Normal cranial ultrasound report template

I'm not robot!

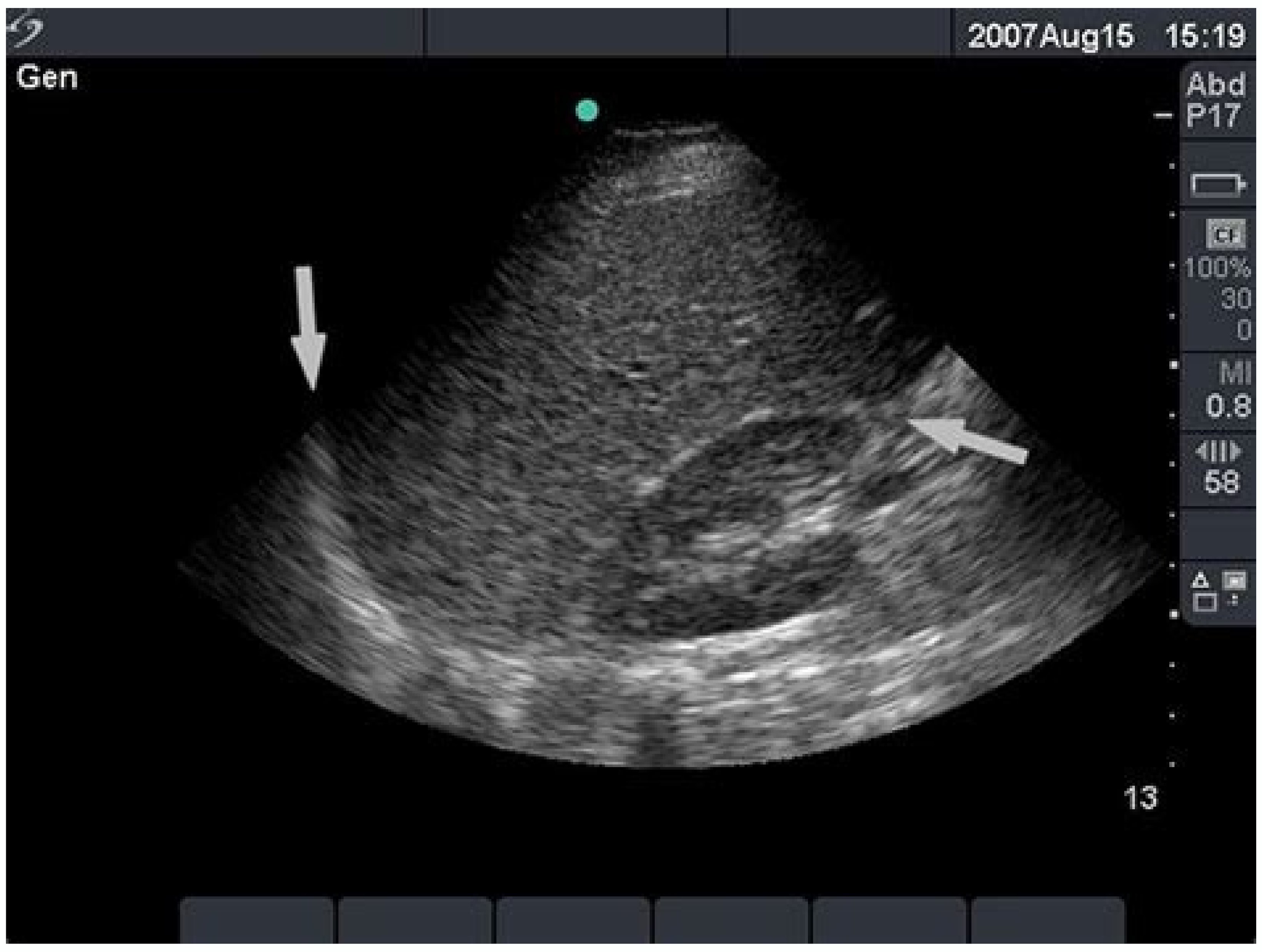
Findings:

LV +LVF = Ø , LVH- 1, Ø RWMA, DDF= I° (IR), LA+RA+RV = Ø , RVF = Ø AV = Ø, MAC-1, MVP – AMVL-1 + MR 1-2, TR 1 sPAP = 45mmHg, Ø PE

Table 5. Characteristics of previous studies reporting test characteristics of thoracic ultrasound (TUS) in various patient populations.

Study	N	Type	Sensitivity	Enrolling physicians and training
Dulchavsky (2001)	382	B, P	95%	Unreported number of surgical residents and attendings "familiar with ultrasound for abdominal trauma." Residents also had hands-on demonstration of normal lung model and viewed one pre-recorded exam.
Rowan (2002)	27	B	97%	Exams performed by 4 different sonographers (1 staff radiologist, 3 radiology residents) "trained in ultrasound pneumothorax detection."
Kirkpatrick (2004)	225	B, P	59%	Unreported number of attending trauma surgeons who trained in TUS "through the use of an animal laboratory, review of video-taped images, and proctoring by the most experienced investigator."
Lichtenstein (2005)	195	I	100%	Unreported number of "intensivists specifically trained in general ultrasound."
Blaivais (2005)	176	B	98%	Five emergency physicians who had completed the ACEP EUS guidelines, were "trained" in TUS by the director, performed "at least 100 trauma US examinations, and at least ten TUS examinations."
Soldati (2006)	186	B	98%	Two EPs "with over 10 year experience in emergency ultrasounograpy and at least 1 y in chest ultrasound."
Zhang (2006)	135	B, P	86%	Three EPs with previous "formal training on emergency bedside ultrasound." Training in TUS not reported.
Soldati (2008)	109	B, M	92%	Two EPs with "at least 1 year experience in chest ultrasound."

B, blunt trauma; *P*, penetrating trauma; *I*, intensive care unit patients; *M*, mixed trauma patients; *EP*, emergency physician



BAB I

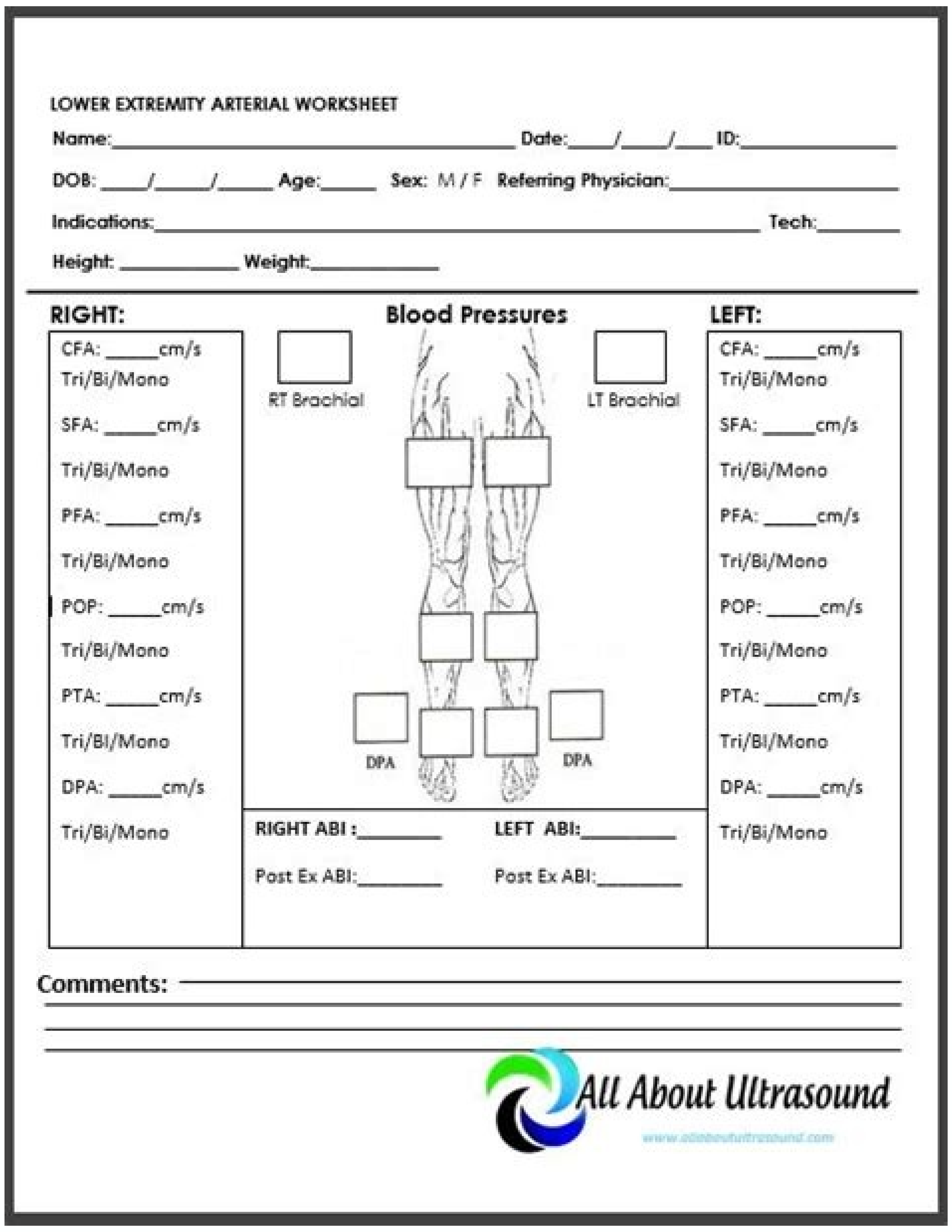
PENDAHULUAN

A. Latar Belakang Masalah

Stroke merupakan penyebab kematian kedua terbanyak dan penyebab utama dari disabilitas. Diperkirakan ada 700.000 kasus stroke di Amerika Serikat setiap tahunnya, dan 200.000 diantaranya dengan serangan berulang. Menurut WHO, ada 15 juta populasi terserang stroke setiap tahun di seluruh dunia dan terbanyak adalah usia tua dengan kematian rata-rata setiap 10 tahun antara 55 dan 85 tahun. (Goldstein,dkk 2006; Kollen,dkk 2006; Lyoyd-Jones dkk,2009).

Setiap tahun kira-kira 40.000 penduduk Australia terkena stroke dan diperkirakan di tahun 2020 jumlah ini meningkat hingga 60%. Penyebab terbanyak adalah oklusi arteri besar, yang berhubungan dengan trombosis dan emboli. Gambaran *Angiography* dan *Transcranial Doppler* (TCD) pembuluh darah intrakranial dalam 6 jam onset stroke iskemik menunjukkan oklusi arteri besar diatas 70% pasien. Oklusi-oklusi ini terbanyak disebabkan oleh emboli dan diduga sumbernya satu atau lebih dari arteri besar yang letaknya proksimal, aorta atau jantung. Hampir 66% sepertinya emboli berasal dari penyakit ateromatosa arteri karotid interna dan eksterna, arteri vertebralis, arteri basilaris dan arteri serebri media. Sekitar 5 – 8% klinis berhubungan dengan penyakit arteri besar pada sirkulasi anterior (arteri karotid, arteri serebri media, arteri serebri anterior). (Levi, 2001).

Transcranial Doppler (TCD) adalah sebuah tes yang mengukur kecepatan aliran darah melalui pembuluh darah otak. TCD digunakan untuk membantu dalam diagnosis emboli, stenosis, vasospasme dari *subarachnoid hemorrhage* (perdarahan dari pecah aneurisma), dan masalah lainnya. Semasa dilakukan tes TCD, gelombang bunyi yang tidak bisa didengar oleh manusia akan ditransmisi melalui jaringan di kepala. Gelombang bunyi ini akan dipantulkan oleh sel darah yang bergerak di dalam pembuluh darah dimana hal ini bisa membantu para radiologis menghitung kecepatan gerakan sel darah tersebut. Gelombang bunyi


LOWER EXTREMITY ARTERIAL WORKSHEET

Name:________________ Date:___/___/___ ID:________

DOB: ___/___/___ Age:___ Sex: M / F Referring Physician:________

Indications:________________ Tech:______

Height: ______ Weight:______

RIGHT:	Blood Pressures	LEFT:
CFA: ___cm/s	RT Brachial	CFA: ___cm/s
Tri/Bi/Mono	LT Brachial	Tri/Bi/Mono
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Comments:________________

All About Ultrasound

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Meaning of ultrasound report. How to write a ultrasound report. How to know fetal length in ultrasound report. What makes a good ultrasound report.

Box 3.1 Sample Diagnostic Shoulder Ultrasound Report: Normal, Complete Examination: Ultrasound of the Shoulder Date of Study: March 11, 2017 Patient Name: Juan Atkins Registration Number: 8675309 History: Shoulder pain, evaluate for rotator cuff abnormality Findings: No evidence of joint effusion. The biceps brachii long head tendon is normal without tendinosis, tear, tenosynovitis, or subluxation/dislocation. The supraspinatus, infraspinatus, subscapularis, and teres minor tendons are also normal. No subacromial-subdeltoid bursal abnormality and no sonographic evidence for subacromial impingement with dynamic maneuvers. The posterior labrum is unremarkable. Additional focused evaluation at site of maximal symptoms was unrevealing. Impression: Unremarkable ultrasound examination of the shoulder. No rotator cuff abnormality. Box 3.2 Sample Diagnostic Shoulder Ultrasound Report: Abnormal, Complete Examination: Ultrasound of the Shoulder Date of Study: March 11, 2017 Patient Name: Chazz Michael Michaels Registration Number: 8675309 History: Shoulder pain, evaluate for rotator cuff abnormality Findings: There is a focal anechoic tear of the anterior, distal aspect of the supraspinatus tendon measuring 1 cm short axis by 1.5 cm long axis. The anterior margin of the tear is adjacent to the rotator interval. There is no involvement of the subscapularis, infraspinatus, or rotator interval. A moderate amount of infraspinatus and supraspinatus fatty degeneration is present. There is a small joint effusion distending the biceps brachii tendon sheath and moderate distention of the subacromial-subdeltoid bursa. No biceps brachii long head tendon abnormality and no subluxation/dislocation. Mild osteoarthritis of the acromioclavicular joint. Additional focused evaluation at site of maximal symptoms was unrevealing. Impression: Focal or incomplete full-thickness tear of the supraspinatus tendon with infraspinatus and supraspinatus muscle atrophy. Box 4.1 Sample Diagnostic Elbow Ultrasound Report: Normal, Complete Examination: Ultrasound of the Elbow Date of Study: March 11, 2011 Patient Name: Kevin Saunderson Registration Number: 8675309 History: Elbow pain, evaluate for tendon abnormality Findings: No evidence of joint effusion or synovial process. The biceps brachii and brachialis are normal. The common flexor and extensor tendons are also normal. No significant triceps brachii abnormality. The anterior bundle of the ulnar collateral ligament and lateral collateral ligament complex are normal. The ulnar nerve, radial nerve, and median nerve at the elbow are unremarkable. No abnormality in the cubital tunnel region with dynamic imaging. Additional focused evaluation at site of maximal symptoms was unrevealing. Impression: Unremarkable ultrasound examination of the elbow. Box 4.2 Sample Diagnostic Elbow Ultrasound Report: Abnormal, Complete Examination: Ultrasound of the Elbow Date of Study: March 11, 2011 Patient Name: Ricky Bobby Registration Number: 8675309 History: Elbow pain, evaluate for tendon abnormality Findings: There is a partial-thickness tear of the distal biceps brachii tendon involving the superficial short head tendon with approximately 2 cm of retraction but with intact long head. Dynamic evaluation shows continuity of the long head excluding full-thickness tear. No joint effusion. The triceps brachii, common extensor, and common flexor tendons are normal. The ulnar, radial, and median nerves are unremarkable, including dynamic evaluation of the ulnar nerve. Unremarkable ulnar and lateral collateral ligaments. No bursal distention. Impression: Partial-thickness tear of the distal biceps brachii tendon. Box 5.1 Sample Diagnostic Wrist Ultrasound Report: Normal, Complete Examination: Ultrasound of the Wrist Date of Study: March 11, 2011 Patient Name: Derrick May Registration Number: 8675309 History: Numbness, evaluate for carpal tunnel syndrome Findings: The median nerve is unremarkable in appearance, measuring 8 mm 2 at the wrist crease and 7 mm 2 at the pronator quadratus. No evidence of tenosynovitis. The radiocarpal, midcarpal, and distal radioulnar joints are normal without effusion or synovial hypertrophy. The wrist tendons are normal without tear or tenosynovitis. Normal dorsal component of the scapholunate ligament. No dorsal or volar ganglion cyst. Unremarkable Guyon canal. Additional focused evaluation at site of maximal symptoms was unrevealing. Impression: Unremarkable ultrasound examination of the wrist. Box 5.2 Sample Diagnostic Wrist Ultrasound Report: Abnormal, Complete Examination: Ultrasound of the Wrist Date of Study: March 11, 2011 Patient Name: Jacobim Mugatu Registration Number: 8675309 History: Numbness, evaluate for carpal tunnel syndrome Findings: The median nerve is hypoechoic and enlarged, measuring 15 mm 2 at the wrist crease and 7 mm 2 at the pronator quadratus. No evidence for tenosynovitis. The radiocarpal, midcarpal, and distal radioulnar joints are normal without effusion or synovial hypertrophy. The wrist tendons are normal without tear or tenosynovitis. Normal dorsal component of the scapholunate ligament. No dorsal ganglion cyst. A 7-mm volar ganglion cyst is noted between the radial artery and flexor carpi radialis tendon. Unremarkable Guyon canal. Additional focused evaluation at site of maximal symptoms was unrevealing. Impression: 1. Ultrasound findings compatible with carpal tunnel syndrome. 2. A 7-mm volar ganglion cyst. Box 6.1 Sample Diagnostic Hip Ultrasound Report: Normal, Complete Examination: Ultrasound of the Right Hip Date of Study: March 11, 2016 Patient Name: Jack White Registration Number: 8675309 History: Hip pain, evaluate for bursitis Findings: The hip joint is normal without effusion or synovial hypertrophy. Limited evaluation of the anterior labrum is unremarkable. No evidence of iliopsoas bursal distention or snapping iliopsoas tendon with dynamic imaging. The remaining anterior tendons, including the rectus femoris and sartorius, as well as the adductors, are normal. Evaluation of the lateral hip is normal. No evidence of abnormal bursal distention around the greater trochanter. The gluteus minimus and medius tendons are normal. No abnormal snapping with dynamic evaluation. Impression: Unremarkable ultrasound examination of the hip. Box 6.2 Sample Diagnostic Hip Ultrasound Report: Abnormal, Complete Examination: Ultrasound of the Right Hip Date of Study: March 11, 2016 Patient Name: Brennan Huff Registration Number: 8675309 History: Hip pain, evaluate for tendon tear Findings: There is a partial tear of the adductor longus origin at the pubis. No evidence of full-thickness tear or tendon retraction. The common aponeurosis and rectus abdominis tendon are normal, as is the pubic symphysis. The hip joint is normal without effusion or synovial hypertrophy. There is a possible tear of the anterior labrum. No paralabral cyst. No evidence of iliopsoas bursal distention or snapping iliopsoas tendon with dynamic imaging. Evaluation of the lateral hip is normal. No evidence of abnormal bursal distention around the greater trochanter. The gluteus minimus and medius tendons are normal. No abnormal snapping with dynamic evaluation. Impression: 1. Partial-thickness tear of the proximal adductor longus. 2. Possible anterior labral tear. Consider MR arthrography if indicated. Box 7.1 Sample Diagnostic Knee Ultrasound Report: Normal, Complete Examination: Ultrasound of the Right Knee Date of Study: March 11, 2016 Patient Name: Meg White Registration Number: 8675309 History: Trauma Findings: The extensor mechanism, including the quadriceps tendon, patella, and patellar tendon, is normal without bursal abnormalities. No significant joint effusion or synovial hypertrophy. The medial collateral and lateral collateral ligaments are normal. Unremarkable iliotibial tract, biceps femoris, popliteus tendon, and common peroneal nerve. No Baker cyst. Limited evaluation of the menisci is unremarkable. Impression: Unremarkable ultrasound examination of the right knee. Box 7.2 Sample Diagnostic Knee Ultrasound Report: Abnormal, Complete Examination: Ultrasound of the Right Knee Date of Study: March 11, 2016 Patient Name: Frank Ricard Registration Number: 8675309 History: Pain, evaluate for cyst Findings: The extensor mechanism, including the quadriceps tendon, patella, and patellar tendon, is normal. There is a moderate-sized joint effusion and no synovial hypertrophy or intra-articular body. The medial and lateral collateral ligaments are normal, as is the iliotibial tract, biceps femoris, popliteus tendon, and common peroneal nerve. There is medial compartment joint space narrowing and osteophyte formation with mild extrusion of the body of the medial meniscus, which is abnormally hypoechoic. No parameniscal cyst. There is a Baker cyst measuring 2 × 2 × 6 cm. Abnormal hypoechogenicity is noted at the inferior margin of the Baker cyst. There is also a hypoechoic cleft involving the posterior horn of the medial meniscus, which extends to the articular surface. Impression: 1. Baker cyst with evidence for rupture. 2. Medial compartment osteoarthritis with moderate joint effusion. 3. Suspect posterior horn medial meniscal tear. Consider MRI for confirmation if indicated. Only gold members can continue reading. Log In or Register to continue Head ultrasound (HUS), also called cranial ultrasound (CUS), is obtained for the diagnosis and follow-up of premature and sick neonates.Head ultrasound has the advantages of: accessibility mobility, i.e. bedside scanning at the NICU and neonatal ward requiring no sedation enabling serial scans, e.g. for assessing brain maturation and/or lesion evolution no ionizing radiation As with all ultrasound studies, head ultrasound is highly operator-dependent. This is not a true disadvantage as such but does necessitate that the radiographer performing the examination be well-trained in the acquisition technique, know how to utilize the available ultrasound machine(s), and be knowledgeable in intracranial anatomy and pathology, so as not to miss any significant finding.An inherent limitation of head ultrasound is that the structures that comprise the acoustic windows (see Approach below, under Technique) all eventually close. ADVERTISEMENT: Supporters see fewer/no ads Indications for a neonatal head ultrasound include: routine head ultrasound for all premature neonates suspicion of brain anomalies on antenatal ultrasound any sick neonate in whom brain pathology is implicated a neonate that had not been screened prenatally For a routine scan, the anterior (bregmatic) fontanelle serves as the acoustic window. Additional acoustic windows, used for visualizing specific intracranial structures: the posterior (lambdoid) fontanelle, mastoid fontanelle, squamosal part of the temporal bone (i.e. temporal window), foramen magnum, coronal suture, and squamosal sutures. a 7.5-8 MHz micro convex transducer is best suited for viewing the neonatal brain through the fontanelles while affording good depth a linear transducer, usually 11-12 MHz, can be used in addition, for a more detailed depiction of superficial structures and lesions a phased array transducer can be used if the fontanelle is small, e.g. at a later age in infancy, but has a narrower field of view and is generally less favored A basic routine scan is performed through the anterior fontanelle. To be sure, the brain of an extremely premature neonate (i.e. 28 weeks or less) will appear less developed than that of a term neonate, including less convoluted gyri and shallower sulci; the following should only serve as a rough guide.On a coronal (transverse) scan, the transducer is first angulated anteriorly, then gradually rotated posteriorly. The following structures should be sought and assessed 1: level of frontal lobes: frontal lobes, interhemispheric fissure, orbits level of frontal horns of lateral ventricles: frontal lobes, interhemispheric fissure, corpus callosum, frontal horns, cavum septi pellucidi, caudate nucleus, basal ganglia, temporal poles, Sylvian fissures level of the foramen of Monro: frontal lobes, interhemispheric fissure, cingulate sulcus, corpus callosum, frontal horns and cavum septi pellucidi, choroid plexus in ventricles, caudate nucleus, basal ganglia, temporal lobes, Sylvian fissures level of the bodies of the lateral ventricles: interhemispheric fissure, corpus callosum, bodies of lateral ventricles with choroid plexus, third ventricle, caudate nucleus, basal ganglia, temporal horns of lateral ventricles, parahippocampal gyrus, parietal lobes, temporal lobes, Sylvian fissures, midbrain, tentorium cerebelli, cerebellar hemispheres and vermis level of the trigones of the lateral ventricles: interhemispheric fissure, cavum vergae (in preterm neonates or as an anatomical variant), corpus callosum, trigones of the lateral ventricles with choroid plexus, parietal lobes, occipital lobes, calcarine fissure through the parieto-occipital lobes: cingulate sulcus, parieto-occipital fissure (well-formed in term neonates), calcarine fissure, parietal lobes, occipital lobes naturally, the skull should appear on all acquisitions On a sagittal (longitudinal) scan, the transducer is positioned at the midline, then angulated all the way to the extreme right and from there gradually back to the midline. After having arrived back at the midline (i.e. the midsagittal structures are visible again), the same scan should be repeated on the left. The following structures should be assessed: midsagittal: cingulate sulcus, corpus callosum, cavum septi pellucidi, cavum vergae (premature neonates or variant), third ventricle, fornix, midbrain, pons, medulla, cerebellar vermis, calcarine fissure, parieto-occipital fissure, quadrigeminal plate, fourth ventricle, cisterna magna, interpeduncular cistern, Sylvian aqueduct extreme parasagittal plane (right/left): Sylvian fissure, insular cortex, precentral, central, and postcentral sulci parasagittal plane though the insula: frontal lobe, temporal lobe, Sylvian fissure, parietal lobe, occipital lobe, insular cortex and sulci (in premature neonates, the latter gradually become visible as the infant matures), precentral, central, and postcentral sulci parasagittal plane though the (right/left) lateral ventricle: frontal lobe, caudate nucleus, basal ganglia, thalamus, temporal lobe, cingulate sulcus, lateral ventricle - frontal horn, body, occipital horn, and temporal horn, choroid plexus; parahippocampal gyrus, cerebellar hemisphere, parietal lobe, parieto-occipital fissure, occipital lobe

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