North Bristol NHS Trust

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

UBHT, NBT and WGH Radiology Guidance

For GPs and Radiology staff

Requesting and Vetting Non-obstetric Ultrasound Examinations.

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CONTENTS

UBHT, NBT and WGH Radiology Guidance for GPs and Radiology staff Requesting and Vetting Non-obstetric Ultrasound Examinations

Introduction

The following new guidelines have been developed by the local ultrasound departments and a GP Representative at the request of the BNSSG, with a view to help general practitioners use ultrasound most effectively to the benefit of all their patients. To do this, advice from the Royal College of Radiologists, British Medical Ultrasound Society, NICE Guidance and relevant local guidelines have been utilised.

As the guidance applies to all three Trusts it is hoped this will help to reduce the challenge of selecting appropriate imaging and reduce the demand for unnecessary scans, therefore creating capacity for more urgent scans. The ultrasound departments will also use the same guidance to vet ultrasound requests, therefore providing a more standardised service to the Primary Care setting.

Please note a complimentary piece of guidance is in the process of being developed for Musculoskeletal Ultrasound and Interventions.

We recognise there may be specific clinical situations that do not fit within the scope of these guidelines. In such cases, or if there are any clinical queries, please contact the relevant departments for advice or to discuss.

Ultrasound Department Contact Details

UBHT Main Ultrasound Department: [redacted]

Weston District General Ultrasound Department: [redacted]

NBT Main Ultrasound Department: [redacted]

TESTES • Link to flowchart – [redacted]		
Not Justified	**Justified**	**Please Request Ultrasound…**
SUSPECTED TORSION *requires an urgent urological referral which should not be delayed by imaging*	Acute pain in the absence of suspected torsion or acute epididymo-orchitis	Testes
	Swelling or mass in body of testes – *requires URGENT referral please refer under 2ww straight to test pathway*	Testes
	Symptoms and examination provide an unclear clinical diagnosis and ultrasound will influence management	Testes
Uncomplicated epididymo-orchitis	Suspected complications post treatment of epididymo-orchitis such as an abscess	Testes
	Persistent pain/symptoms following treatment of epididymo-orchitis	Testes
Previously proven extra testicular mass such as an uncomplicated hydrocele or epididymal cysts	Clinical concern regarding change in symptoms of testicular or scrotal pathology	Testes
Chronic varicocele/hydrocele	New swelling or mass and pain (not testicular), query.	Testes

	varicocele or hydrocele	

ABNORMAL LIVER FUNCTION TESTS (LFTs)		
Not Justified	**Justified**	**Please Request Ultrasound…**
Isolated raise in Bilirubin	Abnormal LFT described in conjunction with the patient's symptoms as indicated by the abnormal liver function tests algorithm pathway https://remedy.bnssgccg.nhs.uk/adults/hepatology/liver-disease/ - next version	Liver or Upper Abdomen
Abnormal raise in LFTs with no further clinical information provided		Liver or Upper Abdomen

GENERAL ABDOMINAL SYMPTOMS		
Not Justified	**Justified**	**Please Request Ultrasound…**
Bloating/distension as the only symptom	**Persistent Bloating/Distention plus relevant clinical history/symptoms (e.g. suspicions of ascites, presence or absence of liver/cardiac disease; palpable mass or raised CA125)** [redacted]	**Upper Abdomen/Abdomen and Pelvis depending on location**

Query malignancy/cancer *this information is too vague*	Clinical symptoms and clinical question raising suspicion of specific malignancy is required	Upper Abdomen/Abdomen and Pelvis depending on location
Query abdominal mass *this information is too vague*	Query abdominal mass or palpable mass, plus location (subcutaneous/deep) and detail regarding suspected organ in question (where appropriate) and symptoms, with clinical question.	Upper/Lower Abdomen or Abdominal Wall depending on location
Abdominal Pain only *this information is too vague*	Abdominal pain plus location, any further symptoms and clinical question	Upper Abdomen/Lower Abdomen/Abdomen depending on location

BILIARY SYMPTOMS		
Not Justified	**Justified**	**Please Request Ultrasound…**
	Gallbladder polyps: Local policy varies between trusts - follow up guidance will be given in the initial diagnostic scan.	Liver/Upper Abdomen depending on location

	Clinical Jaundice +/- pain requires urgent ultrasound and a 2 week wait referral if appropriate	Liver/Upper Abdomen depending on location
	Suspected gallbladder disease with fatty intolerance/dyspepsia	Liver/Upper Abdomen depending on location
	Biliary colic. Query gallstones	Liver/Upper Abdomen depending on location

MISCELLANEOUS ABDOMINAL SYMPTOMS/INDICATIONS		
Not Justified	**Justified**	**Please request Ultrasound…**
Suspected pancreatic cancer requires URGENT direct access CT and 2WW referral		

Query pancreatitis – *ultrasound cannot provide a diagnosis*	Diagnosis of pancreatitis: query gallstones/ductal stone	Liver/Upper Abdomen depending on location
Altered bowel habit/diverticular disease – *ultrasound is highly unlikely to provide a diagnosis*		
Query Appendicitis – *not normally indicated in the primary care setting, referral to secondary care is advised*		
Known diabetes – *up to 70% of patients with DM will have a fatty liver with raised ALT. This is not justification for a scan*		

RENAL TRACT
HAEMATURIA or SUSPECTED BLADDER OR RENAL CANCER requires a 2 Week Wait referral/one stop haematuria clinic if the patient: - is over 50 years with unexplained visible haematuria and no UTI, or - has persistent visible haematuria following treatment for UTI, or - is over 60 years with unexplained microscopic haematuria with dysuria and or raised white cell count

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Not Justified	Justified	Please Request US…
UTI – first episode	• UTI if recurrent: more than 3 episodes in 12 months especially if over 60 years old • UTI – non-responder to antibiotics • UTI – frequent re-infections	Lower Abdomen/Renal
Asymptomatic with history of stone or obstruction	Previous history of stone or obstruction, with loin/flank pain	Lower Abdomen/Renal
Simple Hypertension – *routine imaging not indicated.*	Hypertension resistant to treatment (not controlled by drugs) OR complicated hypertension (eg history of renal / renovascular damage) OR Under 40 years old with moderate / severe hypertension OR other clinical concern	Lower Abdomen/Renal
	Monitoring for tubular sclerosis	Lower Abdomen/Renal
Renal Artery screening / renal artery stenosis – *MRI Renal Artery may be more appropriate, please seek advice from Radiology/urology*		
	GP referral for renal colic	Lower Abdomen/Renal
	Pain passing urine	Lower Abdomen/Renal
	Query Retention	Lower Abdomen/Renal

	Increased urinary frequency and post micturition volume	Lower Abdomen/Renal
** Risk Factors for urinary malignancy ** [redacted]		

HAEMATURIA		
Link to flow chart) – this version		
Not Justified	**Justified**	**Please Request Ultrasound…**
• is aged 45 years and over, with unexplained visible haematuria and no UTI, or has persistent visible haematuria following treatment for UTI, or • is over 60 years with unexplained non-visible haematuria with dysuria and or raised white cell count **Please arrange 2 Week Wait referral to the HAEMATURIA CLINIC.**		
• Age over 60 years with haematuria and recurrent or persistent Urinary Tract Infections • Visible Haematuria in patients aged less than 45 years **Please arrange routine referral to the**		

HAEMATURIA CLINIC.		
Not Justified	**Justified**	**Please Request Ultrasound…**
Nonvisible haematuria outside 2WW criteria If previously investigated recently and no change in symptoms. **Consider renal referral rather than repeating investigations.**	**Non-visible haematuria outside 2WW criteria** • Assess risk factors, also consider offering flexible cystoscopy, with counselling regarding risk of cancer. • >50 yrs < 60 yrs with an isolated incident of microscopic haematuria – routine ultrasound scan referral.	Renal tract ultrasound
GYNAECOLOGY		
Not Justified	**Justified**	**Please Request Ultrasound…**
Pain as the only symptoms – *this is too vague*	Location of pain, negative pregnancy test and further clinical findings/symptoms or clinical question e.g. query ovarian mass, raised CRP/WCC, menstrual irregularities	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
Intermittent Bloating aged less than 40	**Symptoms signifying increased risk of ovarian cancer in a patient over the age of 40 years of age, such as bloating/distention +/- raised CA125 *** [redacted]	**Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear***

Asymptomatic with family history of Ca Ovary for reassurance	Any age patient with symptoms and a family history (first degree relative) of Ca Ovary	
	Palpable mass	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
Menstrual irregularities	Menstrual irregularities for minimum 6 months (interval advised by gynaecology consultants)	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

GYNAECOLOGY continued		
Not Justified	**Justified**	**Please Request Ultrasound…**
	Dyspareunia	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
Follow up of premenopausal benign lesions such as fibroids/cysts with no clinical change/change in symptom unless advised by outpatients or at diagnostic scan	Follow up of benign uterine lesions due to clinical change or change in symptoms	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

	PRE-MENOPAUSAL benign cysts. Please take advice from previous scan. If no scan follow-up guidance provided, contact Radiology department for advice.	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
POST-MENOPAUSAL symptomatic benign cysts – *gynaecology referral is advised outside of the 2ww pathway*	Follow up for POST MENOPAUSAL asymptomatic simple cysts above 3cm.	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

GYNAECOLOGY continued		
Not Justified	**Justified**	**Please Request Ultrasound…**
POST-MENOPAUSAL (PM) complex cyst or simple cyst measuring over 100 mm. *Patient should already be under the care of Gynaecology Outpatients*		
POST-MENOPAUSAL bleeding - refer to gynaecology within 2 week wait pathway COMMUNICATE THIS	PMB – Referral following triage by Outpatients only *PMB – patient declines gynaecology referral.*	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

DIRECTLY TO THE GP [redacted]	*New PMB immediately after pessary change/removal*	
PERI-MENOPAUSAL heavy bleeding despite medical treatment – urgent referral to gynaecology is advised (**not** 2 week wait pathway)		
	Any abnormal PRE-MENOPAUSAL bleeding (negative pregnancy) with a clinical question e.g. query fibroid or endometrial polyp	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
Lost Coil - ? Perforation or with Severe pain – Refer to A&E or Gynae emergency clinic as appropriate	On examination lost threads or query IUCD correctly sited/in situ	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

GYNAECOLOGY continued		
Not Justified	**Justified**	**Please Request Ultrasound…**
Query Polycystic Ovary Syndrome (PCOS) - *diagnosis should be based on clinical findings such as:*		

- *irregular menses* - *clinical symptoms such as hirsutism/acne* - *biochemistry* - *biochemical exclusion of other conditions* - *Ultrasound can be useful in secondary care when investigating fertility i.e. the specialist needs to make this referral*		
NO SCAN: Patients Under 18 – NO SCANS FOR ? PCOS – NO EXCEPTIONS TO THIS RULE • Patients less than 8 years since onset of menarche • ? PCOS with oligo/amenorrhoea as the only information – Blood results are required and the referral will be only be accepted if bloods are **normal.** • Patients with hyperandrogenism – Biochemical and clinical (eg oligo-amenorrhoea, hirsuitism, acne) suggesting PCOS. If a patient has symptoms and confirmatory bloods, the diagnosis can be made and ultrasound is not required. • Previous scan shows no PCOS. [redacted]	Patients over 18 years and greater than 8 years from the onset on menarche, who have clinical features for PCOS or hyperandrogenism, but who have normal blood results	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

[redacted]		
Query PCOS in women using oral contraceptive (Combined Oral Contraceptives s will mask diagnosis of PCOS by suppressing hyperandrogenemia)		
Infertility – *this should be a specialist referral*		
GYNAECOLOGY continued		
Not Justified	**Justified**	**Please Request Ultrasound…**

	High Glucose levels plus another symptom (e.g. pain, bleeding or bloating) https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#gynaecological-cancers	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
	History of haematuria in patient over the age of 55 year with suspicion of PMB https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#gynaecological-cancers	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
	Unexplained PV discharge (1st presentation, with thrombocytosis/ haematuria, over 55 years old). NICE guidance is to rule out endometrial cancer https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#gynaecological-cancers	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*

GYNAECOLOGY continued		
Not Justified	**Justified**	**Please Request Ultrasound…**
Offensive discharge in premenopausal patient	Offensive discharge in pre-menopausal patient with IUCD/infection and clinical question	Pelvis – *if patient cannot have a transvaginal ultrasound please make this clear*
Vaginal, vulval or perineal lumps/cysts – *refer to gynaecology*		
HERNIAS		
Not Justified	**Justified**	**Please Request Ultrasound…**
Clinically reducible inguinal hernia or known hernia, size or increase in size is irrelevant		
Clinically irreducible and /or tender lump in keeping with incarcerated/strangulated hernia – *appropriate onward referral is required.*		
	Inconclusive clinical examination. Query hernia or other eg large lymph node etc, plus symptoms and location –	Groin/Abdominal wall depending on location

	[redacted]	
	Query ventral, lumbar or Spigelian hernia?	Abdominal Wall
	Clinically uncertain, query inguinal or femoral hernia?	Groin

LYMPH NODES		
Not Justified	**Justified**	**Please Request Ultrasound…**
Clinically benign nodes in groin/neck/axilla – *ultrasound is not beneficial.*	If malignancy is suspected (increasing size/fixed/irregular) or there is a history of a previous malignancy, USS can be helpful as biopsy can be carried out at the time and additional imaging can be requested if required.	Neck/Groin/Axilla depending on location
Breast lesions with axillary nodes should be referred to the **Breast Care centre**@ NBT for triple assessment, **NOT** for a standalone USS.		
If widespread lymphadenopathy / B symptoms refer as		

2ww to haematology		

HEAD AND NECK For neck lumps, do not routinely arrange neck u/s scans in primary care as this may cause diagnostic delay		
Not Justified	**Justified**	**Please Request US…**
THYROID: - Routine imaging of established nodules/goitre is not recommended - Routine FNA of benign nodules is not indicated - Routine follow up of benign nodules is not recommended – the risk of malignancy based on US findings requires stratification under BTA guidelines - Patients with hyperthyroidism/ hypothyroidism unless associated with a goitre.		
Refer to H&N team at UHBW for (2ww referral) • Suspected malignancy including rapidly enlarging, hard neck mass • Neck lump of unknown cause • Voice change with large thyroid • Large thyroid with neck nodes • Determining the origin of a cervical mass • Focal salivary gland mass		

• Palpable lump in neck, previously undiagnosed present 3-6 weeks including salivary gland and unexplained lymphadenopathy • Thyroid lump (if there are concerning symptoms eg signs of airway obstruction refer to on call ENT team		
	[redacted]	US Neck

References

NHS Bristol, North Somerset, and South Gloucestershire CCG (2020) [redacted]

NICE Guidance (2019) https://www.nice.org.uk

BMUS recommended good practice guidelines justification of ultrasound requests revision 4: OCTOBER 2021