American College of Radiology™

O-RADS™ Ultrasound v2022 — Governing Concepts

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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 transvaginal technique. Transabdominal imaging may add characterization and may suffice when transvaginal 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.