SOUTH GEORGIA Radiology ASSOCIATES

PYLORUS

Name: ______________________________ Date: __________________

Physician: _______________________ DOB: ____/____/_______ Age(months): ______

Sonographer: ___________________________

Clinical Indications: ____

CRITERIA FOR HYPERTROPHIC PYLORIC STENOSIS:

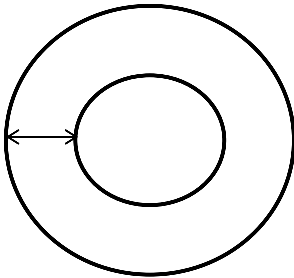
1) MUSCLE THICKNESS **3 mm** or GREATER
   (Measure thickness in two different planes)

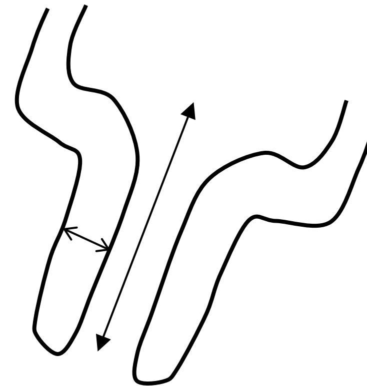
2) LENGTH OF **15 mm** OR GREATER

ULTRASOUND FINDINGS:

1) **MUSCLE THICKNESS:**
   a) transverse _______________
   b) Sagittal _________________

2) **PYLORIC LENGTH** _________________





FLUID WAS SEEN GOING THROUGH CHANNEL **YES** **NO**

IF POSTIVE

CALL RESULTS TO Dr.____________________ PHONE_________________

Additional comments:

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