



ABC's of O-RADS US

UCSF

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Disclosures

- *None relevant to this lecture*

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Outline

- O-RADS US Basics
 - Indications
 - Governing concepts
 - Categories
 - Lexicon

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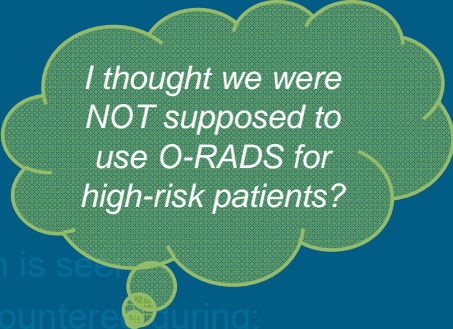
Indications for use

- Options:
 - 1. On every pelvic US exam
 - 2. Case-by-case (more practical approach)
 - Whenever a non-physiologic lesion is seen
 - When physiologic findings are encountered during:
 - High-risk screening US (BRCA mutation, etc.)
 - US requested for evaluation of finding seen on another imaging modality
 - At a minimum, when a lesion is suspected to be neoplastic

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Indications for use

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 - US requested for evaluation of finding seen on another imaging modality
 - At a minimum, when a lesion is suspected to be neoplastic



I thought we were NOT supposed to use O-RADS for high-risk patients?

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Governing concepts

- 1. Recommendations should function as guidance; individual case management may be modified by judgment

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*Governing concepts (8 *rules*)*

- 1. Recommendations should function as guidance; individual case management may be modified by judgment
- 2. Management is for the average-risk patient with no acute symptoms

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*Governing concepts (8 *rules*)*

- 1. Recommendations should function as guidance; individual case management may be modified by judgment
- 2. Management is for the average-risk patient with no acute symptoms

The lexicon and assessment categories apply to all!

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Governing concepts (8 *rules*)

- 1. Recommendations should function as guidance; individual case management may be modified by judgment
- 2. Management is for the average-risk patient with no acute symptoms; if present, management may vary from this system
- 3. Involvement of an US specialist



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US Specialist

- Background
 - US assessment of adnexal lesions can be really challenging
 - Experience is a good thing¹⁻³
- Intent
 - Minimize needless surgery
 - Refer to gyn-onc when appropriate
 - Promote cost effective and judicious use of MRI

¹Mays, et.al. *EM Eur J Cancer* 2016; 58:17-29

²Valentin, L. et.al. *Ultrasound Obstet Gynecol* 2001; 18:357-365

³Timmerman, D. et.al. *Best Pract Res Clin Obstet Gynaecol* 2004; 18:91-104

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US Specialist

- Definition:
 - A physician whose practice includes a focus on US assessment of adnexal lesions
 - Self-designated; no mandated requirements, training or certification
- For radiologists, a fellowship in body or women's imaging that includes pelvic US will be common
- Utilization of the "US specialist" will vary by institution

Andreotti, RF, et.al. *Am Coll Radiol* 2018; 15:1415-1429

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*Governing concepts (8 *rules*)*

- 1. Recommendations should function as guidance; individual case management may be modified by judgment
- 2. Management is for the average-risk patient with no acute symptoms; if present, management may vary from this system
- 3. Involvement of an US specialist
- 4. Postmenopausal = amenorrhea \geq 1 yr

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Governing concepts (8 *rules*)

- 5. Lesion size = largest possible diameter
- 6. Applies only to lesions involving (or suspected to involve) the ovaries or tubes (exception: paraovarian cyst)
- 7. In *If origin unclear, cross-sectional imaging may help; may defer O-RADS scoring in this setting*
- 8. V *TAS alone may suffice if technically adequate to provide adequate lesion characterization* re

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Assessment Categories

- 0
- 1
- 2
- 3
- 4
- 5

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Assessment Categories – Risk of Malignancy (ROM)

- 0 - Technically incomplete exam
- 1 - Normal/physiologic ovary
- 2 - Almost certainly benign
- 3 - Low risk
- 4 - Intermediate risk
- 5 - High risk

US	MRI
N/A	N/A
0	N/A
< 1%	< 0.5%
1 - < 10%	~ 5%
10 - < 50%	~ 50%
≥ 50%	~ 90%
N=5905 ¹	N=1130 ²

¹Andreotti, RF, et.al. *Am Coll Radiol* 2018; 15:1415-1429

²Thomassin-Naggara I, et.al. *JAMA Network Open*. 2020;3(1):e1919896

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Assessment Categories – Management Recommendations

- 0 - Technically incomplete exam
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US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

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- 4 - Intermediate risk
- 5 - High risk

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - Normal/physiologic ovary
- *US may be attempted;
MRI is an option*
- *Not allowed for user uncertainty*
- 5 - High risk

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
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- 4 - Intermediate risk
- 5 - High risk

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
- 2 - Variable imaging f/u ± gynecologist
- 3 - Low risk
- Depends on lesion type, features, menopausal status, size, etc.

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

Options:

- None
- Clinical f/u
- US 8 -12 wks
- US 1 yr
- US specialist
- MRI

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
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- 2 - Variable imaging f/u ± gynecologist
- 3 - Low risk
- 4 - Intermediate risk
- 5 - High risk

US
N/A
0
< 1%
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≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
- 2 - Variable imaging f/u ± gynecologist
- 3 - US specialist or MRI; gynecologist
- 4 - Intermediate risk
- 5 - High risk

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
- 2 - Variable imaging f/u ± gynecologist
- 3 - US specialist or MRI; gynecologist
- 4 - Intermediate risk
- 5 - High risk

Not necessarily both
AND not exclusionary

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
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N/A
0
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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
- 2 - Variable imaging f/u ± gynecologist
- 3 - US specialist or MRI; gynecologist
- 4 - US specialist or MRI; gyn-onc ± gyn
- 5 - High risk

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
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Assessment Categories – Management Recommendations

- 0 - Repeat imaging
- 1 - No imaging follow-up
- 2 - Variable imaging f/u ± gynecologist
- 3 - US specialist or MRI; gynecologist
- 4 - US specialist or MRI; gyn-onc ± gyn
- 5 - Referral to gynecologic-oncologist

US
N/A
0
< 1%
1 - < 10%
10 - < 50%
≥ 50%

Gyn-onc protocol typically includes cross-sectional imaging

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ACR O-RADS Tables

O-RADS Score	Risk Category (PCA Model)	Lexicon Descriptors	Management			
			Pre-menopausal	Post-menopausal		
0	Incomplete Evaluation [N/A]	N/A	Repeat study or alternate study			
1	Normal Ovary [N/A]	Follicle defined as a simple cyst ≤ 3 cm Corpus Luteum ≤ 3cm	None	N/A		
2	Almost Certainly Benign (< 1%)	Simple cyst	≤ 3 cm None 3 cm to 5 cm None Follow up in 8-12 weeks	None None None Follow up in 1 year *	≤ 5 cm None >5 cm but < 10 cm Follow up in 8-12 weeks if persists or enlarges, referral to US specialist, gynecologist, or MRI	
		Non-simple follicular cyst, smooth inner margin	≤ 3 cm but ≤ 10 cm	None Follow up in 8-12 weeks if concerning, US specialist or MRI	Follow up in 1 year * if concerning, US specialist or MRI	US specialist, gynecologist, or MRI Optional initial follow up in 8-12 weeks based upon confidence in diagnosis
3	Low Risk Malignancy (1-10%)	Unilocular cyst (simple or non-simple) ≥ 10 cm Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm Unilocular cyst, with irregular inner wall (>3 mm height), any size Multilocular cyst with smooth inner walls/septations, ≤ 10 cm, CS = 1-3 Solid lesion with smooth outer contour, any size, CS = 1	US specialist or MRI Management by gynecologist	US specialist or MRI if there is enlargement, changing morphology or a developing vascular component	US specialist, gynecologist, or MRI With confident diagnosis, if not removed surgically, annual US follow up should then be considered *	
4	Intermediate Risk (10-10%)	Multilocular cyst, no solid component	Smooth inner wall, ≤ 10 cm, CS = 1-3 Smooth inner wall, any size, CS = 4 Irregular inner wall = irregular septation, any size, CS = any	US specialist or MRI	None if not simple, manage per ovarian criteria	Optional single follow up study in 1 year
		Unilocular cyst with solid component	1-3 papillary projections (ps), or solid component that is not a ps, any size, CS = any	Management by gynecologist with gyn-oncologist consultation or solely by gyn-oncologist	Gynecologist	Gynecologist
		Multilocular cyst with solid component	Any size, CS = 1-2		Gynecologist	Gynecologist
		Solid lesion	Smooth outer contour, any size, CS = 2-3		Gynecologist	Gynecologist
5	High Risk (≥ 10%)	Unilocular cyst, ≥ 4 papillary projections, any size, CS = any Multilocular cyst with solid component, any size, CS = 3-4 Solid lesion with smooth outer contour, any size, CS = 4 Solid lesion with irregular outer contour, any size, CS = any *Nodule and/or septation nodules**	Gynecologist	Gynecologist	Gynecologist	

https://www.acr.org/-/media/ACR/Files/RADS/O-RADS/O-RADS_US-Risk-Stratification-Table.pdf

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ACR O-RADS App

- Smartphone app
 - iPhone, Android
 - Searchwords
 - “acr orads”
 - “acr o-rads”
 - “acr guidance”
 - “o-rads”



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CONSUMER WARNING

- *This is NOT AI or CAD!*
- Proper use of tables and app require you to:
 - Recognize the relevant features
 - Know and use the lexicon terminology

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Let's Talk Lexicon

WHAAAAAAAAAT???

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General Terms

- Physiologic

- Lesion

- Component
 - Part of a lesion

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General Terms

- Solid/Solid-appearing (lesions or components)
 - (+) flow = solid
 - (-) flow = solid or solid-appearing
 - Excludes blood products, fat, cartilage, bone, calcifications
- Vascularity
 - Peripheral
 - Internal
 - Measured by *color score* (CS), subjective 1- 4 scale

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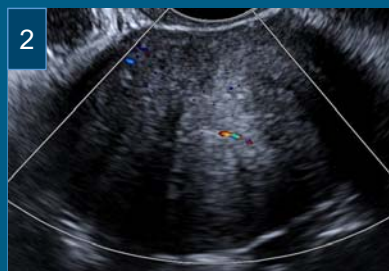
Color Score

None



1

Mild



2

Moderate



3

Very strong

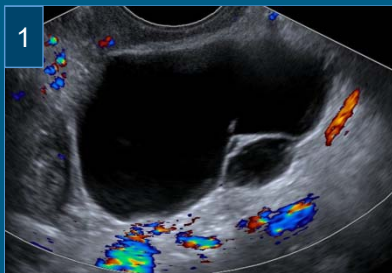


4

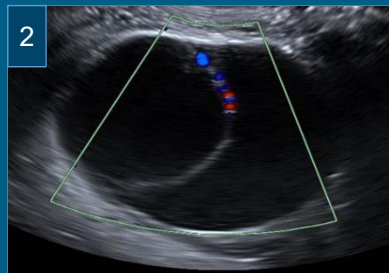
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Color Score

None



2

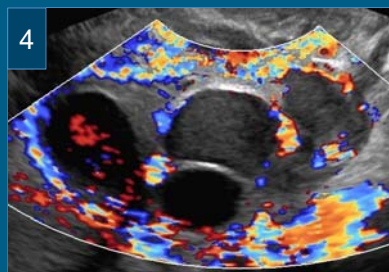


Mild

Moderate



4



Very strong

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Physiologic

- Follicle

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Physiologic

- Follicle
 - Unilocular, anechoic cyst
≤ 3 cm



TIP: Caution against term “cyst”

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Physiologic

- Follicle
- Corpus Luteum

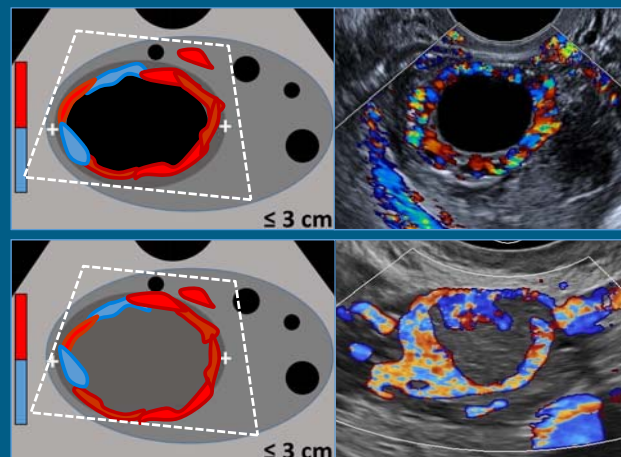
TIP: Caution against term “cyst”

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Physiologic

- Follicle
- Corpus Luteum
 - Cystic with thick walls or solid-appearing ≤ 3 cm
 - Peripheral vascularity

TIP: Caution against term "cyst"

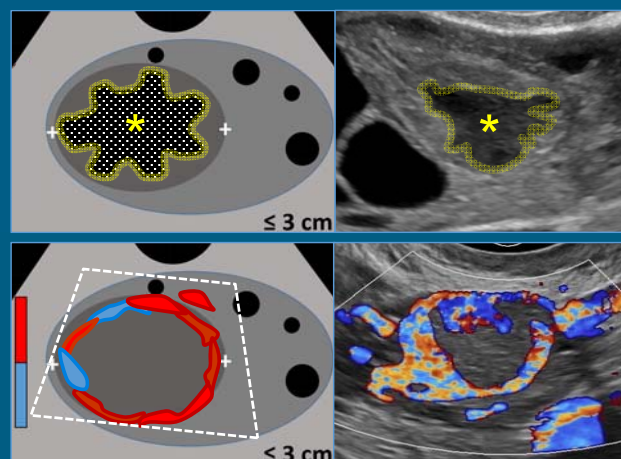


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Physiologic

- Follicle
- Corpus Luteum
 - Cystic with thick walls or solid-appearing ≤ 3 cm
 - \pm crenulated inner margin
 - \pm internal echoes
 - Peripheral vascularity

TIP: Caution against term "cyst"

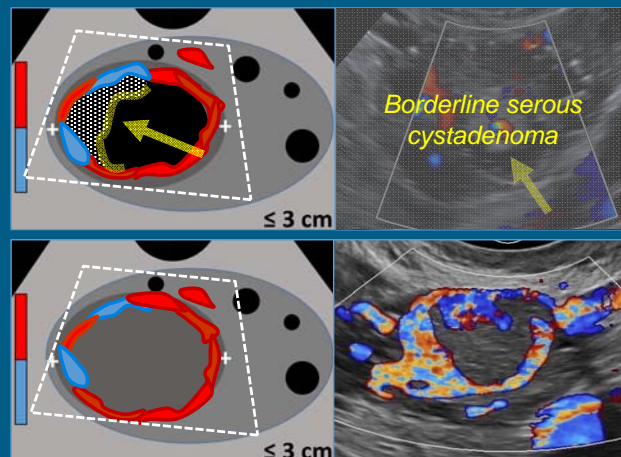


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Physiologic

- Follicle
- Corpus Luteum
 - Cystic with thick walls or solid-appearing ≤ 3 cm
 - \pm crenulated inner margin
 - \pm internal echoes
 - Peripheral vascularity

TIP: Caution against term "cyst"



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Physiologic

- Follicle
- Corpus Luteum

When descriptors are met, terms alone will suffice

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Physiologic – Assessment and Management

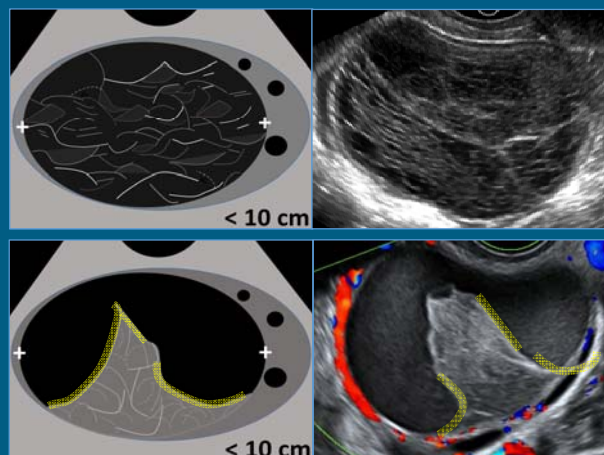
- Follicle
- Corpus Luteum

- O-RADS 1 - No imaging follow-up needed

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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Reticular pattern
 - Retractable clot

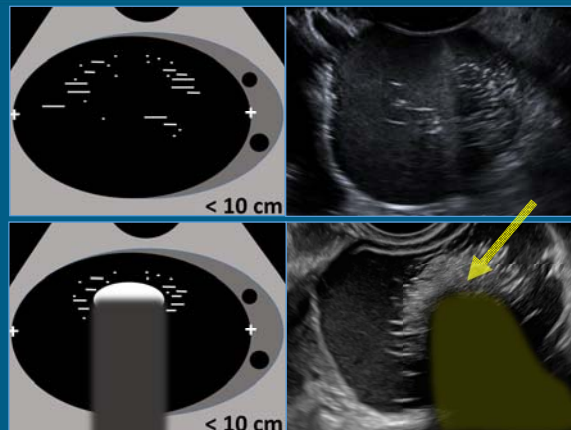


NO INTERNAL FLOW

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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Hyperechoic lines and dots
 - Hyperechoic component with acoustic shadowing

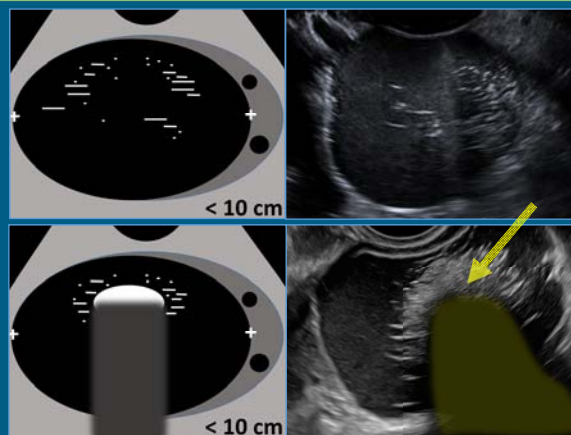


NO INTERNAL FLOW

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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Hyperechoic lines and dots
 - Hyperechoic **component** with acoustic shadowing



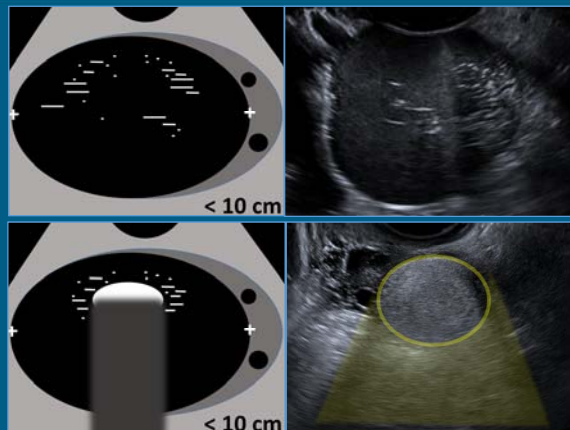
NO INTERNAL FLOW

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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Hyperechoic lines and dots
 - Hyperechoic component with acoustic shadowing

NO INTERNAL FLOW



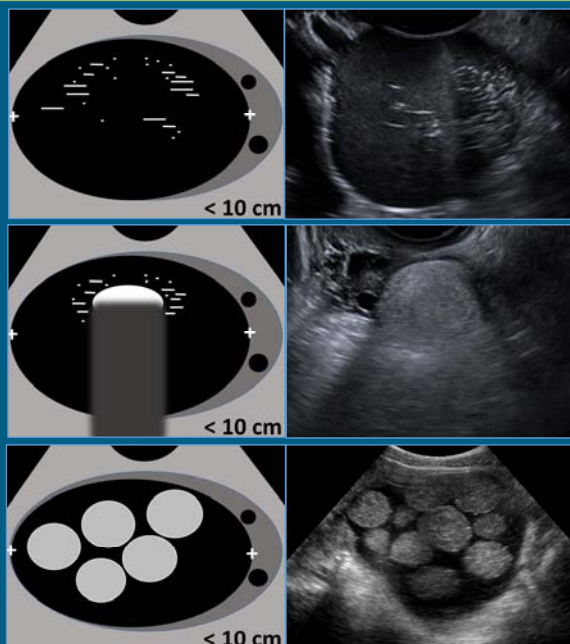
TIP: Cyst fluid not always apparent so may appear as a completely hyperechoic lesion with shadowing

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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Hyperechoic lines and dots
 - Hyperechoic component with acoustic shadowing
 - Floating echogenic spherical structures

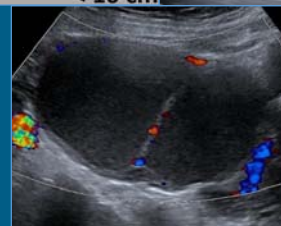
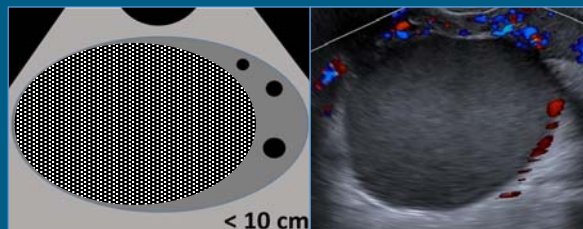
NO INTERNAL FLOW



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Classic Benign Lesions

- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Typical Endometrioma
 - Homogenous low-level or ground glass echoes



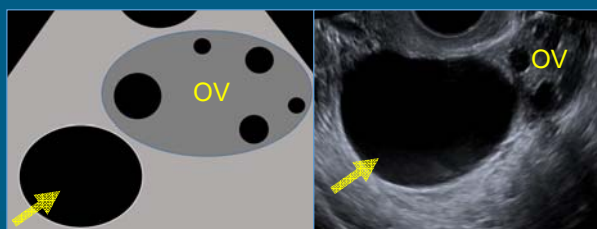
NO INTERNAL FLOW

TIP: Can be unilocular or multilocular

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Classic Benign Lesions

- Extraovarian
 - Paraovarian Cyst
 - Simple cyst separate from the ovary
 - Moves independent from ovary when transducer pressure is applied

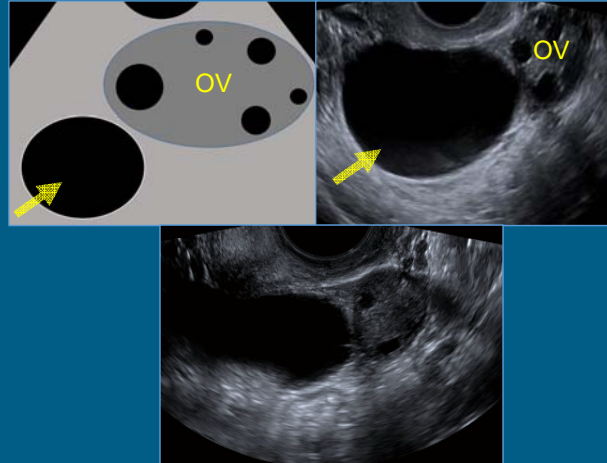


Includes paratubal

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Classic Benign Lesions

- Extraovarian
 - Paraovarian Cyst
 - Simple cyst separate from the ovary
 - Moves independent from ovary when transducer pressure is applied



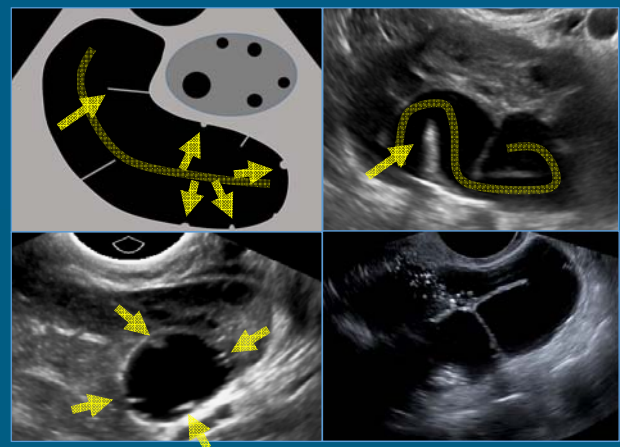
Includes paratubal

NOTE: When **NOT SIMPLE**, assess as per ovarian lesion

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Classic Benign Lesions

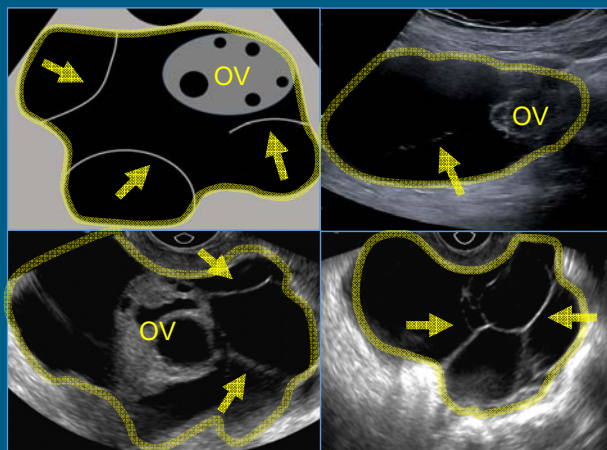
- Extraovarian
 - Paraovarian cyst
 - Typical Hydrosalpinx
 - Tubular
 - Incomplete septations
 - Endosalpingeal folds



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Classic Benign Lesions

- Extraovarian
 - Paraovarian Cyst
 - Typical Hydrosalpinx
 - Typical Peritoneal Inclusion Cyst
 - Ovary at margin or suspended within cystic lesion ± septations
 - Follows contour of adjacent pelvic organs; no mass effect



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Classic Benign Lesions – Assessment and Management

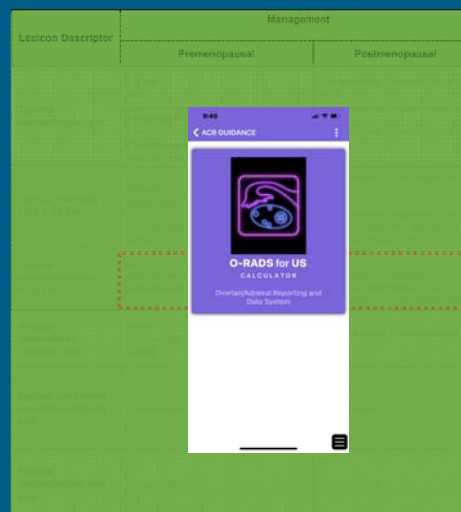
- Ovarian/adnexal
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Typical Endometrioma
- Extraovarian
 - Paraovarian Cyst
 - Typical Hydrosalpinx
 - Typical Peritoneal Inclusion Cyst

O-RADS 2 – Almost certainly benign

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Classic Benign Lesions – Assessment and Management

- Ovarian/adnexal: **<10 cm**
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Typical Endometrioma
- Extraovarian: **any size**
 - Paraovarian Cyst
 - Typical Hydrosalpinx
 - Typical Peritoneal Inclusion Cyst



Duration:
5 yrs
No
O-RADS
score

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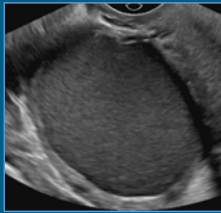
Classic Benign Lesions – Assessment and Management

- Ovarian/adnexal: **≥10 cm**
 - Typical Hemorrhagic Cyst
 - Typical Dermoid Cyst
 - Typical Endometrioma
- O-RADS 3 – Low risk
- Recommend: US specialist or MRI
Manage per Gynecology
- Extraovarian – any size
 - Paraovarian Cyst
 - Typical Hydrosalpinx
 - Typical Peritoneal Inclusion Cyst

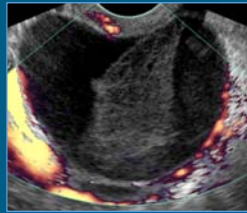
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CAUTION

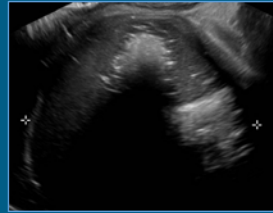
- “Yield” to features of classic B9 lesions to avoid ‘upgrading’



Solid-appearing



Unilocular cystic,
with solid-appearing
component



Unilocular cystic,
with solid-appearing
component



Multilocular cystic,
with solid component

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**Other* Lesions*

- 5 categories
 - 1. Unilocular cystic (-) solid component
 - 2. Unilocular cystic (+) solid component
 - 3. Multilocular cystic (-) solid component
 - 4. Multilocular cystic (+) solid component
 - 5. Solid/solid-appearing ($\geq 80\%$ solid)

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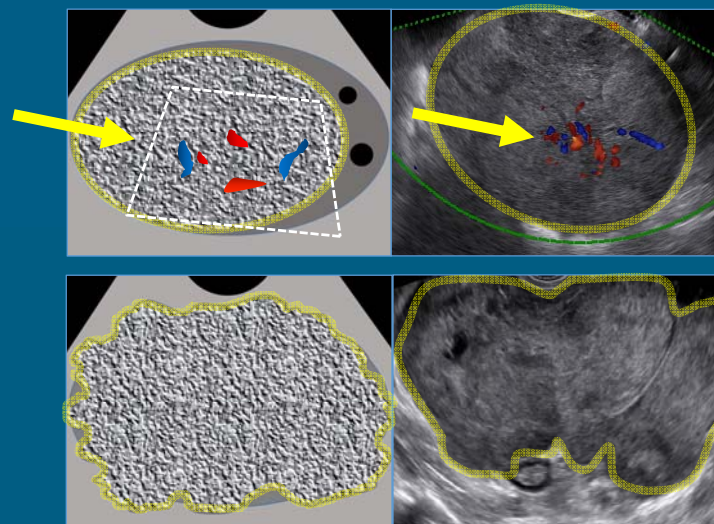
**Other* Lesions*

- 5 categories
 - 1. Unilocular cystic (-) solid component
 - 2. Unilocular cystic (+) solid component
 - 3. Multilocular cystic (-) solid component
 - 4. Multilocular cystic (+) solid component
 - 5. Solid/solid-appearing ($\geq 80\%$ solid)

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Solid - Outer Contour

- Smooth
 - Irregular
 - Includes lobular



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Solid Lesions – Assessment/Management

- Smooth outer contour
 - CS 1: O-RADS 3, Low-risk
 - CS 2-3: O-RADS 4, Intermediate risk
 - CS 4: O-RADS 5, High-risk

- Irregular outer contour
 - O-RADS 5, High-risk

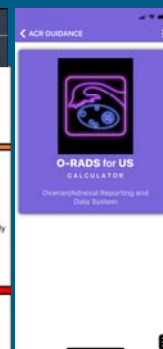
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Solid Lesions – Assessment/Management

- Smooth outer contour
 - CS 1: O-RADS 3, Low-risk
 - CS 2-3: O-RADS 4, Intermediate risk
 - CS 4: O-RADS 5, High-risk

- Irregular outer contour
 - O-RADS 5, High-risk

O-RADS Score	Risk Category (IOTA Model)	Lexicon Descriptors	Management	
			Pre-menopausal	Post-menopausal
3	Low Risk Malignancy [1-10%]	Solid lesion with smooth outer contour, any size, CS = 1	US specialist or MRI; Management by gynecologist	
4	Intermediate Risk [10-50%]	Solid lesion, Smooth outer contour, any size, CS = 2-3	US specialist or MRI; Management by gynecologist with gyn-oncologist consultation or solely by gyn-oncologist	
5	High Risk [≥ 50%]	Solid lesion with smooth outer contour, any size, CS = 4 Solid lesion with irregular outer contour, any size, CS = any	Gyn-oncologist	



Size does not matter

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Other Lesions

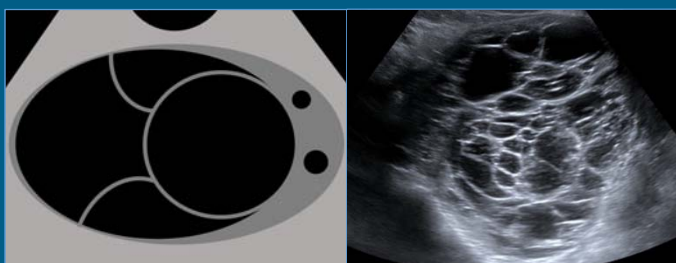
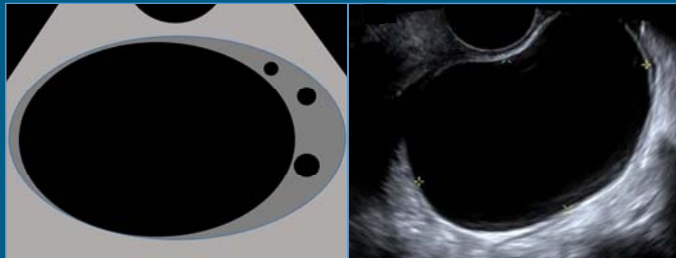
- 5 categories
 - 1. Unilocular cystic (-) solid component
 - 2. Unilocular cystic (+) solid component
 - 3. Multilocular cystic (-) solid component
 - 4. Multilocular cystic (+) solid component
 - 5. Solid/solid-appearing ($\geq 80\%$ solid)

Complete Septation(s)

Complete Septation(s)

- Unilocular
 - No complete septa

- Multilocular
 - ≥ 1 complete septum

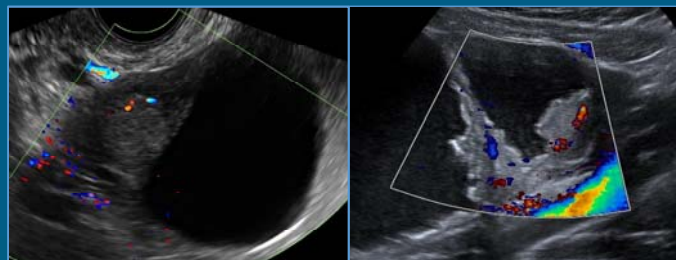


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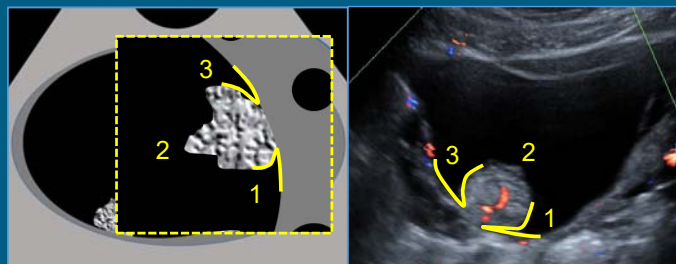
Solid component(s)

- Mural or septal
- ≥ 3 mm in height
 - Protrusion into cyst cavity

Overall size does not matter



- Papillary projection(s)
 - Surrounded by fluid on 3 sides (*acute angles with interface*)
 - # important

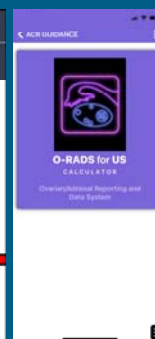


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Cystic With Solid – Assessment/Management

- Unilocular
 - # Papillary projections
 - 0-3: O-RADS 4
 - ≥ 4: O-RADS 5
- Multilocular
 - Color score
 - 1-2: O-RADS 4
 - 3-4: O-RADS 5

O-RADS Score	Risk Category [IOTA Model]	Lexicon Descriptors		Management	
				Pre-menopausal	Post-menopausal
4	Intermediate Risk [10- < 50%]	Unilocular cyst with solid component	1-3 papillary projections (pp), or solid component that is not a pp, any size, CS= any	US specialist or MRI	Management by gynecologist with gyn-oncologist consultation or solely by gyn-oncologist
				Multilocular cyst with solid component	
		High Risk [≥ 50%]	Unilocular cyst, ≥ 4 papillary projections, any size, CS = any	Multilocular cyst with solid component, any size, CS = 3-4	Gyn-oncologist



Lesion size and color score do not matter

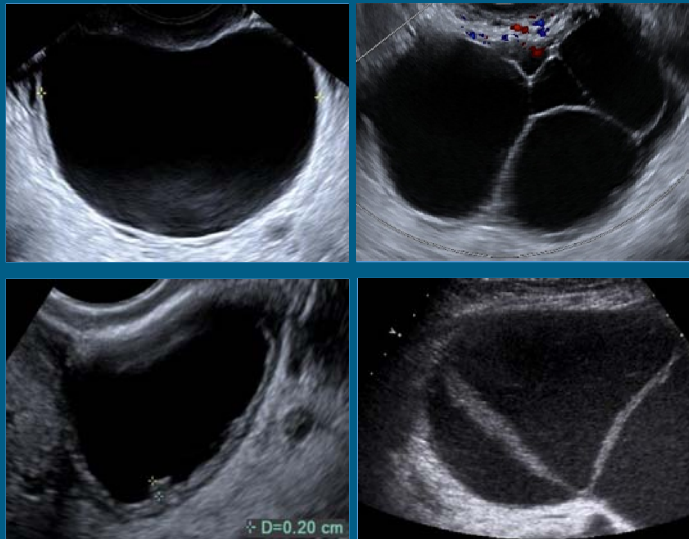
Other Lesions

- 5 categories
 - 1. Unilocular cystic (-) solid component
 - 2. Unilocular cystic (+) solid component
 - 3. Multilocular cystic (-) solid component
 - 4. Multilocular cystic (+) solid component
 - 5. Solid/solid-appearing (≥ 80% solid)

Cystic, No solid – Inner Walls ± Septation(s)

- Smooth
- Irregular
 - Focal wall irregularity < 3 mm in height
 - Septa: no size criteria

Thin vs. thick doesn't matter



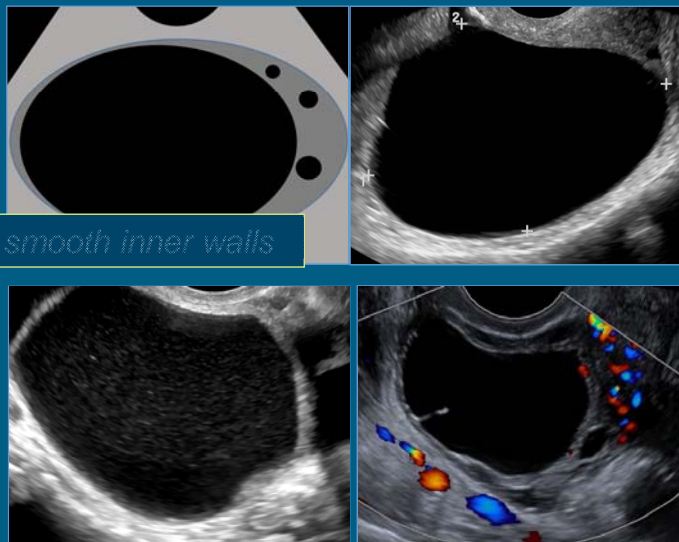
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Cystic, No Solid, Smooth - Internal Contents

- Simple
 - Anechoic

Simple cyst = unilocular, anechoic, smooth inner walls

- Non-simple
 - Scattered echoes
 - Incomplete septa



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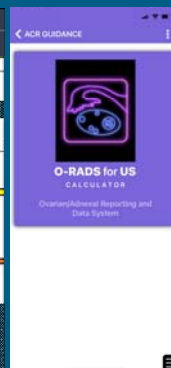
Cystic, No Solid – Assessment and Management

- Unilocular
- Multilocular

Cystic, No Solid – Assessment and Management

- Unilocular
 - Smooth + <10 cm: O-RADS 2
 - Irregular or ≥10 cm: O-RADS 3

O-RADS Score	Risk Category (OTA Model)	Lesion Descriptors	Management	
			Pre-menopausal	Post-menopausal
2	Almost Certainly Benign (1-1%)	Simple cyst	≤ 3 cm	None
			> 3 cm to ≤ 5 cm	None
			> 5 cm but < 10 cm	Follow up in 6 - 12 weeks
		Non-simple unilocular cyst, smooth inner margin	≤ 3 cm	None
> 3 cm but < 10 cm	Follow up in 6 - 12 weeks if concerning, US specialist or MRI			
3	Low Risk (1-10%)	Unilocular (and simple or non-simple) ≥ 10 cm	US specialist or MRI	
		Unilocular cyst, with irregular inner wall (≥ 2 mm height), any size	Management by gynecologist	
		Multilocular cyst with smooth inner walls/septa, ≤ 10 cm, CS = 1-3	Management by gynecologist	
4	Intermediate Risk (10-60%)	Smooth inner wall, ≥ 10 cm, CS = 1-3	US specialist or MRI	
		Smooth inner wall, any size, CS = 4 Irregular inner wall & irregular septation, any size, CS = any	US specialist or MRI	



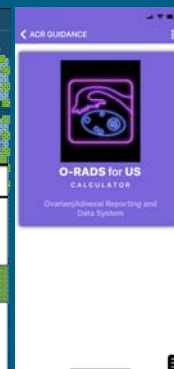
- Multilocular
 - Smooth + <10 cm + CS 1-3: O-RADS 3, Low risk
 - Irregular or ≥10 cm or CS 4: O-RADS 4, Intermediate risk

Cystic, No Solid – Assessment and Management

- Unilocular
 - Smooth + <10 cm: O-RADS 2

O-RADS Score	Risk Category (2021 Model)	Lesion Descriptors	Management			
			Pre-management	Post-management		
2	Almost Certainly Benign (< 1%)	Simple cyst	≤ 3 cm	N/A	None	
			> 3 cm to 5 cm	None	Follow up in 1 year.*	
			> 5 cm but < 10 cm	Follow up in 8 - 12 weeks		
		Classic Benign Lesions: See table on next page for descriptors and management strategies				
		Non-simple unilocular cyst, smooth inner margin	≤ 3 cm	None	Follow up in 1 year.*	If concerning, US specialist or MRI
			> 3 cm but < 10 cm	Follow-up in 8 - 12 weeks	If concerning, US specialist	US specialist or MRI

Duration = 5 yrs



CAVEAT TO SCORING

- Ascites ± peritoneal nodules convert any O-RADS 3 or 4 lesion into an O-RADS 5

CAVEAT TO SCORING

- Ascites* ± peritoneal nodules convert any O-RADS 3 or 4 lesion into an O-RADS 5

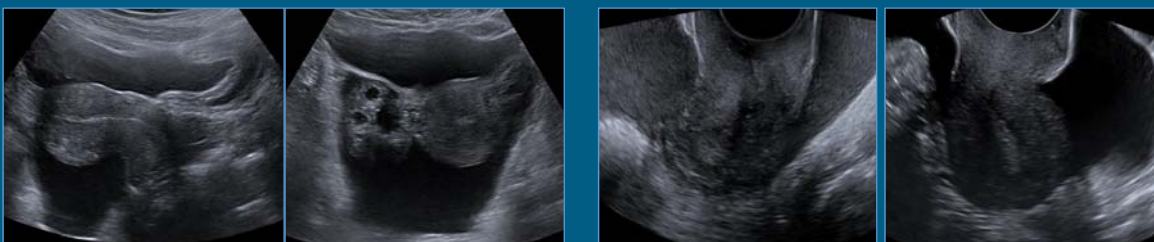
**unexplained*

- If ascites ± peritoneal nodules with an O-RADS 1-2 assessment, must consider other malignant or non-malignant etiologies

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Ascites

- Fluid extending beyond the pouch of Douglas or cul-de-sac and above the uterine fundus when anteflexed, and anterior/superior to uterus when retroflexed



TAS

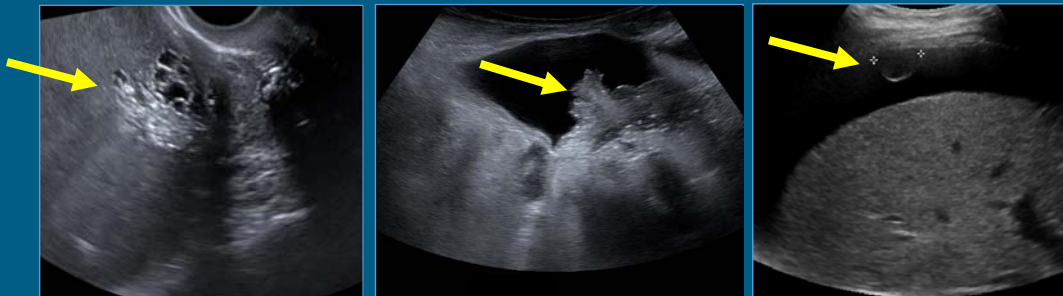
TVS

Internal echoes do not matter

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Peritoneal thickening/nodules

- Nodularity or diffuse thickening of the peritoneal lining(s) or along the bowel serosal surface or peritoneum



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Wrapping it up.....



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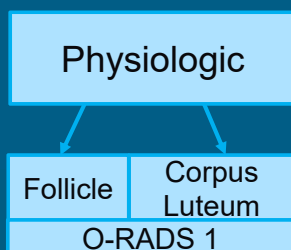
Take-Home Points

- 1st line evaluation – US
- Problem solving – US specialist (if available) and/or MRI
- Knowing the lexicon is key to accurate risk stratification
- Not every feature is relevant for risk stratification
 - Algorithmic approach streamlines the process

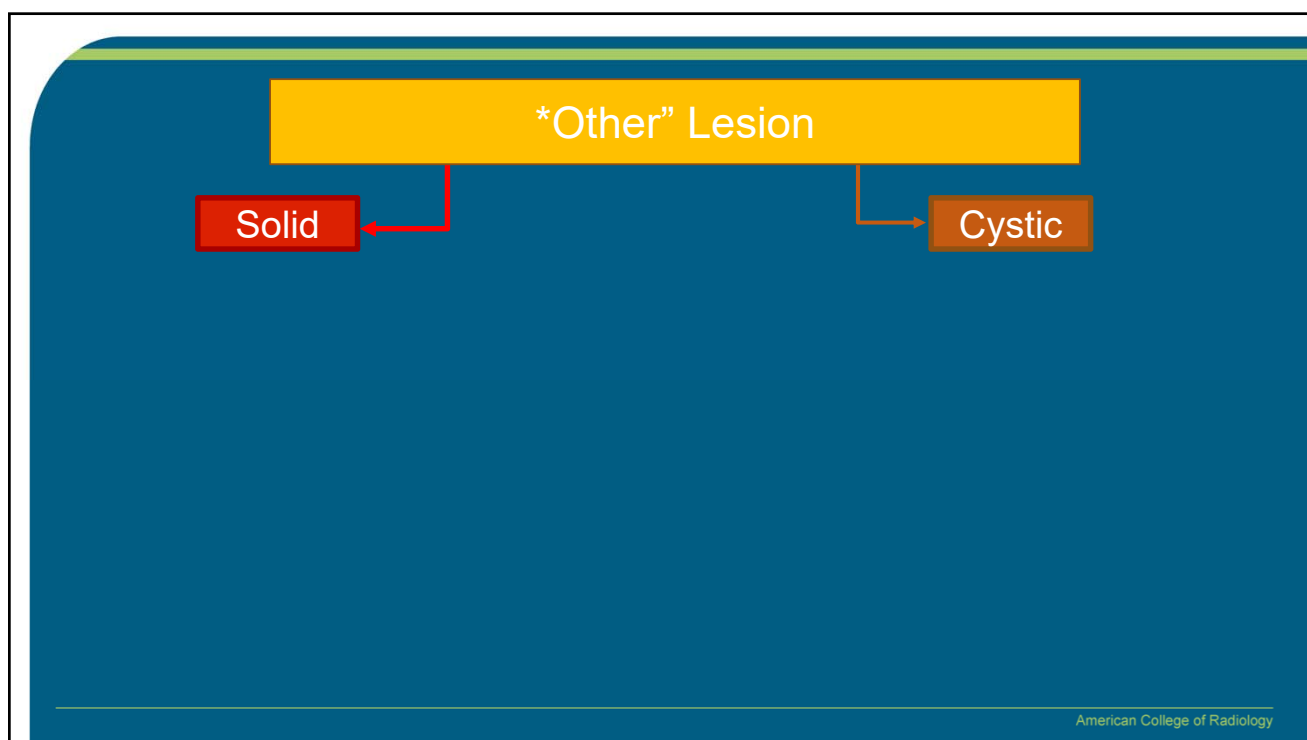
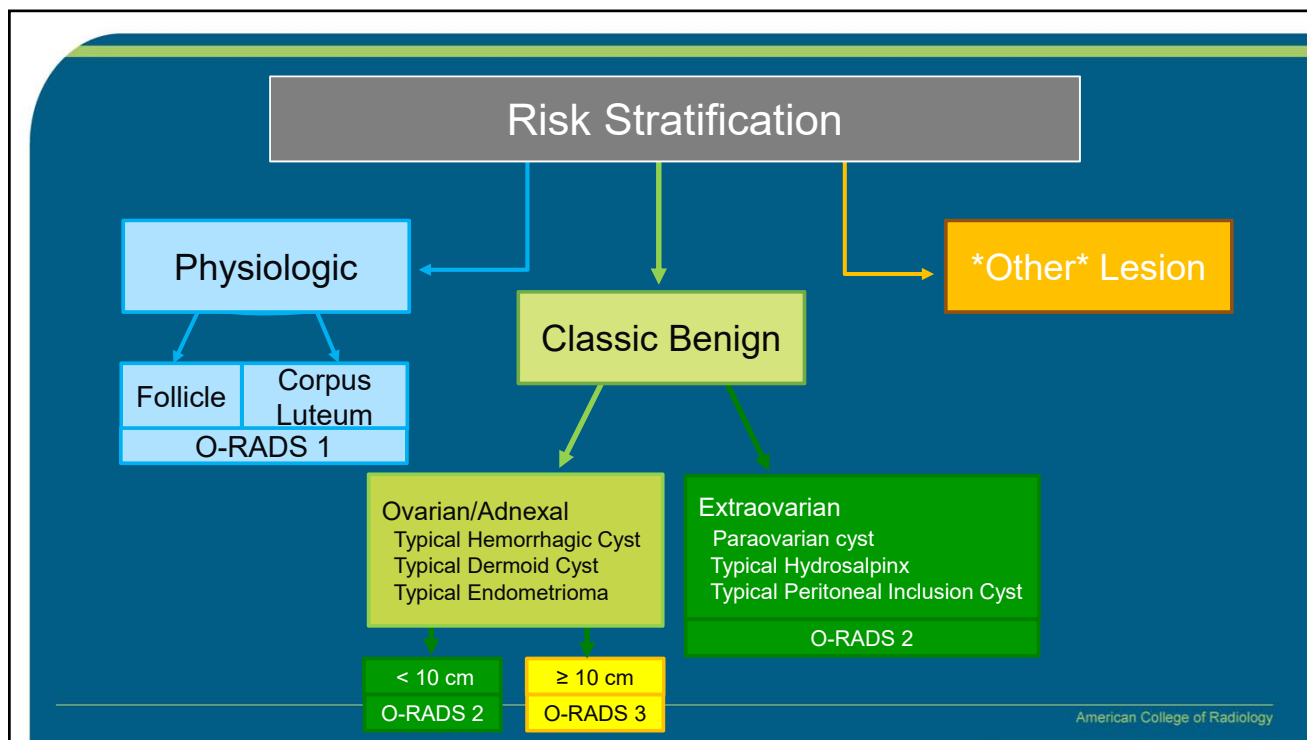


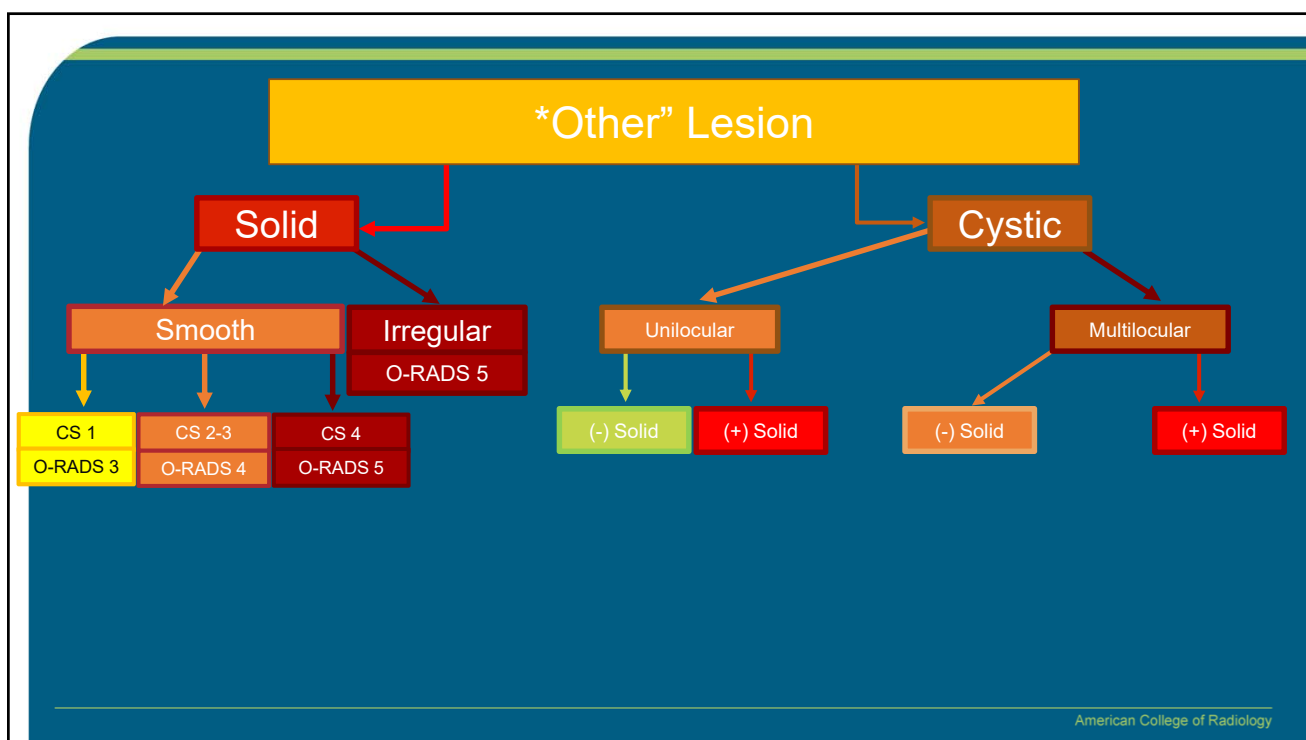
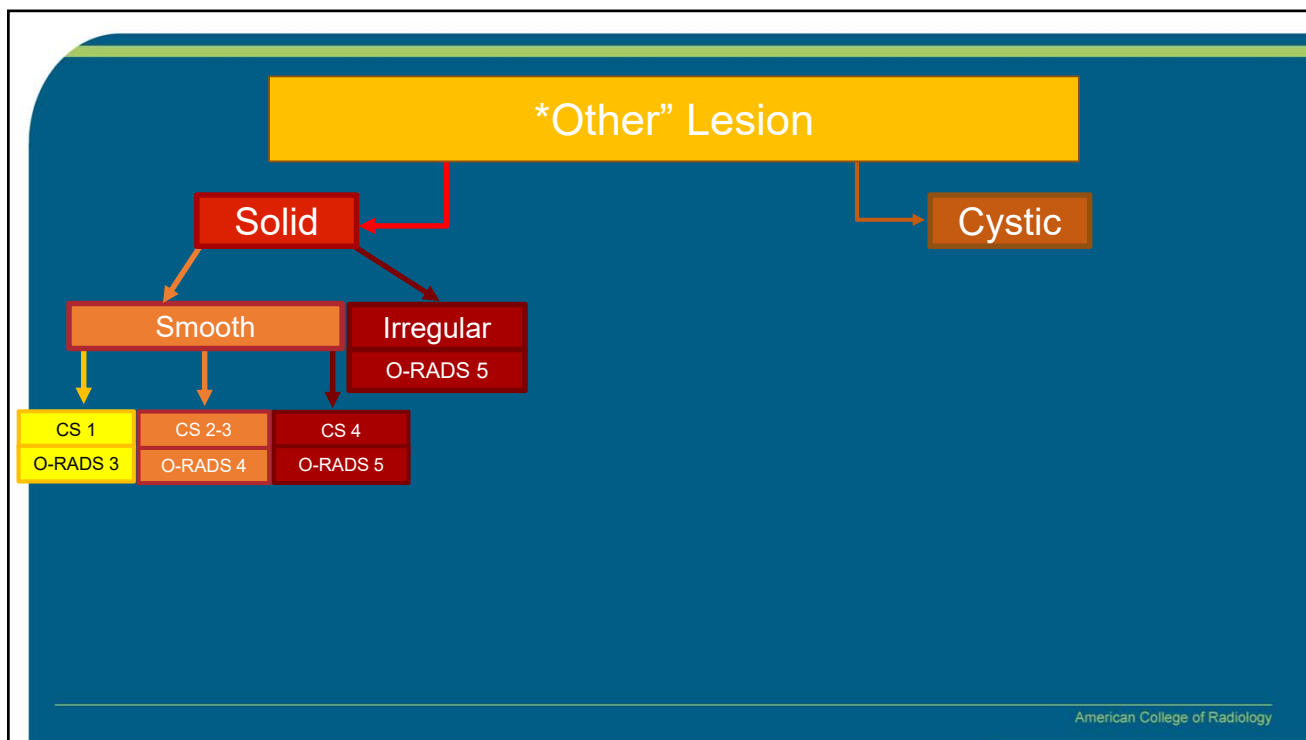
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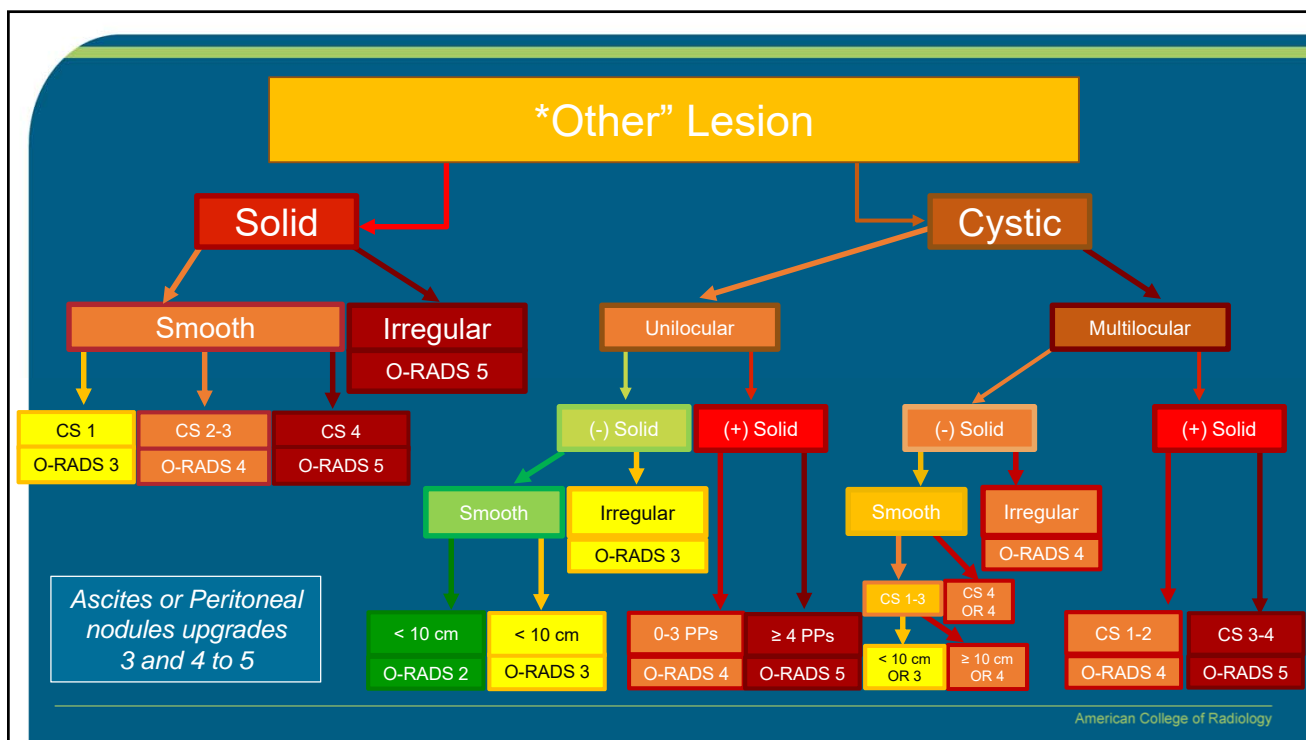
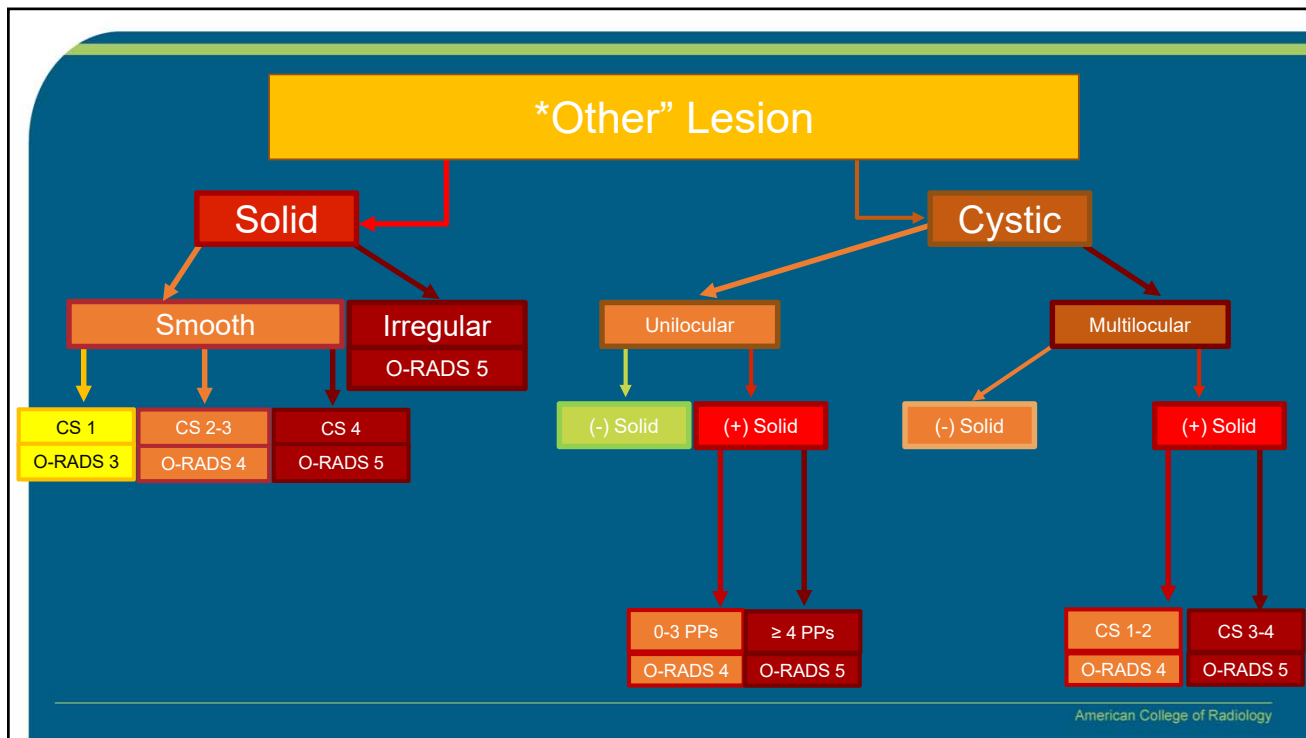
Risk Stratification



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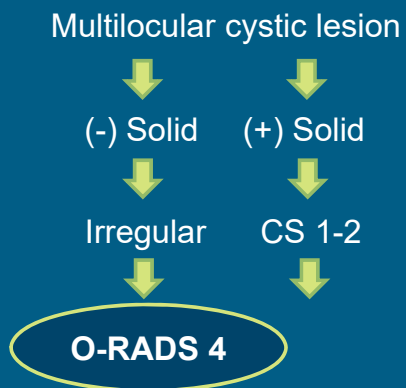






Take-Home Points

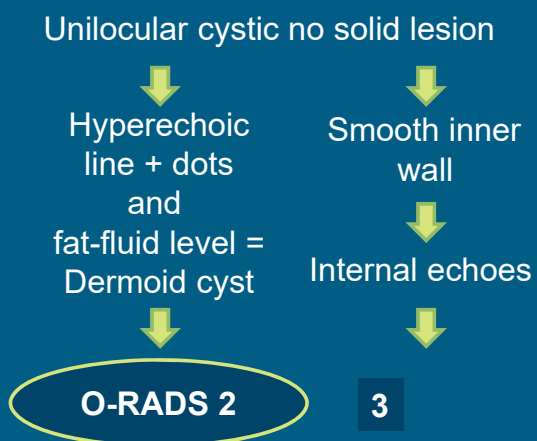
- When in doubt, try different possibilities and use highest score



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Take-Home Points

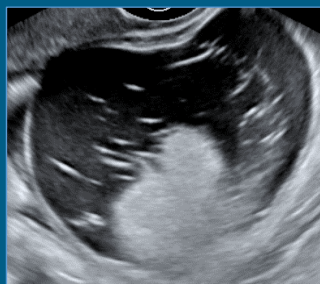
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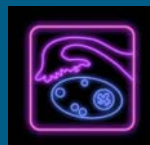
Take-Home Points

- “Complex” and “heterogenous” play no role in the O-RADS system



*“When a word has many meanings, it has no meaning at all.”
- Anonymous*

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Thank you very much for your attention.

Let' go o-rads!

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