

Ref No:

**Guidelines for Vetting Ultrasound Requests
(Excluding Interventional, Breast, Medical Physics, Cardiology,
Obstetrics and Paediatric Ultrasound)**

**SECTION 1
PROCEDURAL INFORMATION**

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1. INTRODUCTION

The Advanced Practitioners in Ultrasound employed by The Rotherham NHS Foundation Trust (TRFT) will primarily use this document. The document is also for referring clinicians in either the primary care setting or the Acute Trust. The document is a guidance for vetting ultrasound requests from the wide variety of referral sources, to ensure the correct procedure is requested and the correct procedure is carried out.

The Ultrasound Department may receive requests from many different sources including wards, Outpatient departments and primary care. A **fully** completed ultrasound request in electronic format will be required for every examination undertaken. Some referrers will still send referrals in via a paper request i.e. from some GP practices who do not have ICE, ISHS, non-Rotherham GP's, RDASH and Sheffield hospitals. The referrals will only be accepted from a medically qualified person or a qualified and registered healthcare practitioner who is on the current Ionising Radiation Medical Exposure Regulations (IRMER) non-medical list of approved referrers. All non-medical requestors of NHS ultrasound scans have an agreed scheme of work approved by TRFT and by the Medical Imaging, Physics and Illustration Quality Governance Committee

The ultrasound scans will be performed by both Advanced Practitioners in Ultrasound and Radiologists from the Clinical Radiology Department in a various locations, both in and out of normal working hours. It is therefore essential that the Ultrasound Department is proactive in managing workload to ensure that the right scan is performed in the right place, by the right person and at the right time. Vetting of ultrasound requests by an ultrasound practitioner is therefore important.

2. EVIDENCE

There are national standards and Guidance for the use of medical Ultrasound to support improved patient safety and a high quality of service. This evidence is provided by; National Institute for Health and Care Excellence (NICE), Royal College of Radiologists (RCR), British Medical Ultrasound Society (BMUS), The Society and College of Radiographers (SCoR), British Thyroid Association, European Society of Musculoskeletal Radiology, British Society of Gastroenterology and European Society of Cardiology.

3. PURPOSE

The purpose of the vetting procedure is to:

- Confirm a suitably qualified/registered practitioner has made the request.
- Ensure there is **sufficient clinical information** to ensure ultrasound is the correct procedure to answer the **specific clinical question** and complies with department guidelines. Physical examination and relevant laboratory

investigations to support the suspected diagnosis/(es) should be included. Suspected diagnoses must be clearly stated and not implied. Non-specific terms such as “Pain ?cause” or “exclude pathology” should not be used.

- Ensure the correct examination has been requested and assign appropriate patient preparation.
- Identify clinically urgent or targeted requests and ensure exams are undertaken in a timely manner.
- Ensure scans are undertaken by the right person, in the right place and at the right time.
- Reject inappropriate requests and give guidance to the referrer to the reasons of rejection.
- Re-direct requests to other appropriate imaging modalities or investigations following discussion with the Radiologists (when necessary) and with the agreement of local commissioners.

4. SCOPE

This guidance applies to all referring practitioners and practitioners undertaking vetting of ultrasound requests in the Clinical Radiology Department at TRFT.

This document will read in conjunction with Ultrasound Guidelines (excluding Interventional, Breast, Medical Physics, Cardiology, Obstetrics and Paediatric Ultrasound).

5. GUIDANCE

5.1 Vetting Ultrasound Requests

The practical workflow of the vetting system is:

- Assess clinical details. The vetting Sonographer should be confident that the ultrasound request provides sufficient clinical information and is appropriate to answer the clinical problem posed.
- If the vetting Sonographer is unsure about the next step for a given request, advice must be sought from another Sonographer with this specialism* or a Radiologist.
- Return any requests that are unjustified or that have insufficient clinical details back to the referring clinician, with an explanation.
- If, from the requesting clinical details, the vetting Sonographer deems an alternative modality would be more suitable, confirmation/advice should be sought from a Radiologist.
- State if the request is for an Urgent or Routine ultrasound list (change as appropriate). Target patients will be identified from the current cancer pathway; however, the remaining vetting system workflow should still be followed.

- Ensure the exam code reflects the clinical details/question to be answered. Amend the code if necessary. **See Appendix 1**
- State clearly any preparation required:
 - S - Starve
 - FB - Full Bladder
 - S and FB - Starve and Full bladder
 - NP - No preparation required
- Indicate which list the patient should be assigned to or move within the vetting page if electronic:
 - Radiologist
 - General
 - Neck (no Fine Needle Aspiration (FNA))
 - Babies Hips
 - Paediatric
 - Vascular
 - MSK
 - Hernia/Soft tissue
- The vetting sonographer must initial all requests that have been vetted.
- If an ICE referral, file in the appropriate list folder and pass to the clerical team in the booking office for referring on to the Radiology Information System (RIS).

*To aid with the vetting process a spreadsheet of 'Sonographers, Who does what' can be located within the 'Important Information Folder', which is located in Ultrasound Room 4, in the Clinical Radiology Department, B level, TRFT. This will be frequently updated to include any changes to staff and increases in skill mix.

5.1.2 Request Return Process

In the event of a request being returned to the referrer either by the vetting Sonographer alone or after discussion with another colleague or Radiologist; to ensure an audit trail is logged, the following process will notify the referring Practitioner:

Referral source	Sonographer action	Clerical action
GP	Complete the return letter and sign. (see Appendix 2)	Add the referral and return letter to the Radiology Information System (RIS) and set the referral in the RIS to the declined filter. The referral can then be set to “Cancelled – no further action” Forward the return letter and original referral to the referral source.
Hospital Clinicians and Practitioners via electronic Outpatient referrals	Document in the RIS “referral returned” and give details for the reason for return and add your initials. Set the referral to the declined/cancelled filter.	Contact the referrer to explain why the referral has been returned, document on the RIS and set the referral to cancelled – no further action.
Hospital Clinicians and Practitioners via electronic In-patient referrals	Document in the RIS “referral returned” and give details for the reason for return and add your initials. Leave the referral on pending in-patients filter.	The In-patient co-ordinator contacts the referrer to pass on the declined information, documents their actions in the RIS and sets the referral to the declined filter.
Paper referrals (various sources)	Complete the return letter and sign.	Add the referral and return letter to the Radiology Information System (RIS) and set the referral in the RIS to the declined filter. Forward the return letter and original referral to the referral source.

5.2 Guidance for Justified/NOT Justified Ultrasound Requests.

The following guidance is designed to support the performing practitioner with vetting common and frequently encountered clinical details. This is not an exhaustive list and therefore a referral, which sits outside the guidance, may need discussion with the referrer, a specialist Sonographer colleague or Radiologist to help validate the appropriate examination.

5.2.1 Upper Abdomen

Clinical Details	US scan is Justified	US scan is NOT Justified
Liver		
<p>See Appendix 3 for more LFT information</p>	<p>Abnormal LFT's plus – patient is symptomatic e.g. Jaundice, pale stools, dark urine, RUQ pain. <i>Please include this information on the request</i></p> <p>Hepatic liver enzymes ↑ ALT or AST. <i>Please include the ALT/AST result on the request</i></p> <p>Cholestatic liver enzymes ↑ ALP with GGT. <i>Please include the ALP & GGT result on the request</i></p> <p>Abnormal LFT's plus – a relevant, specific diagnosis is considered. <i>Please include the LFT result on the request</i></p>	<p>Abnormal/altered/ deranged LFTs (ONLY). Refer back for further information if this is the only information given.</p> <p>Liver function tests – Isolated rise in GGT – US is not indicated.</p> <p>Liver function tests – Isolated rise in Bilirubin – US is not indicated. Bilirubin alone: Gilberts syndrome (an incidental finding of an increased serum bilirubin concentration, typically not exceeding 65-85 micromols/L, with otherwise normal LFTs).</p> <p>NB. A single episode of mildly elevated LFT's in a asymptomatic patient does not justify an Ultrasound scan.</p>

	<p>For Information</p> <p>ALT alone: Fatty liver (risk factors; obesity, hyperlipidaemia, DM) or Drugs (statins/OC).</p> <p>ALP alone: probably bone NOT liver (adolescent growth, Paget's disease, recent fracture).</p> <p>GGT alone: usually alcohol. Consider prescribed drugs. Fatty liver (risk factors; obesity, TGs, DM).</p> <p>AST alone: Muscle injury or inflammation.</p>	
Jaundice	Request must state whether painless or not. Overt and/or painless jaundice - new onset, cause unknown - requires urgent Ultrasound and referral to 2 week wait (2WW) clinic.	
RUQ Pain	Specific localised pain i.e. positive Murphy's sign is an indication for Ultrasound (Request must include this information).	RUQ only - Refer back for further information. Generalised pain as the only symptom is not a justification for Ultrasound.
Upper abdominal mass	When the clinical details mention a suspicions of an enlarged liver or gallbladder pathology as a cause of the upper abdominal mass.	If there is a suspicion of a stomach cancer (OGD or CT is then indicated). If there is h/o lymphoma with palpable mass, CT with contrast should be performed.
Liver cysts (follow-up)		Follow-up of simple liver cysts is not routinely necessary.

Clinical Details	US scan is Justified	US scan is NOT Justified
Gallbladder		
Suspected gallbladder disease	Pain plus fatty intolerance and/or dyspepsia.	
Gallbladder polyp	See Appendix 4 for surveillance.	
Pancreas		
Suspected Pancreatic Cancer		Presenting symptoms of any of the following: Diarrhoea or constipation, nausea or vomiting, back pain with weight loss or new onset diabetes with weight loss. Consider an urgent direct access CT scan (to be performed within 2 weeks) plus upper GI referral.
Diabetes - known		Ultrasound does not have a role in the management of diabetes. Up to 70% of patients with DM have a fatty liver with raised ALT. This does not justify a scan.
Spleen		
Spleen	Suspected enlarged spleen. Thrombocytopenia with suspected enlarged spleen. CLL/haematological disorders with suspected splenic findings.	

Clinical Details	Us scan is Justified	US scan is NOT Justified
Renal Tract		
Urinary tract Infection	<p>Recurrent (≥ 3 episodes in 12 months) with no underlying risk factors.</p> <p>Non-responders to antibiotics.</p> <p>Frequent re-infections.</p>	<p>First episode.</p> <p>Known renal stones with haematuria in adults – CT scan.</p> <p>H/O (in the past) stone or obstruction – CT scan.</p>
Unexplained Hypertension	<p>SECONDARY CARE REFERRALS ONLY To assess for CKD or renal scarring. To assess for aortic aneurysm (scan to include aorta).</p> <p>If previous renal ultrasound has been performed and renal function remains normal, there may not be an indication for a repeat scan.</p> <p>GP advised to refer to secondary care (tends to be young patients with newly diagnosed hypertension for possible secondary causes and those who are difficult to control).</p>	<p>USS renal is not required if the clinical question is ?renal artery stenosis – for MRI.</p> <p>USS renal is not required if the clinical question is ?adrenal mass – for CT.</p> <p>RAS (renal artery screening/Doppler) no longer offered.</p>
Haematuria for Suspected Bladder / Renal Cancer	If referred from Urology due to microscopic.	<p>Visible haematuria requires CT and Urology referral.</p> <p>All haematuria referrals from GP require alternative pathway.</p>

AKI	<p>If pyonephrosis (infected AND obstructed kidney) is suspected, for urgent ultrasound.</p> <p>No identifiable cause for AKI or at risk of obstruction, i.e.</p> <ul style="list-style-type: none"> • Pelvic mass • Prostate enlargement • Urethral catheter use • Previous renal calculi <p>Needs urgent USS.</p> <p>Progressive AKI, non-responsive to first line management strategies, without obvious cause.</p>	Stage 1 AKI, ultrasound not routinely required unless renal function deteriorates and obstruction is suspected.
Flank/loin pain	If referred by Urologist with explanatory clinical information.	<p>Non-specific.</p> <p>If stone disease is suspected refer for CT.</p>
Suspected bladder pathology	Bladder symptoms i.e. suspected outflow obstruction, urinary frequency, nocturia, incontinence. Pre and post micturition volumes documented.	Suspected bladder tumour should be referred via 2 WW cancer referral.
Surveillance of renal cysts / angiomyolipomas		<p>Follow-up of simple renal cysts and angiomyolipomas is not routinely necessary.</p> <p>Any renal masses will have been classified using CT and any follow-up required will be advised by the Radiologist from the CT.</p>

Clinical Details	US scan is Justified	US scan is NOT justified
Aorta		
AAA	<p>Pulsatile abdominal mass with persistent abdominal/back pain.</p> <p>Known AAA (see AAA SOP for follow-up) only as part of vascular pathway.</p>	<p>Suspected rupture requires urgent medical attention.</p> <p>Males over 65 will be called for ultrasound via the AAA screening programme.</p>
General abdominal		
Bloating/ Abdominal distension	<p>Persistent/constant, in women especially over 50.</p> <p>With a palpable mass.</p> <p>With raised Ca125 - <i>Please include the Ca125 result on the request</i></p> <p>Ascites? Usually due to liver or heart failure or malignancy. Likely cause should be indicated on request: Liver/Cardiac.</p>	<p>Refer back for further information if this is the only information given.</p> <p>Intermittent bloating.</p> <p>Malignancy/cancer – CT scan.</p>
Altered bowel habit/ Diverticular disease		<p>Ultrasound does not have a role in the management of IBS or diverticular disease.</p> <p>Refer back for further information.</p> <p>(If bowel cancer is suspected then GI referral via the 2 WW pathway is indicated).</p>

5.2.2 Pelvic Ultrasound

Clinical Details	US scan is Justified	US scan is NOT Justified
Gynaecology		
Pelvic pain? cause	In patients >50, the likelihood of pathology is increased, and the request may be accepted, provided a specific clinical question has been posed.	Ultrasound is unlikely to contribute to patient management if pain is the only symptom.
	<p>Pelvic pain + The addition of another clinical symptom justifies the request.</p> <p>Pelvic pain + Palpable mass.</p> <p>Pelvic pain + Raised CRP or WCC.</p> <p>Pelvic pain + Nausea/Vomiting.</p> <p>Pelvic pain + Menstrual Irregularities.</p> <p>Pelvic pain + Dyspareunia >6 wks duration.</p> <p>Pelvic pain + Severe' or 'sudden' pain.</p> <p>Pelvic pain + ?appendicitis.</p> <p>Pelvic pain + ?ovarian cyst.</p>	<p>H/O ovarian cyst, H/O PCOS, Rule out or ? anything else.</p> <p>These do not represent further clinical symptoms, and the request should be referred back.</p> <p>Vague 'notions' of a diagnosis with no real basis, or requests for purposes of reassurance should be rejected pending more information.</p>

Pelvic bloating	<p>Persistent or frequent occurring over 12 times in one month, in women especially over 50 with a palpable mass.</p> <p>Persistent bloating <i>with the addition</i> of other symptoms, such as a palpable mass/raised Ca125, is acceptable - Please include the Ca125 result on the request</p> <p>A specific clinical question is required.</p>	<p>Alone - Refer back for further information.</p> <p>Intermittent bloating is not acceptable. (CT may be the preferred test in GI tract related symptoms, and further clinical info is required).</p>
Follow-up of benign lesions e.g. fibroids, dermoids, cysts	If the patient has undergone a clinical change , then re-scan is acceptable.	There is no role for US in follow-up or in treatment monitoring.
PMB Should include information about the LMP (i.e. post rather than peri-menopausal) and relevant HRT status.	If from a 2WW clinic referral.	If from a GP - TRFT has a pathway for direct referrals into gynaecology under a 2WW, which includes scan +/- hysteroscopy. Referral to be sent back to the GP with advice to refer under a 2WW.
Vaginal discharge	Vaginal discharge with suspected endometrial cancer. If from a 2WW clinic referral.	<p>Vaginal discharge alone.</p> <p>With suspected endometrial cancer. If from a GP - TRFT has a pathway for direct referrals into gynaecology under a 2WW, which includes scan +/- hysteroscopy. Referral to be sent back to GP with advice to refer under a 2WW pathway.</p>

PCOS	<p>If referral from Gynaecology clinic investigating infertility.</p> <p>If positive clinical symptoms and inconclusive or negative biochemistry*, an ultrasound may be useful – this information should be included in the referral not just ' ? PCOS'</p> <p>*Biochemistry includes Testosterone, SHBG, free Androgen index (NOT LH/FSH)</p>	<p>GP referral: Diagnosis of PCOS should be based on:</p> <ol style="list-style-type: none"> 1. Irregular menses. 2. Clinical symptoms and signs of hyperandrogenism such as acne, hirsutism. 3. Biochemical evidence of hyperandrogenism with a raised free androgen index (the testosterone is often at the upper limit of normal). 4. Biochemical exclusion of other confounding conditions.
RIF/ LIF Pain		<p>Refer back for further information. Generalised pain as the only symptom is not a justification for USS.</p>
Follow-up ovarian cysts	<p>Follow-up as per Ultrasound Guidelines, unless there is a specific clinical change.</p>	

5.2.3 Scrotum

Clinical Details	US scan is Justified	US scan is NOT Justified
Scrotum		
Scrotal mass	Any patient with a swelling or mass in the body of the testis should be referred urgently. GP's can refer via the "Suspicious Testicular Lump Pathway".	
Scrotal pain	<p>From Surgical / UECC if imaging is available immediately.</p> <p>Acute pain, in the absence of suspected torsion is an appropriate ultrasound referral.</p>	<p>Chronic (>3 months) pain in the absence of a palpable mass does not justify USS.</p> <p>Suspected torsion: From a GP requires urgent urological referral which should not be delayed by imaging.</p>

5.2.4 Neck ultrasound

Clinical Details	US scan is Justified	US scan is NOT Justified
Head and Neck		
Thyroid nodule	Generalised thyroid enlargement or ? thyroid nodules.	Routine follow up of benign nodules is not recommended unless there is clinical change.
Salivary mass	<p>If there is a history suggestive of salivary duct obstruction.</p> <p>For a suspected salivary tumour, US (+/- FNA/core biopsy) is recommended. The majority of parotid tumours will be benign, however USS guided FNA or core biopsy is recommended when a mass is detected to exclude malignancy.</p>	
Lymphadenopathy	Clinically suspected neck lymphadenopathy.	

5.2.5 MSK Ultrasound

- Many MSK pathologies are diagnosed successfully by good clinical examination.
- The request should include a clear clinical diagnosis/ question to be answered.
- Vague requests, i.e. Pain ? cause/ ? Knee injury / back pain /? nerve pain / thigh or leg pain, will be returned.
- For ?OA or Fracture, plain film is the first line imaging modality.
- For intra articular joint pathology, MRI is a more complete imaging modality.

Clinical Details	US scan is Justified	US scan is NOT Justified
Groin		
Inguinal and femoral hernia	If characteristic history and exam findings, e.g. pain, reducible palpable lump or cough impulse, <i>but with clinical doubt</i> . (If no clinical doubt refer to appropriate surgical team if necessary, scan should not be necessary).	Irreducible and/or tender lumps suggest incarcerated hernia and require urgent surgical referral.
Abdominal wall and incisional hernia	If characteristic history and exam findings, e.g. pain, reducible palpable lump or cough impulse, but with clinical doubt.	Irreducible and/or tender lumps suggest incarcerated hernia and require urgent surgical referral.
Lymphadenopathy	Clinically suspected groin lymphadenopathy.	

Clinical Details	US scan is Justified	US scan is NOT Justified
Soft tissues		
Soft Tissue / Tendons	<p>Tenosynovitis/rupture. Clinical correlation for significance, particularly rotator cuff.</p> <p>Tendonopathy – specific tendon should be mentioned.</p> <p>Tendon sheath effusions – specific tendon should be mentioned. Cannot differentiate between infected and non-infected effusion – helps with aspiration.</p> <p>Calcific tendonopathy - specific tendon should be mentioned.</p> <p>Foreign body, including implants.</p>	
Soft Tissue Lump	<p>Significant findings (including $\geq 5\text{cm}$, fixed, tender mass, increasing in size, overlying skin changes, etc.) should be scanned on an urgent basis.</p> <p>$<5\text{cm}$ but tender, sudden increase in size, hard etc.</p> <p>If clinical findings are equivocal and diagnosis is essential to management e.g. “wrist mass ?ganglion ?radial artery aneurysm, excision planned” ,then USS is clearly warranted on a routine basis.</p>	<p>$<5\text{cm}$ and stable, soft, mobile, non-tender lumps do not routinely warrant USS. Uncomplicated ganglia and small lipomata do not routinely require imaging.</p>

Clinical Details	US scan is Justified	US scan is NOT Justified
Joints		
	<p>Synovitis.</p> <p>Effusion. To confirm or exclude effusion and guide aspiration if required.</p>	<p>Loose bodies.</p> <p>Labral pathology needs MRI.</p> <p>Cartilage pathology.</p> <p>Intra articular pathology.</p>
Shoulder		
	<p>Site and size of RC tears.</p> <p>Post op cuff failure.</p> <p>LHB dislocation/rupture.</p> <p>Adhesive capsulitis/frozen shoulder. This is a clinical diagnosis (ultrasound examination is unremarkable) however ultrasound may be required to exclude other pathologies.</p> <p>Acromioclavicular OA/instability or sternoclavicular joint disease may be used to confirm origin of mass i.e. osteoarthritic joint if clinical concern.</p>	<p>Occult greater tuberosity fracture, cannot exclude fracture on ultrasound.</p> <p>GHJ instability needs MRI.</p> <p>Labral pathology needs MRI.</p>

Clinical Details	US scan is Justified	US scan is NOT Justified
Elbow		
	<p>Distal biceps tendon insertional tear, (Please note: small insertional tears may be difficult to exclude).</p> <p>Ulnar nerve neuropathy/subluxation to exclude mass at ulnar canal/medial epicondyle and can confirm subluxation.</p> <p>Median/Radial nerve compression to exclude external compression.</p>	<p>Cannot assess for focal neuritis.</p>
Wrist/Hand		
	<p>Pulley/sagittal band injury/ruptures.</p> <p>Thumb/finger collateral ligament injuries.</p> <p>Median nerve. Indicated to look for carpal tunnel mass only.</p> <p>Ulnar nerve compression. To exclude mass causing compression of ulnar nerve.</p>	<p>TFCC tear, MRI superior.</p> <p>TFCC calcification is seen on x ray.</p> <p>Median nerve? Carpal tunnel Syndrome (CTS) cannot diagnose CTS on ultrasound.</p>
Hip		
	<p>Effusion/synovitis.</p> <p>High grade muscle injuries.</p> <p>Trochanteric pain. Can be used to guide injections. Cannot always definitively excluded</p>	<p>Suspected OA, X-Ray required.</p>

	trochanteric bursitis.	
Knee		
	Suprapatellar/infrapatellar/pre patellar bursitis Patellar tendonopathy/tear/calcification. Quadriceps tendonopathy/ tear/ calcification. Baker's cyst	Osteochondritis Ligament instability. Ligaments can be seen, however patients with potential instability may need referral to a specific orthopaedic pathway for assessment +/- MRI.
Ankle/foot		
Clinical examination for tendonopathy is generally accurate however; USS maybe required to exclude an underlying tear.	Peroneal tendon Tenosynovitis / subluxation Posterior tibial tendonopathy Achilles tendon tendonopathy/ tears/calcification. Retro calcaneal/ pre Achilles bursitis Anterior talofibular ligament Calcaneofibular ligament Plantar fasciitis/fibroma Morton's neuroma	Ligament instability. Anterior/ mid lateral ligaments can be seen, however patients with potential instability may need referral to a specific orthopaedic pathway for assessment +/- MRI.

5.2.6 Vascular ultrasound

Clinical Details	US scan is Justified	US scan is NOT Justified
Carotid		
	<p>New or worsening hemispheric neurological symptoms e.g. unilateral motor or sensory deficit, impaired speech or amaurosis fugax.</p> <p>Evaluation of transient ischaemic attack or stroke Plaque visualised on retinal examination.</p> <p>Evaluation of subclavian-vertebral steal.</p> <p>Prior to open heart surgery i.e. CABG/valve replacement.</p> <p>Pulsatile neck mass.</p> <p>No cervical bruit with a previous history of neck irradiation < 10 years.</p> <p>Pulsatile tinnitus.</p>	<p>Syncope, dizziness without other cause ruled out.</p> <p>Follow up or surveillance for carotid disease (asymptomatic) with normal prior scan.</p> <p>Evaluation of carotid artery dissection in trauma setting.</p>
Aorta		
AAA	<p>Family history of aorta and or peripheral vascular aneurysmal disease in patients > 50 years.</p> <p>Personal history of peripheral vascular aneurysmal disease.</p>	<p>? Rupture or dissection – urgent admission</p>

	<p>Surveillance of known AAA.</p> <p>Palpable, pulsatile abdominal mass or abdominal bruit.</p> <p>Unexplained lower back pain, flank pain and abdominal pain.</p>	
Venous		
Lower leg venous (?DVT)	<p>Wells score >2 regardless of D-dimer.</p> <p>Wells <2 and Positive D-dimer.</p>	Negative D dimer and wells <2.
Upper limb venous (?DVT)	<p>Acute unilateral limb swelling.</p> <p>Positive D dimer.</p>	
Venous insufficiency	<p>Varicose veins with lower extremity pain or heaviness.</p> <p>Healed venous ulcer.</p> <p>Visible varicose veins with chronic venous insufficiency e.g. hyperpigmentation, lipodermatosclerosis.</p> <p>Mapping prior to venous ablation procedure.</p>	<p>Lower extremity pain or heaviness without signs of venous disease.</p> <p>Telangiectasia without other stigmata of venous disease.</p>

Clinical Details	US scan is Justified	US scan is NOT Justified
Arterial		
Lower limb arterial	<p>ABPIs are consistent with ischaemic disease and presenting with:</p> <ul style="list-style-type: none"> • Lower limb claudication symptoms. • Leg/foot/toe pain at rest. • Foot/ toe ulcer or gangrene. <p>AS A FIRST LINE, PATIENT NEEDS REFERRAL TO MEDICAL PHYSICS DEPARTMENT NOT RADIOLOGY</p> <p>SECONDARY CARE REFERRALS ONLY</p> <ul style="list-style-type: none"> • Infection of leg/foot without pulses. • Suspected acute limb ischaemia (e.g. cold painful limb with pallor, pulselessness, paresthesia) at the request of a vascular surgeon only. • Psuedoaneurysm following procedure/ trauma with symptoms of pulsatile groin mass, bruit over the groin, significant haematoma and severe pain post procedure. 	<p>Any/all in the presence of normal pulses</p> <ul style="list-style-type: none"> • Nocturnal leg cramps. • Lower extremity swelling. • Diabetes with peripheral neuropathy.
Upper limb arterial	<p>Arm or hand claudication. Finger discoloration or ulcer. Unilateral cold painful hand. Presence of pulsatile mass or hand ischaemia after upper extremity vascular access.</p>	<p>Raynaud's in the presence of normal pulses.</p>

	<p>Suspected positional arterial obstruction (e.g. thoracic outlet syndrome).</p> <p>SECONDARY CARE REFERRALS ONLY</p> <ul style="list-style-type: none">• Pre op radial artery harvest.• Presence of bruit after upper extremity access for intervention.	
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6. DEFINITIONS AND ABBREVIATIONS

6.1 Definitions

None

6.2 Abbreviations

Abbreviation	Full text
2WW	2 Week Wait
AAA	Abdominal Aortic Aneurysm
ABPI	Ankle Brachial Pressure Index
AKI	Acute Kidney Injury
ALP	Alkaline Phosphatase Level
ALT	Alanine Transaminase
AMU	Acute Medical Unit
AST	Aspartate Aminotransferase
ASU	Acute Surgical Unit
BMUS	British Medical Ultrasound Society
CABG	Coronary Artery Bypass Graft
CBD	Common Bile Duct
CKD	Chronic Kidney Disease
CLL	Chronic Lymphocytic Leukaemia
CRP	C-Reactive Protein
CT	Computer Tomography
CTS	Carpal Tunnel Syndrome
DM	Diabetes Mellitus
DVT	Deep Vein Thrombosis
FNA	Fine needle Aspiration
FSH	Follicle Stimulating Hormone
GGT	Gamma-Glutamyl Transpeptidase
GHJ	Glenohumeral Joint
GI	Gastrointestinal
GP	General Practitioner
H/O	History of
IBS	Irritable Bowel Syndrome
ICE	Integrated Clinical environment
IRMER	Ionising Radiation (Medical Exposure) Regulations
ISHS	Integrated Sexual Health Services
IUD	Intra Uterine Device
LFT	Liver Function Test
LH	Luteinising Hormone
LHB	Long Head Bicep
LMP	Last Menstrual Period
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence

OA	Osteoarthritis
OC	Oral Contraceptives
OGD	Oesophago Gastro Duodenoscopy
PACS	Picture Archive and Communication System
PCOS	Poly Cystic Ovaries Syndrome
PMB	Post-Menopausal Bleeding
RAS	Renal Artery Stenosis
RC	Rotator Cuff
RCR	Royal Collage of Radiologists
RDASH	Rotherham, Doncaster and South Humber NHS Trust
RIF/LIF	Right Iliac Fossa/Left Iliac Fossa
RIS	Radiology Information System
RUQ	Right Upper Quadrant
SCOR	Society and College of Radiographers
SHBG	Sex Hormone Binding Globulin
SOP	Standard Operating Procedure
TFCC	Triangular Fibrocartilage Complex
TG'S	Triglycerides
TRFT	The Rotherham Foundation Trust
UECC	Urgent and Emergency Care Centre
USS	Ultrasound Scan
WCC	White Cell Count

7 RELATED GUIDANCE

Reference

- NICE NG12, Suspected Cancer: Recognition and Referral, June 2015:
<http://www.nice.org.uk/guidance/ng12>

Supporting evidence

- Map of Medicine: <http://www.mapofmedicine.com/> June 2012
- A Guide to Justification for Clinical Radiologists.ref no: BFCR (00) 5, RCR, August 2000
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- Fraser A. Interpretation of liver enzyme tests – a rapid guide. *NZFP*; 34, 3: 2007
- Management of thyroid cancer. British Thyroid Association Guidelines: <http://www.british-thyroid-association.org/Guidelines/> 36
- Clinical indications for musculoskeletal ultrasound. Kaluser A, Tagliafico A, Allen G. *Eur Radiol* (2012) 22:1140-1148
- Practical Musculoskeletal Ultrasound. McNally, E. (2nd Ed) Churchill Livingstone, 2014
- Ultrasound of the shoulder. Allen G, Wilson D. *European Journal of Ultrasound* (2001) 14:1 3-9
- <http://www.irefer.org.uk/> The NICE guidance (NG12, Suspected Cancer: Recognition and Referral) published in June 2015 has also been considered in the production of this updated publication.
<https://www.nice.org.uk/guidance/ng12>
- <https://cks.nice.org.uk/acute-kidney-injury#!management> The NICE guidance Acute Kidney Injury. April 2018.

RIS Examination Codes

Code	Explanation	Areas to include within report for this code
ULTRASOUND ABDOMEN		
UABDO	Abdomen	Upper abdominal structures including liver, aorta, pancreas, spleen, kidneys, gallbladder, bile ducts.
UABPE	Abdomen and pelvis	Upper abdominal structures including liver, aorta, pancreas, spleen, kidneys, gallbladder, bile ducts. Pelvic structures including bladder, prostate (male), uterus, ovaries, adnexae (female)
UABRE	Abdomen and renal tract	Upper abdominal structures including liver, aorta, pancreas, spleen, kidneys, gallbladder, bile ducts. Pelvic structures including bladder, prostate (male).
UABTEST	Abdomen and testes	Upper abdominal structures including liver, aorta, pancreas, spleen, kidneys, gallbladder, bile ducts. Testes and epididymides
UKIDS	Renal tract	Kidneys, urinary bladder, prostate (male).
UAORT	Aorta	Abdominal aorta +/- iliacs
UDIAP	Diaphragmatic region	Diaphragm
UMES	Mesenteric	Mesenteric artery
UABDA	Anterior abdominal wall	Anterior abdominal wall (MSK)
UBUTT	Buttock	Buttock (MSK)
UBACK	Back - Para spinal	Back (MSK) or Please see paediatric ultrasound guidelines
UABDP	Paediatric abdomen	Please see paediatric ultrasound guidelines
UKIDP	Paediatric renal	Please see paediatric ultrasound guidelines
ULTRASOUND CHEST		
UAXILL/R	Axilla left / right	Axilla
UCHES	Chest / Pleural cavity	Chest (MSK)

ULTRASOUND PELVIS		
UGPELV	Gynae pelvis	Pelvis either TA and TV please state in report) to include uterus, endometrium, ovaries, adnexae, urinary bladder +/- kidneys
UPETV	Pelvis (Transvaginal)	Pelvic structures to include uterus, endometrium, ovaries and adnexae.
UIUCD	Pelvis for IUCD	Pelvic structures to include uterus, ovaries, adnexae +/- Transvaginal +/- kidneys
UPEND	Doppler Penile	Radiologist only
UPEPR	Trans rectal Prostate	Radiologist only
UTEST	Testes	Scrotal contents to include testes and epididymides.
UHIPR/L	Adult Hip	Used only for MSK
UHIPP	Neonatal hips both	Please see paediatric ultrasound guidelines
UINGU	Groin / Inguinal region	Affected groin to include inguinal canal (MSK)
USPIN	Spine	Used only for MSK soft tissue
USPNA	Adult spine	Used only for MSK soft tissue
USPNP	Neo natal spine	Used only for paediatrics
ULTRASOUND NECK		
UCARO	Doppler carotid arteries	Carotids
UNECK	Neck	Neck to include thyroid, submandibular gland, parotid gland, lymph node chains +/- parathyroid
ULTRASOUND UPPER EXTREMITIES		
UCLAL / R	Clavicle left / right	Clavicle/sternoclavicular joint
UFINL / R	Fingers left / right	Specific query relating to the finger(s)
UHANB / L / R	Hand both / left / right	Hand structures (MSK)
USHLL / R	Shoulder left / right	Shoulder structures (MSK)
USRLJ / RJ	Guided injection shoulder left / right	Radiologist only
USULL / R	Upper limb left / right	Soft tissue structure upper limb (MSK)
UTHUL / R	Thumb left / right	Specific query relating to the thumb
UULVL / R	Doppler veins arm left /	Doppler veins arms

	right	
UWRB / L / R	Wrist both / left / right	Wrist structures (MSK)
UELBL / R	Elbow left / right	Elbow structures
USOTI	Soft tissue	Any superficial area of concern
ULTRASOUND LOWER EXTREMITIES		
UACHT	Achilles tendon	Achilles tendon
UAILF	Doppler iliac and femoral	Iliac and femoral veins
UALLB	Doppler arteries femoro-popliteal	Femoral and popliteal arteries
UANKL / R	Ankle left / right	Ankle structures (MSK)
UCALL / R	Calcaneum left / right	Calcaneum and associated structures (MSK)
UFOOL / R	Foot left / right	Foot structures (MSK)
UKNEL / R	Knee left / right	Knee structures (MSK)
ULIMBL / R	Lower limb left / right	Soft tissue structure lower leg (MSK)
ULLVB / L / R	Doppler veins leg both / left / right	Doppler veins legs
ULVIL / R	Doppler veins legs – insufficiency left / right	Venous insufficiency

Referral Return Letter



Ultrasound Department
Clinical Radiology
The Rotherham Hospital NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Dear

Your request for an ultrasound for:

Name.....

DOB

NHS / Hospital Number.....

Has been returned for the following reason:

Further relevant clinical information is required since this referral does not meet the national and departmental ultrasound standards / guidelines to ensure the correct test is performed.

The clinical question cannot be answered by ultrasound

Is a repeat request/has been recently scanned

Other reason:

.....
.....
.....

Yours Sincerely

Signed

Date.....

Print Name..... Advanced Ultrasound Practitioner

Liver Function Tests

LIVER FUNCTION	units	Normal range
Total Protein	g/L	60 - 80
Albumin	g/L	35 - 50
Globulin	g/L	18 - 36
Calcium	mmol/L	2.20 - 2.60
Adjusted Calcium	mmol/L	2.20 - 2.60
AST	IU/L	(women) 0 - 32 (men) 0 - 40
ALT	IU/L	(women) 0 - 33 (men) 0 - 41
GGT	IU/l	(women) < 40 (men) < 60
Total Bilirubin	umol/L	0 - 21
Alkaline Phosphatase	IU/L	30 - 130

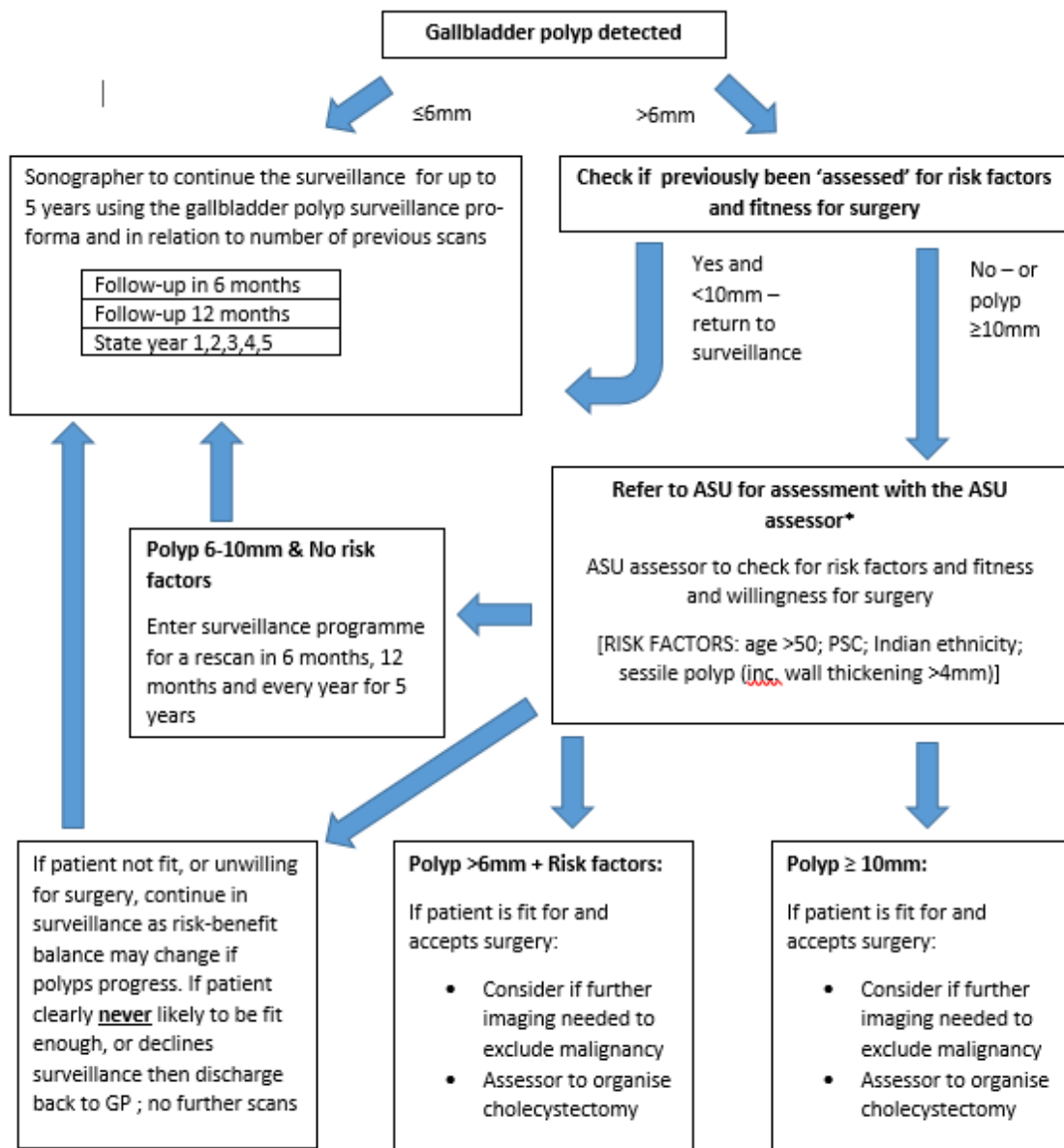
Taken from TRFT Biochemistry manual, The Hub, 2019.

COMMON CAUSES FOR ABNORMAL LFT'S AND DRUG INTERACTION

Liver enzyme	Probable causes	Risk Factors
ALT	Fatty Liver	Obesity Diabetes Mellitus (DM) Hyperlipidaemia Drugs – Statins or OCP
ALP	Probably due to bone NOT liver Adolescent growth Pagets disease Recent #	
GGT	Usually excessive alcohol intake but smoking and OCP can increase GGT	Fatty liver from Increased BMI Triglycerides and DM Prescribed drugs (see below)
AST	Muscle injury or inflammation	
Bilirubin	Gilberts syndrome usually <80mol/L	

Prescribed Drugs	Used for
Phenobarbital, Phenytoin, Carbamazepine	Epilepsy
Cimetidine	Ulcers/reflux
Furosemide	Diuretic
Heparin	Anti coagulant
Isotretinoin	Acne
Phenothiazines, Chlorpromazine, Risperidone	Anti Psychotic
Methotrexate	
Amiodarone, Clopidogrel	Cardiac Drugs
Steroids/Hormones	
Painkillers and NSAID's	

Gallbladder polyp flow chart and Surveillance pro-forma



NOTES

*If ASU assessor not available i.e. evening or weekends please, ask for report to be sent to the surgical team for an appointment and review on ASU

- If symptoms present attributable to gallbladder (in absence of other causes) and polyps present irrespective of size → consider cholecystectomy if fit
- If during follow up, polyp increases by 2mm or more → refer ASU as cholecystectomy is advised
- If during surveillance polyp disappears → discontinue follow up

Based on: Wiles R et al. Management and follow-up of gallbladder polyps : Joint guidelines between the European Society of Gastrointestinal and Abdominal Radiology (ESGAR), European Association for Endoscopic Surgery and other Interventional Techniques (EAES), International Society of Digestive Surgery - European Federation (EFISDS) and European Society of Gastrointestinal Endoscopy (ESGE). *Eur Radiol*. 2017 Sep;27(9):3856-3866.

TRFT GALLBLADDER POLYP SURVEILLANCE: FOLLOW-UP PRO-FORMA

For all patients with a gallbladder polyp/s <6mm or low risk patients as advised by the Surgical team for surveillance – abdominal ultrasound at each attendance.

Patient Name	
Hospital Number	
Date of Birth	
GP/Consultant	
Date of scan	
Polyp size (if multiple state largest polyp identified)	
Year polyp was first documented	

If polyp/s <6mm	✓	Year of Follow up: 1,2,3,4,5 on next scan
Follow up in 6 months (First year).		
Follow up in 12 months (for up to 5 years).		

After initial scan perform follow up in 6 months, 1yr, 2yr, 3yr, 4yr, 5yr.

- If during follow up polyp disappears discontinue follow up.
- If polyp increases by 2mm or more refer to ASU.

Polyp/s >6mm and <10mm that have been identified by the surgical team as low risk	✓	Year of Follow Up : 1,2,3,4,5 on next scan
Follow up in 6 months (First year).		
Follow up in 12 months (for up to 5 years).		

If first scan and polyp >6mm send patient to ASU to be assessed (ext 8279) if unable to attend ask secretaries to send report to surgical team and state in report ‘ copy of report to surgical team please arrange an appointment for review on ASU’ .

FAO SONOGRAPHERS:

Please include in the ultrasound report the follow up action i.e. ‘A follow up scan has been arranged in X months as per protocol’.

Or

State in report ‘The gallbladder polyp has been under surveillance for 5 yrs with no significant change in size, no further follow up required.’

Sonographer.....

Ultrasound Clerk.....

Version (1) Guideline for the Vetting of Ultrasound Request (excluding Interventional, Breast, Medical Physics, Cardiology, Obstetrics and Paediatric Ultrasound)

Guideline for the Vetting of Ultrasound Requests

SECTION 2

DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Ultrasound Advanced Practitioners, Radiologists, Gynaecologists, Urologists, Consultant Surgeons, Medical Imaging, Physics & Illustration CSU Quality Governance Committee

9. APPROVAL OF THE DOCUMENT

This document was approved by Medical Imaging, Physics & Illustration CSU Quality Governance Committee

10. RATIFICATION OF THE DOCUMENT

The document was ratified by Medical Imaging, Physics & Illustration CSU Quality Governance Committee.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as to require an earlier review.

Ultrasound Modality Lead is responsible for the review of this document.

13. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
Medical Imaging, Physics & Illustration CSU Quality Governance Committee members via email	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform the Medical Imaging, Physics & Illustration CSU Quality Governance members if a revision and which document it replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.
Key individuals Staff with a role/responsibility within the document Heads of Departments /Matrons	Author	Meeting/E mail as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.
All staff within area of	Heads of Departments	Meeting / Email as	As soon as received from	Ensure evidence of dissemination to

Version (1)

Guideline for the Vetting of Ultrasound Request (excluding Interventional, Breast,
Medical Physics, Cardiology, Obstetrics and Paediatric Ultrasound)

management	/Matrons	appropriate	the author	<p>staff is maintained. Request removal of paper copies</p> <p>Instruct them to inform all staff of the policy including those without access to emails</p>
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14. IMPLEMENTATION AND TRAINING PLAN

What	How	Associated action	Lead	Timeframe
Inform Sonographers	Via email	Read through document & request read receipt	Authors	Within 1 week of ratification
Inform Sonographers	Via staff meeting/training	Work through document	Authors	Within 1 month of ratification
Evidence of training	Signed document to state all Sonographers have read and been trained on the new guidance	Document to be kept in Ultrasound Modality Lead office	Authors	Within 6 weeks of ratification
Key appendices to be displayed in scan rooms	Printing and laminating of key information		Authors	Within 1 week of ratification
Inform Radiologists	Via email	Read through document & request read receipt	Authors to email, and the Clinical Lead Radiologist to follow-up	Within 1 week of ratification

Training requirements

Any Practitioner performing ultrasound within the Department of Clinical Radiology should have one of the following qualifications and should be registered on the “REGISTER OF COMPETENT ULTRASOUND PRACTITIONERS – DEPARTMENT OF CLINICAL RADIOLOGY TRFT 2010” held by the Ultrasound Modality Lead.

- Certificate/Diploma (as appropriate) in Medical Ultrasound (CMU/DMU) of the Society and College of Radiographers (ScoR) with evidence of appropriate continuous professional development (CPD).
- Postgraduate Certificate/Diploma in Medical Ultrasound (PGCert.MU/PG Dip.MU) approved and validated by a Higher Institute of education and accredited by the Consortium for Sonographic Education (CASE) with evidence of appropriate CPD. The qualification should be relevant to Obstetric Ultrasound practice.
- Sonographers who do not have a UK recognised ultrasound qualification, i.e. those trained overseas, should be registered under the voluntary register of Sonographers (the database is kept and controlled by the ScoR in association with BMUS).

Any Practitioner performing ultrasound within the Department of Clinical Radiology at TRFT must have received appropriate training in the electronic systems: RIS and PACS.

It is an individual’s responsibility to remain up to date/obtain training in any additional/current systems introduced within the Department of Clinical Radiology.

When new procedures are introduced within the department, where possible in house training will be performed. The Trust will support continuing professional development with the appropriate funding of courses/release of staff for training.

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Audit/Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Peer Review	Audit	Sonographers	Annually	Feedback to Medical Imaging, Physics & Illustration CSU Quality Governance & Sonography team meetings	Authors
Referrer enquiries	Responding to queries	Sonographers	When required	Feedback to individual / Sonography team	Authors

Agenda item at staff meetings	Discuss issues / queries. Include in meeting minutes	Authors	Every other Month	Meeting minutes distributed to Sonography team and included on monthly Ultrasound Quality Governance report	Authors
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15.2 Standards/Key Performance Indicators (KPIs)

An incident arising from these procedures is not expected, but in the event of an incident occurring relating to these procedures, a Trust Datix incident report **MUST** be completed and the incident will be investigated fully.

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name:	Guideline for the Vetting of Ultrasound Request (excluding Interventional, Breast, Medical Physics, Cardiology, Obstetrics and Paediatric Ultrasound)	Date/Period of Document:	10 th September 2023
Lead Officer:	Ultrasound Modality Lead	Job title:	Ultrasound Modality Lead

<input type="checkbox"/> Function	<input type="checkbox"/> Policy	<input checked="" type="checkbox"/> Procedure	<input type="checkbox"/> Strategy	<input type="checkbox"/> Other: (State) _____
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Describe the overall purpose / intended outcomes of the above: This guidance is for all referring practitioners and practitioners undertaking vetting of ultrasound requests in the Clinical Radiology Department at TRFT to ensure appropriate referrals are accepted for ultrasound.

*You must assess **each** of the 9 areas separately and consider how your policy may affect people of different groups within those areas.*

1. Assessment of possible adverse (negative) impact against a protected characteristic

Does this have a significant negative impact on equality in relation to each area?	Response		If yes, please state why and the evidence used in your assessment
	Yes	No	
1 Age		✓	
2 Disability		✓	
3 Gender reassignment		✓	
4 Marriage and civil partnership		✓	
5 Pregnancy and maternity		✓	
6 Race		✓	
7 Religion and belief		✓	
8 Sex		✓	
9 Sexual Orientation		✓	

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community or group? Yes No
- Will any group be **excluded** because of the policy? Yes No
- Will the policy have a negative impact on **community relations**? Yes No

If the answer to any of these questions is Yes, you must complete a full Equality Impact Assessment

2. Positive impact:

Could the policy have a significant positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:	Response		If yes, please state why and the evidence used in your assessment
	Yes	No	
1 Eliminate discrimination, harassment and / or victimisation		✓	
2 Advance the equality of opportunity of different groups		✓	
3 Foster good relationships between different groups		✓	

3. Summary

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

Positive				Negative		
HIGH <input type="checkbox"/>	MEDIUM <input type="checkbox"/>	LOW <input type="checkbox"/>	NEUTRAL <input checked="" type="checkbox"/>	LOW <input type="checkbox"/>	MEDIUM <input type="checkbox"/>	HIGH <input type="checkbox"/>
Date assessment completed: 03.09.20			Is a full equality impact assessment required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Date EIA approved by Equality and Diversity Steering Group:						