



SENTARA HEALTH PLANS CLINICAL PRACTICE GUIDELINE:

PELVIC MASS PROTOCOL

Guideline History

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These Guidelines are promulgated by Sentara Health as recommendations for the clinical Management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The Sentara Health Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.

PELVIC MASS



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Referral of women with a pelvic mass to a gynecologic oncologist: ACOG guidelines

Premenopausal women (refer if any are present)
Very elevated CA 125 level*
Ascites
Evidence of abdominal or distant metastases
Postmenopausal women (refer if any are present)
Elevated CA 125 level*
Ascites
Nodular or fixed pelvic mass
Evidence of abdominal or distant metastases

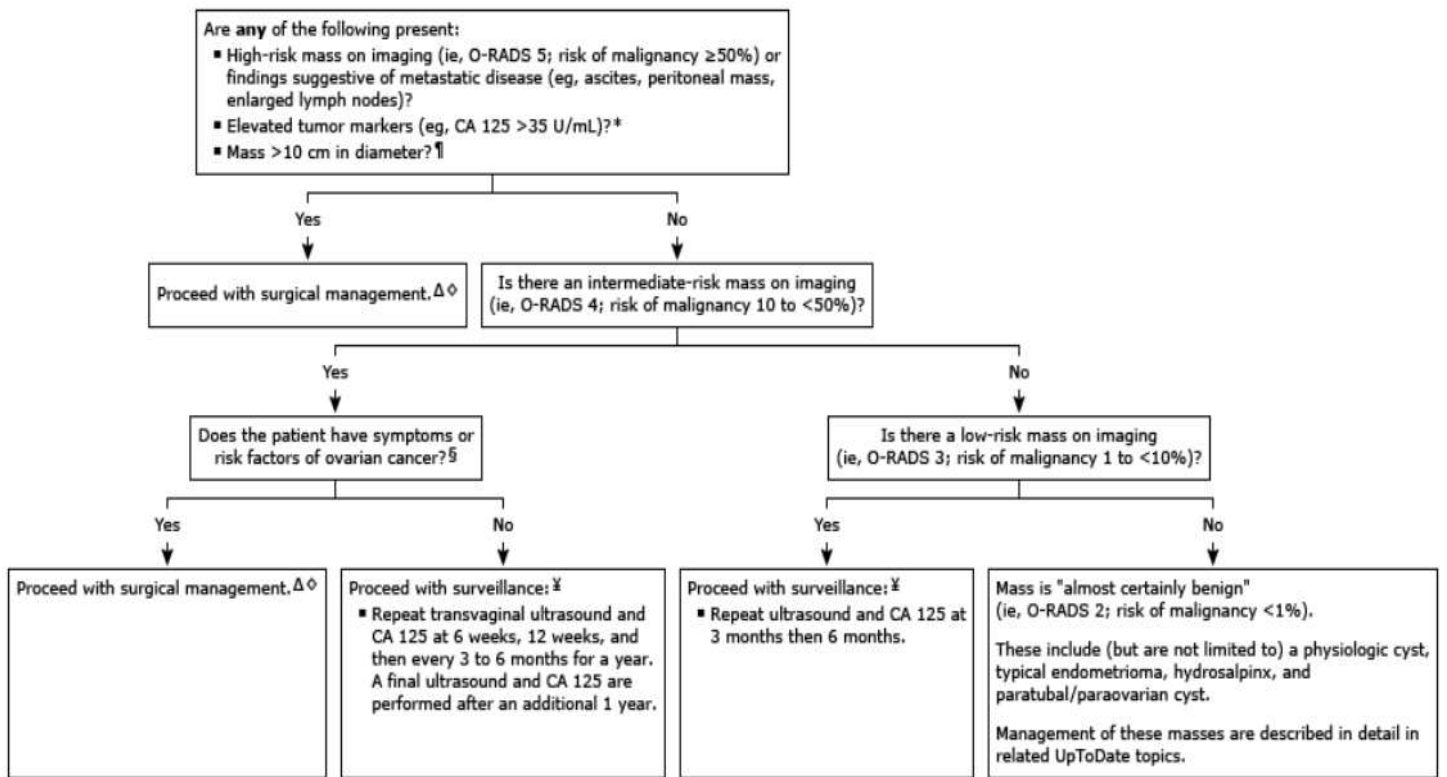
ACOG: American College of Obstetricians and Gynecologists; CA 125: cancer antigen 125.

References:

1. American College of Obstetricians and Gynecologists. *Cancer Diagnosis and Management. In: Guidelines for Women's Health Care, 4th ed, 2014.*
2. Committee Opinion No. 477: the role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer. *Obstet Gynecol* 2011; 117:742.
3. Im SS, Gordon AN, Buttin BM, et al. Validation of referral guidelines for women with pelvic masses. *Obstet Gynecol* 2005; 105:35.
4. Dearking AC, Aletti GD, McGree ME, et al. How relevant are ACOG and SGO guidelines for referral of adnexal mass? *Obstet Gynecol* 2007; 110:841.



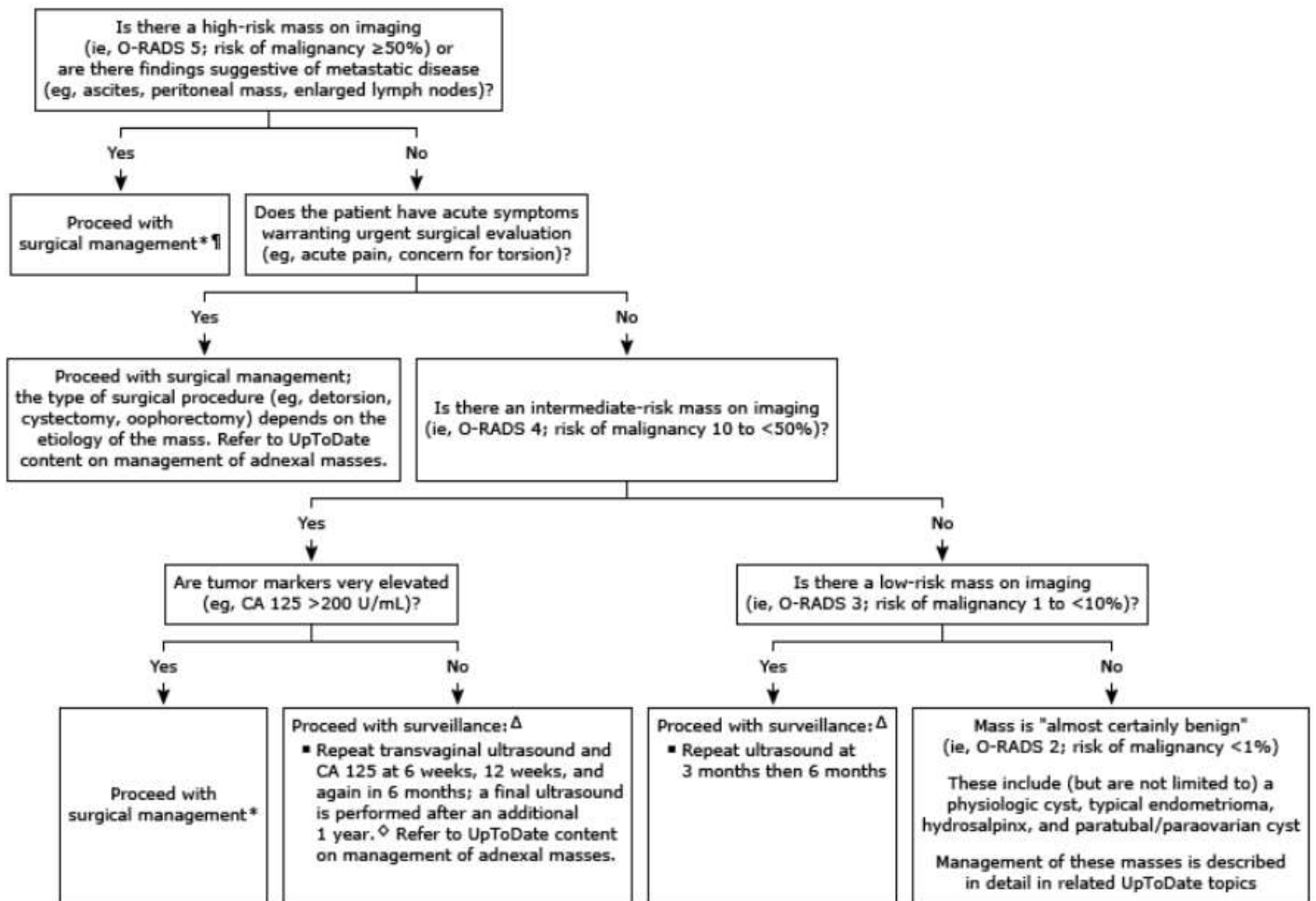
Postmenopausal patient with an adnexal mass on imaging



This algorithm pertains to average-risk patients. Patients with a hereditary ovarian cancer syndrome (eg, *BRCA* mutation, Lynch syndrome) are managed differently; for more information, refer to UpToDate content on hereditary ovarian cancer syndromes.



Nonpregnant, premenopausal patient with an adnexal mass on imaging





Evaluation of ovarian masses in children and adolescents without acute severe abdominal pain

History and examination findings	
Patient group	Potential significance
All patients	
<ul style="list-style-type: none"> ▪ Ovarian mass that is bilateral, solid, fixed, or irregular 	<ul style="list-style-type: none"> ▪ Associated with malignant tumors
<ul style="list-style-type: none"> ▪ Abdominal distension or ascites 	<ul style="list-style-type: none"> ▪ Associated with malignant tumors
Neonates and infants:	
<ul style="list-style-type: none"> ▪ Cyst noted on antenatal ultrasonography 	<ul style="list-style-type: none"> ▪ Fetal/neonatal cysts usually resolve spontaneously by 6 months of age
Prepubertal children	
<ul style="list-style-type: none"> ▪ Increased height velocity 	<ul style="list-style-type: none"> ▪ Onset of puberty (associated with increased incidence of physiologic cysts); rarely may indicate hormone-producing tumors
<ul style="list-style-type: none"> ▪ Early puberty 	<ul style="list-style-type: none"> ▪ Ovarian tumor ▪ Central or peripheral precocious puberty
<ul style="list-style-type: none"> ▪ Virilization 	<ul style="list-style-type: none"> ▪ Sertoli-Leydig cell tumor
Adolescents	
<ul style="list-style-type: none"> ▪ Menstrual history 	<ul style="list-style-type: none"> ▪ May increase/decrease suspicion for: <ul style="list-style-type: none"> • Physiologic cysts • Endometrioma • Congenital anomaly of the vagina or uterus
<ul style="list-style-type: none"> ▪ Sexual history 	<ul style="list-style-type: none"> ▪ May increase/decrease suspicion for: <ul style="list-style-type: none"> • Pregnancy-associated cysts • Tubo-ovarian abscess (associated with STI)



Imaging for all patients

Imaging modality	Findings associated with malignant tumors
Transabdominal ultrasonography	<ul style="list-style-type: none"> ▪ Size ≥8 to 10 cm ▪ Multiple lesions ▪ Bilateral masses ▪ Solid or heterogeneous (solid components >2 cm, thick septations, papillary projections), compared with cystic and homogeneous ▪ Invasive or metastatic compared with well-circumscribed ▪ Calcifications ▪ Ascites
Doppler flow	<ul style="list-style-type: none"> ▪ Increased blood flow (compared with minimal or no blood flow)



Laboratory testing for select patient groups

Patient group	Laboratory tests
Postmenarchal adolescents	<ul style="list-style-type: none"> ▪ Urine beta-hCG
Signs or symptoms of STI	<ul style="list-style-type: none"> ▪ Testing for STI
Increased suspicion for ovarian tumor (eg, based on ultrasonography or associated symptoms)	<ul style="list-style-type: none"> ▪ Panel of ovarian tumor markers (AFP, beta-hCG, LDH, inhibin A and B, CA-125)
Increased suspicion for hormonally active tumor	<ul style="list-style-type: none"> ▪ Estradiol ▪ Testosterone
Patients with ascites	<ul style="list-style-type: none"> ▪ Cytology of ascitic fluid (if fluid is obtained)
Ovarian mass with torsion	<ul style="list-style-type: none"> ▪ Platelet count (thrombocytosis is a nonspecific marker of ovarian malignancy)

This table is meant for use with UpToDate content related to the evaluation of ovarian masses in children and adolescents. Refer to UpToDate content for additional details.

**Select nonneoplastic causes of adnexal mass in children and adolescents^[1,2]**

Origin	Associated clinical features	Ultrasonographic features
Ovarian origin		
Follicular cyst	<ul style="list-style-type: none"> Common in neonates and perimenarchal/menarcheal adolescents 	<ul style="list-style-type: none"> Simple (clear fluid filled), or Complex (containing debris, septae, solid components; echogenic wall)
Corpus luteal cyst	<ul style="list-style-type: none"> Pelvic pain 	<ul style="list-style-type: none"> Complex (internal echoes)
Endometrioma ("chocolate cyst")	<ul style="list-style-type: none"> Rare in adolescents Bilateral in 33% 	<ul style="list-style-type: none"> Complex (unilocular cyst with echogenic debris)
Para-ovarian origin		
Ectopic pregnancy	<ul style="list-style-type: none"> Abdominal pain and vaginal bleeding Increasing beta-hCG 	<ul style="list-style-type: none"> Pregnancy at ectopic site Extraovarian adnexal mass
Hydrosalpinx or pyosalpinx	<ul style="list-style-type: none"> Acute pelvic pain 	<ul style="list-style-type: none"> Dilated tubular structure adjacent to ovary, may have incomplete septations
Paraovarian/paratubal cysts (eg, mesonephric cysts, cysts of the broad ligament)	<ul style="list-style-type: none"> Often asymptomatic Abdominal pain or distension Increases risk of tubal torsion 	<ul style="list-style-type: none"> Simple cysts Size can range from a few millimeters to 15 cm or larger
Tubo-ovarian abscess	<ul style="list-style-type: none"> Usually a complication of PID; may result from intra-abdominal spread Abdominopelvic pain Fever Purulent cervical discharge Cervical motion tenderness Leukocytosis 	<ul style="list-style-type: none"> Complex Multilocular Obscure normal adnexal anatomy Contains speckled fluid with internal echoes (inflammatory debris)

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