



DRAFT Ultrasound Prioritization

DRAFT FOR EXTERNAL REVIEW: The online questionnaire is available at survey.health.gov.bc.ca/Ultrasound.

Scope

This guideline summarizes suggested wait times for common indications where ultrasound is the recommended first imaging test. The purpose is to inform primary care practitioners of how referrals are prioritized by radiologists, radiology departments and community imaging clinics across the province. This guideline is an adaptation of the British Columbia Radiological Society (BCRS) Ultrasound Prioritization Guidelines (2016). Management of the listed clinical problems is beyond the scope of this guideline. However, in some cases, notes and alternative tests are provided for additional clinical context. Primary care practitioners are encouraged to consult a radiologist if they have any concerns or questions regarding which is the appropriate imaging test to choose for a particular problem.

Background

The 2016 BCRS Ultrasound Prioritization Guidelines were developed to provide imaging departments with a consistent, provincial approach to prioritizing commonly ordered ultrasound tests according to suggested maximum wait times. The Guidelines were developed by consensus and are based on best BC expert opinion with representation of radiologists from across the province. Several considerations apply:

- These are guidelines, and as such, are designed to apply in general terms. They are not intended to replace clinical judgement or physician-to-physician discussion.
- Prioritization levels were selected to match other similar guidelines for CT and MRI and are typically assigned by radiologists rather than referring physicians.
- These guidelines should not be applied rigidly to each case, as varying clinical factors may shift a particular indication from one priority level to another.
- Access to ultrasound and the ability to respond to emergent/urgent ultrasound requests will depend on local availability.
- The clinical topics included in this guideline represent broad examples, and do not encompass all possible scenarios or all requirements for ultrasound examinations.
- These guidelines do not apply to inpatients or emergency room patients.

Priority Level Definitions

The priority levels defined below (Table 1) are in alignment with the Canadian Association of Radiologist's national designation Five Point Classification System¹.

Table 1: Priority Level Definitions

Priority Level	Clinical Example	Maximum Suggested Wait Time
P1	An examination immediately necessary to diagnose and/or treat life-threatening disease. Such an examination will need to be done either stat or not later than the day of the request.	Immediately to 24 hours
P2	An examination indicated within one week of a request to resolve a clinical management imperative.	Maximum 7 calendar days
P3	An examination indicated to investigate symptoms of potentially life-threatening importance.	Maximum 30 calendar days
P4	An examination indicated for long-range management or for prevention.	Maximum 60 calendar days
P5	Timed follow-up exam or specified procedure date recommended by radiologist and/or clinician.	

Source: Canadian Association of Radiologists National Maximum Wait Time Access Targets for Medical Imaging (MRI and CT).

Prioritization of Potential Diagnoses

The following potential diagnoses, where ultrasound is the recommended first test, are grouped according to system and then further subdivided into priority levels. For each system an overview table is presented followed by a more detailed table outlining additional notes and alternative tests where appropriate. Refer to *Appendix A: Ultrasound Prioritization Summary* for a one page summary of all potential diagnoses and prioritizations.

► Abdomen and Pelvis

Abdomen and Pelvis: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
<ul style="list-style-type: none"> Acute abdominal pain (e.g., appendicitis, cholecystitis) Acute post-transplant assessment Splenic rupture Septic renal colic/focal pyelonephritis Acute painful hernia, (obstruction, strangulation, or ischemia suspected) Intra-abdominal abscess Painful jaundice Testicular torsion/Epididymitis Testicular rupture 	<ul style="list-style-type: none"> Acute painful hernia, (obstruction, strangulation, or ischemia not suspected) Painless jaundice Acute pancreatitis and its complications Painless hematuria Renal colic Acute renal failure New testicular mass New painless abdominal or pelvic mass 	<ul style="list-style-type: none"> Acute painless hernia/Chronic hernia (if diagnosis in doubt) Extra-testicular mass Renal stone burden 	<ul style="list-style-type: none"> Chronic abdominal pain/bloating Abnormal liver function tests/Known chronic liver disease Pre-transplant work-up Abdominal Aortic Aneurysm/ Endovascular abdominal aortic aneurysm repair follow-up

Abdomen and Pelvis Table: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P1	Acute abdominal pain (e.g., appendicitis, cholecystitis)	<ul style="list-style-type: none"> Choice of first line test will depend on likely origin of pain and suspected clinical diagnosis <ul style="list-style-type: none"> If pancreatitis, suggest CT If bowel ischemia, suggest CT If ultrasound is equivocal for appendicitis, consider CT or MRI Don't do CT for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option (Choosing Wisely Radiology recommendation)
	Acute post-transplant assessment	<ul style="list-style-type: none"> CT for liver transplant if ultrasound inconclusive
	Splenic rupture	<ul style="list-style-type: none"> CT typically ordered as first line imaging for trauma In pediatric and pregnant population, consider ultrasound as first line
	Septic renal colic/focal pyelonephritis	<ul style="list-style-type: none"> In pediatric, young female and pregnant population consider ultrasound as first line CT KUB (kidney/urinary/bladder) can be first line for renal colic
	Acute painful hernia (obstruction, strangulation, or ischemia suspected)	<ul style="list-style-type: none"> If concern for bowel obstruction, consider plain film prior to ultrasound If ultrasound is inconclusive, CT can be used
	Intra-abdominal abscess	
	Painful jaundice	
	Testicular torsion/Epididymitis	
Testicular rupture	<ul style="list-style-type: none"> Specific to trauma as only observed after an episode of trauma 	

Abdomen and Pelvis: Notes and Alternative Tests – continued from page 2		
	Potential Diagnosis	Notes and Alternative Tests
P2	Acute painful hernia (obstruction, strangulation or ischemia not suspected)	<ul style="list-style-type: none"> If ultrasound is inconclusive, CT can be used For acute painless hernia, ultrasound is not recommended
	Painless jaundice	<ul style="list-style-type: none"> CT is recommended for characterization if a mass is seen on ultrasound in the liver or pancreas
	Acute pancreatitis, complications	<ul style="list-style-type: none"> To assess for fluid collections and to identify any gallstones and/or common bile duct stones
	Painless hematuria	<ul style="list-style-type: none"> Includes microscopic and macroscopic hematuria Negative ultrasound still requires follow-up (consider CT)
	Renal colic	<ul style="list-style-type: none"> Ultrasound is first-line imaging test in pediatric patients and pregnant women Consider CT KUB (kidney/urinary/bladder) as first line test in adults
	Acute renal failure	<ul style="list-style-type: none"> To rule out obstructive uropathy
	New testicular mass	
	New painless abdominal or pelvic mass	<ul style="list-style-type: none"> CT is often considered first-line in this situation except in pediatrics In rural and remote areas CT may not be available, in which case ultrasound is modality of first choice
P3	Acute painless hernia/Chronic hernia	<ul style="list-style-type: none"> Generally no imaging is required, ultrasound may be ordered if diagnosis is in doubt.
	Extra-testicular mass	<ul style="list-style-type: none"> E.g., differentiate hydrocele, varicocele, epididymal cyst
	Renal stone burden	<ul style="list-style-type: none"> May be supplemented with CT KUB (kidney/urinary/bladder) or KUB radiograph as needed
P4	Chronic abdominal pain/bloating	<ul style="list-style-type: none"> If associated symptoms suggest potential malignancy, consider P3
	Abnormal liver function tests/ Known chronic liver disease	<ul style="list-style-type: none"> Includes Non-Alcoholic Fatty Liver Disease (NALFLD) or other causes of chronic hepatitis Includes screening for Hepatocellular carcinoma (HCC) in patients with known Hep B/C Interval follow-up may be recommended based on hepatology guidelines²
	Abdominal Aortic Aneurysm /Endovascular abdominal aortic aneurysm repair follow-up	<ul style="list-style-type: none"> CT can be an alternative imaging test or if ultrasound is technically challenging
	Pre-transplant work-up	<ul style="list-style-type: none"> As indicated by pre-transplant orders Urgency may be dictated by anticipated surgery date

► **Obstetrics and Gynecology**

Obstetrics and Gynecology: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
<ul style="list-style-type: none"> Ectopic pregnancy Threatened abortion Embryonic/fetal demise Placental abruption Vasa/vena previa Pre-term labour to determine cervical length Acute pelvic pain of suspected gynecological cause (e.g., query ruptured cyst, pelvic inflammatory disease, ovarian torsion) 	<ul style="list-style-type: none"> Polyhydramnios Oligohydramnios Follow-up of oligohydramnios (unless otherwise specified) Intrauterine growth restriction (IGUR) Post-dates fluid assessment Adnexal cyst 	<ul style="list-style-type: none"> Post-menopausal bleeding Follow up possible fetal abnormality from routine detail scan High risk pregnancy 	<ul style="list-style-type: none"> Dysfunctional uterine bleeding e.g., fibroids, adenomyosis Follow-up placental location Adnexal cyst follow-up (unless otherwise specified) Fetal detail exam (unless otherwise specified)

Obstetrics and Gynecology: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P1	Ectopic pregnancy	<ul style="list-style-type: none"> Indicated if clinically suspect pregnant, positive beta human chorionic gonadotropin (BHCG), or pain and/or bleeding regardless of BHCG level
	Threatened abortion	
	Embryonic/fetal demise³	
	Placental abruption	
	Vasa/vena previa	
	Pre-term labour to determine cervical length	<ul style="list-style-type: none"> Endovaginal ultrasound to be used if a transabdominal scan is inconclusive
	Acute pelvic pain of suspected gynecological cause (e.g., query ruptured cyst, pelvic inflammatory disease, ovarian torsion)	<ul style="list-style-type: none"> MRI can be used in selected cases if ultrasound is inconclusive and if locally available
P2	Polyhydramnios	
	Oligohydramnios	
	Follow-up of oligohydramnios	<ul style="list-style-type: none"> AFI (amniotic fluid index)/fluid volume unless otherwise specified i.e. patient has regularly scheduled checks for AF1
	Intrauterine growth restriction (IUGR)	
	Post-dates fluid assessment	
	Adnexal cyst	
P3	Post-menopausal bleeding	<ul style="list-style-type: none"> Negative ultrasound should not interfere with further investigation to exclude malignancy
	Follow up possible fetal abnormality from routine detail scan	<ul style="list-style-type: none"> Generally as suggested by perinatal specialist
	High risk pregnancy	<ul style="list-style-type: none"> Follow-up amniotic fluid is P3 unless otherwise specified by radiologist and/or clinician (i.e. P2)
P4	Dysfunctional uterine bleeding e.g., fibroids, adenomyosis	
	Follow-up placental location	<ul style="list-style-type: none"> If follow-up recommended, not indicated before 32 weeks
	Adnexal cyst follow-up (unless otherwise specified)	<ul style="list-style-type: none"> Interval follow-up may be recommended based on the Society of Radiologists in Ultrasound guidelines⁴.
	Fetal detail exam (unless otherwise specified)	

► **Musculoskeletal/Extremity**

Musculoskeletal/Extremity: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
<ul style="list-style-type: none"> • Deep vein thrombosis • Septic arthritis/toxic synovitis • Priapism • Abscess 	<ul style="list-style-type: none"> • Acute tendon tears 	<ul style="list-style-type: none"> • New palpable thyroid mass • New palpable mass • Acute rotator cuff tear 	<ul style="list-style-type: none"> • Synovitis/arthropathy follow-up • Tendinopathy, Chronic shoulder pain, Non-operative rotator cuff tear • Bursitis • Chronic palpable mass • Multi nodular goiter • Carpal tunnel syndrome or other neuropathy • Baker's cyst • Follow-up soft tissue/breast mass

Musculoskeletal/Extremity: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P1	Deep vein thrombosis	<ul style="list-style-type: none"> • Correlate with D dimer if available
	Septic arthritis/toxic synovitis	<ul style="list-style-type: none"> • If effusion present, may prompt fine needle aspiration
	Priapism	<ul style="list-style-type: none"> • Typically referred by urology or emergency department
	Abscess	<ul style="list-style-type: none"> • To confirm presence of fluid and exclude solid mass
P2	Acute tendon tears	<ul style="list-style-type: none"> • Typically achilles or biceps require emergent surgery or management • Except rotator cuff tears which typically are not surgical • Unless specified under P4
	New palpable thyroid mass	<ul style="list-style-type: none"> • Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function test unless there is a palpable abnormality of the thyroid gland. (Choosing Wisely Endocrinology and Metabolism Recommendation)
P3	New palpable mass	<ul style="list-style-type: none"> • To determine if the mass is cystic or solid • If suspicious features on clinical exam or sonograph, CT or MRI may be recommended
	Acute rotator cuff tear	<ul style="list-style-type: none"> • As part of orthopedic referral or pre-surgical • MRI is an alternative test usually suggested by a radiologist if ultrasound is inconclusive, or ordered by a surgeon
	Synovitis/arthropathy follow-up	<ul style="list-style-type: none"> • Typically ordered by rheumatologists for patients on biologics for inflammatory arthritis
P4	Tendinopathy, Chronic shoulder pain, Non-operative rotator cuff tear	
	Bursitis	
	Chronic palpable mass	<ul style="list-style-type: none"> • E.g., differentiate lipoma, sebaceous cyst, or other
	Multi nodular goiter	<ul style="list-style-type: none"> • Follow-up studies can be used to confirm stability
	Carpal tunnel syndrome or other neuropathy	<ul style="list-style-type: none"> • May be useful if other diagnostic tests are equivocal • Usually requires specialist referral
	Baker's Cyst	
	Follow-up soft tissue/breast mass	<ul style="list-style-type: none"> • To confirm stability

► Pediatrics

Pediatrics: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
<ul style="list-style-type: none"> • Pyloric stenosis • Intussusception • Clinically suspicious intra-abdominal/ pelvic mass 	<ul style="list-style-type: none"> • Increasing head circumference (Hydrocephalus) • Biliary atresia as the cause of neonatal jaundice 	<ul style="list-style-type: none"> • Follow-up antenatal hydronephrosis 	<ul style="list-style-type: none"> • Developmental dysplasia of the hip (DDH) • Spine ultrasound (prior to 5 months of age) • Urinary tract infection • Chronic liver disease • Renal anomaly

Pediatrics: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P1	Pyloric stenosis	
	Intussusception	
	Clinically suspicious intra-abdominal/pelvic mass	
P2	Increasing head circumference (Hydrocephalus)	<ul style="list-style-type: none"> • Providing the fontanelles are still open
	Biliary atresia as the cause of neonatal jaundice	<ul style="list-style-type: none"> • When jaundice is refractory or severe • Usually requested by pediatrician
P3	Follow-up antenatal hydronephrosis	<ul style="list-style-type: none"> • Refer to <i>Associated Documents</i> - BC Children's Hospital Antenatal Hydronephrosis Imaging Guideline
P4	Developmental dysplasia of the hip (DDH)	<ul style="list-style-type: none"> • P4 provided that requisition is sent in at birth, exam should be completed by 4-6 weeks • If requisition is sent later, DDH may become a P2 or P3 exam so that exam is completed by 4-6 weeks
	Spine ultrasound (prior to 5 months of age)	<ul style="list-style-type: none"> • Typically for dysraphism or cord tethering
	Urinary tract infection (UTI)	<ul style="list-style-type: none"> • For recurrent UTIs, to rule out or confirm bladder problems
	Chronic liver disease	<ul style="list-style-type: none"> • Or for Cystic Fibrosis liver evaluation
	Renal anomaly	

► **General**

General: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
<ul style="list-style-type: none"> Abscess 	<ul style="list-style-type: none"> Cancer staging or metastatic workup New suspicious palpable mass 		<ul style="list-style-type: none"> Scrotal or pelvic ultrasound as part of workup for Varicocele Embolization/Uterine Artery Embolization Peyronie's disease

General: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P1	Abscess	
P2	Cancer staging or metastatic workup	<ul style="list-style-type: none"> CT is often the preferred modality
	New suspicious palpable mass	<ul style="list-style-type: none"> E.g., new breast or lymph node mass
P4	Scrotal or pelvic ultrasound as part of workup for Varicocele Embolization/Uterine Artery Embolization	<ul style="list-style-type: none"> Typically referred by specialists
	Peyronie's disease	<ul style="list-style-type: none"> Typically referred by specialists

► **Vascular**

Vascular: Overview			
P1	P2	P3	P4
Immediately to 24 hours	Max 7 calendar days	Max 30 calendar days	Max 60 calendar days
	<ul style="list-style-type: none"> Carotid ultrasound with acute stroke 		<ul style="list-style-type: none"> Carotid doppler screening

Vascular: Notes and Alternative Tests		
	Potential Diagnosis	Notes and Alternative Tests
P2	Carotid ultrasound with acute stroke	<ul style="list-style-type: none"> CT is obligatory for stroke assessment but carotid ultrasound is a useful supplement Carotid ultrasound tends to be used to clarify degree of stenosis if a large amount of calcified plaque present on computed tomography angiography (CTA) limits assessment of degree of stenosis or if a bruit has been heard
P4	Carotid doppler screening	

Resources

- Canadian Association of Radiology *Diagnostic Imaging Referral Guidelines* (2012)
<http://www.car.ca/en/standards-guidelines/guidelines.aspx>
- American College of Radiology Appropriateness Criteria
<https://www.acr.org/Quality-Safety/Appropriateness-Criteria>
- Society of Radiologists in Ultrasound
<http://www.sru.org>

- Choosing Wisely Radiology Recommendations:
Radiology: <http://www.choosingwiselycanada.org/wp-content/uploads/2014/04/Radiology.pdf>
Endocrinology and Metabolism: <https://choosingwiselycanada.org/endocrinology-and-metabolism/>

► **Appendices**

Appendix A: BC Guidelines Ultrasound Prioritization Summary

► **Associated Documents**

- BC Children’s Hospital Antenatal Hydronephrosis Imagine Guideline
Algorithm:
http://www.childhealthbc.ca/sites/default/files/BCCH_Antenatal%20Hydronephrosis%20Imaging%20Guideline%202015.PDF
Preamble to algorithm:
http://www.childhealthbc.ca/sites/default/files/BCCH_Antenatal%20Hydronephrosis%20Imaging%20Guideline%20Preamble%2008%20April2015.pdf

► **References**

1. Canadian Association of Radiologists National Maximum Wait Time Access Targets for Medical Imaging (MRI and CT).
2. Heimbach J, Kulik LM, Finn R, et al. AASLD guidelines for the treatment of hepatocellular carcinoma. *Hepatology*. 2017; Jan 28. [Epub ahead of print].
3. Doubilet PM, Benson CB, Bourne T, et al. Diagnostic Criteria for Nonviable Pregnancy Early in the First Trimester. *N Engl J Med*. 2013;369:1443-1451.
4. Levine D, Brown D, Andreotti RF et al. Management of Asymptomatic Ovarian and Other Adnexal Cysts Imaged at US: Society of Radiologists in Ultrasound Consensus Conference Statement. *Ultrasound Quarterly*. 2010;26(3):121-131.

This guideline is based on expert BC clinical practice current as of the Effective Date. This guideline was developed by the Guidelines and Protocols Advisory Committee based on the British Columbia Radiological Society Ultrasound Prioritization Guidelines (May 2016), approved by the Doctors of BC, and adopted by the Medical Services Commission.

Disclaimer

<p>The principles of the Guidelines and Protocols Advisory Committee are to:</p> <ul style="list-style-type: none"> • encourage appropriate responses to common medical situations • recommend actions that are sufficient and efficient, neither excessive nor deficient • permit exceptions when justified by clinical circumstances 	<p>Contact Information: Guidelines and Protocols Advisory Committee, PO Box 9642 STN PROV GOVT Victoria BC V8W 9P1 Email: hlth.guidelines@gov.bc.ca Website: www.BCGuidelines.ca</p>
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The Clinical Practice Guidelines (the “Guidelines”) have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problem. **We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a health care professional.**



Appendix A: Ultrasound Prioritization Guideline Summary

For notes and additional tests, refer to *BC Guidelines: Ultrasound Prioritization Guideline*

	Priority Level 1 Immediately to 24 hours	Priority Level 2 Max 7 calendar days	Priority Level 3 Max 30 calendar days	Priority Level 4 Max 60 calendar days
Abdomen	<ul style="list-style-type: none"> Acute abdominal pain (e.g., appendicitis, cholecystitis) Acute post-transplant assessment Splenic rupture Septic renal colic/focal pyelonephritis Acute painful hernia, (obstruction, strangulation, or ischemia suspected) Intra-abdominal abscess Painful jaundice Testicular torsion/Epididymitis Testicular rupture 	<ul style="list-style-type: none"> Acute painful hernia, (obstruction, strangulation, or ischemia not suspected) Painless jaundice Acute pancreatitis and its complications Painless hematuria Renal colic Acute renal failure New testicular mass New painless abdominal or pelvic mass 	<ul style="list-style-type: none"> Acute painless hernia/Chronic hernia (if diagnosis in doubt) Extra-testicular mass Renal stone burden 	<ul style="list-style-type: none"> Chronic abdominal pain/bloating Abnormal liver function tests/ Known chronic liver disease Abdominal Aortic Aneurysm/ Endovascular abdominal aortic aneurysm repair follow-up Pre-transplant work-up
Obstetrics and Gynecological	<ul style="list-style-type: none"> Ectopic pregnancy Threatened abortion Embryonic/fetal demise Placental abruption Vasa/vena previa Pre-term labour to determine cervical length Acute pelvic pain of suspected gynecological cause (e.g., query ruptured cyst, pelvic inflammatory disease, ovarian torsion) 	<ul style="list-style-type: none"> Polyhydramnios Oligohydramnios Follow-up of oligohydramnios (unless otherwise specified) Intrauterine growth restriction (IGUR) Post-dates fluid assessment Adnexal cyst 	<ul style="list-style-type: none"> Post-menopausal bleeding Follow up possible fetal abnormality from routine detail scan High risk pregnancy 	<ul style="list-style-type: none"> Dysfunctional uterine bleeding e.g., fibroids, adenomyosis Follow-up placental location Adnexal cyst follow-up (unless otherwise specified) Fetal detail exam (unless otherwise specified)
Musculoskeletal/Extremity	<ul style="list-style-type: none"> Deep vein thrombosis Septic arthritis/toxic synovitis Priapism Abscess 	<ul style="list-style-type: none"> Acute tendon tears 	<ul style="list-style-type: none"> New palpable thyroid mass New palpable mass Acute rotator cuff tear 	<ul style="list-style-type: none"> Synovitis/arthropathy follow-up Tendinopathy, Chronic shoulder pain, Non-operative rotator cuff tear Bursitis Chronic palpable mass Multi nodular goiter Carpal tunnel syndrome or other neuropathy Baker's cyst Follow-up soft tissue/breast mass
Pediatrics	<ul style="list-style-type: none"> Pyloric stenosis Intussusception Clinically suspicious intra-abdominal /pelvic mass 	<ul style="list-style-type: none"> Increasing head circumference (Hydrocephalus) Biliary atresia as the cause of neonatal jaundice 	<ul style="list-style-type: none"> Follow-up antenatal hydronephrosis 	<ul style="list-style-type: none"> Developmental dysplasia of the hip Spine ultrasound (prior to 5 months of age) Urinary tract infection Chronic liver disease Renal anomaly
General	<ul style="list-style-type: none"> Abscess 	<ul style="list-style-type: none"> Cancer staging or metastatic workup New suspicious palpable mass 		<ul style="list-style-type: none"> Scrotal or pelvic ultrasound as part of workup for Varicocele Embolization/Uterine Artery Embolization Peyronie's disease
Vascular		<ul style="list-style-type: none"> Carotid ultrasound with acute stroke 		<ul style="list-style-type: none"> Carotid doppler screening

Adaptation of the British Columbia Radiological Society Ultrasound Prioritization guideline (March 2016).