**Hampshire Hospitals NHS Foundation Trust Guidelines for Justification of Ultrasound Requests January 2019**

Based on:

British Medical Ultrasound Society; Recommended Good Practice Guidelines for Justification of Ultrasound Requests, November 2016

Royal College of Radiologists; iRefer, 8th Edition, 2018

[National Institute for Health and Care Excellence Guidelines](https://www.nice.org.uk/guidance)

HHFT Multidisciplinary Clinical Consultation

CCG Clinical Consultation

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# For indications that fall outside these guidelines, radiologist discussion is recommended on the Hot Hub telephone number:

Basingstoke and North Hampshire Hospital 01256 313982 Royal Hampshire County Hospital 01962 825000

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| **INDICATION** | **COMMENT** | **JUSTIFIED** |
| ABDOMEN |  |  |
| Significant unintended weight loss | For suspicion of malignancy, as per NICE  guidelines consider 2WW referral and CT  If direct access CT is not available and a 2WW is **not** being triggered, Ultrasound is justified | **YES** |
| Iron deficiency anaemia | Ultrasound not indicated unless there is a  specific clinical question | **NO** |
| ‘Altered LFTs’ See footnote 1 | Please include more information  **Duration** of abnormality.  A single episode of mild – moderate elevation does not justify an US scan  **Specific LFT** results must be included or be available on ICE  Include a **specific diagnosis** to be considered | **NO** |
| ‘Raised ALT’ (other LFTs normal) | Please include more information | **NO** |
| See footnote 1 | US is **NOT** justified in patients with risk factors (DM, obesity, statins & other medications which affect the liver) | **NO** |
|  | US is **NOT** justified for a single episode of raised ALT | **NO** |
|  | US is justified if raised ALT (>120) is **persistent** (3-6 months) despite following weight loss and altered lifestyle guidance and/or change in medication | **YES** |
|  | US is justified if persistently raised ALT >120 (3 months) and no other risk factors | **YES** |
| Jaundice | Any jaundice requires an ultrasound  New onset painless jaundice requires urgent US and **2WW** referral | **YES** |
| Pain (RUQ) | Assessment of gallbladder | **YES** |
| Suspected GB disease | Pain plus fatty intolerance and/or dyspepsia | **YES** |

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| GB polyp | 1 or multiple <6mm NO routine f/up recommended  6-10mm f/up US at 6 months. If no change, annual US for 5 yrs. If no change at 5 yrs STOP. Any **size increase** refer to HPB  >10mm refer HPB | **NO YES**  **YES** |
| Bloating/ abdominal distension | As the only symptom  Persistent or frequent occurring over 12 times in one month, in women especially over 50 with other symptoms or raised Ca125  With a palpable mass With ascites  Suspecting Liver/Cardiac  Suspecting malignancy –  2WW and CT scan recommended | **NO YES**  **YES**  **YES NO** |
| Suspected Pancreatic Cancer | Presenting symptoms: Weight Loss  Nausea and vomiting Back pain  New onset diabetes  Recommend 2WW referral and CT scan Ultrasound cannot assess the entire pancreas | **NO** |
| Altered bowel habit/ diverticular disease | No role in management of IBS or DD  If suspected bowel ca refer via **2WW** | **NO**  **NO** |
| Diabetes | US does not have a role in the diagnosis or management of Diabetes.  Up to 70% of patients with DM have a fatty liver with raised ALT.  This does not justify a scan. | **NO** |

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| RENAL TRACT |  |  |
| UTI (ADULT) | First episode | **NO** |
|  | Recurrent (>/= 3 episodes in 12 months) | **YES** |
|  | Non-responders to antibiotics | **YES** |
|  | Frequent re-infection | **YES** |
|  | H/O stone or obstruction | **YES** |
| UTI (CHILDREN) See footnote 2 | As per NICE guidelines | **YES** |
| Hypertension | Routine imaging is not indicated.  RAS (renal artery screening) is **NOT** offered | **NO** |
| Renal Failure | Acute or acute on chronic  To assess renal size and rule out obstructive causes | **YES** |
| Haematuria (micro/macro) | Most haematuria at HHFT go through the  ‘haematuria **one-stop** clinic’ | **YES** |
| Renal Colic | Females <40  Any Males and Females >40 Direct access for CT KUB | **YES**  **NO** |

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| SMALL PARTS |  |  |
| Lymphadenopathy | Patients with clinically benign groin, axillary or  neck lymphadenopathy do not need US  Small nodes in the groin, neck or axilla are commonly palpable. If new and a source of sepsis is evident, US is not required  Signs of **malignancy** include increasing size, fixed mass, rubbery consistency | **NO**  **YES** |
| Soft tissue lump | **2WW** sarcoma referral if >5cm, tender or  enlarging  <5cm stable, soft, non-tender lumps | **YES**  **NO** |
| Scrotal mass | Following full clinical examination:  Any patient with a swelling or mass in the body of the testis should be referred for **URGENT** US  **Extra-testicular** mass, eg epididymal cyst Generalised scrotal swelling ‘?hydrocoele’  Suspected varicocoele | **YES**  **NO NO**  **YES** |
| Scrotal pain | Chronic (>3 months) pain in the absence of a  palpable mass does **NOT** justify US  Acute pain ?torsion requires **URGENT**  Urology/Surgical referral  Acute pain in the absence of suspected torsion Eg.,Epididymo-orchitis ?Abscess | **NO**  **NO**  **YES** |
| Inguinal hernia | Characteristic history and exam findings  including reducible palpable lump or cough impulse. Ultrasound **NOT** justified. | **NO**  **Consider Surgical**  **referral** |
|  | Irreducible and/or tender lumps may suggest incarcerated hernia and require **URGENT** surgical referral. |  |
|  | **Vague** request ?hernia ?something else | **NO** |
|  | If groin pain, consider MSK causes and refer accordingly | **NO** |
| HEAD & NECK |  |  |
| Thyroid | Ultrasound may be required where there is **doubt** as to the origin of a cervical mass, ie thyroid in origin  Clinical features that increase the likelihood of malignancy include history of irradiation, male sex, age (<20,>70), fixed mass, hard/firm consistency, cervical nodes, change in voice, family history of MEN II or papillary Ca  Routine **follow up** of benign nodules (U2) is not recommended | **YES**  **NO** |
| Salivary mass | History suggestive of salivary duct obstruction  Suspected salivary mass/tumour | **YES**  **YES** |

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| GYNAECOLOGY See Footnote 4 |  |  |
| Pelvic pain ?cause | US is unlikely to contribute to patient  management if pain is the only symptom  In patients **>50**, the likelihood of pathology is increased.  Please include a **specific clinical question** | **NO**  **YES** |
| Pelvic pain + | The addition of another clinical symptom  justifies the request | **YES** |
| Palpable mass Raised CRP/WCC Menstrual irregularity Deep dyspareunia Lack of GI symptoms | Please include a **specific clinical question**/ differential diagnosis. |  |
| Pelvic pain + |  |  |
| H/o ovarian cyst H/o PCOS | These do not represent further clinical symptoms | **NO** |
| ‘Severe’ or ‘Sudden’ Loose stools  ?appendicitis  ?ovarian cyst | Reassurance scans will be referred back pending more information | **NO** |
| Bloating See footnote 3 | As only symptom or intermittent bloating  Persistent or frequent (>12 times/month), especially over 50.  Persistent ***and*** palpable mass/ raised Ca 125  (Referral and alternative tests required for GI tract related symptoms) | **NO**  **YES YES** |
| F/up of benign lesions, e.g. fibroid, dermoid, cyst | Usually there is no role for US in follow-up of  these lesions in pre-menopausal women unless: | **NO** |
|  | On the advice of secondary care | **YES** |
|  | The patient has undergone a **clinical change** | **YES** |
|  | Follow-up US of benign lesions can be performed at 4 months and 1 year in **post- menopausal** women to ensure no change | **YES** |

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| PMB | Please include information about the LMP (i.e.  post- rather than peri-menopausal) and relevant HRT status | **YES** |
| Heavy menstrual bleeding See Footnote 4 | US recommended if   * Uterus is palpable abdominally * Vaginal examination yields a pelvic mass * Pharmaceutical treatment fails | **YES** |
| Irregular bleeding inter menstrual, post-coital, frequent, prolonged, irregular cycle  See Footnote 5 | As only symptom <40  With abdominopelvic mass Heavy irregular bleeding >40  - Refer to Gynaecology for consideration of  hysteroscopy | **NO**  **YES YES** |
| Post natal bleeding | Women who are up to 21 days PN should be  referred to O&G for consultant input or DPAU scan  Women who are over 3 weeks PN should be seen in the EPAU **or** main scanning department | **NO**  **YES** |
| PCOS | Only useful in **secondary care** if investigating  subfertility  Diagnosis of PCOS is based on:   1. Irregular menses 2. Symptoms and signs of hyperandrogenism 3. Biochemical evidence of hyperandrogenism 4. Biochemical exclusion of other confounding conditions | **NO** |
| Investigation of subfertility | Accepted if concurrent referral made to fertility  service | **YES** |
| IUCD/Mirena | US to assess for presence of fibroids if  placement of Mirena is considered  US to identify presence of IUCD when threads not visible  Sonographer will arrange AXR if IUCD not found on US | **YES**  **YES** |

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| MSK |  |  |
| Shoulder | Impingement/rotator cuff pathology  SCJ OA/pathology | **YES**  **NO** |
| Elbow | Common flexor/extensor tenosynovitis | **YES** |
| Wrist/hand | Specific tendon/joint | **YES** |
| Hip | Palpable lump – bursitis? | **YES** |
| Knee | Patellar/quadriceps tendinopathy  Popliteal cyst Meniscal pathology | **YES**  **YES NO** |
| Ankle/foot | Achilles tendinopathy  Plantar fasciitis Mortons neuroma  Anterior talofibular ligament | **YES**  **YES YES NO** |
| Any body part | Diffuse pain/swelling | **NO** |
|  | Non-specific requests, eg “joint/tendon/ligament pathology?” | **NO** |
|  | Palpable lump – if changing | **YES** |
|  | Whole limb requests | **NO** |
|  | Intra-articular pathology | **NO** |

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# FOOTNOTES

1. Liver Function tests - Isolated enzyme rises – US generally not indicated

ALT alone: Fatty liver (risk factors; obesity, hyperlipidaemia, DM) or Drugs (statins/ oral contraceptive pill)

ALP alone: Probably bone, not liver (adolescent growth, Paget’s disease, recent fracture)

GGT alone: Usually alcohol. Consider prescribed drugs. Fatty liver (risk factors; obesity, TGs, DM)

AST alone: Muscle injury or inflammation.

Bilirubin alone: Gilberts syndrome (usually <80mols/L)

1. UTIs in under 16s.<https://www.nice.org.uk/guidance/cg54/chapter/1-guidance>
2. Ovarian cancer – NICE guidance for women aged 18 and over. [https://pathways.nice.org.uk/pathways/ovarian- cancer#path=view%3A/pathways/ovarian-cancer/ovarian-cancer-detection-in- primary-care.xml&content=view-index](https://pathways.nice.org.uk/pathways/ovarian-cancer%23path%3Dview%3A/pathways/ovarian-cancer/ovarian-cancer-detection-in-primary-care.xml%26content%3Dview-index)
3. Heavy Menstrual Bleeding<https://www.nice.org.uk/guidance/ng88>
4. HHFT Gynaecology referral guidance<http://www.hampshirehospitals.nhs.uk/media/295023/gynae_guidelines_aug2014.pdf>