

# POLICY STATEMENT\*

## SUGGESTED TERMINOLOGY AND EXPECTATIONS FOR ULTRASOUND EXAMINATIONS USED IN OBSTETRICS

No. 65, July 1997

*This document has been reviewed and approved by the Diagnostic Imaging Committee of the Society of Obstetricians and Gynaecologists of Canada and was approved by its Council.*

There is a clear difference in the types of ultrasound examinations currently being performed on obstetrical patients. Indications for ultrasonography during pregnancy are multiple and diverse, and the type of examination may vary according to the information sought.<sup>1</sup> The various types of ultrasound examinations depend on the relevant indications, the expectations of the requesting health care provider, and the resources available, including the technological skills of the sonologist.

Ultrasound examinations that are being performed currently in various regional obstetrical ultrasound facilities can be classified as being either 1. Community-based (often private offices or small hospital ultrasound units and/or radiology departments); 2. Within district or medium-sized hospitals with available obstetrical, gynaecological, paediatric, radiological, and other consultative services; or 3. In regional centres where sophisticated ultrasound facilities are available often in

conjunction with neonatal expertise to assist in the assessment and management of complex pregnancies.

There is currently no consensus in Canada on a common terminology for the various ultrasound examinations performed nor a consensus regarding expectations and ultrasound features that should be included for various indications.

The following is a proposed terminology for various obstetrical ultrasound examinations with the expectations of the ultrasound features to be assessed and reported.<sup>2</sup> The SOGC endorses the following terminology:

1. The complete ultrasound examination
2. Limited ultrasound examination
3. The comprehensive ultrasound examination

The SOGC Diagnostic Imaging Committee recommends, based on the current obstetrical literature, that a second trimester (16–20 weeks) **complete** ultrasound

\*Policy Statements: this policy reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of the contents may be reproduced in any form without prior written permission of SOGC.



examination be offered to all pregnant women.<sup>3</sup> It is acceptable to perform a limited scan if the patient has had a previous complete scan, refuses a complete scan or if a complete scan is scheduled for a future date.

1. **The complete ultrasound examination** includes verification, documentation, and reporting of:
  - fetal number
  - fetal position
  - documentation of fetal life
  - placental location
  - assessment of amniotic fluid volume
  - survey of fetal anatomy for malformations
  - evaluation of maternal pelvic masses
  - assessment of gestational age
  - evaluation of fetal growth based on prior ultrasound examination and/or clinical history
  - estimation of fetal weight in third trimester and evaluation of fetal growth trend based on prior ultrasound examination and/or clinical history
  - multiple pregnancies require documentation of placental number, comparison of size, number of sacs, genitalia, presence, and nature of the separating membrane/s

The SOGC Guidelines for the Performance of an Ultrasound Examination describe in detail the key images, measurements, anatomy review, documentation, and interpretation.<sup>3</sup>

2. **The limited ultrasound examination** relates to the specific nature of information required based on indication for the examination.
3. **A comprehensive ultrasound examination** differs from the complete scan by where it is done and by whom. It is indicated for a patient who is suspected of carrying a physiologically or anatomically defective fetus by history, clinical evaluation or prior ultrasound examination.

These examinations should be performed/interpreted by physicians with recognized skills in and knowledge of ultrasound interpretation of complex fetal conditions/anomalies.

These examinations should be performed in regional referral centres that have available multidisciplinary consultation and expertise.

J SOC OBSTET GYNAECOL CAN 1997;19:876-77

#### REFERENCES

1. Technical Bulletin. American College of Obstetrics and Gynecology, No. 187. Dec. 1993.
2. Technical Bulletin. American College of Obstetrics and Gynecology, No. 187. Dec. 1993.
3. Guidelines for the Performance of Ultrasound Examination in Obstetrics and Gynaecology. J Soc Obstet Gynaecol Can 1995;17;3:263-6.

INDICATION	MINIMAL U/S FEATURES TO BE DOCUMENTED AND REPORTED	OTHER
1. First Trimester	Gestational sac, CRL, BPD ( if seen), placental location, FH if multiple pregnancy: number of sacs and number of placentae, presence or absence of dividing membrane(s)	Haemorrhage, adnexae
2. Ultrasound Guided Amniocentesis/cordocentesis/CVS	Placental location, pre- and post-procedure FHR, evidence of bleeding, documentation of catheter or needle placement	
3. Confirmation of Fetal Life or Death	Documentation of absence of cardiac motion, absence of limb motion, gas in abdomen (Robert's sign), overlapping skull bones (Spaulding's sign), skull halo	
4. Targetted Assessment of Cervix	Cervical length (post-void), dilatation, funnelling, fluid in endocervical canal and/or vagina, position of cervical suture (if present)	
5. Biophysical Profile Score	Recording and scoring of fetal tone, gross body movements, breathing movements, and amniotic fluid volume, +/- NST if score = or < 6/8	Doppler or other findings— may be included in some local protocols
6. Amniotic Fluid Assessment	4 quadrant amniotic fluid index or deepest vertical pocket, and/or subjective visual impression	
7. Doppler Flow	Umbilical Doppler flow measurements using S/D, RI or PI, absent or reversed end diastolic flow	