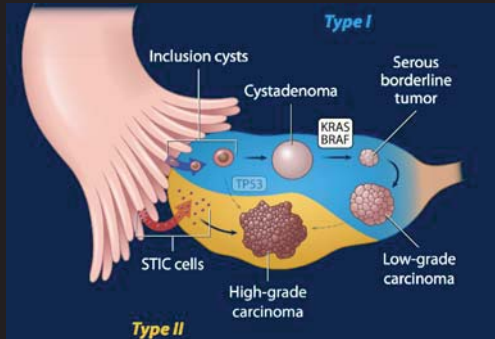


ORADS: UNKNOWN CASES The basics!

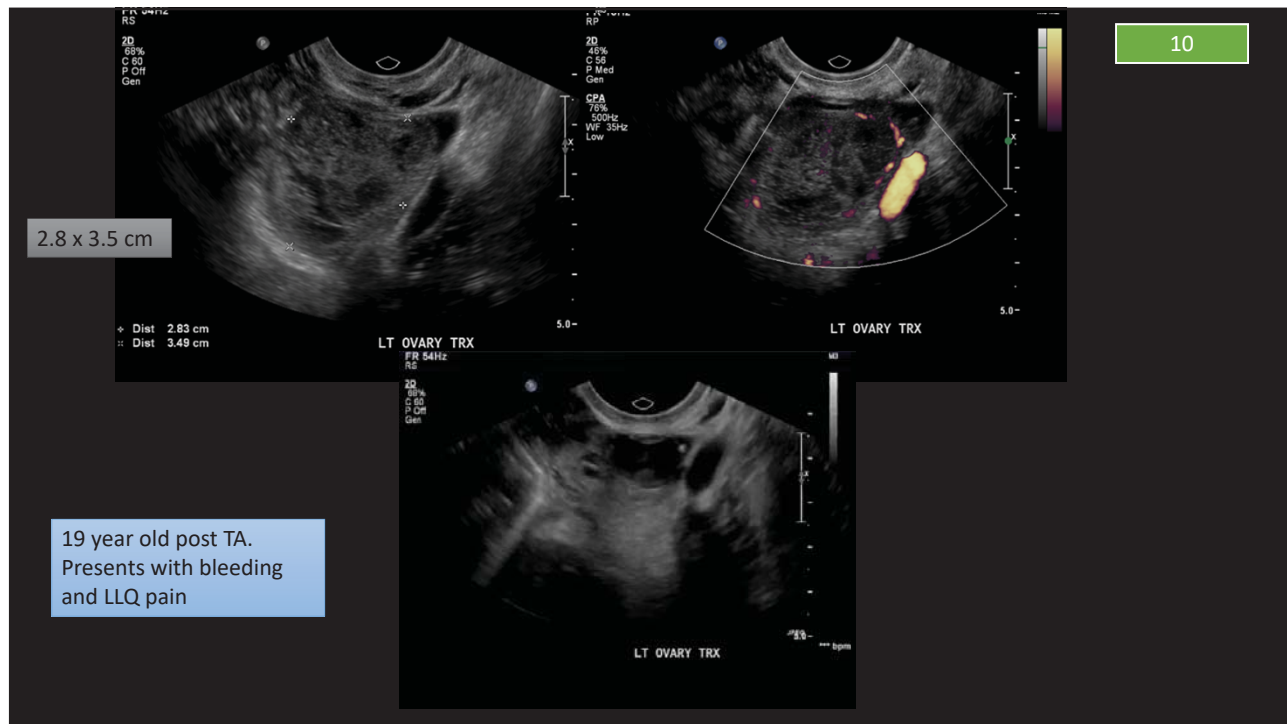


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What are going to do ?

- Case based approach to ORADS
- Minimal complexity:
 - no hidden information or tricks!
- Please participate; it will be fun!
- **Anonymous:** Vegas rule!
- Each case will be accompanied by one question
- Take a few minutes to note down information
- There is a timer so please note
- If needed feel free to use the app to guide you





What category does this lesion fall into?

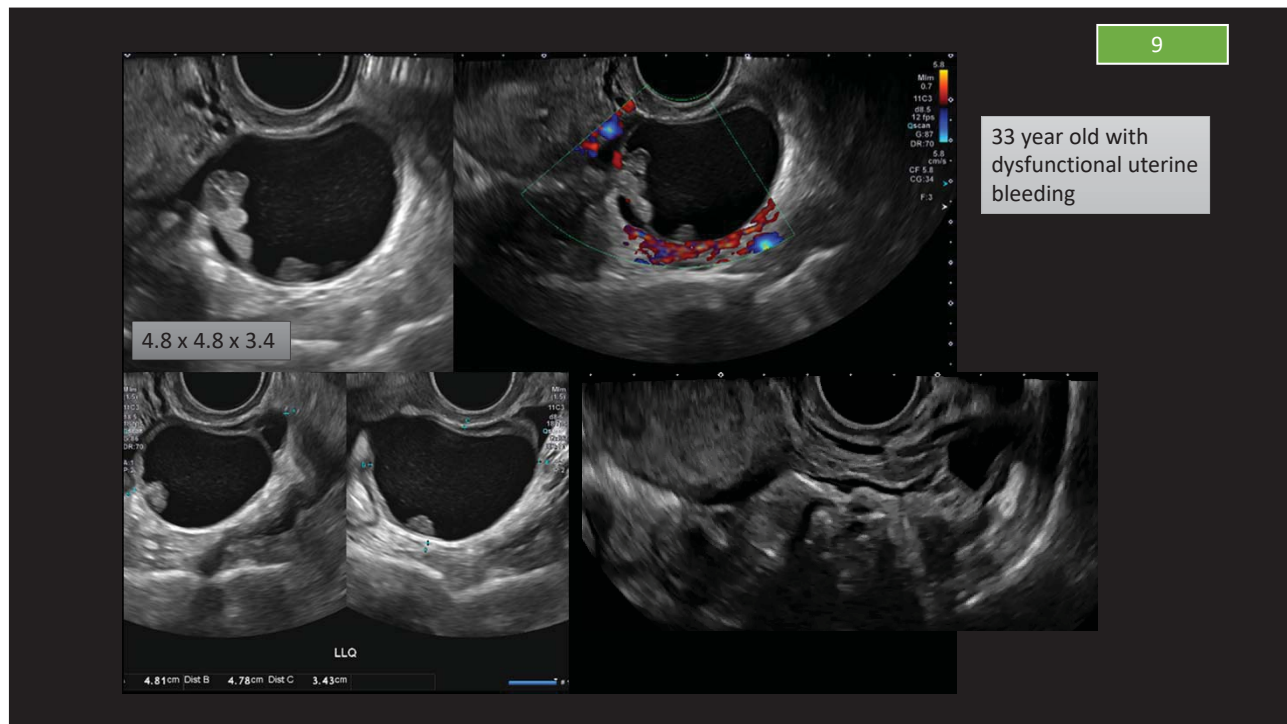
- A. Physiologic follicle
- B. Corpus luteum
- C. Hemorrhagic cyst
- D. Dermoid cyst
- E. endometrioma

1	Normal Ovary [N/A]	Follicle defined as a simple cyst ≤ 3 cm Corpus Luteum ≤ 3 cm	None	N/A
2	Almost Certainly Benign (< 1%)	Simple cyst	≤ 3 cm	N/A
			> 3 cm to 5 cm	None
			> 5 cm but ≤ 10 cm	Follow up in 1 year *
	Classic Benign Lesions	See Figure 3 for separate descriptors	See Figure 3 for management strategies	
		Non-simple unilocular cyst, smooth inner margin	≤ 3 cm	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
3	Low Risk Malignancy [1-10%]	Unilocular cyst ≥ 10 cm (simple or non-simple) Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm Unilocular cyst, any size with irregular inner wall > 3 mm height Multilocular cyst ≤ 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1	US specialist or MRI Management by gynecologist	
4	Intermediate Risk (10 - 50%)	Multilocular cyst, no solid component	≥ 10 cm, smooth inner wall, CS = 1-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
			Any size, smooth inner wall, CS = 4	
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	
		Multilocular cyst with solid component	Any size, CS = 1-2	
		Solid	Smooth, any size, CS = 2-3	
5	High Risk ($\geq 50\%$)	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any Multilocular cyst with solid component, any size, CS = 3-4 Solid smooth, any size, CS = 4 Solid irregular, any size, CS = any Asoles and/or peritoneal nodules**	GYN-oncologist	

Lexicon Term	Definition	Suggested Management Premenopausal	Suggested Management Postmenopausal
Typical hemorrhagic cyst	Reticular pattern: Fine thin intersecting lines representing fibrin strands Retracting clot: An avascular echogenic component with angular, straight, or concave margins	≤ 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	US specialist, gynecologist or MRI US specialist, gynecologist or MRI

Teaching points:

- May appear solid to begin with
- Look for absence of internal flow
- Temporal change in morphology/involution in size may help further
- In this category size and menstrual status are relevant
- If size > 10 cms remember change in category



What category would you assign this finding?

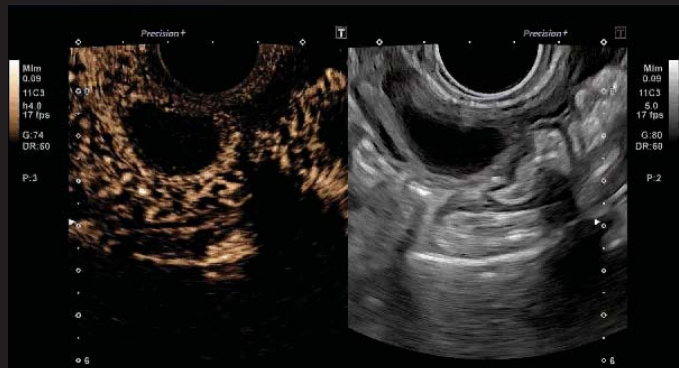
- A. Unilocular with no solid component
- B. Unilocular with solid component
- C. Multilocular with no solid component
- D. Multilocular with solid component

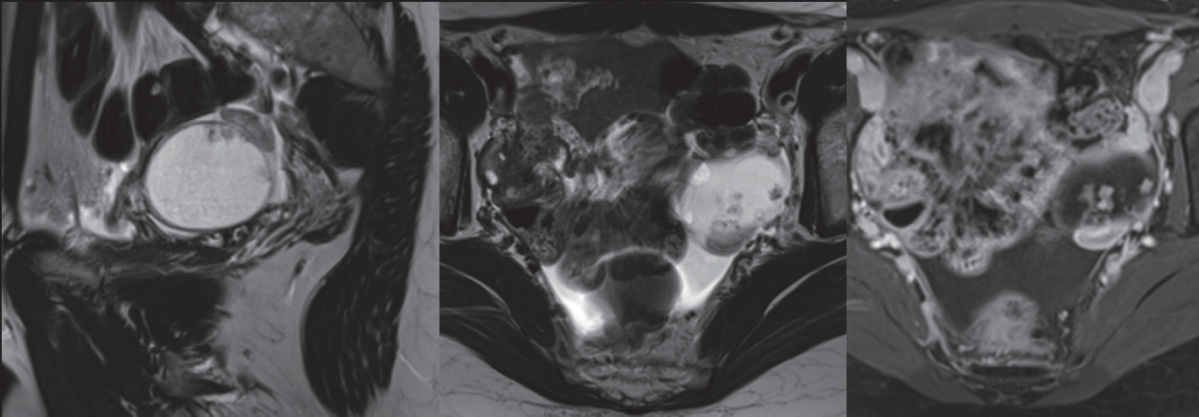
3	Low Risk Malignancy [1-<10%]	Unilocular cyst ≥ 10 cm (simple or non-simple)	US specialist or MRI Management by gynecologist	
		Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm		
		Unilocular cyst, any size with irregular inner wall <3 mm height		
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1		
4	Intermediate Risk [10- < 50%]	Multilocular cyst, no solid component	≥ 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	
		Multilocular cyst with solid component	Any size, CS = 1-2	
		Solid	Smooth, any size, CS = 2-3	
5	High Risk [$\geq 50\%$]	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any	GYN-oncologist	
		Multilocular cyst with solid component, any size, CS = 3-4		
		Solid smooth, any size, CS = 4		
		Solid irregular, any size, CS = any Ascites and/or peritoneal nodules**		

TEACHING POINT

How do we discriminate a solid component from a papillary projection

- Height of ≥ 3 mm
- Surrounded by fluid on 3 sides
- Protrudes from wall or from septation
- Greater than 4 papillary projections change from ORADS 4 to 5



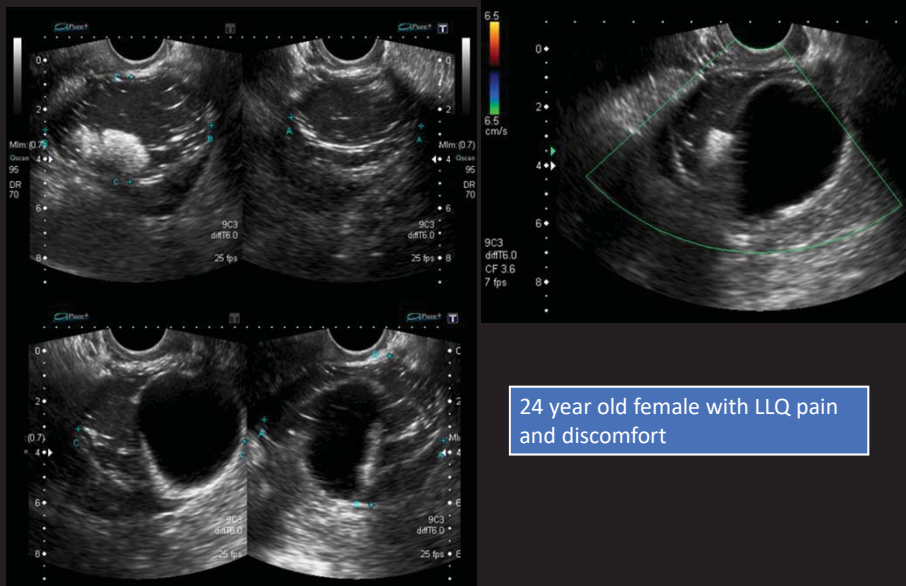


BOT

- Borderline ovarian tumour
- Seen in about 10-15% of serous and mucinous lesions
- Cytologic features of malignancy without stromal invasion

IMAGING features

- overlap with endometrioma but with mural nodule
- Cystic mass with honeycomb nodule



8

24 year old female with LLQ pain and discomfort

5.7 x 6.5 x 5.2 cms

Which of the following descriptors best applies to this finding?

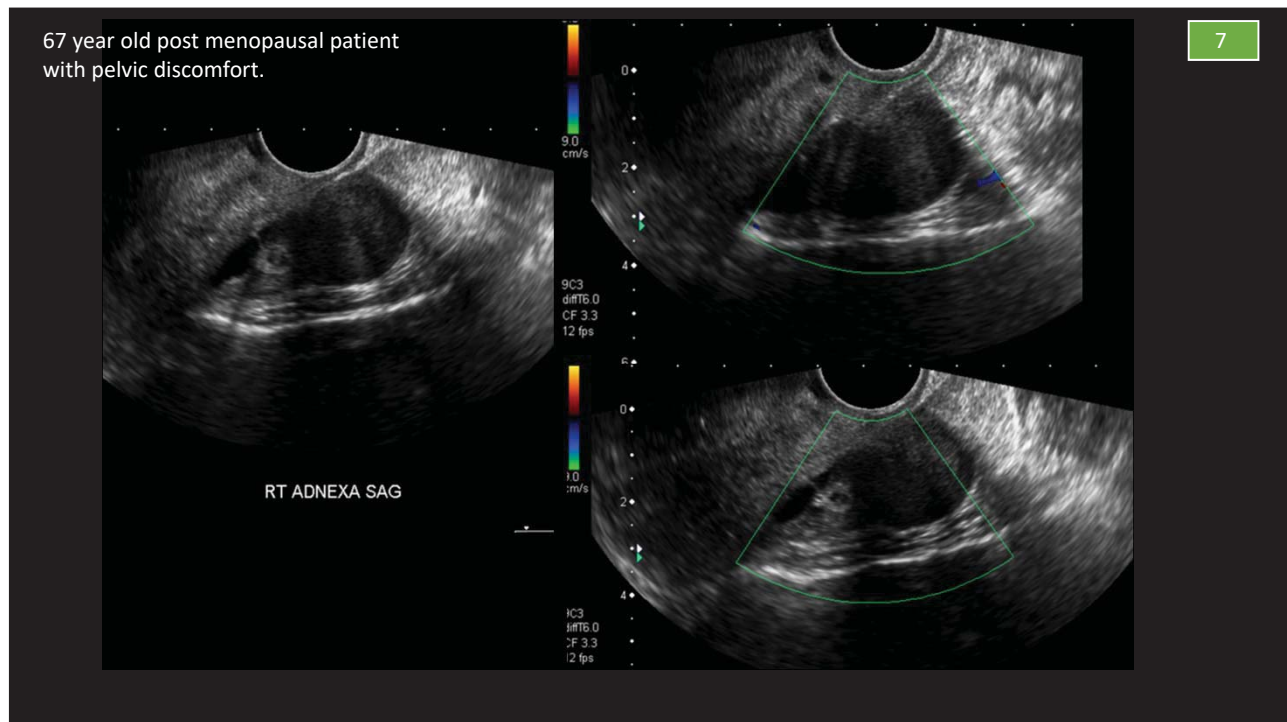
- A. Homogenous low level echoes
- B. Heterogeneous echoes
- C. Reticulated appearance
- D. Hyperechoic lines and dots
- E. Floating spherical structures

1	Normal Ovary [N/A]	Follicle defined as a simple cyst < 3 cm Corpus Luteum < 3cm	None	N/A
2	Almost Certainly Benign [1-1%]	Simple cyst Classic Benign Lesions	≤ 3 cm > 3 cm to 5 cm	None None Follow up in 8-12 weeks See Figure 3 for management strategies
3	Low Risk Malignancy [1-10%]	Unilocular cyst ≥ 10 cm (simple or non-simple) Typical: dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm Unilocular cyst, any size with irregular inner wall < 3 mm height Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1	≤ 3 cm > 3 cm but < 10 cm	None Follow up in 8-12 weeks if concerning, US specialist US specialist or MRI Management by gynecologist
4	Intermediate Risk [10-50%]	Multilocular cyst, no solid component Unilocular cyst with solid component Multilocular cyst with solid component Solid	≥ 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color, CS = 2-3 Any size, 0-3 papillary projections, CS = any Any size, CS = 1-2 Smooth, any size, CS = 2-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
5	High Risk [≥ 60%]	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any Multilocular cyst with solid component, any size, CS = 3-4 Solid smooth, any size, CS = 4 Solid irregular, any size, CS = any Foci and/or pitted nodules**		GYN-oncologist

Teaching points:

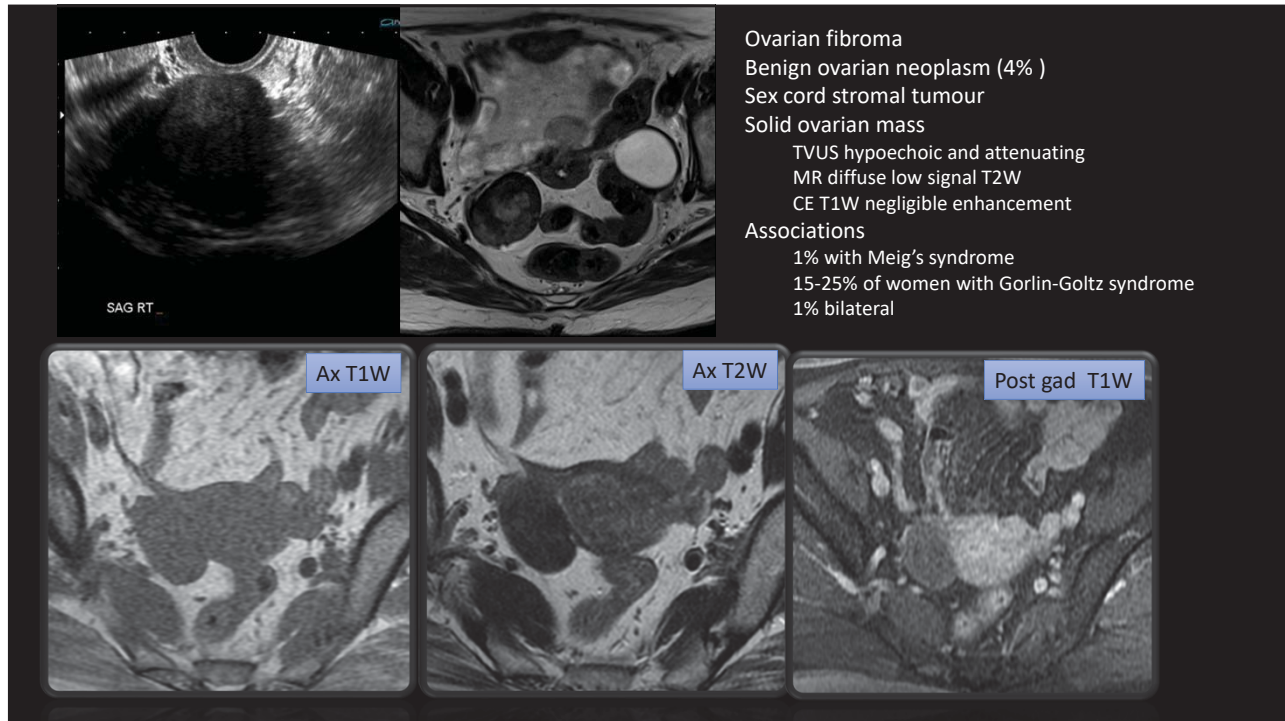
- Look for classic descriptors
- Most pleomorphic of category
- 10-15% are bilateral
- Remember size >10 cm changes category
- Change in morphology /size and /or vascularity may also render classification obsolete or unclassifiable
- Pitfalls: include dermoid being mistaken for bowel gas
- Hemorrhage in acute setting may be echogenic and overlap with dermoid plug

Typical dermoid cyst < 10 cm	<ul style="list-style-type: none"> • Hyperechoic component with acoustic shadowing • Hyperechoic lines and dots • Floating echogenic spherical structures 	<ul style="list-style-type: none"> • Optional initial follow up in 8-12 weeks based upon confidence in diagnosis • If not removed surgically, annual US follow up should then be considered * 	<ul style="list-style-type: none"> US specialist, gynecologist, or MRI With confident diagnosis, if not removed surgically, annual US follow up should then be considered *
Typical endometrioma < 10 cm	Ground glass/homogeneous low-level echoes	US specialist or MRI if there is enlargement, changing morphology or a developing vascular component	MRI if there is enlargement, changing morphology or a developing vascular component



Which single imaging criteria will have most impact on scoring this lesion?

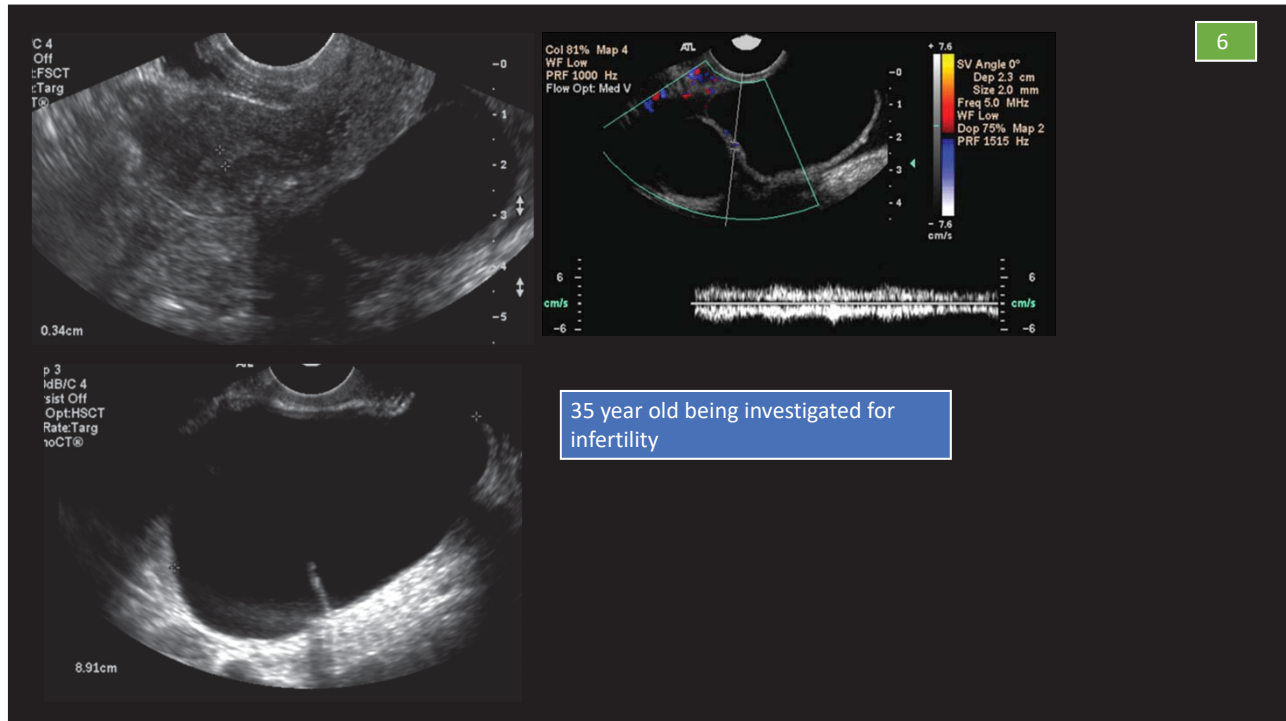
- A. Size
- B. Colour score
- C. Presence of acoustic shadowing
- D. Presence of calcification



3	Low Risk Malignancy [1-10%]	Unilocular cyst ≥ 10 cm (simple or non-simple)	US specialist or MRI Management by gynecologist
		Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm Unilocular cyst, any size with irregular inner wall <3 mm height Multilocular cyst < 10 cm, smooth inner wall, CS = 1-2 Solid smooth, any size, CS = 1	
4	Intermediate Risk [10- 50%]	Multilocular cyst, no solid component	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
		Unilocular cyst with solid component	
		Multilocular cyst with solid component	
		Solid	
		≥ 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score	
5	High Risk [$\geq 50\%$]	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any	GYN-oncologist
		Multilocular cyst with solid component, any size, CS = 3-4	
		Solid smooth, any size, CS = 4	
		Solid irregular, any size, CS = any	
		Ascites and/or peritoneal nodules**	

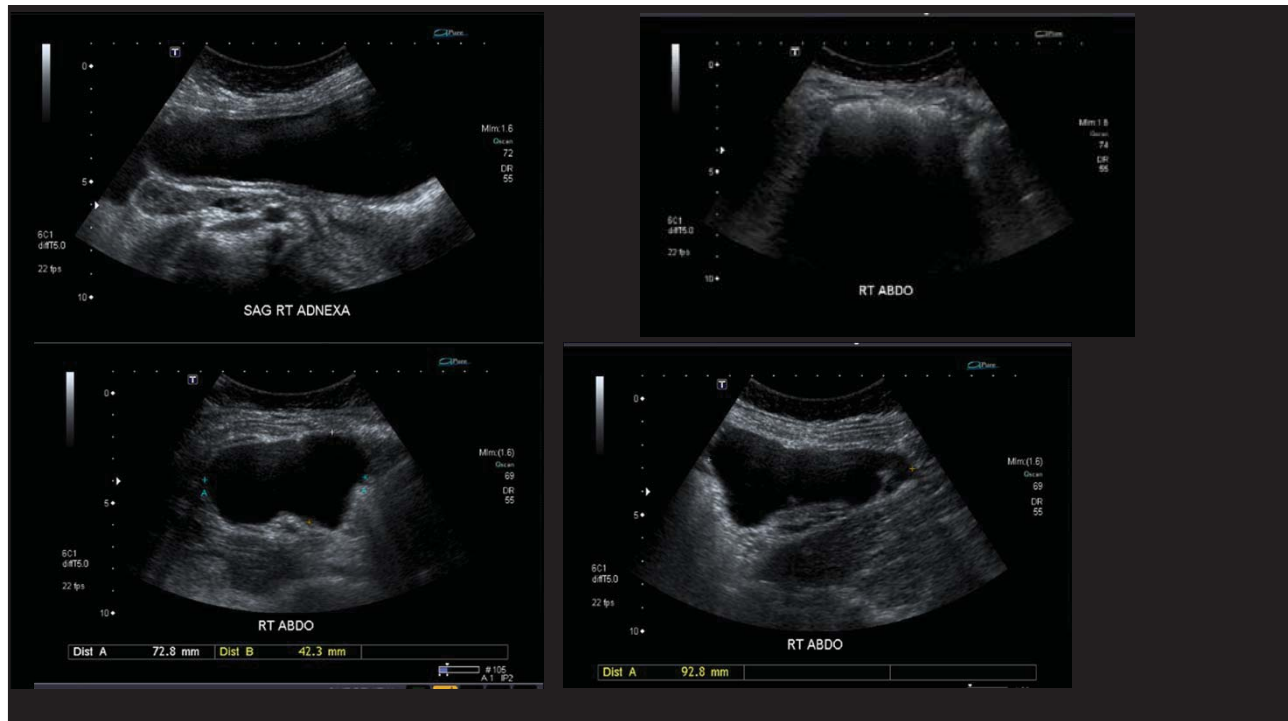
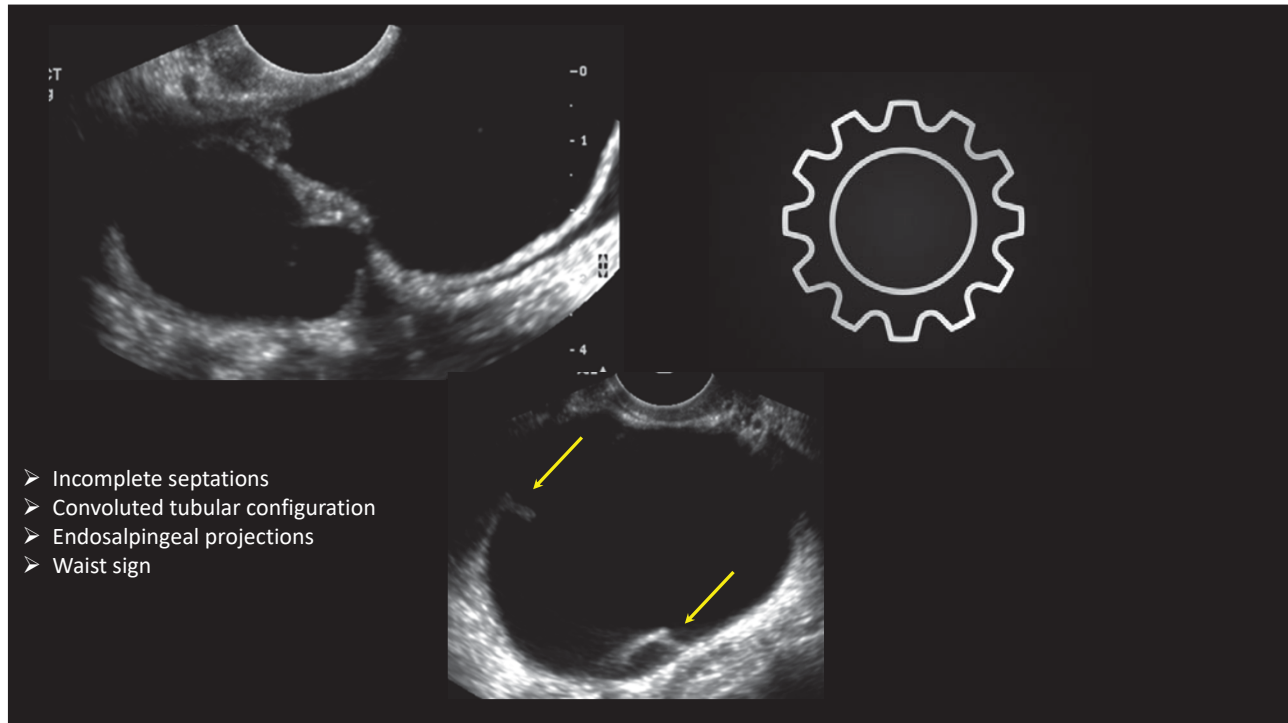
Teaching points

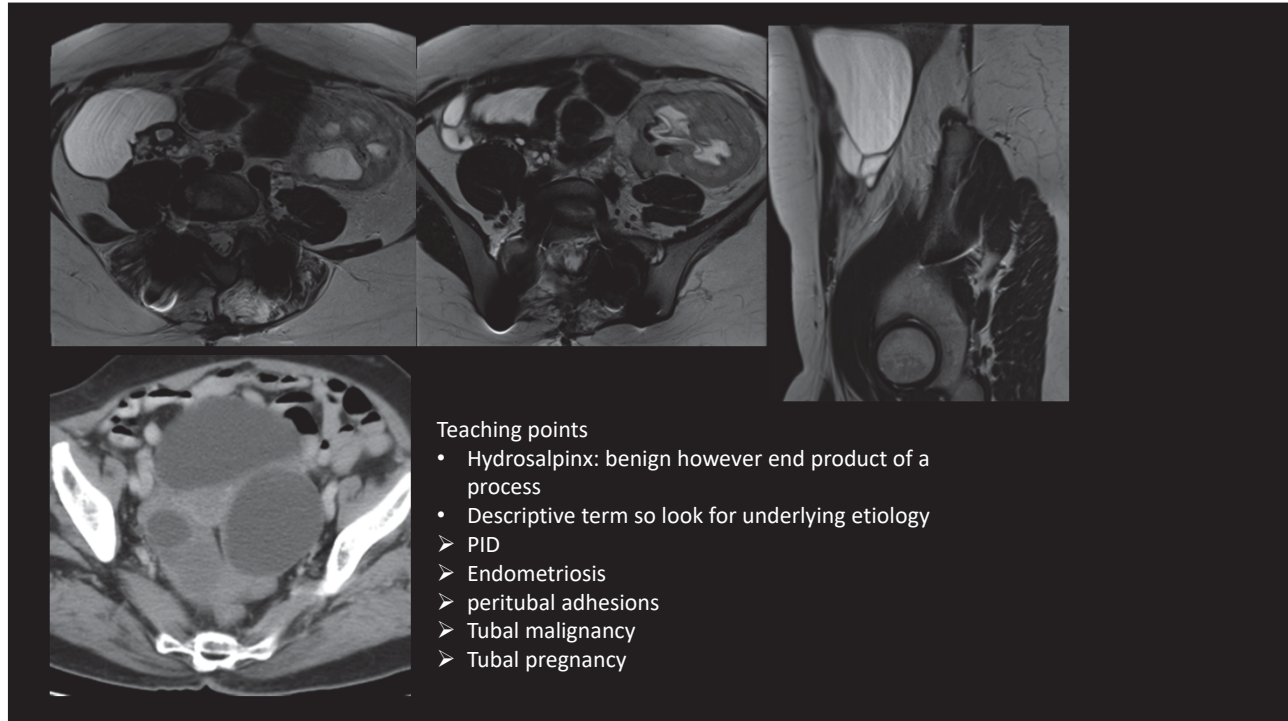
1. CS is an important discriminator in this category as can place lesion in ORADS 3-5 depending on score
2. Presence of acoustic shadowing is a benign feature .Not currently incorporated in score (despite being part of lexicon and IOTA calculator).Will likely be modified in upcoming iterations



What category does this finding fall into ?

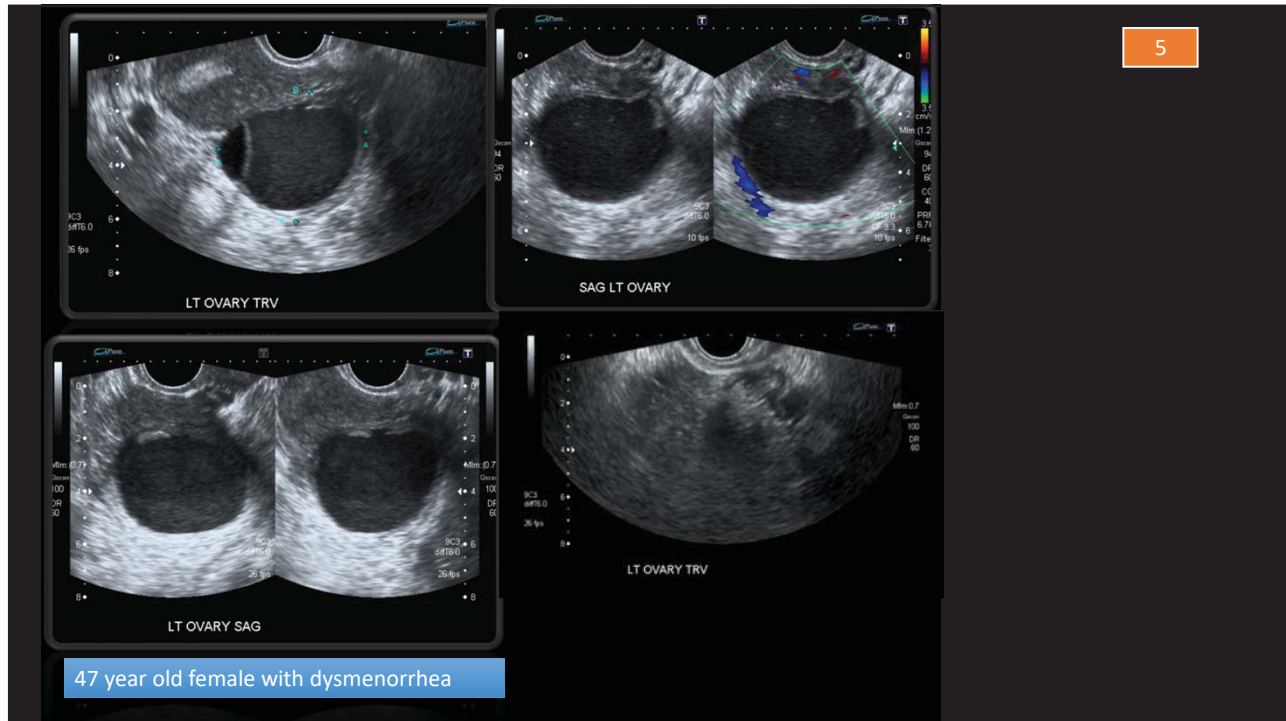
- A. ORADS 1
- B. ORADS 2
- C. ORADS 3
- D. ORADS 4
- E. ORADS 5





1	Normal Ovary [N/A]	Follicle defined as a simple cyst < 3 cm Corpus Luteum < 3cm	None	N/A
2	Almost Certainly Benign (1-1%)	Simple cyst Classic Benign Lesions	<ul style="list-style-type: none"> ≤ 3 cm > 3 cm to 5 cm 	<ul style="list-style-type: none"> None Follow up in 6-12 weeks See Figure 3 for management strategies
		Non-simple unilocular cyst, smooth inner margin	<ul style="list-style-type: none"> ≤ 3 cm > 3 cm but < 10 cm 	<ul style="list-style-type: none"> None Follow-up in 8-12 weeks if concerning, US specialist 1 year* if concerning, US specialist or MRI US specialist or MRI
3	Low Risk Malignancy (1-10%)	Unilocular cyst ≤ 10 cm (simple or non-simple) Typical dermoid cysts, endometriomas, hemorrhagic cysts ≤ 10 cm Unilocular cyst, any size with irregular inner wall < 3 mm height Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1		US specialist or UWB Management by gynecologist
4	Intermediate Risk (10-50%)	Multilocular cyst, no solid component Unilocular cyst with solid component Multilocular cyst with solid component Solid	<ul style="list-style-type: none"> ≥ 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color, 30%* Any size, 0-3 papillary projections, CS = any Any size, CS = 1-2 Smooth, 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%)	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any Multilocular cyst with solid component, any size, CS = 3-4 Solid smooth, any size, CS = 4 Solid irregular, any size, CS = any Foci and/or pelloidal nodules**		GYN-oncologist

<p>Typical hydrosalpinx/ any size</p> <ul style="list-style-type: none"> Incomplete septation Tubular Endosalpingeal folds: Short round projections around the inner wall of a fluid distended tubular structure 	Gynecologist	Gynecologist
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What category does this lesion fall into?

- A. Unilocular cystic with solid component
- B. Corpus luteum
- C. Hemorrhagic cyst
- D. Dermoid cyst
- E. Endometrioma

1	Normal Ovary (N/A)	Follicle defined as a simple cyst ≤ 3 cm Corpus Luteum ≤ 3cm	None	N/A
2	Asymptomatic Simple Cyst (< 1%)	Simple cyst ≤ 3 cm > 3 cm to 5 cm	N/A None	None Follow up in 4-6 weeks
	Classic Benign Lesions	See Figure 3 for separate descriptors	See Figure 3 for separate descriptors	See Figure 3 for management strategies
	Non-simple unilocular cyst, smooth inner margin	≤ 3 cm > 3 cm but < 10 cm	None Follow-up in 8-12 weeks if concerning, US specialist	1 year* if concerning, US specialist or MRI US specialist or MRI
3	Low Risk Malignancy (1-10%)	Unilocular cyst ≥ 10 cm (simple or non-simple) Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm Unilocular cyst, any size with irregular inner wall < 3 mm height Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1	US specialist or MRI Management by gynecologist	
4	Intermediate Risk (10-30%)	Multilocular cyst, no solid component Any size, smooth inner wall, CS = 1 Any size, irregular inner wall and/or irregular septation, any color Doppler Unilocular cyst with solid component Any size, 0-3 papillary projections, CS = any Multilocular cyst with solid component Any size, CS = 1-2 Solid Smooth, any size, CS = 2-3	US specialist or MRI Management by gynecologist with OTH-oncologist consultation or solely by OTH-oncologist	
5	High Risk (> 30%)	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any Multilocular cyst with solid component, any size, CS = 3-4 Solid smooth, any size, CS = 4 Solid irregular, any size, CS = any Asterisks and/or peritoneal nodules**	OTH-oncologist	

Typical dermoid cyst < 10 cm	<ul style="list-style-type: none"> • Hyperechoic component with acoustic shadowing • Hyperechoic lines and dots • Floating echogenic spherical structures 	Optional initial follow up in 8-12 weeks based upon confidence in diagnosis If not removed surgically, annual US follow up should then be considered *	US specialist, gynecologist, or MRI With confident diagnosis, if not removed surgically, annual US follow up should then be considered *
Typical endometrioma < 10 cm	Ground glass/homogeneous low-level echoes	US specialist or MRI if there is enlargement, changing morphology or a developing vascular component	MRI if there is enlargement, changing morphology or a developing vascular component

Experienced imager

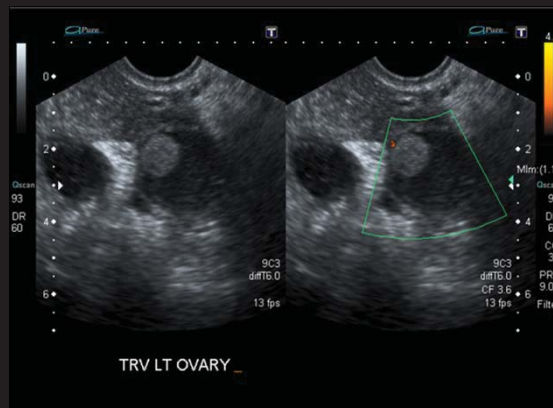
Will not discard a benign diagnosis if the following features exist

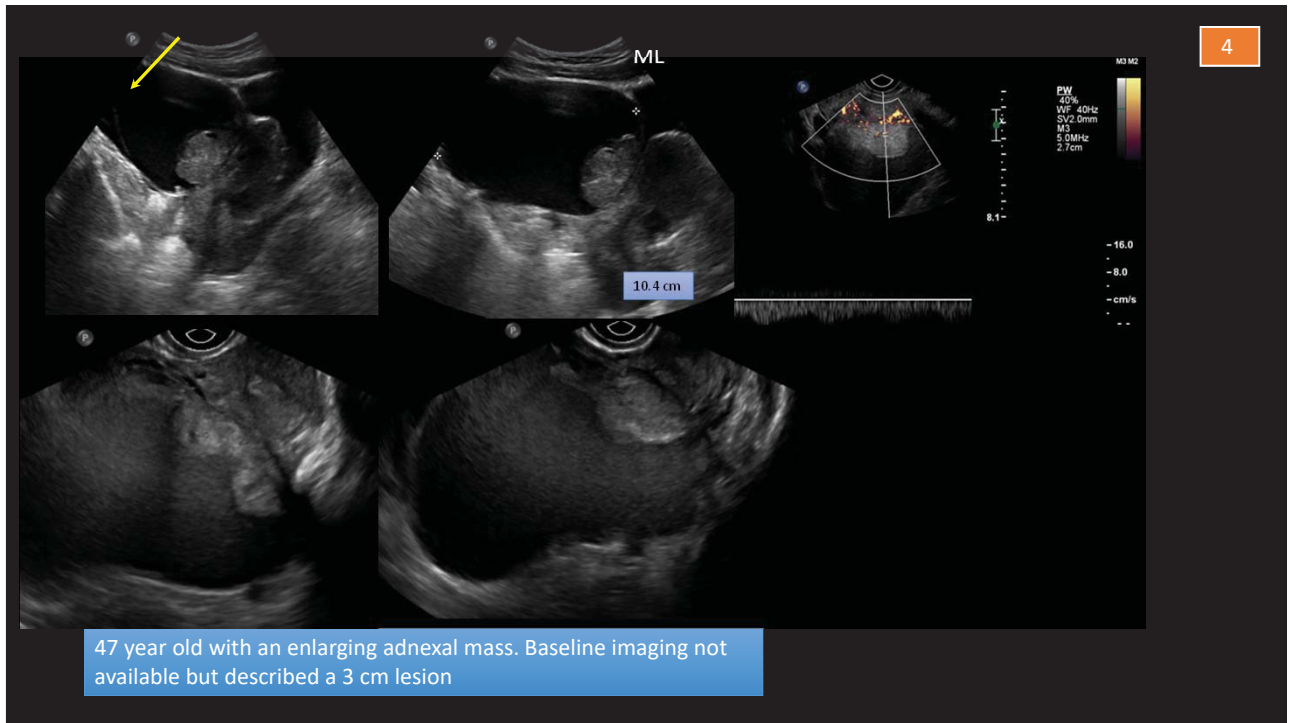
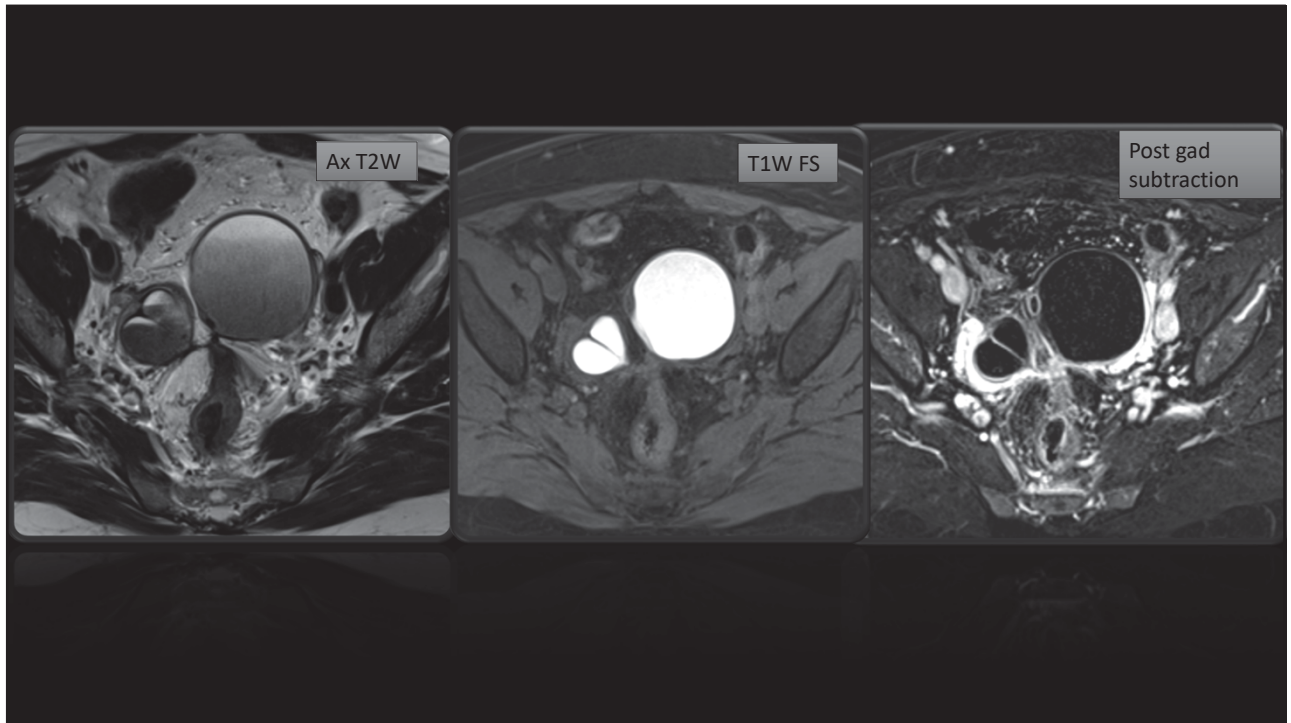
- Few thin septations
- Can be multilocular
- Presence of flow within these septations
- Punctate echogenic foci in wall of cyst

Remember governing concepts

Change in size, morphology or vascular component

- additional triage
- ORADS does not apply





47 year old with an enlarging adnexal mass. Baseline imaging not available but described a 3 cm lesion

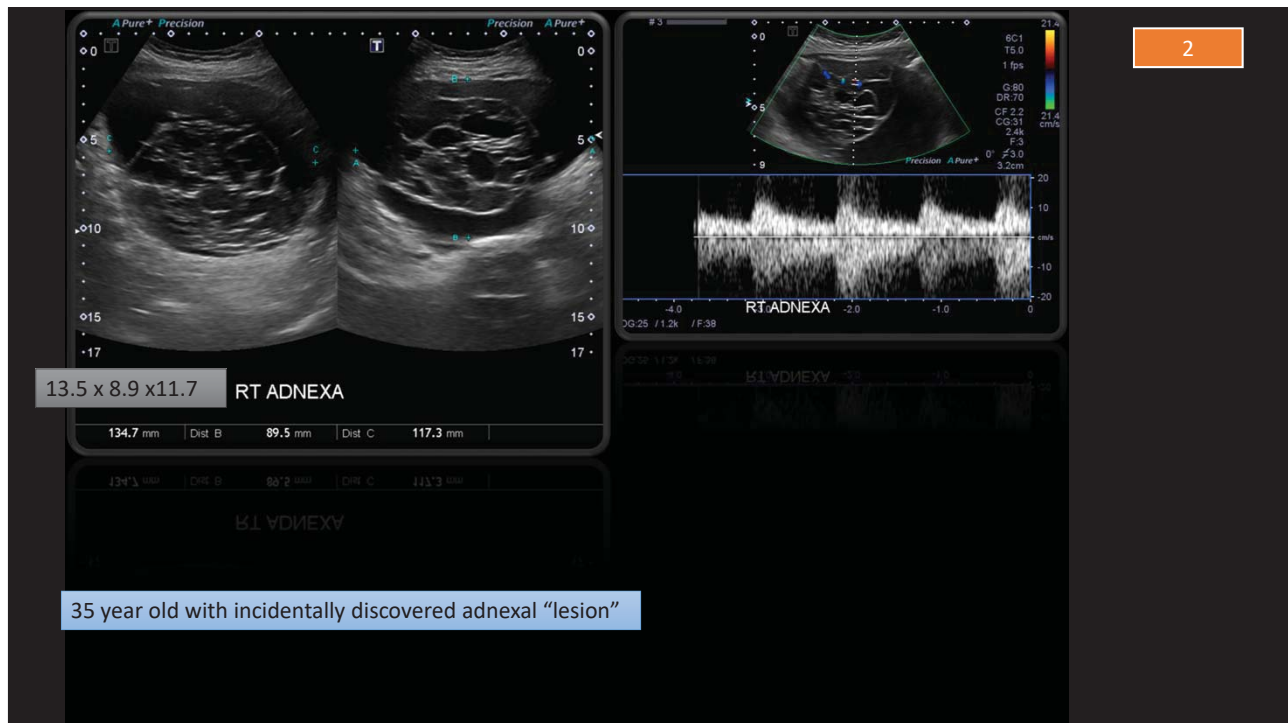
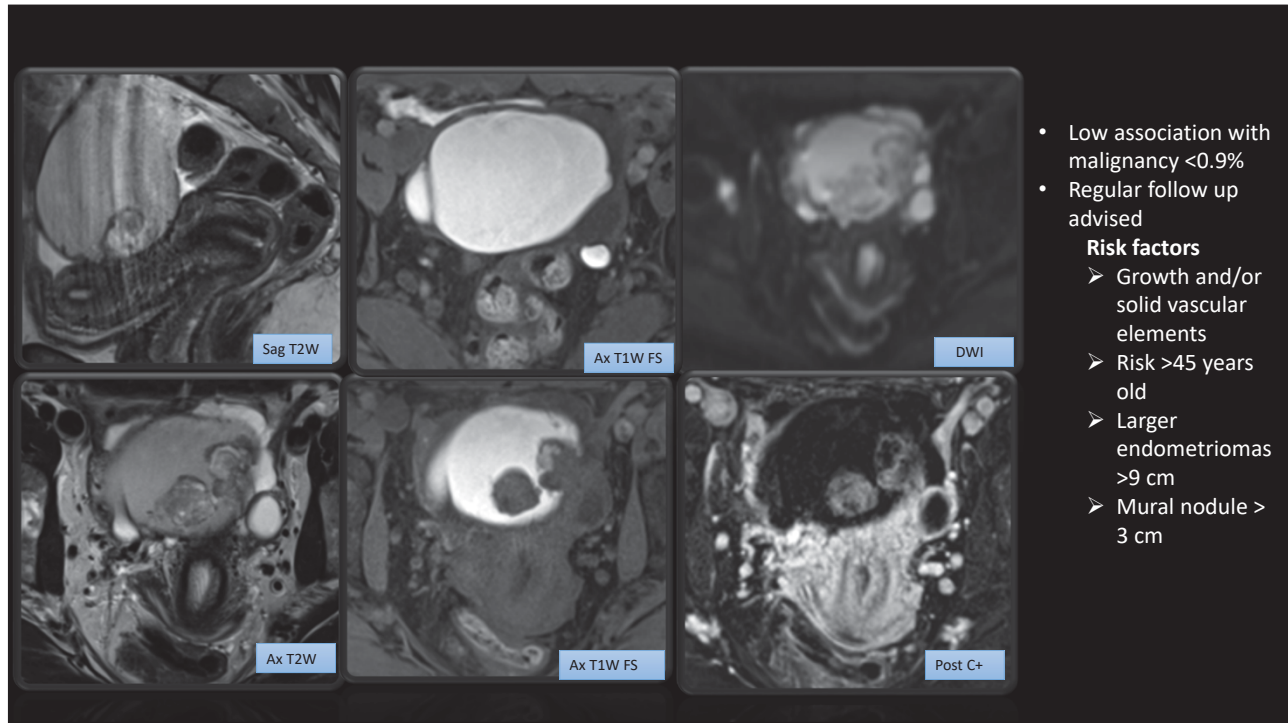
In this multilocular cystic lesion what is the colour score(CS)?

- A. Colour score 1
- B. Colour score 2
- C. Colour score 3
- D. Colour score 4

3	Low Risk Malignancy [1- <10%]	Unilocular cyst ≥ 10 cm (simple or non-simple)	US specialist or MRI Management by gynecologist	
		Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm		
		Unilocular cyst, any size with irregular inner wall <3 mm height		
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3		
		Solid smooth, any size, CS = 1		
4	Intermediate Risk [10- < 50%]	Multilocular cyst, no solid component	≥ 10 cm, smooth inner wall, CS = 1-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
			Any size, smooth inner wall, CS = 4	
			Any size, irregular inner wall and/or irregular septation, any color score	
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	
		Multilocular cyst with solid component	Any size, CS = 1-2	
	Solid	Smooth, any size, CS = 2-3		
5	High Risk [$\geq 50\%$]	Unilocular cyst, any size > 4 papillary projections, CS = any	GYN-oncologist	
		Multilocular cyst with solid component, any size, CS = 3-4		
		Solid smooth, any size, CS = 4		
		Solid irregular, any size, CS = any		
	Ascites and/or peritoneal nodules**			

Teaching points

- CS refers to vascularity within lesion itself not surrounding parenchyma
- Optimize settings and use regional structures as internal standard
- Presence of flow confirms a lesion is solid but absence is less predictive
- Don't sweat small stuff (discrimination between categories)



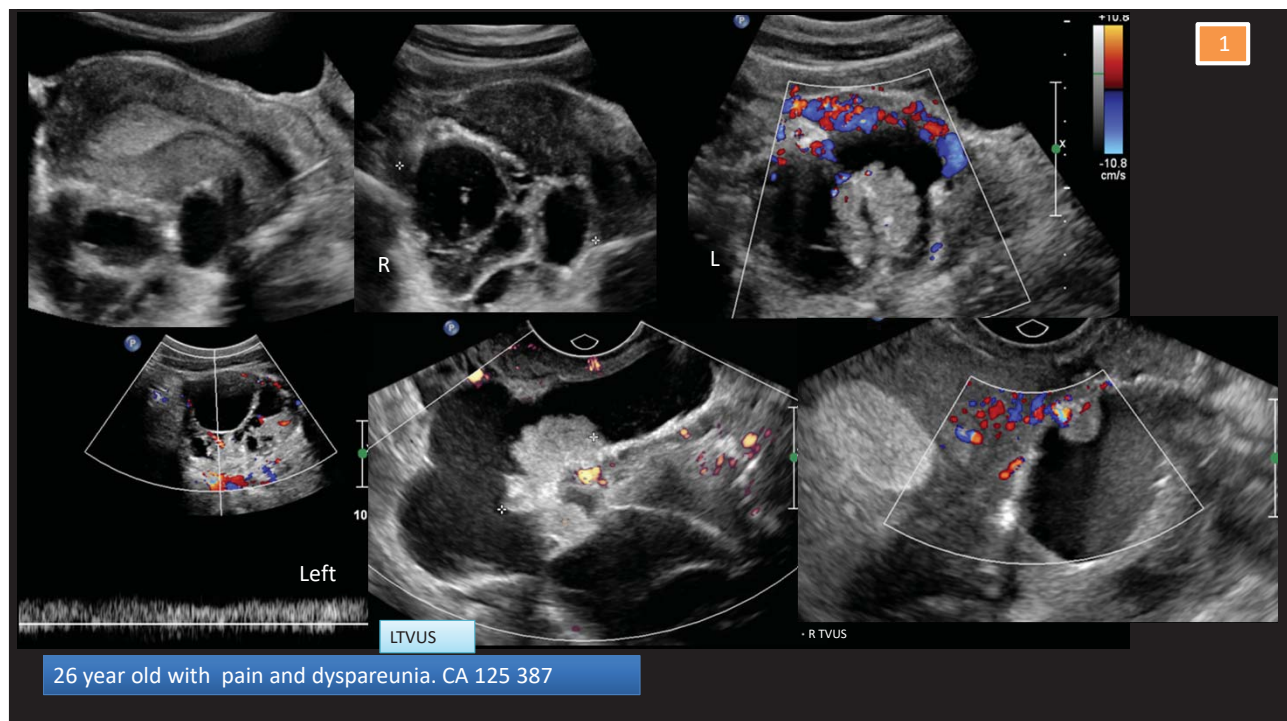
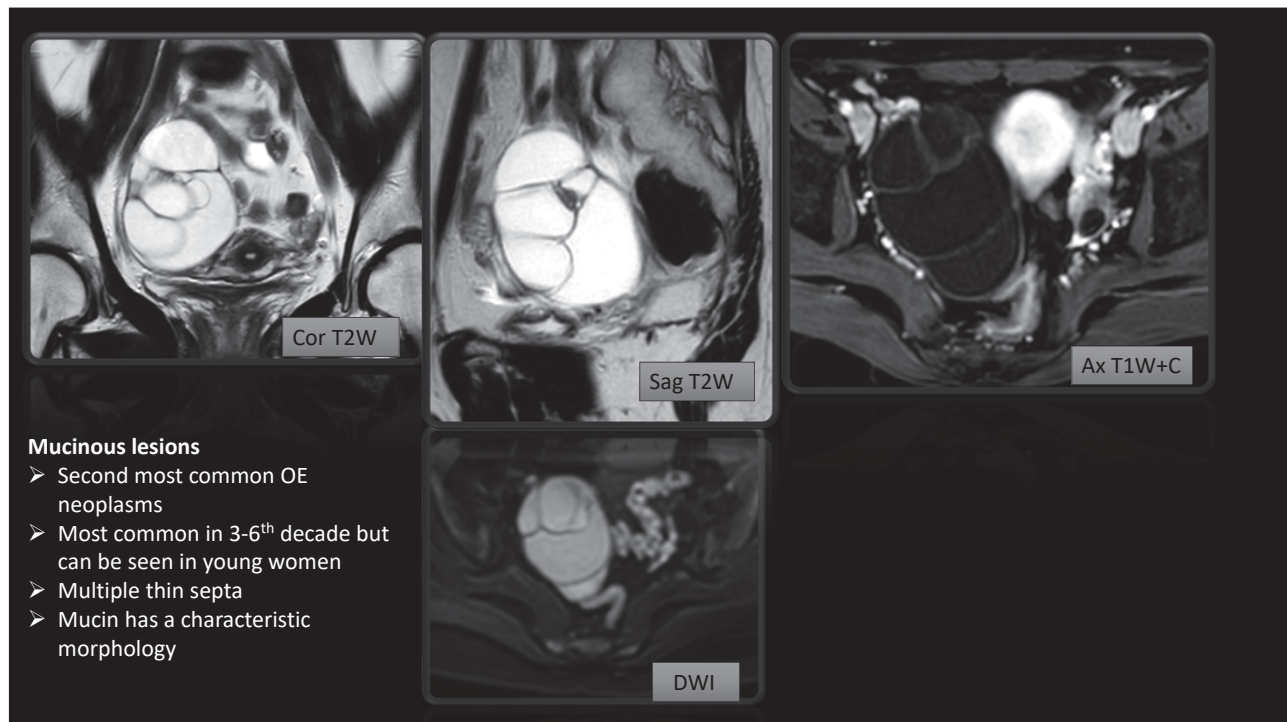
In this multilocular cystic lesion pick ALL discriminators that allow you to score the finding

- Size (> or < 10 cms)
- Presence of acoustic shadowing
- Inner wall morphology
- Colour score
- Presence of ascites

3	Low Risk Malignancy [1-<10%]	Unilocular cyst \geq 10 cm (simple or non-simple)	US specialist or MRI Management by gynecologist	
		Typical dermoid cysts, endometriomas, hemorrhagic cysts \geq 10 cm		
		Unilocular cyst, any size with irregular inner wall <3 mm height		
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3		
		Solid smooth, any size, CS = 1		
4	Intermediate Risk [10- < 50%]	Multilocular cyst	\geq 10 cm, smooth inner wall, CS = 1-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
		no solid component	Any size, irregular inner wall and/or irregular septation, any color score	
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	
		Multilocular cyst with solid component	Any size, CS = 1-2	
		Solid	Smooth, any size, CS = 2-3	
5	High Risk [\geq 50%]	Unilocular cyst, any size, \geq 4 papillary projections, CS = any	GYN-oncologist	
		Multilocular cyst with solid component, any size, CS = 3-4		
		Solid smooth, any size, CS = 4		
		Solid irregular, any size, CS = any		
		Ascites and/or peritoneal nodules**		

Teaching points

- CS category is important but has been placed in a range to help categorize into high risk categories
- Here vascularity is being assessed in the inner wall and septations



Which of the following features changes the ORADS score in this lesion ?(pick all that apply)

- A. Presence of ascites
- B. Size of lesion
- C. Inner wall morphology
- D. Colour score

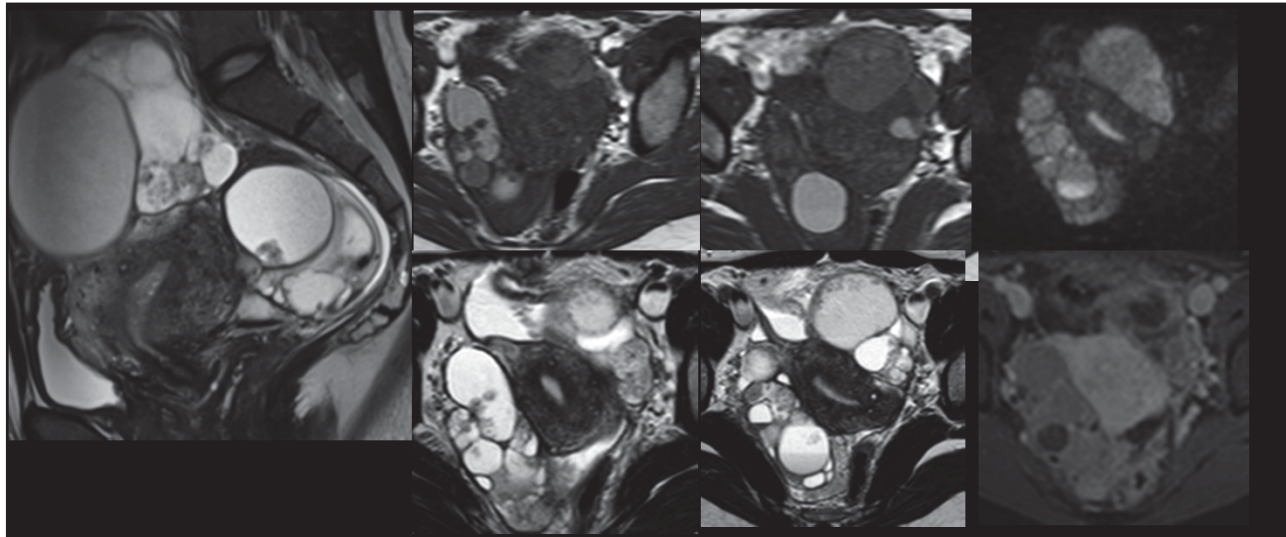
3	Low Risk Malignancy [1-<10%]	Unilocular cyst \geq 10 cm (simple or non-simple)		US specialist or MRI Management by gynecologist
		Typical dermoid cysts, endometriomas, hemorrhagic cysts \geq 10 cm		
		Unilocular cyst, any size with irregular inner wall <3 mm height		
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3		
		Solid smooth, any size, CS = 1		
4	Intermediate Risk [10- < 50%]	Multilocular cyst, no solid component	\geq 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	
		Multilocular cyst with solid component	Any size, CS = 1-2	
		Solid	Smooth, any size, CS = 2-3	
5	High Risk [\geq 50%]	Multilocular cyst with solid component, any size, CS = 3-4		GYN-oncologist
		Solid smooth, any size, CS = 4		
		Solid irregular, any size, CS = any		
		Ascites and/or peritoneal nodules**		

TEACHING POINT

With multilocular cystic and solid lesions CS is an important discriminator

1-2=ORADS 4

3-4=ORADS 5

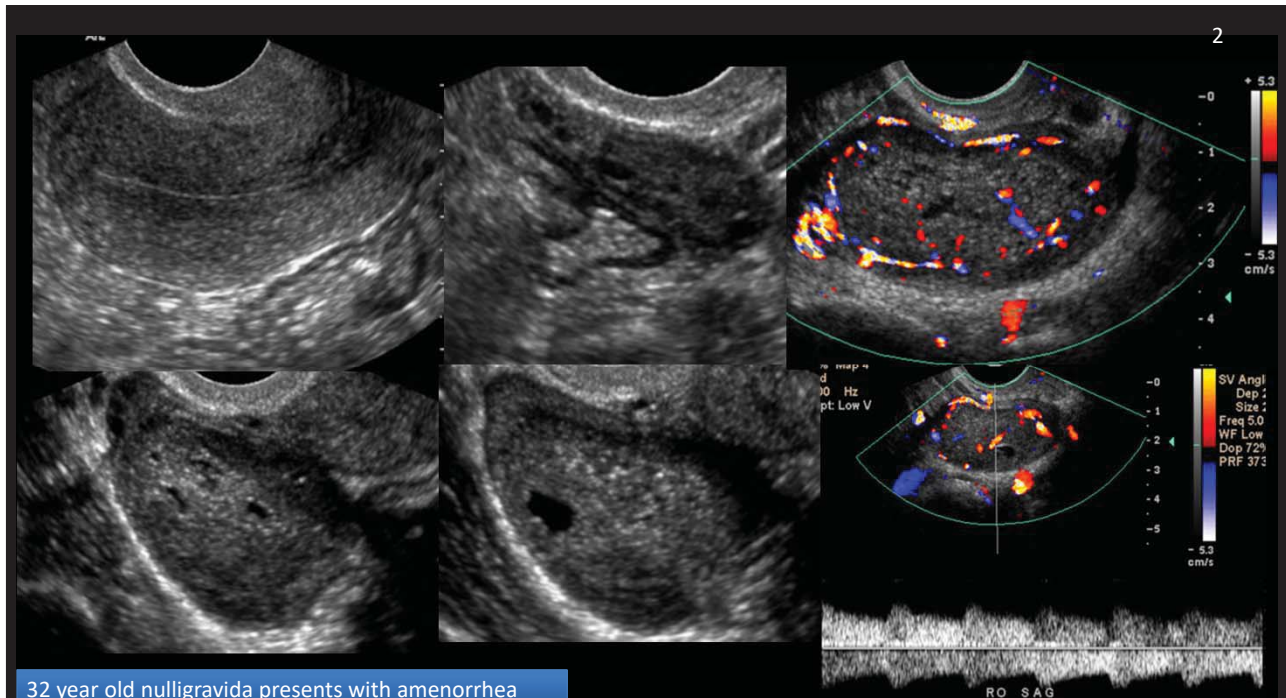


Low grade serous ovarian carcinoma
 Typically complex cystic masses

- Septations and papillary solid components
- Solid components exhibit vascularity
- Bilateral in 74-77%

Type 1 LGSC

- Stepwise progression from benign serous lesion to BOT
- Indolent but up to 30% recur
- 5 yr survival 40-56%



32 year old nulligravida presents with amenorrhea

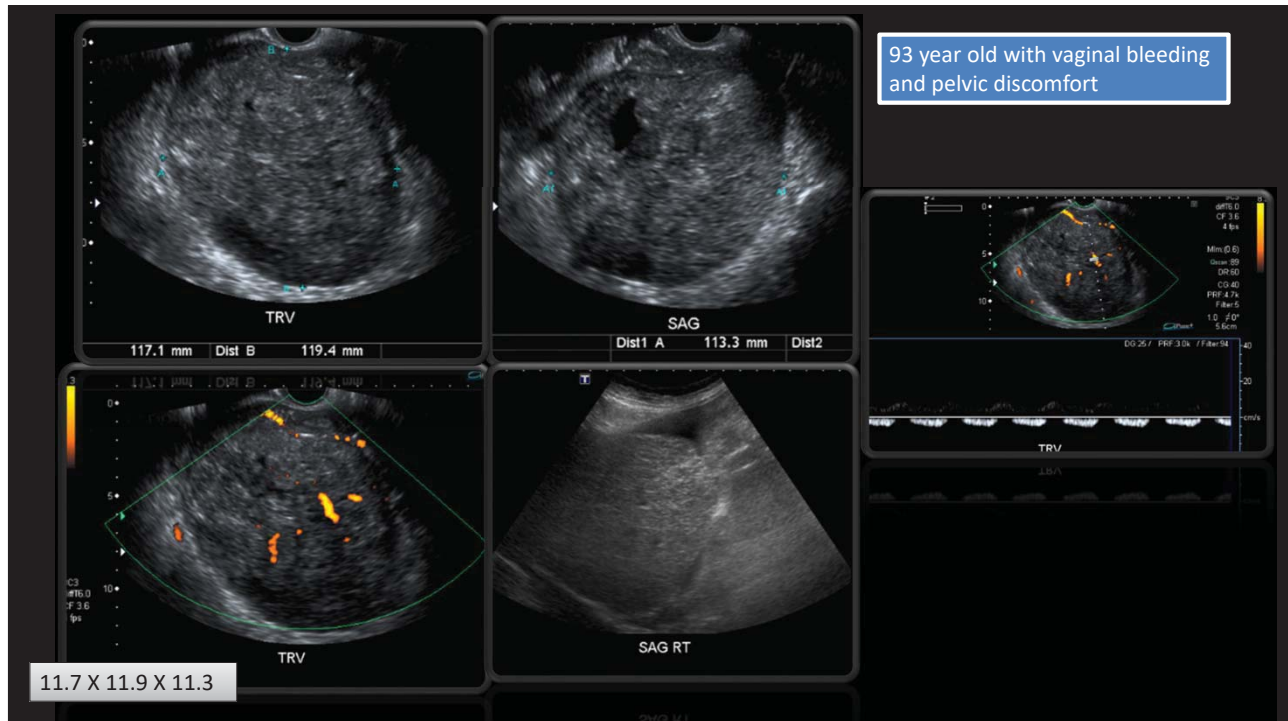
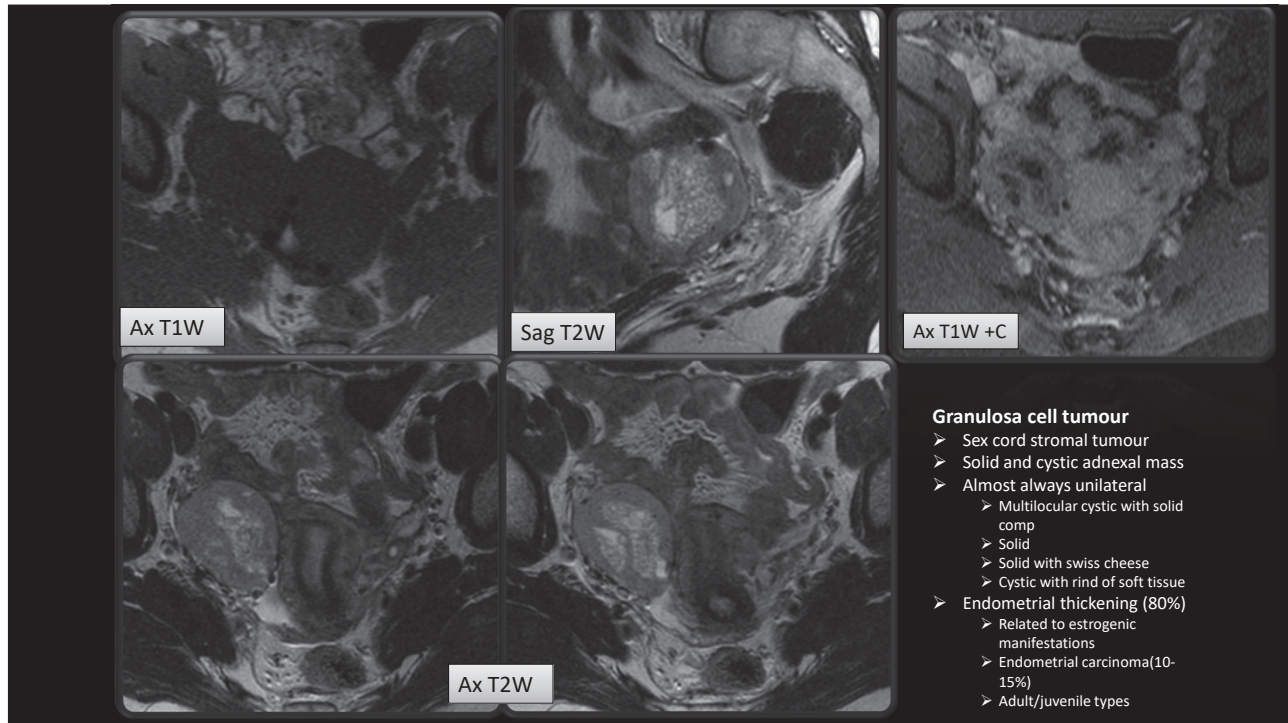
Which classifiers apply to a solid lesion?(pick all that are correct)

- A. Should be at least 50% solid
- B. Should be at least 80% solid
- C. Includes components of a lesion such as blood products or mucin
- D. Should be less echogenic than anechoic fluid
- E. Outer contour is key predictor

3	Low Risk Malignancy [1-<10%]	Unilocular cyst \geq 10 cm (simple or non-simple) Typical dermoid cysts, endometriomas, hemorrhagic cysts \geq 10 cm Unilocular cyst, any size with irregular inner wall $<$ 3 mm height Multilocular cyst $<$ 10 cm, smooth inner wall, CS = 1-3 Solid smooth, any size, CS = 1	US specialist or MRI Management by gynecologist								
4	Intermediate Risk [10- < 50%]	<table border="1"> <tbody> <tr> <td>Multilocular cyst, no solid component</td> <td>\geq 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score</td> </tr> <tr> <td>Unilocular cyst with solid component</td> <td>Any size, 0-3 papillary projections, CS = any</td> </tr> <tr> <td>Multilocular cyst with solid component</td> <td>Any size, CS = 1-2</td> </tr> <tr> <td>Solid</td> <td>Smooth, any size, CS = 2-3</td> </tr> </tbody> </table>	Multilocular cyst, no solid component	\geq 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score	Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any	Multilocular cyst with solid component	Any size, CS = 1-2	Solid	Smooth, any size, CS = 2-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist
Multilocular cyst, no solid component	\geq 10 cm, smooth inner wall, CS = 1-3 Any size, smooth inner wall, CS = 4 Any size, irregular inner wall and/or irregular septation, any color score										
Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any										
Multilocular cyst with solid component	Any size, CS = 1-2										
Solid	Smooth, any size, CS = 2-3										
5	High Risk [\geq 50%]	Unilocular cyst, any size, \geq 4 papillary projections, CS = any Multilocular cyst with solid component, any size, CS = 4 Solid smooth, any size, CS = 4 Solid irregular, any size, CS = any Ascites and/or peritoneal nodules**	GYN-oncologist								

Teaching points:

- Outer contour of a solid lesion is key predictor
- If irregular has a 93% PPV for malignancy
- Risk assessment then is not influenced by size or CS

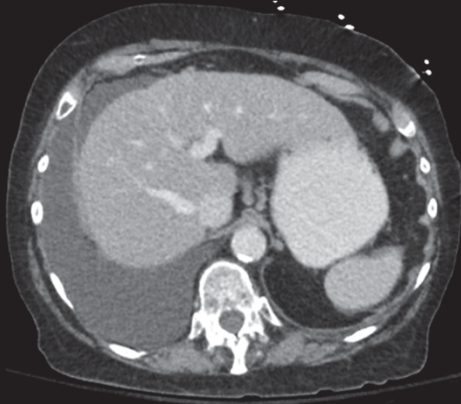


What ORADS category is this lesion?

- A. ORADS 1
- B. ORADS 2
- C. ORADS 3
- D. ORADS 4
- E. ORADS 5

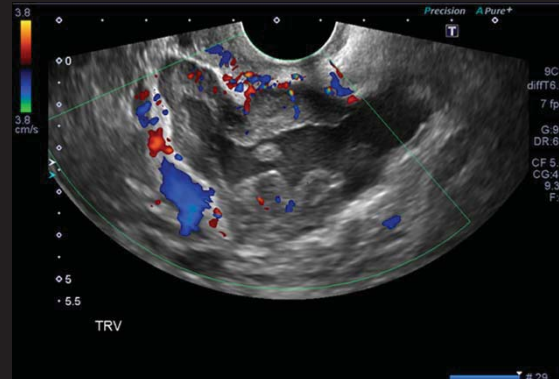
3	Low Risk Malignancy [1-<10%]	Unilocular cyst \geq 10 cm (simple or non-simple)		US specialist or MRI Management by gynecologist	
		Typical dermoid cysts, endometriomas, hemorrhagic cysts \geq 10 cm			
		Unilocular cyst, any size with irregular inner wall <3 mm height			
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3			
		Solid smooth, any size, CS = 1			
4	Intermediate Risk [10- < 50%]	Multilocular cyst, no solid component	\geq 10 cm, smooth inner wall, CS = 1-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist	
			Any size, smooth inner wall, CS = 4		
		Unilocular cyst with solid component	Any size, irregular inner wall and/or irregular septation, any color score		
			Any size, 0-3 papillary projections, CS = any		
5	High Risk [\geq 50%]	Multilocular cyst with solid component	Any size, CS = 4-5	GYN-oncologist	
		Solid	Smooth, any size, CS = 2-3		
5	High Risk [\geq 50%]	Unilocular cyst, any size, \geq 4 papillary projections, CS = any		GYN-oncologist	
		Multilocular cyst with solid component, any size, CS = 3-4			
		Solid smooth, any size, CS = 4			
		Solid irregular, any size, CS = any			
		Ascites and/or peritoneal nodules**			

Intermediate risk lesion
Or is it ?



Ascites if fluid extends superior to fundus if anteverted uterus and if superior & anterior to the uterus when retroflexed

- With lesions where ascites is less plausible (1-2) exclude non malignant etiologies
- Fluid overload/CHF
- CRF
- Cirrhosis



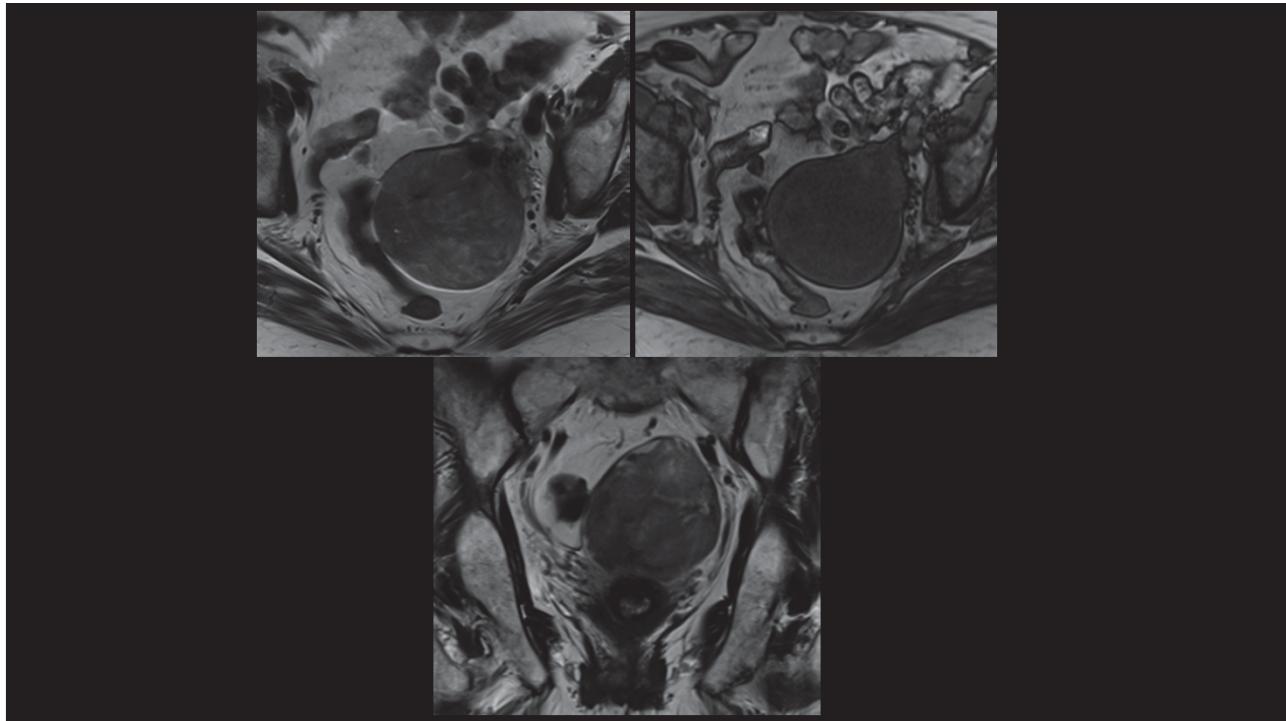
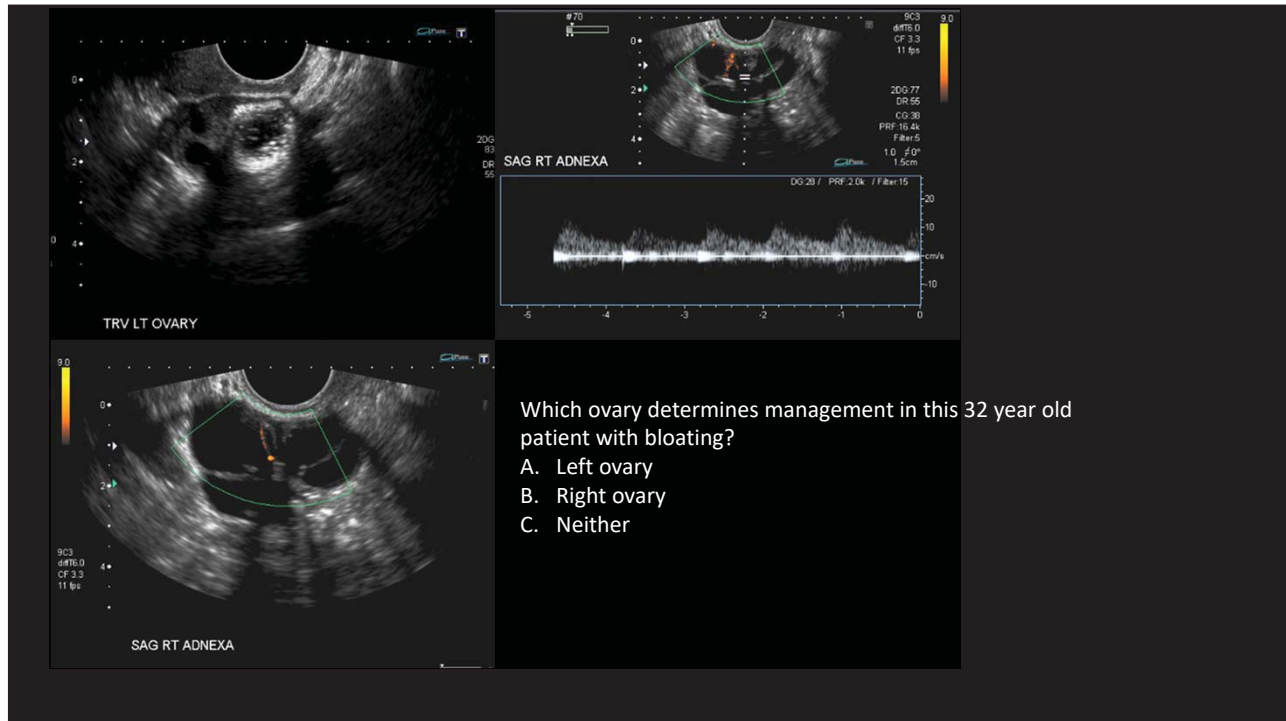
Low to int risk lesions (3-4)

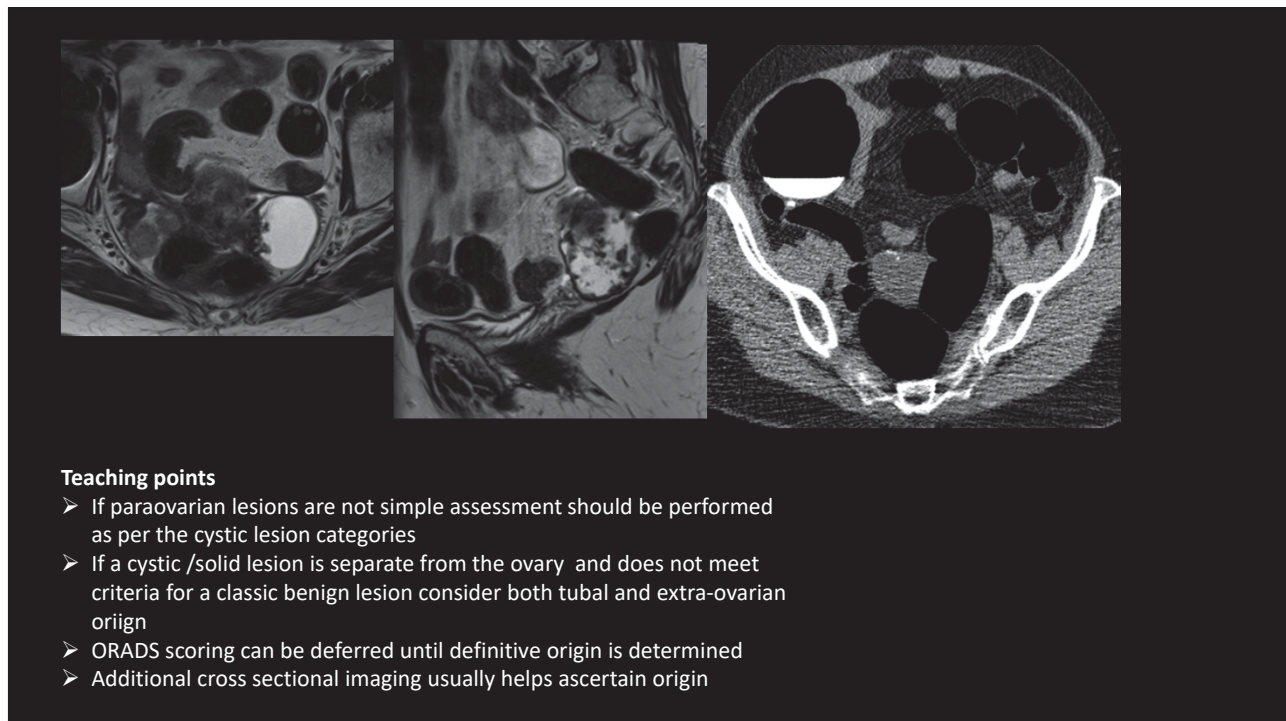
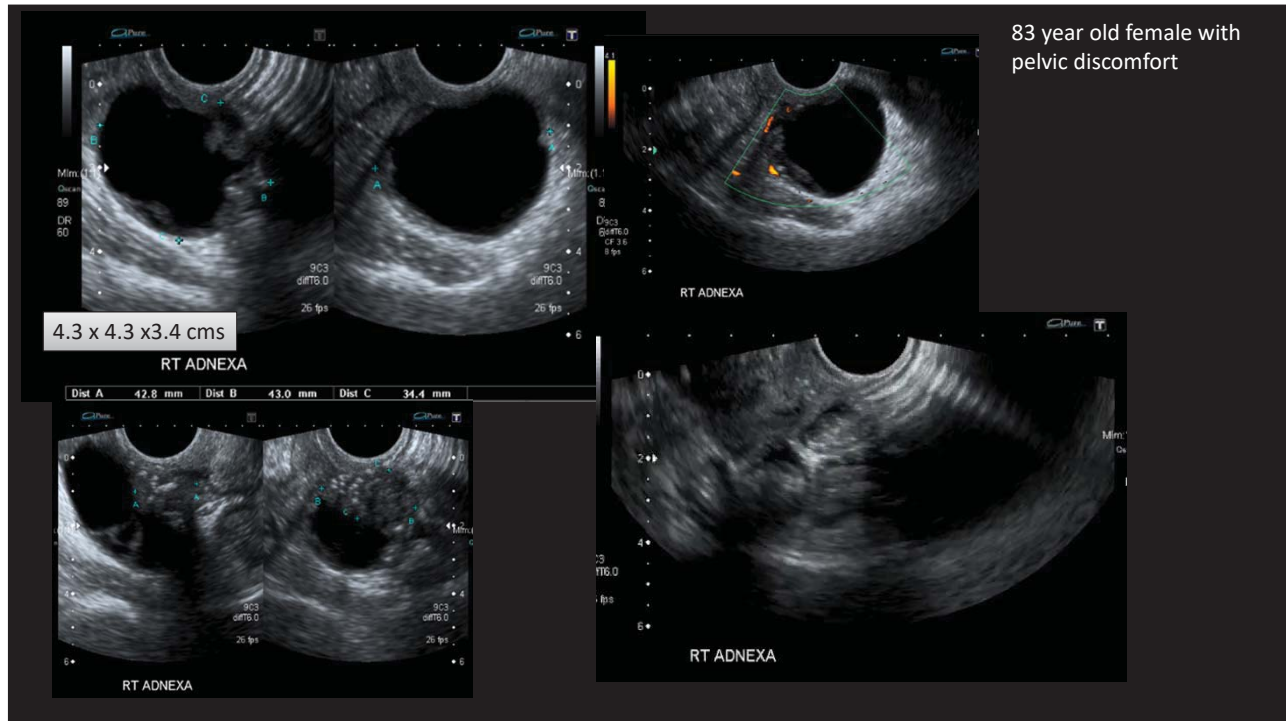
Peritoneal nodularity upgrades risk to a category 5

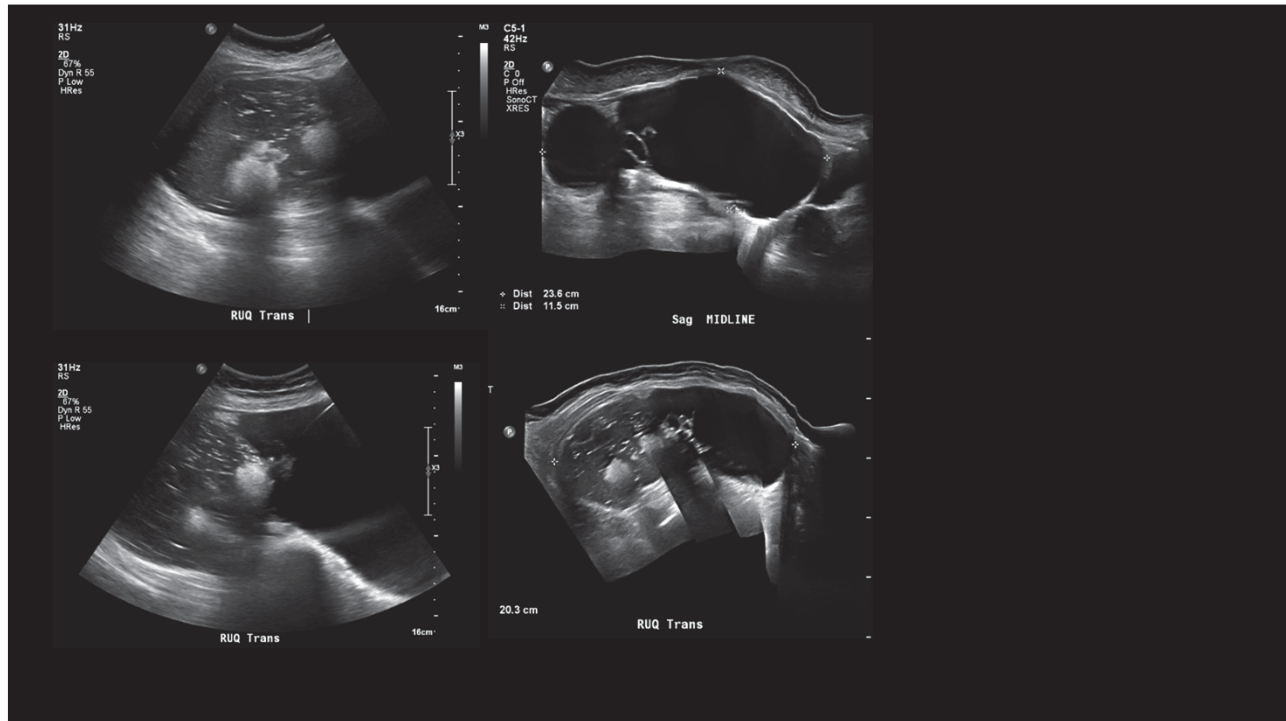
Focal or diffuse nodularity or irregular thickening of the peritoneal reflections
Other etiologies can occur :TB.florid PID,GI malignancy

Challenging cases









What ORADS category is this lesion?

- A. ORADS 1
- B. ORADS 2
- C. ORADS 3
- D. ORADS 4
- E. ORADS 5