Common symptoms and symptom complexes are addressed by this tool. Imaging requests for patients with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or patient’s Primary Care Physician (PCP) may provide additional insight.

This version incorporates MSI accepted revisions prior to 7/22/11
# 2011 Pelvis Imaging Guidelines

## 2011 Pelvis Imaging Guideline Number and Title

|----------------|--------------------------|-------------------------------|----------------|-----------------|-----------------------------|------------------|-------------------------------|------------------------------|--------------------------------|--------------------------------|--------------------------------|----------------|--------------------------------|----------------|----------------|--------------------------------|----------------|----------------|----------------|-------------------------------------------------|----------------|----------------|----------------|------------------------------------------|

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# 2011 Pelvis Imaging Guidelines

## Evidence Based Clinical Support

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**ABBREVIATIONS for PELVIS IMAGING GUIDELINES**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CA-125</td>
<td>cancer antigen 125 test</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>FSH</td>
<td>follicle-stimulating hormone</td>
</tr>
<tr>
<td>GTN</td>
<td>gestational trophoblastic neoplasia</td>
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<tr>
<td>HCG</td>
<td>human chorionic gonadotropin</td>
</tr>
<tr>
<td>IC/BPS</td>
<td>Interstitial cystitis/bladder pain syndrome</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>KUB</td>
<td>kidneys, ureters, bladder (frontal supine abdomen radiograph)</td>
</tr>
<tr>
<td>LH</td>
<td>luteinizing hormone</td>
</tr>
<tr>
<td>MRA</td>
<td>magnetic resonance angiography</td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
</tr>
<tr>
<td>MSv</td>
<td>millisievert</td>
</tr>
<tr>
<td>PA</td>
<td>posteroanterior projection</td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>TA</td>
<td>transabdominal</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid-stimulating hormone</td>
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<tr>
<td>TV</td>
<td>transvaginal</td>
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<tr>
<td>UCPPS</td>
<td>Urologic Chronic Pelvic Pain Syndrome</td>
</tr>
<tr>
<td>WBC</td>
<td>white blood cell count</td>
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</table>
Abdominal imaging begins at the diaphragm and extends to the umbilicus or iliac crest.

Pelvic imaging begins at the umbilicus and extends to the pubis.

CT imaging is a more generalized modality.
- CT pelvis with contrast (CPT®72193) is the usual modality unless there is a contrast allergy or the study is to look for a renal stone in the lower pelvis.
- **CT-guided Procedures:**
  - CPT®77012 is used to report imaging guidance for needle placement during biopsy, aspiration, and other percutaneous procedures.

MRI imaging is preferred as a more targeted study or for patients allergic to iodinated contrast.
- MRI without contrast (CPT®72195) is the usual modality to view the pelvis.
- Pelvic MRI without and with contrast (CPT®72197) is appropriate for evaluating the ovary or retroperitoneum.
- MRI of the pelvis with contrast only is essentially never performed. If contrast is indicated, MRI pelvis without and with contrast (CPT®72197) should be performed.
- **MR-guided Procedures:**
  - CPT®77021 is used to report imaging guidance for needle placement during biopsy, aspiration, and other percutaneous procedures.

Prior to considering advanced imaging, patients should undergo a recent detailed history, careful gynecological and/or urological exam (including appropriate laboratory studies such as blood count, tumor markers, and gonadotropins if indicated), and the use of non advanced imaging modalities such as plain x-ray and transvaginal ultrasound (CPT®76830).

Transvaginal ultrasound (TV) (CPT®76830) is the optimal study to evaluate pelvic pathology. Transabdominal ultrasound (CPT®76856 or CPT®76857) can be performed if requested as a complimentary study to the TV ultrasound.
- Transabdominal ultrasound alone (CPT®76856 or CPT®76857) may be a satisfactory substitute in pediatric patients or certain non-sexually active adults.

**Ultrasound-guided Procedures:**
- CPT®76942 is used to report imaging guidance for needle placement during biopsy, aspiration, and other percutaneous procedures.

**Coding for Ultrasound Examination of a Soft Tissue Mass:**
- Pelvic wall—CPT®76857
- Buttocks--CPT®76857
- Penis-- CPT®76857
- Groin-- CPT®76882
- Perineum-- CPT®76857
Other soft tissue areas- CPT®76999

- Pelvic CT or MRI may be indicated to further evaluate abnormalities seen on other imaging modalities such as plain x-rays, ultrasound, etc. if the results will affect patient management decisions and/or the results will assist in planning surgery.
- Pelvic CT or MRI may be indicated to further evaluate abnormalities seen on other imaging modalities such as plain x-rays, ultrasound, etc. if the results will affect patient management decisions and/or the results will assist in planning surgery.

**Tissue Transfer Flaps**
- In individuals under consideration for DIEP or other free tissue transfer flaps for breast reconstruction, CTA or MRA of the body part from which the tissue transfer is being taken can be performed for preoperative planning.
  - For example, for DIEP flap, CTA (CPT®74175 and CPT®72191) or MRA (CPT®74185 and CPT®72198) of the abdomen and pelvis can be performed for preoperative planning
  - There is currently insufficient evidence-based data to support the need for routine advanced imaging for TRAM flaps or other flaps performed on a vascular pedicle.
- To avoid radiation exposure, pregnant women should be evaluated by ultrasound or MRI where it is a clinical option.
- If a prior imaging study has been completed for a condition, a follow-up study for the same condition is generally not indicated unless there has been a change in the patient’s condition or previous imaging results showed an indeterminate finding.

**PELVIC SIGNS AND SYMPTOMS — FEMALE**

**PV-2~ABNORMAL UTERINE BLEEDING**

- Initial evaluation includes pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]), saline infusion sonohysterography (CPT®76831), hysteroscopy and possible biopsy.
  - Premenopausal women should be treated conservatively with hormone therapy. If there is failure to respond to this treatment, evaluation by biopsy and/or hysteroscopy is indicated.
  - Postmenopausal women should be evaluated by biopsy and/or hysteroscopy.
- MRI pelvis without contrast (CPT®72195) is indicated only if transvaginal ultrasound is unable to differentiate a submucous myoma from a polyp and the MRI results will affect surgical planning as stated by the surgeon.
- **References:**
PV-3~AMENORRHEA

- Initial imaging should be by pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]), hysterosalpingogram and/or hysteroscopy to look for genital and urinary tract abnormalities.
- Suspicion of a hormonally active adrenal tumor should be evaluated using **AB-21.2 Adrenal Endocrine Tumors** in the Abdomen Imaging Guidelines.
- Pelvic imaging (CT pelvis with contrast [CPT® 72193]) for androgen secreting ovarian tumors may be necessary if needed to plan surgery.
- Amenorrhea with intact uterus and history of normal puberty should be evaluated with pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) and endocrine work-up.
  - If pregnancy test is negative, then TSH, LH, FSH, and prolactin levels should be measured.
    - If prolactin is elevated refer to **HD-27.1 Pituitary Microadenomas** in the Head Imaging Guidelines.
    - If FSH is lower than reference range, MRI brain without and with contrast (CPT®70553) can be performed.
    - If TSH, LH, prolactin, and FSH are within reference range, then a complete hormone evaluation should be performed (e.g. androgen hormones, etc.)
  - If ultrasound identifies the following entities then advanced imaging is not indicated unless requested for surgical planning by the operating surgeon:
    - Asherman’s Syndrome (intrauterine scarring and adhesions)
      - Diagnosis is made using pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) with without saline infusion, hysterosalpingography and/or hysteroscopy.
    - Polycystic Ovarian Syndrome (PCO)
    - Androgen secreting ovarian tumor
    - Androgen secreting adrenal tumor

- **Amenorrhea with Genital Tract Abnormalities**
  - Suspected genital and urinary tract abnormalities should be evaluated initially with ultrasound of the abdomen (CPT®76700 or CPT®76705) and pelvis (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]).
  - Patients with absent uterus or foreshortened vagina should have karyotype evaluation.
  - Advanced imaging is not generally indicated

- **Amenorrhea with Delayed Puberty**
  - Initial evaluation includes measurement of thyroid function tests, bone age, LH, FSH and prolactin.
    - If LH and FSH are low or within the reference range and bone age is normal, then MRI brain without and with contrast (CPT® 70553) can be performed.
➢ If prolactin levels are elevated, then MRI brain without and with contrast with attention to the pituitary (CPT® 70553) can be performed.
  o Advanced imaging of the abdomen/pelvis is not indicated.

• Reference:

PV-4~ADENOMYOSIS

• Adenomyosis is a histologic diagnosis and imaging has limitations.
• Adenomyosis is suspected by history and physical examination.
• If hormonal therapy is going to be tried first, then MRI is not indicated in patients with suspected adenomyosis.
• Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) is the primary screening modality for imaging the female pelvis.
  o Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) along with color Doppler ultrasound is the diagnostic procedure of choice for the initial evaluation of suspected adenomyosis and is useful to evaluate other potential etiologies of the symptoms.
  o If ultrasound is inconclusive or there has been a failure of several months of hormone suppression and a more definitive diagnosis is necessary for surgical planning only, MRI pelvis without contrast (CPT®72195) can be performed.
The adnexa include the ovaries, Fallopian tubes, and ligaments that hold the uterus in place.

Management of adnexal masses involves either observation or surgical intervention.

Adnexal masses have a long list of diagnostic possibilities and ultrasound results must be correlated with history, physical exam, and laboratory testing.

- Tumor markers useful for adnexal mass evaluation include:
  - CA-125 (epithelial cancer, leiomyoma, endometriosis, PID, inflammatory disease such as lupus, and inflammatory bowel disease)
    - Although CA-125 can be elevated with benign entities such as endometriosis, the elevated CA-125 titers generally do not increase over time in these patients.
  - Beta hCG, LDH, and AFP (germ cell tumors)
  - Inhibin A and B (granulosa cell tumor)
- Transvaginal (TV) ultrasound imaging (CPT®76830) is the initial study of choice. Transabdominal ultrasound (CPT®76856 or CPT®76857) can be performed if requested as a complimentary study to the TV ultrasound.
- Color Doppler ultrasound may be helpful in selected situations.

MRI of the pelvis (CPT®72197 or CPT®72195 if pregnant) for the evaluation of a pelvic mass is less sensitive and only slightly more specific than transvaginal ultrasound and usually adds little to the plan of care.

- MRI may be useful in classifying malignant masses if requested by the operating surgeon.

**Reference:**

- CT of the pelvis without and with contrast (CPT® 72194) is helpful as a preoperative study to evaluate for metastatic disease when cancer is known or suspected.
PV-5.1 Simple Adnexal Cysts

- If TV ultrasound (CPT®76830) classifies an adnexal mass as a simple or thin walled cystic mass or follicular cyst (ovarian) or tubular cystic mass (fallopian tube):
  - Repeat TV ultrasound (CPT®76830) is recommended whenever there is uncertainty in the diagnosis. Simple cysts up to 10 cm in diameter as measured by ultrasound are almost universally benign and may safely be followed without intervention, even in postmenopausal women.
  - Follow-up should be with pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830[transvaginal]) every year for lesions ≤ 7 cm and every 6 months for lesions greater than 7 cm but < 10 cm in both premenopausal and postmenopausal women.
  - If elevated tumor markers are present, surgical intervention should be considered.
    - Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon.
  - Cysts >10 cm with normal tumor markers have not been studied and the current recommendation is to consider surgical intervention.
    - Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon.

- References:
  - Radiology 2010;256(3):943-954

PV-5.2 Complex Adnexal Masses

- Complex adnexal masses are usually ovarian in origin, and in premenopausal women, most commonly represent hemorrhagic cysts or endometriomas.
  - The initial evaluation in the premenopausal age group is influenced by the presence or absence of abdominal or pelvic symptoms.
    - Symptomatic patients may have conditions that require immediate interventions, such as antibiotics and possible surgery for tubo ovarian abscess, medical treatment or surgery for ectopic pregnancy, surgery for ovarian torsion, and expectant management for most ruptured ovarian cysts.
    - Appropriate evaluation includes a history and physical examination, quantitative beta hCG, CBC, and transvaginal ultrasound (CPT®76830). Additional studies such as serial
hematocrit measurements and appropriate cultures may also be indicated.

- Ultrasound characteristics usually suggest the diagnosis, and in **premenopausal women**, a follow up ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) can be done in six to twelve weeks or following a menstrual cycle to evaluate for resolution.
  - A pregnancy test is important to narrow the differential diagnosis.
  - If follow-up imaging confirms a hemorrhagic cyst that has not completely resolved, a repeat ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) can be performed in 6 months (sooner if new symptoms occur).
  - Rarely, young women with acute symptoms may have a malignancy. These are often germ cell tumors.
    - Evaluation for tumor markers specific for many germ cell tumors, including beta hCG, AFP, and LDH, should be performed.
    - If tumor markers are elevated or the mass is suspicious for primary ovarian cancer by ultrasound (ultrasound shows solid areas or excrescences, greater than 3 mm irregular septations, nodule with Doppler-detected blood flow, and/or free abdominal/pelvic fluid), evaluation for surgical intervention should be considered.
    - Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon.
  - An ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) should be evaluated based on the appropriate Oncology Imaging guideline.
    - Advanced imaging such as MRI of the pelvis (CPT®72197 or CPT®72195 if pregnant) should be considered only if classification of the ovarian mass will affect patient management decisions.

**References:**
- *Radiology* 2010;256(3):943-954

- **Postmenopausal women** (≥ age 47) with a complex adnexal mass by ultrasound (ultrasound shows solid areas or excrescences, greater than 3 mm irregular septations, nodule with Doppler-detected blood flow, and/or free abdominal/pelvic fluid), should be evaluated for surgical intervention and have tumor markers measured. Any elevation of CA 125 levels is highly suspicious for malignancy. Most pelvic complex cysts or solid masses in postmenopausal women will require surgical intervention.
Some women for whom the usual management of a pelvic mass would include surgery are at increased risk for perioperative morbidity and mortality. In such cases, repeat imaging may be a safer alternative than immediate surgery, although the frequency of follow-up imaging has not been determined.

- These cases should be sent for Medical Director review

Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon, although CT abdomen and pelvis without and with contrast (CPT®74178) should be considered only if abdominal metastatic disease is suspected.

The ovary is a relatively common site for metastases from some primary malignancies. An ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) should be evaluated based on the appropriate Oncology Imaging guideline.

- Advanced imaging such as MRI of the pelvis (CPT®72197 or CPT®72195 if pregnant) should be considered only if classification of the ovarian mass will affect patient management decisions.

References:

- Radiology 2010;256(3):943-954

Other Adnexal Masses:

- Endometrioma
  - Initial follow-up ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) for both pre- and postmenopausal women can be performed at 6 to 12 weeks and then every 6 months if not surgically resected.

- Dermoids
  - Once the diagnosis is confirmed by ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]), or CT (CPT®72194) or MRI (CPT®72195 or CPT®72197), if surgical resection is not performed, then follow-up ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) for both pre- and postmenopausal women can be obtained once a year.

- Hydrosalpinxes or peritoneal cysts
  - Individualized follow-up as clinically indicated

Reference:

- Radiology 2010;256(3):943-954

PV-5.3 Screening for Ovarian Cancer

- See ONC-22 Ovarian Cancer in the Oncology Imaging Guidelines
**PV-6~ENDOMETRIOSIS**

- Endometriosis is a surgical diagnosis and imaging is of little value unless the pelvic clinical exam is abnormal.
- Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) is the first line diagnostic exam for suspected endometriosis*.  
  *Hum Reprod 2007;22(12):3092-3097*
- In most patients, ultrasound followed by medical treatment or laparoscopy should be considered prior to advanced imaging.
  o Laparoscopy remains the definitive test for diagnosis and evaluation of endometriosis in most patients.*  
  *Eur Radiol 2006 Feb;16(2):285-298*
  *ACOG Committee Opinion, Number 310, April 2005*
- MRI is helpful in detecting rectal involvement and has been shown to accurately detect rectovaginal endometriosis and cul-de-sac obliteration in the more than 90% of cases when sonographic gel was inserted in the vagina and rectum. MRI can also enable complete lesion mapping prior to surgical excision of known endometriosis that was diagnosed during a previous surgery.*  
  *Eur Radiol 2006 Feb;16(2):285-298*
  *Hum Reprod 1999 April;14(4):1080-1086*
  *Fertil Steril 2005;83:442-447*

**PV-7~PELVIC INFLAMMATORY DISEASE (PID)**

- Ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) is the initial study for imaging of pelvic inflammatory disease (PID) that does not respond well to antibiotic therapy or for complicated PID.
- In rare cases where there is extensive abscess formation as determined by ultrasound, CT of the abdomen and pelvis with contrast (CPT®74177) may be helpful.
- If a CT-guided percutaneous drainage procedure is planned, then CPT®77012 (CT Guidance for needle placement) should be used to report the procedure rather than the codes for diagnostic CT scan of the abdomen and pelvis.
2011 PELVIS IMAGING GUIDELINES

PV-8~POLYCYSTIC OVARY SYNDROME

- The most common hormonal disorder among women of reproductive age
- One of the leading causes of infertility
- Ovaries are often enlarged and contain numerous small cysts located along the outer edge of each ovary
- Signs and symptoms may include:
  - anovulation resulting in infrequent or prolonged menstrual periods
  - excessive amounts or effects of androgenic (masculinizing) hormones (e.g. excess hair growth)
  - acne
  - obesity
- Diagnostic work up:
  - History, specifically menstrual pattern, obesity, hirsutism, and absence of breast discharge
  - Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal])
    - Diagnosis is confirmed if ultrasound shows 12 or more small follicles measuring 2 to 9 mm in diameter in at least one ovary or a total ovarian volume of >10 cm³
  - Serum levels of androgens. Free testosterone level is thought to be the best measure.
- Advanced imaging is not indicated for the diagnosis or follow up of Polycystic Ovary Syndrome unless elevated serum levels of androgens are found and an adrenal etiology is suspected. In that circumstance, CT with bolus arterial phase (CPT®74160) can be performed.
  - Also see AB-21.2 Adrenal Endocrine Tumors in the Abdomen Imaging Guidelines

PV-9~INFERTILITY EVALUATION, FEMALE

- Medicaid does not have coverage benefits for work up and/or treatment of infertility in most states, including Florida, North Carolina, and Arizona
  - For information on Medicaid Family Planning coverage benefits for all 50 states, go to:
    http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=10&rgn=35&sub=183
  - Benefits, coverage policies, and eligibility issues pertaining to each Health Plan take precedence over MedSolutions’ guidelines.
  - Therefore, imaging studies such as pelvic ultrasound, CT, or MRI should not be authorized if performed as part of an infertility evaluation for a
Medicaid client if that particular state Medicaid does not have coverage benefits for infertility.

- **ICD-9 Codes:**
  - 628.0 through 628.9 Infertility, female
  - 606 Infertility, male
  - Other possible diagnosis codes used for infertility work up:
    - Amenorrhea
    - Anovulation
    - Ovarian Cyst
    - Polycystic Ovary Syndrome
    - Pain
    - Dysmenorrhea
    - Abnormal bleeding

- **Common Drugs Used for Infertility Work up:**
  - clomiphene (Clomid, Serophene)
  - gonadotropins (Pergonal, Repronex, Fertinex, Follistim, Gonal F, Novarel, Ovidrel, Pregnyl, Menogon, Puregon, Menopur)

- Ultrasounds are often ordered monthly, usually around the same time each month, to evaluate whether ovulation has occurred (ultrasound would be done in the luteal phase which is the latter phase of the menstrual cycle).

- Blood work for infertility may include levels of FSH, LH, progesterone, estradiol

### PV-10~INTRAUTERINE DEVICE (IUD)

- **Ultrasound to evaluate the position of an IUD**
  - The routine use of ultrasound prior to, and immediately following insertion of an IUD, including a routine 6 week follow-up ultrasound study is not indicated.
  - **Indications for ultrasound (CPT®76830) include the following:**
    - Abnormal pelvic exam prior to IUD insertion, such as pelvic mass, irregularly shaped uterus, or enlarged uterus.
    - Suspected complication at the time of IUD insertion:
      - Suspected abnormal IUD position at time of insertion
      - Suspected uterine perforation
      - Severe pain immediately following insertion
      - Excessive bleeding immediately following insertion
    - Inability to feel or see IUD string following insertion
    - Failure to improve with conservative treatment such as antibiotics for cramping, light bleeding, and/or low grade fever following IUD placement

- **References:**
- **Other imaging studies to evaluate a suspected lost IUD:**
  - Plain x-ray should be performed if pregnancy test is negative and ultrasound is equivocal or nondiagnostic in locating a lost IUD.
  - Advanced imaging such as CT or MRI is not indicated unless ultrasound and plain x-ray are equivocal or nondiagnostic.

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**PV-11~PELVIC PAIN/DYSpareunia, female**

- Complete clinical pelvic examination and pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) are indicated for the initial evaluation of pelvic pain/dyspareunia.
- Pelvic pain/dyspareunia accompanied by fever, elevated WBC, failure of conservative treatment (including the use of hormones or antibiotics when appropriate), or palpable mass should be initially evaluated by pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]).
  - If pelvic ultrasound is normal, other causes should be considered such as chronic cystitis or bowel disease. Urological work-up, gastroenterology work-up, and laparoscopy should be performed prior to considering advanced imaging.
  - CT pelvis with contrast (CPT®72193) is only appropriate if ultrasound has equivocal findings.*
- Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) with color Doppler (CPT®93975 or CPT®93976) should be performed if ovarian torsion is a consideration.
  
  *ACOG Practice Bulletin No. 51: Chronic pelvic pain; March 2004 (Reaffirmed 2010)

- **Chronic Pelvic Pain**
  - Evaluation should include, but is not limited to, urine culture and cultures for sexually transmitted diseases.
  - Diagnostic studies should include pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) with color Doppler, laparoscopy, and/or diagnostic bladder studies.
  - Treatment should include, but is not limited to, antibiotics, pain management, and ovarian suppression.
  - If pelvic congestion is suspected or for further evaluation of unexplained chronic pelvic pain, an interventional radiologist may request the following imaging studies for pre-procedure planning for pelvic vessel embolization:
    - Pelvic MRI (CPT®72195) and/or pelvic MRV (CPT®72198),
    - Pelvic CT (CPT®72193) and/or pelvic CTV (CPT®72191)

- **References:**
  - Stein B. Diagnosis and management of pelvic congestion syndrome and varicoceles. pp. 1-11
  - Prostate Cancer and Prostatic Dis 2009;12(2):177-183
• **Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS)**
  o **Definition:** An unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes*
    *Neurourology and Urodynamics 2009;28:274
  o Work-up should include history, physical exam, laboratory exam (urinalysis and urine culture), and measurement of post void residual urine by bladder catheterization or by ultrasound (CPT®76856 or CPT®76857 or CPT®76830 [female])
    ➢ A trial of antibiotics is appropriate when infection is suspected
  o Cystoscopy and/or urodynamics should be considered when the diagnosis is in doubt, but are not necessary for making the diagnosis in uncomplicated presentations.
  o **Advanced Imaging:**
    ➢ CT abdomen and/or pelvis, contrast as requested, may be indicated for the following:
      ▪ nondiagnostic ultrasound or abnormality on ultrasound that requires further evaluation
      ▪ evaluation of complicated IC/BPS (when ordered by the urologist, surgeon, urogynecologist, or other specialist)
    ➢ MRI abdomen and/or pelvis, contrast as requested, may be indicated for the following:
      ▪ evaluation of equivocal results on CT
  o **Reference:**
• **Pelvic Pain/Hip Pain—Rule Out Piriformis Syndrome**
  o See **PN-2.4 Sciatic Neuropathy** in the Peripheral Nerve Disorders Imaging Guidelines and **MS-25.8 Piriformis Syndrome** in the Musculoskeletal Imaging Guidelines.

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**PV-12~LEIOMYOMATA**

• Pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) is the preferred screening procedure for leiomyomata.
• Abnormal uterine bleeding from suspected submucous leiomyoma should be evaluated by saline sonohysterography or panoramic hysteroscopy* initially.
  o If these studies are equivocal, and if imaging is needed for surgical planning, MRI pelvis without contrast (CPT®72195) can be performed.
• Preoperative ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) should be performed prior to myomectomy.
If ultrasound is indeterminate, MRI pelvis without contrast (CPT®72195) may be considered if requested by the operating surgeon for surgical planning.

- MRI pelvis without and with contrast (CPT®72197) can be performed if leiomyoma necrosis is suspected.
- MRI pelvis without and with contrast (CPT®72197) can be performed in those cases in which arterial embolization is being considered. MRI accurately assesses the number, location, and size of leiomyomata for pretreatment planning and post treatment response.*
  * AJR 2003, 181:851-856

- For uterine artery embolization, size of the dominant fibroid must be considered. Some studies have reported treatment failure to be more likely with fibroids >8 cm.*
  * Obstet Gynecol Surv 2002;57:810-815

- MRA pelvis (CPT®72198) can be considered if it is necessary for preprocedural planning and is requested by the interventional radiologist planning the arterial embolization.

- There are currently no published guidelines regarding follow up MRI in patients who have undergone uterine artery embolization.
  - There are no compelling evidence-based data to support the need for follow up MRI in asymptomatic patients who are status post uterine artery embolization.
  - In patients with persistent or recurrent symptoms such as continued abnormal bleeding, pain, or pelvic pressure, pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) should be performed as the initial imaging study.
    ➢ If ultrasound is equivocal, pelvic MRI without and with contrast (CPT®72197) can be performed.
  - In patients with fever, pain, or other acute symptoms status post embolization, pelvic MRI without and with contrast (CPT®72197) can be performed.
    * J Vasc Interv Radiol 2004;15:115-120

### PV-13~PERIURETHRAL CYSTS AND URETHRAL DIVERTICULA

- Also see AB-46 Urinary Tract Infection (last solid bullet).
- Symptomatic infection of congenital periurethral glands can result in urethral diverticula. Symptoms include pain, urinary urgency, frequency of urination, recurrent urinary tract infection, dribbling after urination, or incontinence.
  - MRI pelvis without and with contrast (CPT®72197) can be performed to evaluate known or suspected urethral diverticula or other urethral abnormalities.
  - Ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]), urethrography, or CT urethrography are other
studies used to evaluate urethral diverticula or other urethral pathology.

- **Reference:**
  - ACR Appropriateness Criteria, Recurrent lower urinary tract infections in women, 2011

**PV-14~UTERINE ANOMALIES**

- In the detection of uterine anomalies, particularly during infertility evaluation, pelvic ultrasound (CPT®76856 or CPT®76857 and/or CPT®76830 [transvaginal]) are the initial imaging modalities of choice.
- If ultrasound defines a complex anomaly, is not definitive, or is requested for surgical planning, then pelvic MRI without contrast (CPT®72195) is recommended.*
  *Radiographics 2003; 23:1401-1421 and 1423-1439

**PREGNANCY RELATED**

**PV-15~FETAL MRI**

- Ultrasound (ideally performed at a tertiary care center) remains the predominate modality for evaluating disorders related to the fetus and pregnancy overall. MRI is used as an adjunct to ultrasound in evaluating fetal abnormalities.
  - See MedSolutions Obstetrical Ultrasound Imaging Guidelines 2011
- Fetal MRI is appropriately reported as an MRI of the pelvis with one code from the set: (CPT®72195-CPT®72197).
  - Although this study is for evaluation of fetal structures, the actual MRI sequences are those of the mother’s pelvic region.
  - MRI is being used to diagnose and image the contents of the pelvis; in this case, the content of the pelvis is a fetus.
    - It is appropriate to report one code for MRI of the pelvis in the case of twins or other multiple gestations.¹
- **Central Nervous System Evaluation:** MRI is used if ultrasound is equivocal and additional information is needed for counseling purposes.²
- **Non-Central Nervous System Anomalies:** MRI may be used if needed for surgical planning.
  - The use of MRI for evaluating fetal size (estimating weight), growth restriction, dystocia, or amniotic fluid volume as compared to ultrasound has not been established.²
  - The use of MRI to evaluate placenta accreta or any placenta implantation has not been established to be superior to ultrasound.²
  - Functional MRI in pregnancy has not been established.²
  - MRI is helpful in the antenatal evaluation of conjoined twins in whom postnatal separation is being anticipated.
• **References:**
  - Clinical Examples in Radiology Fall 2006, Vol. 2 Issue 4
  - Obstetrics & Gynecology 2008;112:145-157

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**PV-16~MOLAR PREGNANCY AND GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN)**

- A recurrent molar pregnancy is called gestational trophoblastic neoplasia (GTN). These cells are malignant and can metastasize to other organs such as lungs, brain, bone, and vagina.
- Treatment is usually methotrexate.
- Patients should have head CT without and with contrast (CPT®70470), CT abdomen and pelvis with contrast (CPT®74177), and chest x-ray as a metastatic work up.
- Weekly HCG tests are performed until they fall to zero.

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**PV-17~PELVIMETRY**

- Pelvimetry for cephalic dystocia (failure to progress in active labor because of a disproportion between the fetal head and the size of the bony pelvis) is investigational.
- Pelvimetry may be done for breech presentations in which vaginal delivery is anticipated.
- Pelvimetry is usually done with plain x-ray, low dose CT pelvis without contrast (CPT®72192), or MRI pelvis without contrast (CPT®72195).
  - Low dose CT is institution specific and if protocol is not followed, the fetus will receive full ionizing radiation dose.

- **References:**
  - Obstet Gynecol 2004;104:647-651
  - Obstet Gynecol 2003;102:1445-1454
PELVIC SIGNS AND SYMPTOMS—MALE

PV-18~IMPOTENCE/ERECTILE DYSFUNCTION

- Brain MRI without and with contrast (CPT®70553) should be restricted to hypogonadism as documented by low bio-available/free testosterone of <20 ng/dl or total serum testosterone of less than 80% of the lower limit of normal (i.e. <150 ng/dl is lower limits for most labs), or patients with elevated prolactin.
  - Also see HD-27.3 Male Hypogonadism in the Head Imaging Guidelines
- Duplex ultrasound (CPT®93980) can be used to assess penile vasculature in Peyronie’s disease*
- Erectile dysfunction is frequently an early symptom of peripheral vascular disease.
  - Penile Doppler ultrasound (CPT®93980) can be performed for the evaluation of erectile dysfunction
  - Also see PVD-1 General Guidelines (Bullet 4) in the Peripheral Vascular Disease Imaging Guidelines.
- Functional MRI or PET studies are considered investigational.

**Coding**
- CPT®93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
- CPT®93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
  - CPT®93975 and CPT®93976 should not be reported together during the same session
- CPT®93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study

**Reference:**

PV-19~PENIS—SOFT TISSUE MASS

- Soft-tissue lesions of the penis should be evaluated initially by high resolution Doppler ultrasound (CPT®76857).
- If ultrasound is equivocal (not clearly benign, simple cyst or Peyronie’s disease) or if primary penile cancer is suspected, MRI of the pelvis without and with contrast (CPT®72197) can be performed.

**References:**
PV-20~PROSTATITIS/ HEMATOSPERMIA/
UROLOGIC CHRONIC PELVIC PAIN SYNDROME

- Suspected prostatitis should be evaluated by physical exam, urinalysis, and digital rectal exam with evaluation of prostate secretions. Initial treatment is 2 to 4 weeks of antibiotics.
  - Failure to improve with initial treatment should be evaluated with transrectal ultrasound (CPT®76872).
    - CT pelvis with contrast (CPT®72193) may be used to differentiate between abscess and tumor if ultrasound is equivocal.*

- Chronic prostatitis is a clinical diagnosis and advanced imaging is not indicated.
  - Physical examination, including digital rectal examination, should be performed.
  - Treatment is a 4 week trial of antibiotics
    - Failure to improve should be evaluated by transrectal ultrasound (CPT®76872).
      - CT pelvis with contrast (CPT®72193) may be used to differentiate between abscess and tumor if ultrasound is equivocal.*

- Hematospermia
  - Usually associated with inflammatory conditions of the seminal vesicles or prostate.
  - In men younger than age 40, hematospermia is uniformly benign. In older men, hematospermia is rarely associated with malignancy.
  - Initial evaluation should include the following:
    - Careful physical examination, including digital rectal exam, and
    - Laboratory studies which include evaluation of prostatic secretions, urinalysis, and PSA (particularly if patient is over age 50)
  - If prostatitis or urethritis is suspected, a 2 week trial of antibiotics is indicated initially.
  - Imaging Studies:
    - Transrectal ultrasound (TRUS) (CPT®76872) should be performed as the initial imaging study if an imaging study is deemed necessary.
      - Transrectal ultrasound allows clear visualization of the seminal vesicles, prostate, and ampullary portions of the vas deferentia.
    - MRI pelvis without contrast (CPT®72195) can be considered to evaluate suspected hemorrhage within the seminal vesicles, radiation injury, neoplasia, failure of conservative treatment, or abnormal findings on transrectal ultrasound.

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Cystourethroscopy may aid in pinpointing the source of bleeding.
Cystoscopy should be performed if there is concomitant hematuria.

**Reference:**
- ACR Appropriateness Criteria, *Hematospermia,* 2010

### Urologic Chronic Pelvic Pain Syndrome
- Urologic chronic pelvic pain syndrome (UCPPS) is a symptom-based umbrella term for interstitial cystitis/painful bladder syndrome (IC/PBS) and chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) in men.
- Urology consultation is helpful in patients with chronic pelvic pain, including patients with chronic prostatitis who have failed antibiotics and have a negative transrectal ultrasound (CPT®76872).
  - Imaging is rarely necessary in the evaluation of chronic pelvic pain with the exception of transrectal ultrasound (CPT®76872) for prostate evaluation.*
    *Prostate Cancer and Prostatic Dis 2009;12(2):177-183
  - MRI of the lumbar spine without contrast (CPT® 72148) and/or sacral plexus MRI without contrast (CPT® 72195) may be requested but are rarely abnormal.*
- Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS)
  - **Definition:** An unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes*
    *Neurourology and Urodynamics 2009;28:274
  - Work-up should include history, physical exam, laboratory exam (urinalysis and urine culture), and measurement of post void residual urine by bladder catheterization or by ultrasound (CPT®76856 or CPT®76857 or CPT®76830 [female])
    - A trial of antibiotics is appropriate when infection is suspected
  - Cystoscopy and/or urodynamics should be considered when the diagnosis is in doubt, but are not necessary for making the diagnosis in uncomplicated presentations.
  - **Advanced Imaging:**
    - CT abdomen and/or pelvis, contrast as requested, may be indicated for the following:
      - nondiagnostic ultrasound or abnormality on ultrasound that requires further evaluation
      - evaluation of complicated IC/BPS (when ordered by the urologist, surgeon, urogynecologist, or other specialist)
    - MRI abdomen and/or pelvis, contrast as requested, may be indicated for the following:
evaluation of equivocal results on CT

- Reference:

- Pudendal Neuralgia
  - Pudendal Nerve Terminal Motor Latency Test and Quantitative Sensory Threshold Test should be performed prior to considering advanced imaging if Pudendal Neuralgia is suspected.

### PV-21~SCROTAL PATHOLOGY

- Acute scrotal pain, masses, trauma, inguinal hernia, varicocele, or inflammation should be evaluated by Doppler ultrasound (CPT® 76870 and/or CPT® 93975 or CPT® 93976) of the scrotum. MRI of the pelvis without and with contrast (CPT® 72197) can be considered if ultrasound is inconclusive, but must be performed within a short time frame.*
  
  *ACR Appropriateness Criteria, Acute onset of scrotal pain—without trauma, without antecedent mass, 2011

- Testicular microlithiasis
  - Co-exists with testicular tumors in 5%-10% of patients.
  - Unknown whether there is an increased risk of tumor development in patients with pre-existing microcalcifications
  - There is no consensus on appropriate follow-up imaging if testicular microlithiasis is found. Most commonly, annual ultrasound (CPT® 76870) is recommended.

- Ultrasound Coding
  - CPT® 76870 Ultrasound of scrotum and contents
  - CPT® 93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
  - CPT® 93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
  - CPT® 93975 and CPT® 93976 should not be reported together during the same session

### UNDESCENDED TESTIS:
(See PACPV-15 in the Pediatric and Congenital Pelvis Imaging Guidelines)
PELVIS GUIDELINES (NOT OTHERWISE COVERED)

PV-22~FISTULA IN ANO

- MRI pelvis without and with contrast (CPT® 72197) is indicated for the assessment of complex or recurrent fistulas. Preoperative MRI frequently alters the surgical approach and MRI guided surgery can significantly decrease postoperative recurrence in complex cases by 75%.*

* AJR 2004;183:135-140
PV-23 INCONTINENCE

- PV-23.1 Urinary Incontinence
  - Types of incontinence
    - Stress incontinence: associated with impaired sphincter function. Results in inability to retain urine when pressure is raised, as in coughing or sneezing.
    - Urgency incontinence: associated with detrusor muscle in the wall of the bladder. Involuntary loss of urine associated with the sensation of a sudden compelling urge to void.
    - Mixed stress and urgency incontinence
    - Neurogenic urinary incontinence
  - Initial work-up of non-neurogenic incontinence:
    - History, physical examination, urine cultures
    - Measurement of post void residual urine by bladder catheterization or by ultrasound (CPT®76856 or CPT®76857 or CPT®76830 [female])
    - Video-urodynamic study may be indicated
  - Complicated incontinence:
    - Defined as recurrent or total incontinence, incontinence that has failed conservative treatment, or incontinence associated with any of the following:
      - pain
      - hematuria
      - recurrent infection
      - significant voiding symptoms such as pain or dysuria
      - radical pelvic surgery
      - suspected fistula
      - suspected mass
      - pelvic or prostate irradiation
    - Complicated incontinence requires specialist evaluation (urologist, surgeon, urogynecologist) to determine the appropriate work-up, including the need for imaging studies.
  - Initial work-up of neurogenic urinary incontinence:
    - History, physical examination
    - Ultrasound of the urinary tract (CPT®76770 or CPT®76775)
    - Urodynamic studies
  - Possible etiology of neurogenic urinary incontinence:
    - Suprapontine cerebral lesion (e.g. Parkinson’s disease, stroke, multiple sclerosis)
- Suprasacral infrapontine spinal cord lesion (e.g. trauma, multiple sclerosis)
- Peripheral nerve lesion (e.g. radical pelvic surgery, conus/cauda equine lesion such as lumbar disc prolapse)

  **Advanced imaging for evaluation of incontinence:**
  - CT abdomen and/or pelvis, contrast as requested, may be indicated for the following:
    - nondiagnostic ultrasound or abnormality on ultrasound that requires further evaluation
    - evaluation of complicated incontinence (when ordered by the urologist, surgeon, urogynecologist, or other specialist)
    - suspected fistulae
    - detecting ectopic ureters if ultrasound is nondiagnostic
    - pre-operative planning when ordered by the operating physician
  - MRI abdomen and/or pelvis, contrast as requested, may be indicated for the following:
    - evaluation of equivocal results on CT
    - evaluation of pelvic floor anatomy and pelvic organ prolapse
    - pre-operative planning when ordered by the operating physician
  - MRI may be indicated for evaluation of the brain, spine, or other regions of the nervous system in neurogenic urinary incontinence
  - Dynamic MRI or abdomen and/or pelvis may be indicated for the following:
    - pre-operative planning when ordered by the operating physician
    - persistent incontinence following surgery

  **References:**
  - *BJU Int* 2005;95(5):699-703
  - *AJR* 2003;180:1037-1044

**PV-23.2 Fecal Incontinence**

  **Evaluation for individuals without CNS or spinal cord pathology:**
  - History, physical examination
  - Transanal, endoanal or transrectal ultrasound (CPT®76872) to evaluate the anal sphincter.
  - Anal manometry
  - Pudendal nerve terminal motor latency
  - EMG
  - Defecography is an x-ray imaging study using barium. It can be used for the planning of rectocele and enterocoe repair.
MR Defecography—there are currently insufficient evidence-based data to generate appropriateness criteria for MR defecography.

MRI pelvis without and with contrast (CPT® 72197) or MRI colpocystography may be useful for surgical planning prior to anal sphincter surgery when external sphincter atrophy is suspected due to negative or equivocal Pudendal Nerve Terminal Latency. The need for MRI should be determined by the operating surgeon.*

*Am J Gastroenterol 2004;99(8):1585-1604

References:

Evaluation for individuals with suspected or known CNS or spinal cord pathology:
- Specialist consultation is helpful in determining the need for advanced imaging.
**PV-24~PATENT URACHUS**

- **Patent urachus** which is suspected due to umbilical discharge should initially be evaluated by ultrasound (CPT®76856 or CPT®76857 and/or CPT®76700 or CPT®76705).
  - The urachus is a “tube” connecting the fetal bladder to the umbilical cord. It is usually obliterated during fetal growth, but if it remains patent, there can be a connection between the bladder and the umbilicus.
- CT pelvis with contrast (CPT®72193) can be performed if ultrasound is equivocal or if needed for surgical planning.
Evidence Based Clinical Support
PV-4~ADENOMYOSIS

- Adenomyosis is characterized by benign invasion of ectopic endometrium into the myometrium with hyperplasia of adjacent smooth muscle.
- Common symptoms include dysmenorrhea, menorrhagia, and abnormal uterine bleeding, and enlarged uterus.
- Differentiation of adenomyosis from leiomyoma is important because treatment will differ. Hysterectomy is the only definitive treatment for symptomatic adenomyosis. Embolization of adenomyosis has poor long term results with only 55% of treated patients showing clinical improvement after 2 years.*
  *Radiology 2005;234:948-953
- The only way to accurately diagnose adenomyosis is pathologically after hysterectomy.
- Transvaginal ultrasound has a reported sensitivity of 53%-89% in diagnosing adenomyosis, and a specificity of 67%.
  *Radiographics 2005;25:21-40
- MRI has a sensitivity of 78%-88% and specificity of 67%-93% in diagnosing adenomyosis.*
  *Radiographics 2005;25:21-40

Evidence Based Clinical Support
PV-5~SUSPECTED ADNEXAL MASS

- A study of 505 consecutive resected adnexal masses over 3.5 years showed that 457 (90%) were benign. Lesions smaller than 4 cm were benign in 211 of 218 cases (97%), 246 of 287 lesions (86%) larger than 4 cm were benign. Every lesion that did not have a solid component was benign. Every non-benign lesion had some solid component. 244 of 250 (98%) of lesions without Doppler flow were benign, while lesions with flow were benign in 76 of 106 (72%) cases.*
  *RSNA meeting 2003

Evidence Based Clinical Support
PV-6~ENDOMETRIOSIS

- Transvaginal ultrasound has a better sensitivity, specificity, positive predictive value, negative predictive value and accuracy in cases of deep retro-cervical and recto-sigmoid endometriosis when compared with MRI and digital vaginal examination and is an important preoperative examination for the definition of surgical strategies.*
  *Hum Reprod 2007;22(12):3092-3097
• Low Dose CT utilizes a single view with 0.25 mSv radiation exposure, but most facilities will do multiple views with total exposure of 10 mSv (same as a normal CT pelvis).
PELVIS IMAGING GUIDELINE REFERENCES

PV-2~Abnormal Uterine Bleeding


PV-3~Amenorrhea


PV-5~Suspected Adnexal Mass


PV-6~Endometriosis


PV-8~Polycystic Ovary Syndrome

PV-10~Intrauterine Device (IUD)

PV-11~Pelvic Pain/Dyspareunia, Female
- ACOG Practice Bulletin No. 51: *Chronic pelvic pain* March 2004 (Reaffirmed 2008)
- Stein B. Diagnosis and management of pelvic congestion syndrome and varicoceles. pp. 1-11.

PV-12~Leiomyomata

PV-13~Periurethral Cysts and Urethral Diverticula

PV-14~Uterine Anomalies

PV-15~Fetal MRI

PV-17~Pelvimetry
- ACOG Committee on Obstetric Practice. *ACOG Committee Opinion.* Number 299, September 2004 (replaces Number 158, September 1995).


PV-18~Impotence/Erectile Dysfunction


PV-19~Penis—Soft Tissue Mass


PV-20~Prostatitis/Hematospermia/Urologic Chronic Pelvic Pain Syndrome


PV-21~Scrotal Pathology


PV-22~Fistula in Ano

PV-23~Incontinence
PV-23.1 Urinary Incontinence

PV-23.2 Fecal Incontinence

Evidence Based Clinical Support References
PV-4~Adenomyosis, Evidence Based Clinical Support

PV-5~Suspected Adnexal Mass, Evidence Based Clinical Support
- RSNA meeting 2003.

PV-6~Endometriosis, Evidence Based Clinical Support