



Clinical Protocol

## Scrotum and Contents

1. Image testicle (R/L) in B-mode:
  - TRANS – sup, med, inf.
  - LONG – central, medial, lateral.
  - Measure in MID section pole-to-pole and AP.
2. Obtain arterial and venous color Doppler waveforms.
3. Take comparison images of both testicles in B-mode and color Doppler.
  - If use dual screen, make sure gain settings are same.
4. Image epididymis long in B-mode and color Doppler.
  - Obtain images of head, body, and tail.
5. If findings are concerning for torsion, image/evaluate spermatic cord.
6. If no testicle seen in hemiscrotum, take images of ipsilateral inguinal canal/inguinal ring and pelvis/retroperitoneum to look for ectopic or undescended testicle.
7. **If Doppler ordered, *ADD-ON Spectral Analysis of Gonads Worksheet* MUST BE COMPLETED. *This includes RIs.***
8. Document any varicoceles and confirm with Valsalva.
9. Evaluate for hydrocele and scrotal skin thickness.

Measure all cysts and masses in three dimensions and evaluate with color Doppler.

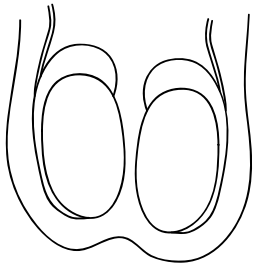
**Absence of flow in testicles is Critical Finding and must be reported STAT.**



INDICATIONS	DATE/TIME
	SONOGRAPHER

RIGHT	Testes	LEFT
_____ x _____ x _____ Long AP Trans	Size (cm)	_____ x _____ x _____ Long AP Trans
<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased	Perfusion	<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased
<input type="checkbox"/> Arterial Flow <input type="checkbox"/> Venous Flow	Doppler (if performed)	<input type="checkbox"/> Arterial Flow <input type="checkbox"/> Venous Flow
	Findings	

RIGHT	Epididymis	LEFT
<input type="checkbox"/> Normal <input type="checkbox"/> Enlarged	Head Size (cm)	<input type="checkbox"/> Normal <input type="checkbox"/> Enlarged
<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased	Perfusion	<input type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased
	Findings	

RIGHT	Additional Findings	LEFT
<input type="checkbox"/> Hydrocele <input type="checkbox"/> Varicocele Skin Thickness <input type="checkbox"/> Normal <input type="checkbox"/> Thickened		<input type="checkbox"/> Hydrocele <input type="checkbox"/> Varicocele Skin Thickness <input type="checkbox"/> Normal <input type="checkbox"/> Thickened
<input type="checkbox"/> Yes <input type="checkbox"/> No    Color Flow and Spectral Doppler Analysis ordered (and performed).		

SONOGRAPHER CONFIRMATION: My signature confirms that instructions have been provided to the conscious patient regarding this exam, that US utilizes sound waves rather than ionizing radiation, and that coupling gel is used to improve the quality of the exam.	_____ Sonographer's Signature
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FMC    KMC    CMC    TMC    NHSC KIC    MIC    PI    TI MFP    SFP    Other	Name / MR # / Label
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**US Scrotum and Contents Worksheet**