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Comparison of Transabdominal Versus Transvaginal Ultrasound in the Assessment and Figo Classification of Uterine Fibroids: A Comparative Cross-Sectional Study

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Abstract

Objective: To compare Transabdominal ultrasound (TAUS) and Transvaginal ultrasound (TVUS) in the detection, assessment, and FIGO classification of uterine fibroids, with particular emphasis on fibroid size, location, morphology, vascularity, and endometrial cavity distortion.

Materials & Methods: A comparative cross-sectional study was conducted over six months at the University of Lahore Affiliated Ultrasound Clinic involving 120 female patients aged 20–55 years with suspected uterine fibroids. Both TAUS and TVUS were performed using 2–5 MHz and 5–9 MHz transducers, respectively. TAUS assessed uterine morphology, fibroid size, number, and location, while TVUS provided detailed evaluation of fibroid dimensions, endometrial cavity distortion, intramural involvement, and relationship with the uterine serosa. Both techniques were used to classify fibroids according to the FIGO system, with color Doppler applied when required.

Results: Among 120 patients, most were aged 41–50 years (37.5%), multiparous (55.8%), and presented with menorrhagia (40%). TVUS showed significantly higher fibroid detection (96.7%) than TAUS (90.0%), particularly for small and submucosal fibroids. FIGO type 4 was the most common classification. Both techniques showed substantial agreement (κ=0.69; 73.3%). Small fibroids, submucosal location, multiple fibroids, and endometrial cavity distortion were significant predictors of classification disagreement. Overall, TVUS demonstrated better diagnostic performance for detecting and classifying small and submucosal fibroids.

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Conclusion: TVUS showed better detection of small and submucosal fibroids, while combining both techniques improved comprehensive assessment and FIGO classification accuracy.
Keywords: Transabdominal Ultrasound, Tranvaginal Ultrasound, FIGO Classification, Uterine Fibroids.

1. Introduction

Uterine fibroids, also known as uterine leiomyomas, are the most common benign smooth muscle tumors of the uterus, predominantly affecting women of reproductive age. They originate from the myometrial smooth muscle cells and may vary considerably in size, number, and anatomical location [1]. Although many women remain asymptomatic, uterine fibroids can present with heavy menstrual bleeding, pelvic pain, dysmenorrhea, abdominal enlargement, infertility, recurrent pregnancy loss, and pressure-related urinary or gastrointestinal symptoms. The clinical presentation largely depends on the size, number, and anatomical relationship of the fibroids with the endometrial cavity and uterine serosa [2-3]. Ultrasonography is considered the first-line imaging modality for evaluating uterine fibroids because of its accessibility, affordability, non-invasive nature, and absence of ionizing radiation [4]. Among the available ultrasound techniques, transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) are commonly used for the detection, localization, measurement, and characterization of uterine fibroids. However, both techniques have different diagnostic capabilities depending on the patient's body habitus, uterine size, fibroid location, and acoustic accessibility [5-8]. Transabdominal ultrasound provides a broader field of view and is particularly useful for evaluating enlarged uteri, multiple fibroids, and large pelvic masses[9]. It allows assessment of the overall uterine architecture and the relationship of large fibroids with surrounding pelvic structures. However, its diagnostic accuracy may be reduced by increased abdominal wall thickness, bowel gas, and limited spatial resolution, particularly when evaluating small fibroids or their precise relationship with the endometrial cavity [10].

In contrast, transvaginal ultrasound provides higher-resolution imaging because the transducer is positioned closer to the uterus. It offers better visualization of the endometrium, myometrium, uterine junctional region, and smaller fibroids. TVUS is particularly valuable in distinguishing submucosal from intramural fibroids and assessing the degree of myometrial involvement. Nevertheless, its field of view may be limited in patients with markedly enlarged uteri or large fibroids extending beyond the pelvis [11-12]. The International Federation of Gynecology and Obstetrics (FIGO) classification system provides a standardized anatomical approach for describing uterine fibroids according to their relationship with the endometrial cavity, myometrium, and uterine serosa. It categorizes fibroids into types 0–8, including submucosal, intramural, subserosal, and other anatomical locations. Accurate FIGO classification is clinically important because it assists gynecologists in selecting appropriate treatment strategies, including hysteroscopic myomectomy, laparoscopic myomectomy, open surgery, and other minimally invasive interventions [13]. Despite the widespread use of both ultrasound techniques, differences may exist in their ability to accurately determine the FIGO classification of uterine fibroids. Transvaginal ultrasound may provide superior visualization of the endometrial relationship, whereas transabdominal ultrasound may better demonstrate large and multiple fibroids [14-15]. Therefore, comparing their diagnostic performance is important for establishing an appropriate imaging approach.

The objective of this study is to compare the diagnostic accuracy of transabdominal and transvaginal ultrasound in the assessment and FIGO classification of uterine fibroids, using pelvic MRI as the reference standard. The study will also evaluate the sensitivity, specificity, overall diagnostic accuracy, and agreement of both imaging techniques in determining the anatomical classification of uterine fibroids.

2. Materials and Methods

A comparative cross-sectional study was conducted to evaluate the diagnostic performance of Transabdominal ultrasound (TAUS) and Transvaginal ultrasound (TVUS) in the assessment and classification of uterine fibroids according to the International Federation of Gynecology and Obstetrics (FIGO) classification system. The study was carried out in the University Institute of radiological Sciences & MIT, University of Lahore Affiliated Ultrasound Clinic, over a period of six months. A total of 120 female patients with suspected or previously diagnosed uterine fibroids were included in the study. Participants were recruited using a non-probability consecutive sampling technique.

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2.1. Inclusion Criteria

- Female patients aged 20–55 years.
- Patients presenting with clinically suspected uterine fibroids.
- Patients with uterine fibroids identified on initial ultrasound examination.
- Patients willing to undergo both transabdominal and transvaginal ultrasound.

2.2. Exclusion Criteria

- Pregnant women.
- Patients with a previous history of hysterectomy.
- Patients with suspected uterine malignancy.
- Patients with active pelvic inflammatory disease.
- Patients who refused transvaginal ultrasound.

2.3. Data Collection Procedure

After obtaining informed consent, demographic and clinical information was recorded, including age, presenting symptoms, menstrual history, parity, and relevant gynecological history. All patients underwent transabdominal and transvaginal ultrasound examinations. Both examinations were performed using a high-resolution ultrasound machine equipped with appropriate transducers. Transabdominal ultrasound was performed using a 2–5 MHz curvilinear transducer. Patients were instructed to maintain a comfortably full urinary bladder before examination to improve the acoustic window. The examination included:

- Assessment of uterine size, shape, and orientation.
- Identification of the number and location of fibroids.
- Measurement of fibroid dimensions in three planes.
- Assessment of uterine contour and myometrial architecture.
- Evaluation of the relationship between fibroids and the endometrial cavity.
- Assessment of the relationship between fibroids and uterine serosa.
- Evaluation of associated pelvic abnormalities.

Transvaginal ultrasound was performed using a 5–9 MHz endocavitary transducer. Patients were instructed to empty their urinary bladder before the examination. The following parameters were evaluated:

- Detailed assessment of uterine morphology.
- Identification of small and multiple fibroids.
- Measurement of fibroid dimensions.
- Assessment of endometrial cavity distortion.
- Evaluation of the percentage of intramural involvement.
- Assessment of the relationship between fibroids and uterine serosa.
- Identification of submucosal, intramural, and subserosal fibroids.
- Assessment of fibroid vascularity using color Doppler when required.

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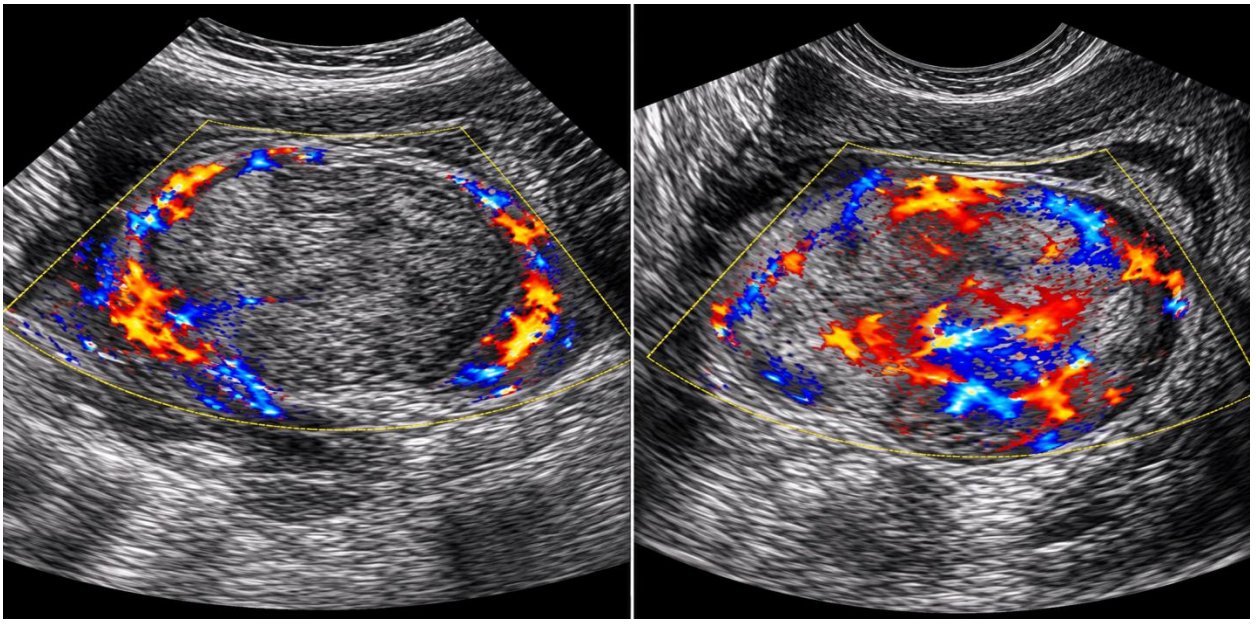


Figure 1: Color Doppler images demonstrate predominantly peripheral vascularity in the left image and prominent central (intralesional) vascularity in the right image, illustrating different blood flow patterns within uterine fibroids.

3. Results

The demographic and clinical characteristics of the study population (n=120) showed that the majority of patients belonged to the 41–50 years age group, comprising 45 (37.5%) patients, followed by 31–40 years with 42 (35.0%) patients. A total of 18 (15.0%) patients were aged 20–30 years, while 15 (12.5%) patients belonged to the 51–55 years age group. Regarding parity, most patients were multiparous, accounting for 67 (55.8%) cases, followed by primiparous women in 29 (24.2%) cases. Nulliparous women constituted 24 (20.0%) of the study population. In terms of clinical presentation, menorrhagia was the most common presenting complaint, reported by 48 (40.0%) patients, followed by dysmenorrhea in 25 (20.8%) patients and pelvic pressure/pain in 22 (18.3%) patients. Infertility was observed in 13 (10.8%) patients, while abdominal enlargement was reported by 7 (5.8%) patients. Only 5 (4.2%) patients were asymptomatic at the time of presentation. Overall, menorrhagia was the predominant clinical presentation, and multiparous women in the 41–50 years age group represented the largest proportion of the study population (Table 1).

Table 1: Demographic and Clinical Characteristics of Patients (n=120)

Variables	Frequency	Percentage
Age (years)		
20–30	18	15.0
31–40	42	35.0
41–50	45	37.5
51–55	15	12.5
Parity		
Nulliparous	24	20.0
Primiparous	29	24.2
Multiparous	67	55.8
Clinical presentation		
Menorrhagia	48	40.0
Dysmenorrhea	25	20.8
Pelvic pressure/pain	22	18.3
Infertility	13	10.8
Abdominal enlargement	7	5.8
Asymptomatic	5	4.2
Total	120	100

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The comparative analysis of ultrasound parameters in (Figure 2) demonstrated that transvaginal ultrasound (TVUS) detected uterine fibroids in 116 (96.7%) patients compared to 108 (90.0%) patients on transabdominal ultrasound (TAUS), showing a statistically significant difference (p=0.039). Multiple fibroids were identified in 65 (54.2%) patients on TVUS and 58 (48.3%) on TAUS, although the difference was not statistically significant (p=0.180). Similarly, single fibroids were observed in 51 (42.5%) patients on TVUS compared to 50 (41.7%) on TAUS (p=0.890). Regarding fibroid size, small fibroids (less than 2 cm) were detected in 27 (22.5%) patients using TVUS compared to 18 (15.0%) using TAUS, demonstrating a statistically significant difference (p=0.021). Heterogeneous echotexture was observed in 79 (65.8%) patients on TVUS and 71 (59.2%) on TAUS (p=0.110). Calcified fibroids were identified in 12 (10.0%) patients on TVUS and 14 (11.7%) on TAUS (p=0.690), while cystic degeneration was observed in 19 (15.8%) and 17 (14.2%) patients, respectively (p=0.710). Peripheral vascularity was detected in 82 (68.3%) patients on TVUS compared to 75 (62.5%) on TAUS, with no statistically significant difference (p=0.190). Overall, TVUS demonstrated a significantly higher detection rate of uterine fibroids and small fibroids (less than 2 cm) compared to TAUS. However, no statistically significant differences were observed in the detection of multiple or single fibroids, heterogeneous echotexture, calcification, cystic degeneration, or peripheral vascularity.

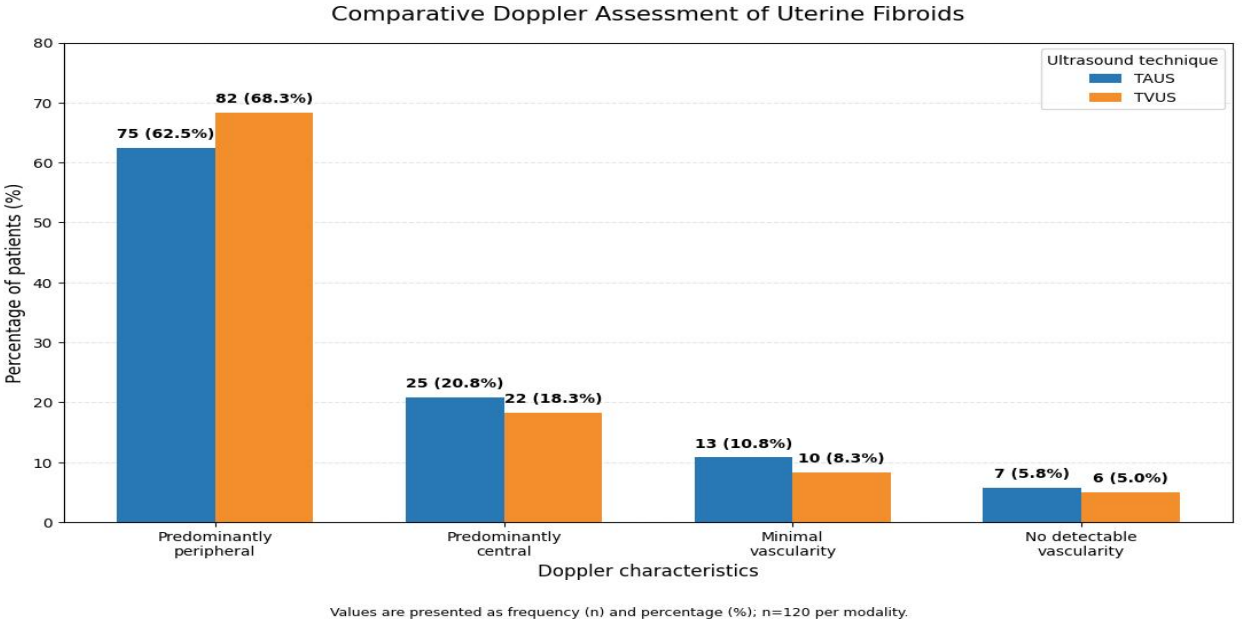


Figure 2: Comparative Detection and Morphological Assessment of Fibroids

The distribution of uterine fibroids according to FIGO classification in (Figure 3) showed that, on transabdominal ultrasound (TAUS), FIGO type 4 (completely intramural) was the most frequently identified type, accounting for 32 (26.7%) cases, followed by type 5 (subserosal, 50% or more intramural) in 20 (16.7%) cases and type 3 (intramural, contacting endometrium) in 18 (15.0%) cases. Type 6 was observed in 14 (11.7%) cases, type 2 in 12 (10.0%), type 7 in 8 (6.7%), type 1 in 7 (5.8%), type 8 in 5 (4.2%), and type 0 in 4 (3.3%) cases. Similarly, on transvaginal ultrasound (TVUS), FIGO type 4 remained the most common classification, identified in 30 (25.0%) cases, followed by type 3 in 20 (16.7%), type 5 in 18 (15.0%), type 2 in 15 (12.5%), and type 6 in 12 (10.0%) cases. Type 1 was observed in 10 (8.3%) cases, while types 0 and 7 were each identified in 6 (5.0%) cases. Type 8 was the least common, accounting for 3 (2.5%) cases. Overall, both ultrasound techniques demonstrated a similar distribution of uterine fibroid locations, with completely intramural fibroids (FIGO type 4) being the predominant type.

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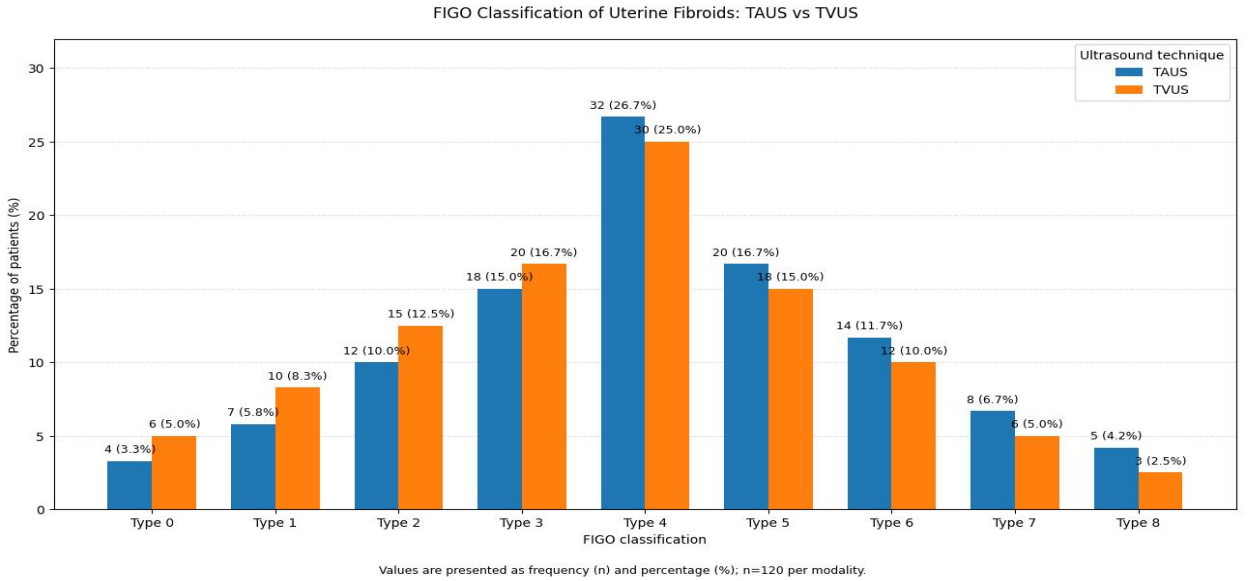


Figure 3: FIGO Classification of Uterine Fibroids According to Ultrasound Technique

The comparison of fibroid dimensions between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) demonstrated that the mean maximum fibroid diameter was slightly higher on TAUS (4.82 ± 1.91 cm) compared to TVUS (4.61 ± 1.84 cm), with a statistically significant difference (p=0.041). Similarly, the mean anteroposterior diameter was 3.91 ± 1.42 cm on TAUS and 3.76 ± 1.39 cm on TVUS; however, this difference was not statistically significant (p=0.083). The mean transverse diameter was 4.20 ± 1.57 cm on TAUS compared to 4.05 ± 1.48 cm on TVUS, showing no statistically significant difference (p=0.076). The mean longitudinal diameter was also higher on TAUS (4.74 ± 1.88 cm) than TVUS (4.53 ± 1.81 cm), with a statistically significant difference (p=0.048). Furthermore, the estimated mean fibroid volume was 54.8 ± 39.6 cm^3 on TAUS compared to 50.7 ± 37.2 cm^3 on TVUS, demonstrating a statistically significant difference (p=0.032). Overall, TAUS yielded slightly higher measurements of fibroid dimensions and estimated volume than TVUS. Statistically significant differences were observed in maximum fibroid diameter, longitudinal diameter, and estimated fibroid volume, whereas anteroposterior and transverse diameters showed no significant differences (Table 2).

Table 2: Comparison of Fibroid Dimensions Between TAUS and TVUS

Measurement parameters	TAUS (Mean ± SD)	TVUS (Mean ± SD)	p-value
Maximum fibroid diameter (cm)	4.82 ± 1.91	4.61 ± 1.84	0.041
Anteroposterior diameter (cm)	3.91 ± 1.42	3.76 ± 1.39	0.083
Transverse diameter (cm)	4.20 ± 1.57	4.05 ± 1.48	0.076
Longitudinal diameter (cm)	4.74 ± 1.88	4.53 ± 1.81	0.048
Estimated fibroid volume (cm^3)	54.8 ± 39.6	50.7 ± 37.2	0.032

The comparative assessment of endometrial cavity distortion between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) showed that a normal endometrial cavity was identified in 63 (52.5%) patients on TAUS compared to 56 (46.7%) on TVUS, with no statistically significant difference (p=0.180). Mild cavity distortion was observed in 27 (22.5%) patients on TAUS and 30 (25.0%) on TVUS (p=0.650). Similarly, moderate cavity distortion was detected in 18 (15.0%) patients using TAUS compared to 21 (17.5%) using TVUS (p=0.590). Severe endometrial cavity distortion was identified in 12 (10.0%) patients on TAUS and 13 (10.8%) on TVUS, with no statistically significant difference (p=0.830). Overall, TVUS demonstrated slightly higher frequencies of mild, moderate, and severe endometrial cavity distortion, whereas TAUS identified a greater proportion of patients with a normal endometrial cavity. However, none of these differences were statistically significant (all p-values greater than 0.05), suggesting comparable performance of both ultrasound techniques in assessing endometrial cavity distortion (Table 3).

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Table 3: Comparative Assessment of Endometrial Cavity Distortion

Endometrial findings	TAUS n (%)	TVUS n (%)	p-value
Normal endometrial cavity	63 (52.5)	56 (46.7)	0.180
Mild cavity distortion	27 (22.5)	30 (25.0)	0.650
Moderate cavity distortion	18 (15.0)	21 (17.5)	0.590
Severe cavity distortion	12 (10.0)	13 (10.8)	0.830
Total	120 (100)	120 (100)	

The comparative Doppler assessment of uterine fibroids between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) demonstrated that predominantly peripheral vascularity was the most common Doppler pattern, identified in 75 (62.5%) patients on TAUS compared to 82 (68.3%) on TVUS, with no statistically significant difference (p=0.190). Predominantly central vascularity was observed in 25 (20.8%) patients using TAUS and 22 (18.3%) using TVUS (p=0.640). Minimal vascularity was detected in 13 (10.8%) patients on TAUS compared to 10 (8.3%) on TVUS (p=0.510). Furthermore, no detectable vascularity was observed in 7 (5.8%) patients on TAUS and 6 (5.0%) on TVUS, with no statistically significant difference (p=0.780). Overall, predominantly peripheral vascularity was the most frequent Doppler finding with both ultrasound techniques. Although TVUS demonstrated a slightly higher detection frequency of peripheral vascularity, TAUS showed marginally higher frequencies of central, minimal, and absent vascularity. However, none of the differences between the two techniques were statistically significant (all p-values greater than 0.05), indicating comparable Doppler assessment of uterine fibroids using TAUS and TVUS (Table 4).

Table 4: Comparative Doppler Assessment of Uterine Fibroids

Doppler characteristics	TAUS n (%)	TVUS n (%)	p-value
Predominantly peripheral vascularity	75 (62.5)	82 (68.3)	0.190
Predominantly central vascularity	25 (20.8)	22 (18.3)	0.640
Minimal vascularity	13 (10.8)	10 (8.3)	0.510
No detectable vascularity	7 (5.8)	6 (5.0)	0.780
Total	120 (100)	120 (100)	

The comparative assessment of FIGO subgroups between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) demonstrated that submucosal fibroids (FIGO types 0–2) were identified in 31 (25.8%) patients on TVUS compared to 23 (19.2%) on TAUS, showing a statistically significant difference (p=0.031). Intramural fibroids (FIGO types 3–4) were equally identified by both techniques, accounting for 50 (41.7%) cases each, with no statistically significant difference (p=1.000). Subserosal fibroids (FIGO types 5–7) were detected in 42 (35.0%) patients on TAUS compared to 36 (30.0%) on TVUS, demonstrating a statistically significant difference (p=0.048). Other fibroid locations (FIGO type 8) were observed in 5 (4.2%) patients on TAUS and 3 (2.5%) on TVUS, with no significant difference (p=0.480). Regarding agreement between the two ultrasound techniques, exact FIGO classification agreement was observed in 88 out of 120 cases (73.3%), whereas classification disagreement occurred in 32 (26.7%) cases. Cohen's kappa coefficient was 0.69, indicating substantial agreement between TAUS and TVUS for FIGO classification of uterine fibroids. Overall, TVUS demonstrated a higher detection frequency of submucosal fibroids, whereas TAUS identified a higher proportion of subserosal fibroids. Both techniques showed identical detection frequencies for intramural fibroids. The overall agreement findings suggest good consistency between the two ultrasound modalities, although some discrepancies remain in the anatomical classification of fibroids (Table 5).

Table 5: Comparative Assessment of FIGO Subgroups

FIGO subgroup	TAUS n (%)	TVUS n (%)	p-value
Submucosal (0–2)	23 (19.2)	31 (25.8)	0.031
Intramural (3–4)	50 (41.7)	50 (41.7)	1.000
Subserosal (5–7)	42 (35.0)	36 (30.0)	0.048
Other (8)	5 (4.2)	3 (2.5)	0.480
Total	120 (100)	120 (100)	
Agreement parameters			
Exact FIGO classification agreement		88/120 (73.3%)	
Classification disagreement		32/120 (26.7%)	
Cohen's kappa		0.69	

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The analysis of (Figure 4) factors associated with discordant FIGO classification between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) revealed that small fibroids (less than 2 cm) were associated with discordant classification in 17 (53.1%) cases, showing a statistically significant association (p=0.004). Similarly, submucosal fibroids demonstrated discordance in 19 (59.4%) cases (p=0.001). Endometrial cavity distortion was observed in 21 (65.6%) discordant cases, with a statistically significant association (p=0.002). Multiple fibroids were also associated with discordant classification in 20 (62.5%) cases (p=0.008). In contrast, fibroids larger than 5 cm showed discordant classification in only 7 (21.9%) cases, and this association was not statistically significant (p=0.120). Overall, small fibroid size, submucosal location, endometrial cavity distortion, and multiple fibroids were significantly associated with discordance in FIGO classification between TAUS and TVUS. However, fibroids larger than 5 cm were not significantly associated with classification disagreement.

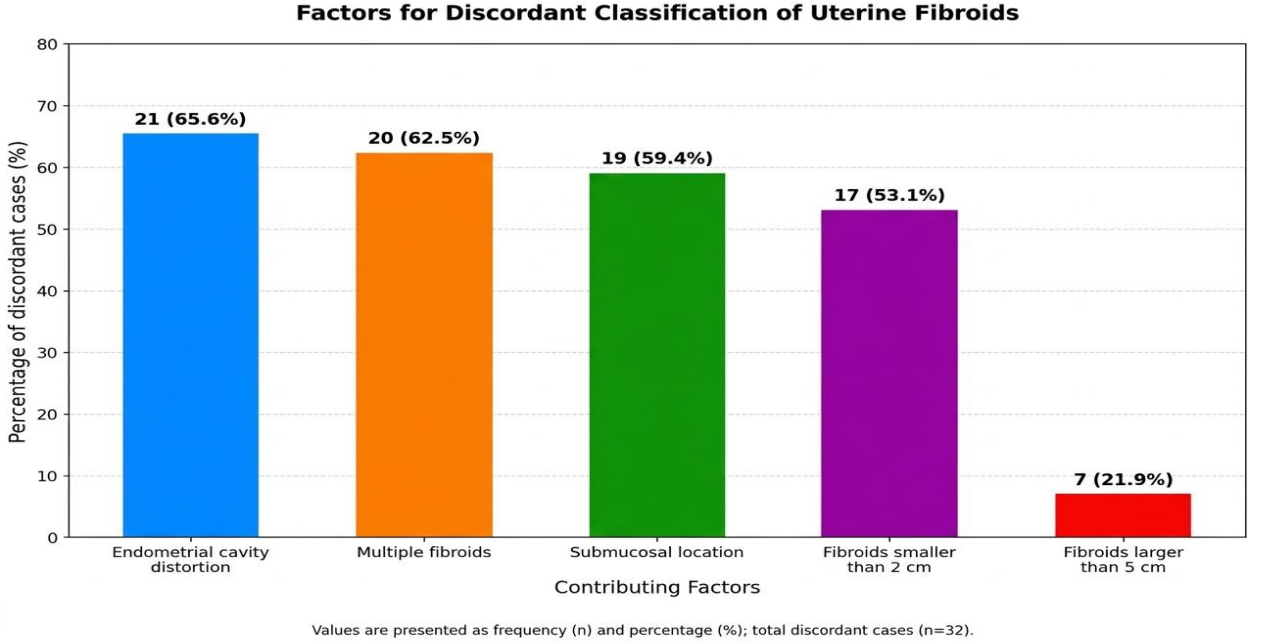


Figure 4: Factors Associated with Discordant FIGO Classification Between Ultrasound Techniques

The multivariable logistic regression analysis identified several independent factors associated with discordant FIGO classification between transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS). Fibroid size less than 2 cm was significantly associated with classification discordance, with an adjusted odds ratio (OR) of 3.42 (95% CI: 1.38–8.47; p=0.008), indicating approximately 3.4 times higher odds of disagreement. Similarly, submucosal fibroid location demonstrated a strong association with discordance (adjusted OR: 4.16; 95% CI: 1.72–10.05; p=0.002), representing approximately four times higher odds of classification disagreement. The presence of multiple fibroids was also significantly associated with discordant classification (adjusted OR: 2.31; 95% CI: 1.01–5.28; p=0.047). Furthermore, endometrial cavity distortion was an independent predictor of classification disagreement, with an adjusted OR of 3.78 (95% CI: 1.51–9.46; p=0.004). In contrast, fibroid size greater than 5 cm was not significantly associated with discordance (adjusted OR: 0.71; 95% CI: 0.27–1.86; p=0.480). Overall, fibroid size less than 2 cm, submucosal location, multiple fibroids, and endometrial cavity distortion were significant independent predictors of discordant FIGO classification between TAUS and TVUS. Among these factors, submucosal location demonstrated the strongest association with classification disagreement, followed by endometrial cavity distortion (Table 6).

Table 6: Multivariable Analysis of Factors Associated with Discordant Ultrasound Classification

Variables	Adjusted OR	95% CI	p-value
Fibroid size less than 2 cm	3.42	1.38–8.47	0.008
Submucosal location	4.16	1.72–10.05	0.002
Multiple fibroids	2.31	1.01–5.28	0.047
Endometrial cavity distortion	3.78	1.51–9.46	0.004

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Fibroid size greater than 5 cm	0.71	0.27–1.86	0.480

4. Discussion

The present study compared the diagnostic performance of transabdominal ultrasound (TAUS) and transvaginal ultrasound (TVUS) in the detection, measurement, and FIGO classification of uterine fibroids among 120 patients. The majority of patients belonged to the 41–50 years age group (37.5%), and menorrhagia was the most common clinical presentation (40.0%). These findings are consistent with the established association of uterine fibroids with reproductive and perimenopausal age and abnormal uterine bleeding. In the present study, TVUS demonstrated a significantly higher fibroid detection rate than TAUS (96.7% vs. 90.0%; p=0.039), particularly for small fibroids measuring less than 2 cm (22.5% vs. 15.0%; p=0.021). Similarly, a 2025 comparative study involving 90 patients reported higher diagnostic accuracy for TVUS (96.40%) than TAUS (71.42%), supporting the superior diagnostic capability of TVUS [16]. Regarding fibroid measurements, TAUS demonstrated slightly higher mean maximum diameter (4.82 ± 1.91 cm vs. 4.61 ± 1.84 cm) and estimated volume (54.8 ± 39.6 cm^3 vs. 50.7 ± 37.2 cm^3). These differences may reflect variations in imaging planes, probe positioning, and measurement boundaries. Previous literature also emphasizes that ultrasound-based fibroid measurements may vary according to lesion location, uterine size, and operator technique [17]. FIGO classification revealed that intramural fibroids were the predominant subgroup (41.7%), followed by subserosal fibroids on TAUS and submucosal fibroids on TVUS. TVUS identified significantly more submucosal fibroids (25.8% vs. 19.2%; p=0.031), highlighting its advantage in evaluating the endometrial cavity and small intracavitary components. The overall exact classification agreement was 73.3%, with a Cohen's kappa of 0.69, indicating substantial agreement. These findings support the established role of TVUS in detailed anatomical assessment and FIGO classification of uterine leiomyomas [18].

The present study further demonstrated that small fibroid size, submucosal location, multiple fibroids, and endometrial cavity distortion were significantly associated with classification disagreement. Submucosal location showed the strongest association (adjusted OR 4.16; p=0.002). These findings suggest that complex anatomical relationships and smaller lesion dimensions may create difficulties in accurate classification using either technique independently. Overall, the findings indicate that TVUS provides better detection of small and submucosal fibroids, whereas TAUS provides complementary information regarding overall uterine anatomy and larger lesions. Therefore, combining both ultrasound approaches may improve the assessment and FIGO classification of uterine fibroids and support appropriate clinical management.

5. Conclusion

TVUS demonstrated better detection of uterine fibroids, particularly small and submucosal lesions, while TAUS provided slightly higher fibroid measurements. Both techniques showed substantial agreement in FIGO classification . Combining TAUS and TVUS is recommended for more comprehensive assessment and accurate classification of uterine fibroids.

5.1. Conflict of Interest: None

5.2. Source of Funding: None

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