

O-RADS MRI After Initial Ultrasound for Adnexal Lesions: *AJR* Expert Panel Narrative Review

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The Ovarian-Adnexal Reporting and Data System (O-RADS) ultrasound (US) and MRI risk stratification systems were developed by an international group of experts in adnexal imaging to aid radiologists in assessing adnexal lesions. The goal of imaging is to appropriately triage patients with adnexal lesions. US is the first-line imaging modality for assessment, whereas MRI can be used as a problem-solving tool. Both US and MRI can accurately characterize benign lesions such as simple cysts, endometriomas, hemorrhagic cysts, and dermoid cysts, avoiding unnecessary or inappropriate surgery. In patients with a lesion that does not meet criteria for one of these benign diagnoses, MRI can further characterize the lesion with an improved specificity for cancer and the ability to provide a probable histologic subtype in the presence of certain MRI features. This allows personalized treatment, including avoiding overly extensive surgery or allowing fertility-sparing procedures for suspected benign, borderline, or low-grade tumors. When MRI findings indicate a risk of an invasive cancer, patients can be expeditiously referred to a gynecologic oncologic surgeon. This narrative review provides expert opinion on the utility of multiparametric MRI when using the O-RADS US and MRI management systems.

The goal of imaging in the assessment of adnexal lesions is to triage patients appropriately, thereby avoiding unnecessary or overly extensive surgery and expediting the evaluation of patients with potential ovarian cancer. Previously published algorithmic risk stratification systems exist and have used ultrasound (US) features to classify adnexal lesions; these guidelines include the International Ovarian Tumor Analysis simple rules, the Gynecologic Imaging-Reporting and Data System, and the Society of Radiologists in Ultrasound guidelines [1–3]. The American College of Radiology (ACR) Ovarian-Adnexal Reporting and Data System (O-RADS) US and MRI committees have published lexicons and risk stratification systems partially based on previously published systems in order to standardize terminology and provide a data-driven risk score for assigning a probability of malignancy based on large population studies [4–8]. The overarching goal of these risk assessment and management systems is to triage patients appropriately.

US is the first-line imaging modality when there is a clinical concern for an adnexal lesion or when an adnexal lesion is identified on another imaging examination, and it has a sensitivity greater than 90% and specificity greater than 80% for the diagnosis of ovarian cancer [1, 3, 5, 9–17]. An adnexal lesion may also be discovered incidentally on US when a patient is undergoing pelvic imaging for a variety of indications from abnormal bleeding to pelvic pain. Most adnexal lesions seen on US can be accurately characterized as physiologic or benign. When imaging shows characteristic features of a simple cyst, hemorrhagic cyst, endometrioma, or dermoid cyst, a benign diagnosis can be assigned, and the

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frequency of cancer in these lesions is less than 1% [5, 18, 19]. When an adnexal lesion does not have the appearance of a classic benign lesion, the risk of malignancy ranges from 1% to more than 50% according to the O-RADS US risk score [5]. The variability in cancer risk on US is partly because of overlapping imaging features of benign and malignant entities and reader experience level [5]. In such lesions, MRI has been shown to increase the specificity for malignancy by decreasing the false-positive rate [13, 20–31]. A multicenter prospective study found the O-RADS MRI risk score performed well, with sensitivity of 93%, specificity of 91%, PPV of 90%, and NPV of 98% for the diagnosis of cancer when certain imaging features were present, such as a high-risk time-intensity curve [8]. Currently, no large multicenter studies have been performed to evaluate when MRI is most helpful after US, and the available literature focuses on the use of MRI for sonographically indeterminate adnexal lesions. The new O-RADS US lexicon and risk stratification systems do not include a classification of adnexal lesions as “indeterminate” but rather place adnexal lesions into risk categories: almost certainly benign and low risk, intermediate risk, and high risk for cancer (Fig. 1). In all of these O-RADS US categories, MRI can play a role in guiding management by further assessing the lesion using the O-RADS MRI risk stratification schema (Fig. 2 and Table 1). This narrative review provides expert opinion on the utility of multiparametric MRI when using the O-RADS US and MRI management systems.

Why Is MRI Valuable?

Multiparametric MRI allows more accurate characterization of both the fluid and solid components of an adnexal lesion com-

pared with US, accounting for MRI’s increased specificity for the diagnosis of malignancy. The presence of solid tissue with a high-risk enhancement curve has a PPV for cancer of approximately 90% [8]. Conversely, the absence of enhancement in an adnexal lesion has an NPV that exceeds 98% [8]. Furthermore, MRI can accurately predict the underlying pathology when certain characteristic imaging findings are present (e.g., papillary projections suggest a benign, borderline, or low-grade serous tumor; solid tissue that is hypointense on both T2-weighted MRI and high b-value DWI, referred to in O-RADS MRI as “dark T2/dark DWI,” indicates a benign fibrous tumor) [21, 32–34]. Recognizing these characteristic findings is crucial, particularly when triaging a lesion to a gynecologist versus a gynecologic oncologist for surgical evaluation or when considering fertility-sparing surgery [21, 35–41]. Appropriate adnexal lesion characterization by imaging allows patients with benign lesions to avoid unnecessary or overly extensive surgery and allows patients with ovarian cancer to be promptly referred to a gynecologic oncologist. Avoiding surgery or overly extensive resection decreases stress on the patient, strain on hospital resources, and complications [42]. Referring patients with ovarian cancer to a gynecologic oncologist for the initial evaluation and surgery improves clinical outcomes [43].

When Is MRI Helpful?

MRI is helpful in further characterization and risk assessment of lesions discovered on US when there is a clinical need for improved specificity for malignancy or for differentiation between benign or borderline/low-grade tumor and invasive ovarian cancer [9, 10, 21,

TABLE 1: Clinical Scenarios Where Referral to MRI May Be Helpful After Ultrasound (US) for an Adnexal Lesion

| Reason for Referral to MRI | O-RADS US Category | Role of MRI | Possible Outcomes on MRI and Clinical Benefit |
|--|--------------------|---|---|
| Clinical need for improved specificity for malignancy or tumor subtype | 3, 4, or 5 | Assessment of the morphology, signal intensity, and enhancement of any solid tissue | MRI can increase the PPV for cancer and suggest the histopathologic subtype when certain imaging features are present. MRI can help in the following scenarios: <ul style="list-style-type: none"> • Patient with an isolated adnexal lesion and no signs of metastatic disease, where there is a clinical need for a specific diagnosis • Patient who desires a fertility-sparing surgery to differentiate among benign, borderline, low-grade tumors and invasive cancers • In a poor surgical candidate, to support surveillance if the lesion has an O-RADS MRI category of 2 or 3 and nonsurgical assessment and treatment of cancer if the lesion has an O-RADS MRI category of 4 or 5 |
| Incompletely visualized lesion on ultrasound | 0 | Complete visualization of the lesion to assess the risk of malignancy | Classification of the lesion as O-RADS MRI category 1 through 5 to guide further management |
| Nonsimple unilocular cyst in postmenopausal patient | 2 | Assess for any solid tissue to exclude malignancy because postmenopausal patients should not have hemorrhagic or proteinaceous cysts and the risk of a neoplasm in this scenario is increased | Classification of O-RADS MRI category 2 or 3 supports continued surveillance or nononcologic surgical consultation Classification as O-RADS MRI category 4 or 5 supports gynecologic oncologic surgical consultation for further management |
| O-RADS US category 3 and 4 adnexal lesions | 3 or 4 | Assessment of fluid content and of any solid tissue | Classification as O-RADS MRI category 2 or 3 supports conservative management Classification as O-RADS MRI category 4 or 5 supports gynecologic oncologic surgical consultation for further management |

Note—O-RADS = Ovarian-Adnexal Reporting and Data System.

38–40]. This need for specific assessment depends on the patient's age, clinical scenario, and desire for a nonsurgical or limited surgical resection for fertility preservation or other health reasons. Even when a lesion is assessed as O-RADS US category 5 (PPV, > 50%), MRI may be helpful, particularly in young patients and in patients who would like to avoid surgery. In a multicenter study, investigators noted that although 62% of O-RADS US category 5 lesions were cancer, 22% of lesions were physiologic findings or endometriomas and 16% were benign neoplasms (dermoid cysts or cystadenomas) [44]. MRI can potentially downgrade the lesion if the lesion has no enhancement or has classic benign features (e.g., fat or endometriotic fluid). This added information helps the referring physician decide to continue to monitor the lesion by imaging in the case of a lesion with benign features versus potentially consider surgery if cancer is suspected. In addition to specific clinical scenarios, MRI may be helpful when an adnexal lesion is incompletely visualized on US, is a nonsimple unilocular cyst in a postmenopausal patient, or is scored as O-RADS US category 3 or 4.

These patients may benefit from evaluation by MRI, because MRI may downgrade the lesion to an O-RADS MRI category 2, allowing conservative management, or may upgrade the lesion to having a higher PPV for cancer, prompting referral to a gynecologic oncologist. Table 1 describes specific scenarios in which this expert panel considers MRI an appropriate next step after US in the evaluation of an adnexal lesion.

Incompletely Visualized Lesion on Ultrasound

When an adnexal lesion is not well seen on US, it is scored as O-RADS US category 0. Inadequate evaluation of the adnexa may occur as a result of artifacts from bowel or a leiomyomatous uterus or in the setting of a large adnexal lesion (> 10 cm). MRI can be helpful in these cases because of the modality's large FOV and multiplanar capabilities (Fig. 3). Furthermore, MRI can assess the composition of the fluid (e.g., simple, lipid, endometriotic, hemorrhagic, or proteinaceous) as well as the presence of enhancing solid tissue. This assessment of the lesion's fluid and solid components allows classification of the lesion into O-RADS MRI categories 2 through 5. In the setting of a large lesion, the multiplanar capabilities of MRI allow examination of the entire lesion. Lastly, approximately 10% of adnexal lesions referred for MRI from US are found to be nonovarian, and MRI can classify the lesion origin with an accuracy of 93% [8].

Nonsimple Unilocular Cyst in Postmenopausal Patients

When a lesion discovered on US is diagnosed as benign (O-RADS US category 2), the referring physician and, more importantly, the patient can be reassured that the risk of malignancy is less than 1% [5]. In these patients, correlation should be made with clinical history and laboratory assessment, and the management recommendations provided in the O-RADS US risk score table should be followed [8]. However, MRI may be considered for further evaluation of an O-RADS US category 2 lesion when assigned in a postmenopausal patient with a nonsimple unilocular cyst that has a smooth inner margin. In this scenario, MRI can potentially upgrade or downgrade the lesion, which would help the referring clinician and patient decide between following the lesion versus proceeding with surgical evaluation. If MRI shows no enhancement of the lesion, there is essentially no chance of cancer; if MRI shows

wall enhancement or tiny internal papillary projections, then the chance of cancer will depend on the lesion's O-RADS MRI category (O-RADS MRI category 3: 5%; category 4: 50%; category 5: 90%).

O-RADS Ultrasound Category 3 and 4 Lesions

MRI can also be used to further assess lesions assigned O-RADS US category 3 (PPV, < 10%) or category 4 (PPV, 10–49%). The diagnosis is uncertain for lesions assigned these O-RADS US categories given the overlapping appearance of benign and malignant lesions on US. A lesion that is not clearly benign or is at high risk for malignancy on US may be a benign neoplasm, such as a cystadenoma, dermoid cyst, or fibroma, or may be a follicle, corpus luteum, or proteinaceous or hemorrhagic cyst [13, 14, 18, 44] (Figs. 4 and 5). In a multicenter study of more than 900 patients evaluated by US in radiology departments, 68% of O-RADS US category 3 lesions and 48% of O-RADS US category 4 lesions were physiologic findings or endometriomas on follow-up imaging [44]. Superior characterization of fluid and soft tissue and the use of contrast media increase the specificity of MRI for benign diagnoses such that MRI may downgrade O-RADS US category 3 and 4 lesions to a physiologic finding or other classic benign lesion. MRI may also upgrade an O-RADS US category 3 or 4 lesion when the lesion on MRI shows solid enhancing tissue with intermediate or high signal on T2-weighted imaging or DWI. Furthermore, MRI can be specific in the diagnosis of the underlying histopathology when certain features are present (Fig. 5). In a patient of childbearing age, this information from MRI can be used to decide to pursue surveillance for a lesion suspected to be benign, possible fertility-sparing surgery for a lesion suspected to be a benign neoplasm or a borderline or low-grade tumor, or complete oncologic surgical resection for a lesion suspected to be invasive cancer. In a patient who is a poor surgical candidate, the information from MRI can be used to decide to pursue surveillance for an O-RADS MRI category 2 or 3 lesion versus nonsurgical assessment and treatment of cancer for an O-RADS MRI category 4 or 5 lesion.

How to Evaluate Adnexal Lesions on MRI After Ultrasound

MRI of an adnexal lesion should be performed on a 1.5-T or 3-T scanner using a multiparametric approach. Optimizing MR images includes both patient preparation and technical considerations. Patient preparation includes fasting for 4–6 hours before the examination, use of an antiperistaltic agent, and instruction to void within 30 minutes before imaging. Technical considerations include selection of sequences to properly assess an adnexal finding for fluid and solid components. Required sequences include axial in- and opposed-phase T1-weighted images, T2-weighted images in two planes (e.g., axial and sagittal), postcontrast T1-weighted images, and DWI (using $b \geq 1000$ s/mm²) (Table 2). Protocols should include a fat-saturated and non-fat-saturated set of either T1-weighted or T2-weighted sequences to depict macroscopic fat within lesions. This set of sequences is in addition to the in- and opposed-phase T1-weighted sequences that depict microscopic fat. Lesion size should be considered when prescribing the sequence's slice orientation and FOV to ensure complete lesion coverage. The T2-weighted and postcontrast T1-weighted sequences should use a slice thickness of 3 mm or less to depict small papillary projections within ovarian neoplasms.

TABLE 2: MRI Protocol for Adnexal Mass Characterization at 1.5- or 3-T MRI

| Sequence | Dimensions | Plane | Fat Saturated | Contrast Media | Comments |
|----------|-------------------------------|--|---------------|----------------|--|
| T2W | 2D | Sagittal | No | No | Slice thickness: 4 mm or less |
| T2W | 2D | Axial | No | No | Slice thickness: 3 mm or less |
| T1W | 2D | Axial | No | No | In phase and opposed phase Slice thickness: 4 mm or less |
| T1W | 3D ^a (dynamic) | Optimal plane for coverage of lesion and visualization of the uterus | Yes | Yes | Multiple phases for a total imaging duration of approximately 4 min Begin the scanning and inject at 30 s without interruption of scan acquisition Slice thickness: 3 mm or less |
| T1W | 3D ^a (not dynamic) | Optimal plane for coverage of lesion and visualization of the uterus | Yes | Yes | Precontrast and single postcontrast phase scanned at 30–40 s after the end of the contrast material injection Slice thickness: 3 mm or less |
| DWI | 2D | Axial | Yes | No | Similar location as T2-weighted image Section thickness: 4 mm or less b = 0–50 and 1000 s/mm ² or greater |

Note—Scanning parameters should be adjusted according to field strength and vendor for optimum image quality. FOV may vary according to patient-related considerations and size of the adnexal lesion. T2W = T2-weighted imaging, T1W = T1-weighted imaging.

^aThree-dimensional dynamic contrast-enhanced T1-weighted image series is recommended for optimal evaluation and increased specificity. A nondynamic scan can be used in place of the dynamic scan; however, specificity for cancer will decrease.

A dynamic contrast-enhanced perfusion sequence is recommended for the postcontrast imaging to allow evaluation of time-intensity curves and assist in risk stratification [31]. This dynamic sequence requires a temporal resolution per phase of 15 seconds or less. From the dynamic contrast-enhanced acquisition, time-intensity curves for the lesion and the myometrium can be generated using commercially available software, including the software packages used for kinetic analysis in breast or prostate MRI. If the dynamic contrast-enhanced series is not performed, then a precontrast sequence and a single postcontrast sequence acquired at 30–40 seconds after the end of the contrast material injection can be performed. However, without a dynamic series, lesions with nonfibrous solid tissue components can only be classified as O-RADS MRI category 4 or 5 because of the inability to show a low-risk time-intensity curve (O-RADS MRI category 3) [31]. Subtraction sequences should be routinely generated to assess for enhancement in lesions with T1-hyperintense content.

Future Direction

The potential value of performing MRI after US for the assessment of adnexal lesions provides numerous opportunities for further investigation. First, quantitative analyses of DWI data may show the role of ADC thresholds or other quantitative DWI parameters in substratifying adnexal lesions [30]. Second, although time-intensity curves have been shown to improve the stratification of lesions as having a low, intermediate, or high risk for cancer, future studies could address how this stratification affects patient referral patterns [31]. Third, large cohort studies could explore the impact of using the O-RADS risk stratification systems to select between surveillance and surgery and how this stratification affects patient outcomes and costs. Such additional data will provide evidence to guide the further refinement of the O-RADS US and MRI risk stratification systems and better understand the benefit of performing MRI after US for the evaluation of adnexal lesions.

Consensus Statements

- MRI is valuable in the characterization and risk assessment of adnexal lesions discovered on US when there is a clinical need for improved specificity for malignancy and a need to differentiate benign and borderline/low-grade tumors from high-grade cancer (e.g., patients considering fertility-sparing surgery or who are poor surgical candidates).
- In addition to O-RADS US category 0, 3, and 4 lesions, O-RADS US category 2 and 5 lesions may also benefit from MRI evaluation in certain settings, including potentially downgrading or upgrading the risk category in a patient who is a poor surgical candidate or excluding high-grade tumor in a patient seeking fertility-sparing treatments.
- MRI of an adnexal lesion should be performed on a 1.5-T or 3-T scanner using a multiparametric protocol that includes a precontrast axial in- and opposed-phase T1-weighted sequence, precontrast T2-weighted sequence in two planes, fat-saturated and non-fat-saturated T1- or T2-weighted sequences, DWI with a b value of 1000 s/mm² or greater, and a postcontrast dynamic contrast-enhanced T1-weighted series with subtraction images and time-intensity curve analysis.

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O-RADS Ultrasound Risk Stratification and Management System

| O-RADS Score | Risk Category [IOTA 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 | 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 |
| 3 | Low Risk Malignancy [1-10%] | Unilocular cyst (simple or non-simple) ≥ 10 cm | | US specialist or MRI Management by gynecologist | |
| | | 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 | | | |
| 4 | Intermediate Risk [10-50%] | Multilocular cyst, no solid component | Smooth inner wall, ≥ 10 cm, CS = 1-3 | US specialist or MRI Management by gynecologist with gyn-oncologist consultation or solely by gyn-oncologist | |
| | | | Smooth inner wall, any size, CS = 4 | | |
| | | | Irregular inner wall ± irregular septation, any size, CS = any | | |
| | | Unilocular cyst with solid component | 1-3 papillary projections (pp), or solid component that is not a pp, any size, CS= any | | |
| | | Multilocular cyst with solid component | Any size, CS = 1-2 | | |
| | | Solid lesion | Smooth outer contour, any size, CS = 2-3 | | |
| 5 | High Risk [≥ 50%] | Unilocular cyst, ≥ 4 papillary projections, any size, CS = any | | Gyn-oncologist | |
| | | 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 | | | |
| | | Ascites and/or peritoneal nodules** | | | |

CS=color score; GYN = gynecologic; IOTA = International Ovarian Tumor Analysis; N/A = not applicable
 * At a minimum, at least one-year follow-up showing stability or decrease in size is recommended with consideration of annual follow-up of up to 5 years, if stable. However, there is currently a paucity of evidence for defining the optimal duration or interval of timing for surveillance.
 **Presence of ascites with category 1-2 lesion, must consider other malignant or non-malignant etiologies of ascites

Fig. 1— Ovarian-Adnexal Reporting and Data System (O-RADS) ultrasound (US) guidance. Material is reproduced without modification with permission from American College of Radiology (©American College of Radiology; www.acr.org/-/media/ACR/Files/RADS/O-RADS/O-RADS_US-Risk-Stratification-Table.pdf), pursuant to Creative Commons BY-NC-ND license and terms contained therein (creativecommons.org/licenses/by-nc-nd/4.0/legalcode), including disclaimer in Section 5.

A, Image shows official O-RADS US risk stratification table.

(Fig. 1 continues on next page)



**O-RADS Ultrasound Risk Stratification and Management System
Classic Benign Lesions (O-RADS 2)**

| Lexicon Descriptor | Definition | Management | |
|---|---|---|---|
| | | Premenopausal | Postmenopausal |
| Typical hemorrhagic cyst | Reticular pattern: Fine thin intersecting lines representing fibrin strands | ≤ 5 cm None | US specialist, gynecologist or MRI |
| | Retracting clot: An avascular echogenic component with angular, straight, or concave margins | >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 |
| 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 endometriomas < 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 |
| Simple paraovarian cyst/any size | Simple cyst separate from the ovary that typically moves independent of the ovary when pressure is applied by the transducer | None If not simple, manage per ovarian criteria | Optional single follow up study in 1 year |
| Typical peritoneal inclusion cyst/any size | Follows the contour of the adjacent pelvic organs or peritoneum, does not exert mass effect and typically contains septations. The ovary is either at the margin or suspended within the lesion. | Gynecologist | Gynecologist |
| Typical hydrosalpinx/ any size | <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 |

*There is currently a paucity of evidence for defining the optimal duration or interval of timing for surveillance. Evidence does support an increasing risk of malignancy in endometriomas following menopause.

Fig. 1 (continued)— Ovarian-Adnexal Reporting and Data System (O-RADS) ultrasound (US) guidance. Material is reproduced without modification with permission from American College of Radiology (©American College of Radiology; www.acr.org/-/media/ACR/Files/RADS/O-RADS/O-RADS_US-Risk-Stratification-Table.pdf), pursuant to Creative Commons BY-NC-ND license and terms contained therein (creativecommons.org/licenses/by-nc-nd/4.0/legalcode), including disclaimer in Section 5.

B, Image shows supplementary table for classic benign lesions.



O-RADS MRI Risk Stratification and Management System

| O-RADS MRI Score | Risk Category | Positive Predictive Value for Malignancy [^] | Lexicon Description |
|------------------|-------------------------|---|---|
| 0 | Incomplete Evaluation | N/A | N/A |
| 1 | Normal Ovaries | N/A | No ovarian lesion Follicle defined as simple cyst ≤ 3 cm in a premenopausal woman Hemorrhagic cyst ≤ 3 cm in a premenopausal woman Corpus luteum +/- hemorrhage ≤ 3 cm in a premenopausal woman |
| 2 | Almost Certainly Benign | <0.5% [^] | Cyst: Unilocular- any type of fluid content <ul style="list-style-type: none"> No wall enhancement No enhancing solid tissue* Cyst: Unilocular – simple or endometriotic fluid content <ul style="list-style-type: none"> Smooth enhancing wall No enhancing solid tissue Lesion with lipid content** <ul style="list-style-type: none"> No enhancing solid tissue Lesion with "dark T2/dark DWI" solid tissue <ul style="list-style-type: none"> Homogeneously hypointense on T2 and DWI Dilated fallopian tube - simple fluid content <ul style="list-style-type: none"> Thin, smooth wall/endosalpingeal folds with enhancement No enhancing solid tissue Para-ovarian cyst – any type of fluid <ul style="list-style-type: none"> Thin, smooth wall +/- enhancement No enhancing solid tissue |
| 3 | Low Risk | ~5% [^] | Cyst: Unilocular – proteinaceous, hemorrhagic or mucinous fluid content*** <ul style="list-style-type: none"> Smooth enhancing wall No enhancing solid tissue Cyst: Multilocular - Any type of fluid, no lipid content <ul style="list-style-type: none"> Smooth septae and wall with enhancement No enhancing solid tissue Lesion with solid tissue (excluding T2 dark/DWI dark) <ul style="list-style-type: none"> Low risk time intensity curve on DCE MRI Dilated fallopian tube – <ul style="list-style-type: none"> Non-simple fluid: Thin wall /folds Simple fluid: Thick, smooth wall/ folds No enhancing solid tissue |
| 4 | Intermediate Risk | ~50% [^] | Lesion with solid tissue (excluding T2 dark/DWI dark) <ul style="list-style-type: none"> Intermediate risk time intensity curve on DCE MRI If DCE MRI is not feasible, score 4 is any lesion with solid tissue (excluding T2 dark/DWI dark) that is enhancing ≤ myometrium at 30-40s on non-DCE MRI Lesion with lipid content <ul style="list-style-type: none"> Large volume enhancing solid tissue |
| 5 | High Risk | ~90% [^] | Lesion with solid tissue (excluding T2 dark/DWI dark) <ul style="list-style-type: none"> High risk time intensity curve on DCE MRI If DCE MRI is not feasible, score 5 is any lesion with solid tissue (excluding T2 dark/DWI dark) that is enhancing > myometrium at 30-40s on non-DCE MRI Peritoneal, mesenteric or omental nodularity or irregular thickening with or without ascites |

[^]Approximate PPV based on data from Thomassin-Naggar, et al. O-RADS MRI Score for Risk Stratification of Sonographically Indeterminate Adnexal Masses. JAMA Network Open. 2020;3(1):e1919896. Please note that the PPV provided applies to the score category overall and not to individual characteristics. Definitive PPV are not currently available for individual characteristics. The PPV values for malignancy include both borderline tumors and invasive cancers.

* Solid tissue is defined as a lesion component that enhances and conforms to one of these morphologies: papillary projection, mural nodule, irregular septation/wall or other larger solid portions.

** Minimal enhancement of Rokitansky nodules in lesion containing lipid does not change to O-RADS MRI 4.

*** Hemorrhagic cyst ≤3cm in pre-menopausal woman is O-RADS MRI 1.

DCE = dynamic contrast enhancement with a time resolution of 15 seconds or less

DWI = diffusion weighted images

MRI = magnetic resonance imaging

Fig. 2—Image shows Ovarian-Adnexal Reporting and Data System (O-RADS) MRI risk stratification table. Terms “dark T2/dark DWI” and “T2 dark/DWI dark” indicate solid tissue that is homogeneously hypointense on T2-weighted imaging and DWI. N/A = not applicable. Material is reproduced without modification with permission from American College of Radiology (©American College of Radiology www.acr.org/-/media/ACR/Files/RADS/O-RADS/O-RADS-MR-Risk-Stratification-System-Table-September-2020.pdf), pursuant to Creative Commons BY-NC-ND license and terms contained therein (creativecommons.org/licenses/by-nc-nd/4.0/legalcode), including disclaimer in Section 5.

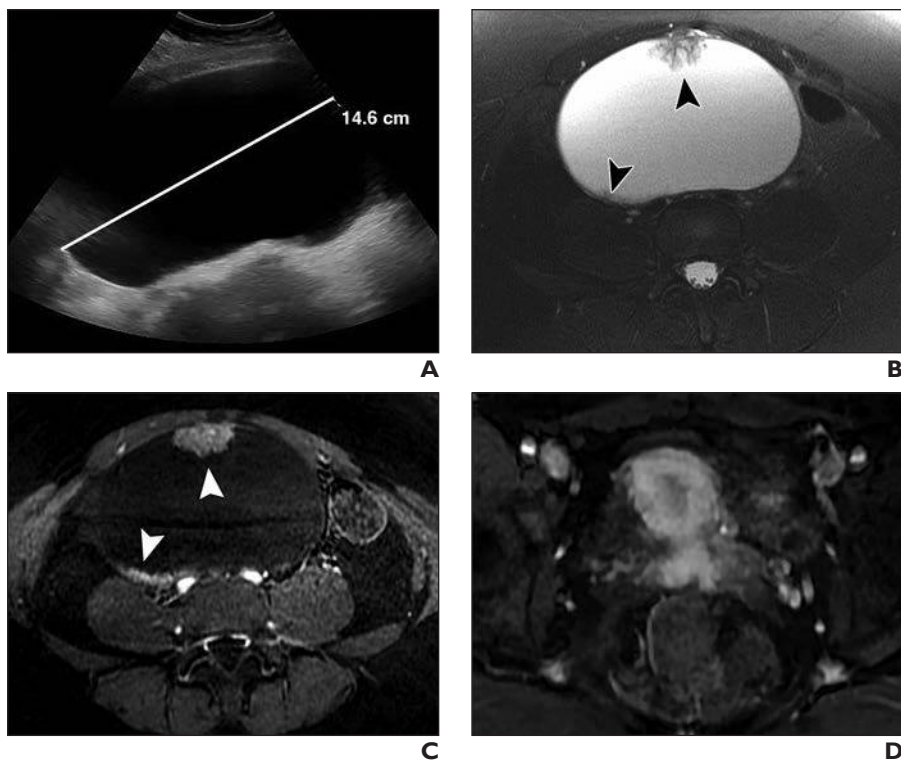


Fig. 3—25-year-old woman with adnexal lesion. **A**, Transabdominal gray-scale ultrasound (US) image shows simple-appearing cyst measuring 14.6 cm (line). Visualized portions show no obvious solid components. Cyst was classified as Ovarian-Adnexal Reporting and Data System (O-RADS) US category 0 because of size and reverberation artifact along right lateral and anterior portions of lesion. MRI was performed 2 weeks after ultrasound. **B**, Axial T2-weighted MR image shows papillary projection along anterior wall and smaller papillary projection along posterior wall (arrowheads). **C**, Axial postcontrast T1-weighted MR image shows enhancement of papillary projections (arrowheads). **D**, Axial postcontrast T1-weighted MR image shows enhancement of myometrium. Enhancement of papillary projection was less than or equal to enhancement of myometrium. Lesion was classified as O-RADS MRI category 4. Final surgical pathology was serous borderline tumor.

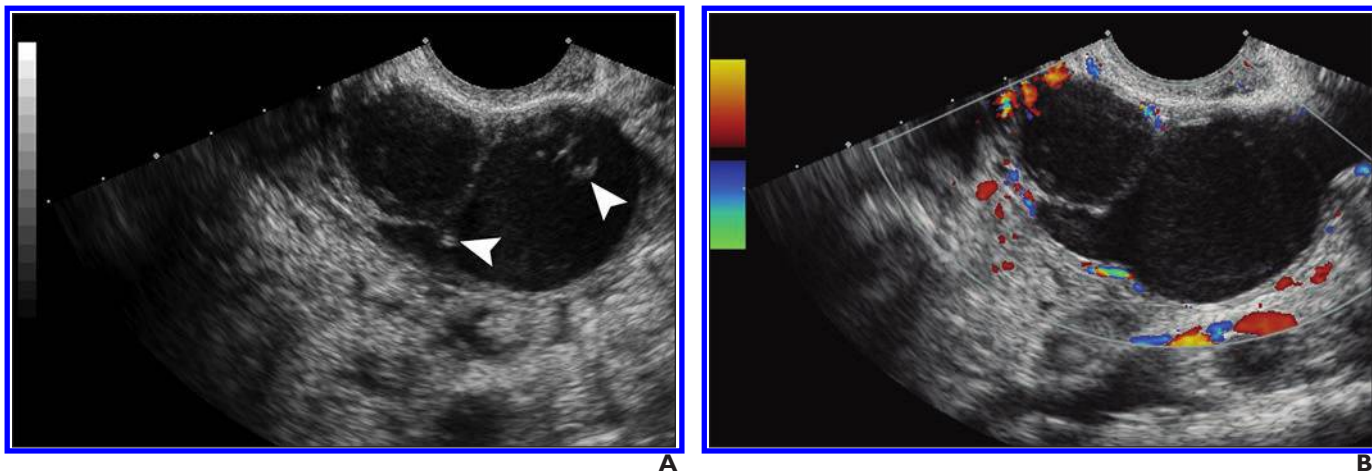
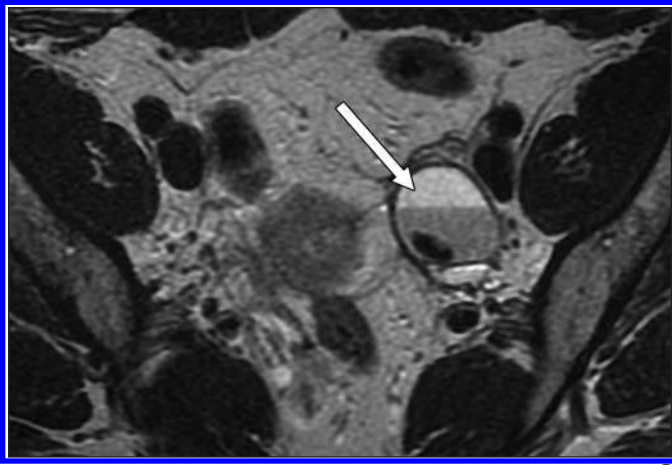
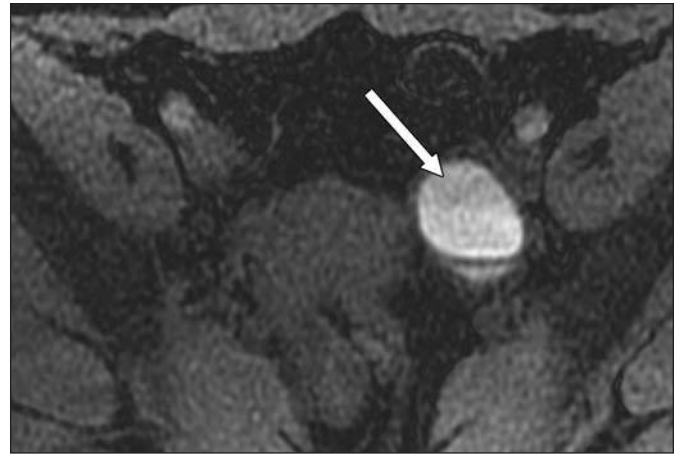


Fig. 4—52-year-old woman with left adnexal lesion. **A**, Gray-scale ultrasound (US) image shows multilocular cyst with irregular septation and nodules (arrowheads). **B**, Color Doppler US image shows no flow in irregular septation or in any other portion of lesion. Ovarian-Adnexal Reporting and Data System (O-RADS) US category was 4. MRI was performed for further evaluation.

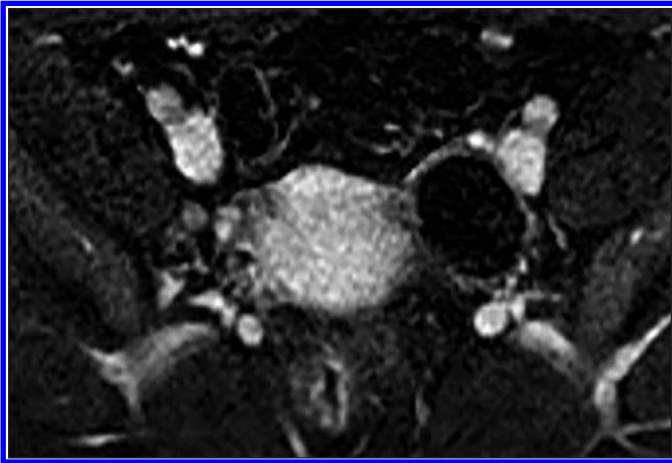
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C



D

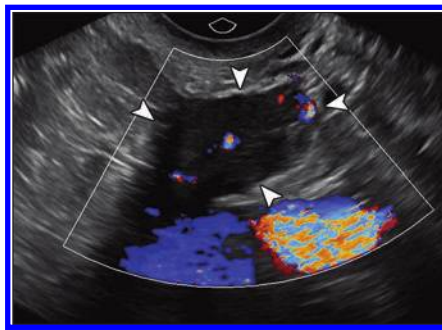


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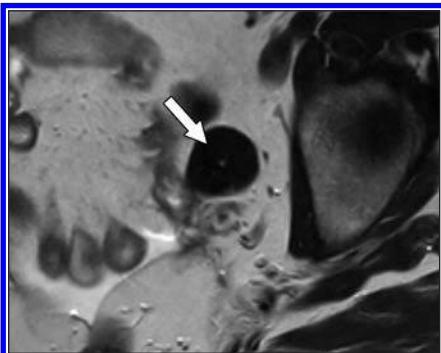
Fig. 4 (continued)—52-year-old woman with left adnexal lesion.
C, Axial T2-weighted MR image shows layering blood products of varying signal intensity in lesion (*arrow*).
D, Axial fat-saturated T1-weighted MR image shows layering blood products of varying hyperintense signal intensity in lesion (*arrow*).
E, Subtracted axial postcontrast T1-weighted MR image shows no internal enhancement in left adnexal lesion. O-RADS MRI category was 2. Final surgical pathology was endometrioma.



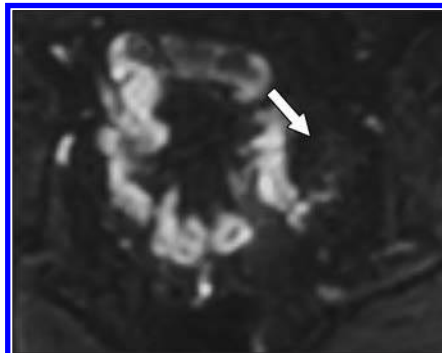
A



B



C



D

Fig. 5—50-year-old woman with right adnexal lesion.
A, Gray-scale ultrasound (US) image shows solid lesion (*arrowheads*) with lobular outer contour. Crosses indicate edges of lesion.
B, Color Doppler ultrasound image shows flow in solid lesion (*arrowheads*). Ovarian-Adnexal Reporting and Data System (O-RADS) US category was 5. MRI was performed for further characterization.
C, Axial T2-weighted MR image shows homogeneous hypointensity of lesion (*arrow*).
D, Axial DWI ($b = 1200 \text{ s/mm}^2$) shows homogeneous hypointensity of lesion (*arrow*). Lesion is likely fibroma and consistent with description of hypointensity on T2-weighted imaging and DWI ("dark T2/dark DWI") in O-RADS MRI. Such lesions are assessed as O-RADS MRI category 2, and enhancement-related findings do not contribute to category assessment. Patient was managed nonoperatively.