1. O-RADS Ultrasound (US) applies to the ovaries, lesions involving (or suspected to involve) the ovaries and/or fallopian tubes, and paraovarian cysts, when the intent is to stratify risk of malignancy. Scenarios when O-RADS does not apply include (but are not limited to): pelvic inflammatory disease, ectopic pregnancy, torsion of a normal ovary, and those lesions clearly identified as non-ovarian/non-tubal in origin (eg, an exophytic or broad ligament myoma). If the origin of a lesion is indeterminate, options include CT and MRI.

2. Most nonvisualized and all absent ovaries are classified as “O-RADS: not applicable”. When only one ovary is visualized, it may be assessed per lexicon descriptors to obtain an O-RADS score. An exam may be considered “O-RADS 0: technically inadequate” when ovarian visualization is expected based on the indication for the exam but is not seen.

3. In cases of multiple or bilateral lesions, each lesion should be separately characterized, and management driven by the lesion with the highest O-RADS score. Separate recommendations should be provided when management of one lesion is independent of the other.

4. When menopausal status is relevant for risk stratification or management, patient should be categorized as pre– or postmenopausal. The postmenopausal category is defined as amenorrhea ≥1 year; (early = postmenopausal for <5 years, late = postmenopausal for ≥5 years). If uncertain or the uterus is absent, manage as per the postmenopausal status if age is >50; (early = >50 but <55, late = ≥55).

5. Some O-RADS US management recommendations include the involvement of a physician whose practice includes a focus on ultrasound assessment of adnexal lesions, denoted as an “ultrasound specialist”. While there are no mandated requirements or guidelines that define such a specialist, potential qualifications include sufficient experience with the appearance of adnexal pathology on US to improve the likelihood of correct diagnoses and participation in quality assurance activities related to adnexal imaging.

6. Imaging assessment of a lesion is generally based on transvagal technique. Transabdominal imaging may add characterization and may suffice when transvagal technique is not feasible or limited. When possible, orthogonal cine clips are strongly encouraged.

7. Single largest diameter of a lesion is used for risk stratification (scoring) and management. Reporting three dimensions is helpful to assess interval change, for which average linear dimension (L + W + H/3) should be used.

8. Lexicon terminology and lesion characterization apply to most lesions regardless of risk or symptoms. When uncertain about feature selection, (eg, smooth versus irregular, color score, etc.) use the higher risk category to score the lesion.

9. Management recommendations should serve as guidance rather than requirements and are based on average risk and no acute symptoms. Individual case management may be modified by risk (eg, personal or family history of ovarian cancer, BRCA mutation, etc.), symptoms, other clinical factors, and professional judgement, regardless of the O-RADS score.
From initial exam, then management per gynecology (eg, clinical factors). If stable, follow-up at 12 and 24 months from initial exam, then as clinically indicated. For changing morphology, reassess using lexicon descriptors.

Shorter imaging follow-up may be considered in some scenarios (eg, clinical factors). If smaller.

MRI with contrast has higher specificity for solid lesions, and cystic lesions with solid component(s).

There is a paucity of evidence for defining the optimal duration or interval for imaging surveillance. Shorter follow-up may be considered in some scenarios (eg, clinical factors). If stable, follow-up at 12 and 24 months from initial exam, then as clinically indicated. For changing morphology, reassess using lexicon descriptors. Clinical management with gynecology as needed.

**Not due to other malignant or non-malignant etiologies; specifically, must consider other etiologies of ascites in categories 1–2.
### O-RADS™ US v2022 — Classic Benign Lesions

**Release Date:** November 2022

#### Lesion

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<th>Descriptors and Definitions</th>
<th>Management</th>
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<tr>
<td><strong>Typical Hemorrhagic Cyst</strong></td>
<td>If sonographic features are only suggestive, and overall assessment is uncertain, consider follow-up US within 3 months</td>
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| Unilocular cyst, no internal vascularity*, and at least one of the following:  
  - Reticular pattern (fine, thin intersecting lines representing fibrin strands)  
  - Retractile clot (intracystic component with straight, concave, or angular margins) | Imaging:  
  - Premenopausal:  
    - ≤5 cm: None  
    - >5 cm but <10 cm: Follow-up US in 2–3 months  
  - Early postmenopausal (<5 years):  
    - ≤10 cm, options to confirm include:  
      - Follow-up US in 2–3 months or  
      - US specialist (if available) or  
      - MRI (with O–RADS MRI score)  
  - Late postmenopausal (≥5 years):  
    - Should not occur; recategorize using other lexicon descriptors.  
  Clinical: Gynecologist** |
| **Typical Dermoid Cyst** | Imaging:  
  - ≤3 cm: May consider follow-up US in 12 months***  
  - >3 cm but <10 cm: If not surgically excised, follow-up US in 12 months***  
  Clinical: Gynecologist** |
| Cystic lesion with ≤3 locules, no internal vascularity*, and at least one of the following:  
  - Hyperechoic component(s) (diffuse or regional) with shadowing  
  - Hyperechoic lines and dots  
  - Floating echogenic spherical structures | **Typical Endometrioma** |
| Cystic lesion with ≤3 locules, no internal vascularity*, homogeneous low–level/ground glass echoes, and smooth inner walls/septation(s)  
  ± Peripheral punctate echogenic foci in wall | Imaging:  
  - Premenopausal:  
    - <10 cm: If not surgically excised, follow-up US in 12 months***  
  - Postmenopausal:  
    - <10 cm and initial exam, options to confirm include:  
      - Follow-up US in 2–3 months or  
      - US specialist (if available) or  
      - MRI (with O–RADS MRI score)  
  Then, if not surgically excised, recommend follow-up US in 12 months***  
  Clinical: Gynecologist** |
| Simple cyst separate from the ovary | Imaging: None  
  Clinical: None |
| Fluid collection with ovary at margin or suspended within that conforms to adjacent pelvic organs  
  ± Septations (representing adhesions) | Imaging: None  
  Clinical: Gynecologist** |
| Anechoic, fluid–filled tubular structure  
  ± Incomplete septation(s) (representing folds)  
  ± Endosalpingeal folds (short, round projections around inner walls) | **Typical Hydrosalpinx** |

*Excludes vascularity in walls or intervening septation(s)  
**As needed for management of clinical issues  
***There is a paucity of evidence for defining the need, optimal duration or interval of timing for surveillance. If stable, consider US follow-up at 24 months from initial exam, then as clinically indicated. Specifically, evidence does support an increased risk of malignancy in endometriomas following menopause and those present greater than 10 years.