a sports injury, but ultrasound sites are strongly suspected of testicular malignancies instead. There is no sonography evidence of trauma. Finally, when creating a diagnostic comment, the sonographer must be aware of his/her level of ability. Sonographers should exercise careful thresholds to seek advice and second opinions from senior colleagues such as expert sonographers, radiologists or sonologists, especially if they need a multimodal approach to reach the diagnosis. Compliance with evidence-based practice principles is particularly important. In many cases, sonographers can refer to established local, national or international guidelines when make recommendations: 36, 46-54 No evidence of intrauterine or ectopic pregnancy was detected. This is an unknown place (PUL) pregnancy. Clinical monitoring and continuous bHCG are recommended. Repeated transvaginal ultrasound, bHCG can be provided when it reaches 1000 iu / l, or when the clinical presentation of the patient is changed. The discovery of late-stage end-of-life dilation of the umbilical artery in the fetus at 28 weeks is of great concern and immediate professional obstetric opinion is recommended. By the way, simple asymptomatic ovarian cysts with a diameter of less than 5 cm in pre-menopausal women generally do not guarantee further monitoring. Alternatively, the report should clearly state which tests and when patients should be re-referenced. We recommend AAA monitoring in 6 months. I made repeated ultrasound reservations at the Vascular Laboratory in dd/mm/yyyy. As the final step in creating the report, you need to make sure that the sonographer is dealing with all clinical issues. In special circumstances, such as in the event of an unexpected or urgent nature, the actions taken should be recorded in the report. I informed Mrs. Smith that she had severe deep vein thrombosis, and I arranged for her to go to the emergency room for the examination. Considering the urgency of the findings, I talked about the results with Dr. T Smith, a urologist registrar, over the phone. Ultrasound confirms clinical suspicion of large AAA measuring up to 7.4 cm of AP diameter. I immediately consulted with Dr. J. Smith, a vascular consultant. You should be aware of the names and names of all individuals involved in the exam. This includes sonographers, trainees, registrars, chamerones, radiologists, nurses, and clinicians. This allows the referencer to contact the person with direct knowledge of the inspection directly if the reference needs clarification or intends to discuss the report further. However, such information may enhance the report by informing the reference clinician which standards were used to interpret the test. Such practices are common in his/herological reports. The grading of renal expansion and management comments detected before new Zealand National Birth Asymptomatic Renal Expansion Consensus Group Statement 2017. After birth Grade N (normal) - AP renal pelvic diameter &lt;10mm, follow-up recommendation without peripheral expansion: normal scan of 1 month ago - normal scan after 1 month to repeat in 3 months - further follow-up Multiple standards for interpretation of the same discovery are used by different ultrasonic sources and may also be useful when the application of different criteria may affect the final result. Interpretation of carotid artery stenosis was carried out in accordance with a joint recommendation on the reporting of carotid artery ultrasound in the United Kingdom (2009). Ultrasound reports should be balanced between brevity and sufficient clinical details. 32, 44, 57, 58 sonographers should fully understand the information relevant to the reference clinician and adjust the report accordingly by prioritizing clinically important observations. Clinicians tend to prefer structured, detailed reports rather than serridial reports written in a story format. Renal parenchima shows normal thickness and echo texture. Mass, stone, hydronephrosis was not detected. The same information provided in a concise and structured format: right kidney: 10.5 cm long, normal structured reports also make it easy to compare with previous reports because the information is always in the same expected location and in the same format. The Ultrasound provider seeks input from the source in the development of the report template and strives to develop a structured, consistent reporting style that meets the needs of the consumer to ensure that the report meets the expectations of the consumer (Figure 3). A range of report samples and templates are available online .13, 23 and 63 body of simple structured obstetrics reports developed by sonographers with input from obstetric teams (Waikato Hospital, Hamilton, New Zealand). In some cases, a detailed report may be preferred, but in some cases a simple story report may be suitable for testing the nature of the subject. Target ultrasound right post-swing wrist indications: 53-year-old male, T2DM, bee folliculitis on the dorsum of the right wrist, joint outflow, septic arthritis, ? Areas of redness and swelling, including the back wrist, show a single subcutaneous abscess of 52x47x9 mm, and the internal volume is 11.5ccs. The distance from the surface of the skin to the center of the abscess is 10 mm. Conclusion: Subcutaneous abscesses are suitable for transdermal drainage. Sonographers should keep in mind that highly specialized reports commonly understood in the environment of sub-specialists or inpatients may need to be adjusted or presented for understanding by recipients working in outpatient or primary care. Clear, concise, specific, clear, and easy to understand by a variety of recipients, from sub-specialists to GP's to other medical professionals involved in patient care. . 41, 64 more and more, reports are also read by patients.41, 65 sonographers should refer to established guidelines or vocabulary and follow widely accepted formal terms. For example, the term complex should not be used to describe ovarian foundries because the term is ambiguous and may refer to the appearance of the range from normal (hemorrhagic cyst) to malignancy (ovarian cyst cancer). Description of normal appearance usually includes the term normal, not surprising, sonography abnormal or abnormality is not detected. Some authors prefer the more conclusive term normal, but it is important to recognize that the lack of abnormality does not necessarily guarantee that the organ in question is normal in all respects. For example, patients exhibiting hepatobiliary ultrasound with adetectable LPT due to acute hepatitis are most likely to exhibit normal ultrasound appearance of the liver. It would be wrong to say that the liver is normal. The liver is certainly not normal. It would be accurate to say that ultrasound appearance is normal or no unusual anatomical causePointed out or looks terribly pronounced in the liver. Figure 4 includes a sample of descriptive ultrasound terms commonly used. Generally used explained ultrasonic terms. Highly specific histological terms should be used with caution. Ultrasound mainly provides anatomical and acoustic features of discovery. In some cases, it may be appropriate to provide histological claims: 4cm solid, xenologous, angiologous nephromas were detected, which could represent renal cell carcinoma in the polar region of the left kidney. In other examples, the appearance of sonography represents a wider range of pathologies, and broader and more comprehensive terms are appropriate. Solid hypomyphyotic testicular mass (not semi-cell tumor) uniformly echo-primitive lesions of the fetal chest about malignant tumors are most likely to represent congenital pulmonary pleychic malformations (rather than type 3 cystic adenoma malformations) reports should be written in clear and specific forms. Examples of common sentences and wording errors and pitfalls are shown in the sentences and wording errors and pitfalls in Figure 5.25,32. Writing in the first person shows compassion and can add a nice personal touch to other formal and passive reports. I explained to Jenny and her husband that further scanning was needed to complete the evaluation of fetal anatomy and that they had arranged to return a week later. I discussed the results of the carotid Doppler test with Mrs. Smith and reassured her about the lack of carotid artery disease. The use of abbreviations is not recommended because they can be ambiguous or unfamiliar to the recipients of the report. Consider that medilExicon 71, the largest online database of 70 pharmaceutical and medical abbreviations, contains more than 230 000 abbreviations. For example, the abbreviation AML, normal anatomy (front mitral valve leba), from benign renal neoplasm (vascular muscle vesicles) to ominous hemetological malignancies (acute myeloid leukemia), has seven potential applications. Only the most commonly understood abbreviations, such as RIF and AAA, are allowed. If an abbreviation is required, it must be defined the first time it is used in the text. The former accessory Saphenus Vein (AASV) is also incompetent and will result in varicose veins under 20cm under the folds of the inguinal area. AASV is suitable for thermal ablation. Whenever possible, sonographers should use consistent terminology to describe the same discovery in the same patient in the same discovery and follow-up test in different patients. Inconsistencies in the description can be difficult for the reference physician to interpret. For example, for the same stable patient with long-standing cirrhosis due to autoimmune hepatitis without interval change in three years, the following three descriptions were provided: 1 year: liver size, shape and echo texture is normal. YearsThe liver appears as expected because of its known history. Year 3: Hepatic texture quality is not noticeable, no no nodules, increased bulk and minor volume redistribution of the left leba, there is no evidence of portal HTN. These types of reports, vascular surgeons to show a strong preference of the figure rather than text34 of plain text, have been commonly used in vascular laboratories (Figure 6). Another type of graphical report that may become popular in the future is an image-rich radiology report. Such a report contains a selection of annotated images. Left image: Provided by author, Tristram Vascular Ultrasound, Hamilton, New Zealand. Right image: Deb Coglan, Precision Vascular Imaging, Courtesy of Brisbane, Australia. The ultrasound report is a formal document and represents an important waypoint on the patient's control path. Therefore, the sonographer is responsible for ensuring that the report is accurate in every respect and is prepared and available as soon as possible immediately after the inspection is complete. . 77 errors vary from minor embarrassment due to misspelled and word substitutions to serious errors related to the opposite meaning (blood vessels vs. blood vessels) or the wrong side ('left' vs. 'right'). Formal reporting is an important professional skill for sonographers, radiologists, sonologists and point-of-care practitioners. Many sonographers have already played a reporting role and have been recognized for such a role in employment contracts. This article provides a detailed overview of current best practices that take into account existing guidelines and published literature. The reporting strategies and examples provided in this article are useful as vinets that sonographers can implement to enhance their reporting style. 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