PIPADOR REVISION

MRCOG Part 1 Revision Notes

Ovarian Cysts

CLINICAL MANAGEMENT • LECTURE 458

VISUAL EXAMINATION REVISION NOTES

2026 Edition

458

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Ovarian Cysts

Assessment and management of ovarian cysts in pre- and postmenopausal women (RCOG GTG 62 & 34) and torsion

< 50 mm	RMI ≥ 200	LDH, AFP, hCG	Torsion
Simple cyst — no follow-up (premenopausal)	Refer gynae-oncology	< 40 with complex mass	Emergency

■ KEY FACTS: Learning objectives

- Define functional, benign and malignant ovarian cysts and the RMI.
- Describe assessment and management of ovarian cysts in premenopausal (RCOG GTG 62) and postmenopausal women (RCOG GTG 34).
- Recognise and manage ovarian torsion and cyst complications.

458.1 Key definitions

Term	Definition
Functional cyst	Physiological follicular or corpus luteum cyst — usually resolves within 2–3 cycles
Simple cyst	Unilocular, thin-walled, anechoic, no solid parts — very low malignancy risk
Complex cyst	Septations, solid areas, papillary projections or mixed echogenicity
Risk of Malignancy Index (RMI I)	U (ultrasound score) × M (menopausal status 1 or 3) × CA-125
IOTA simple rules / ADNEX, O-RADS	Validated ultrasound-based risk models used by expert sonographers
Ovarian torsion	Twisting of the ovary on its pedicle, compromising blood supply — surgical emergency

■ IN PLAIN ENGLISH: Ovarian cysts

Most ovarian cysts in younger women are **functional or benign** and need no treatment. After the menopause the risk of cancer is higher, so CA-125 and the RMI guide who needs specialist (oncology) care.

458.2 Premenopausal women

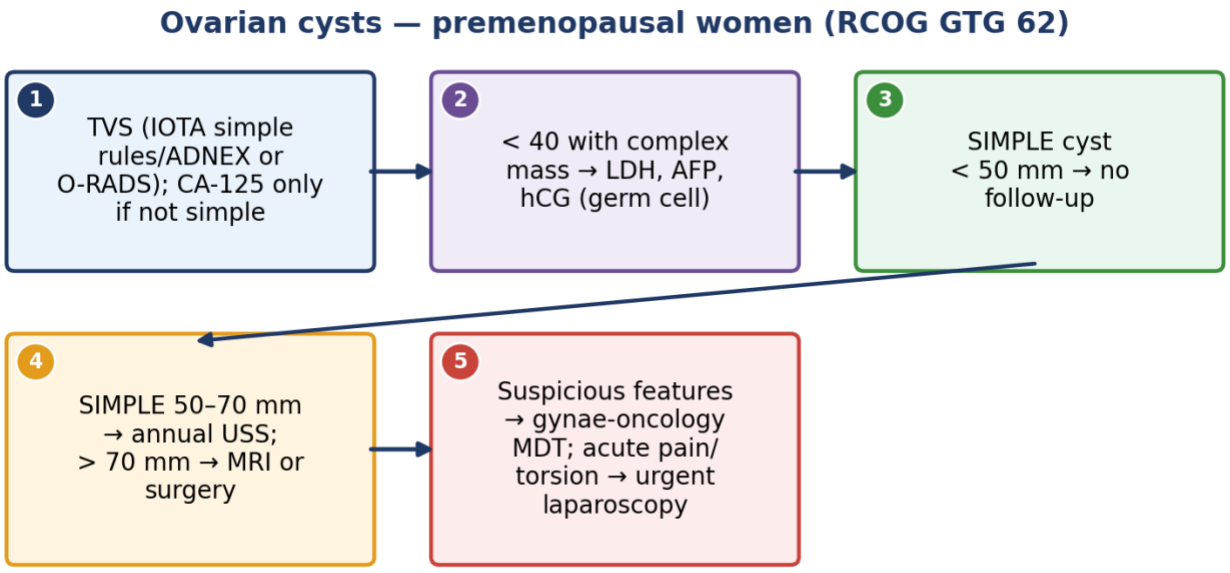


Figure 458.1 — Premenopausal women (RCOG GTG 62)

- CA-125 is not needed for simple cysts on TVS in premenopausal women (raised by endometriosis, PID, menstruation, pregnancy).
- Women < 40 with a complex mass: LDH, AFP and hCG (germ cell tumours).
- Surgery (laparoscopic **cystectomy** preserving ovarian tissue) for persistent, enlarging or symptomatic cysts
  - Dermoids and endometriomas often need surgery depending on size/symptoms.

458.3 Postmenopausal women

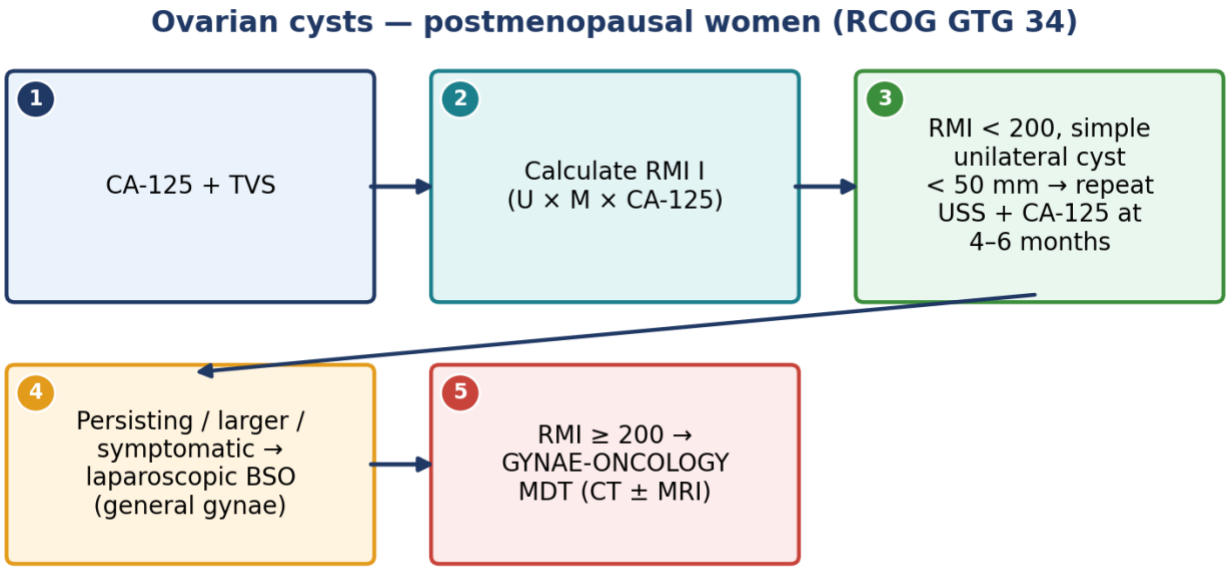


Figure 458.2 — Postmenopausal women (RCOG GTG 34)

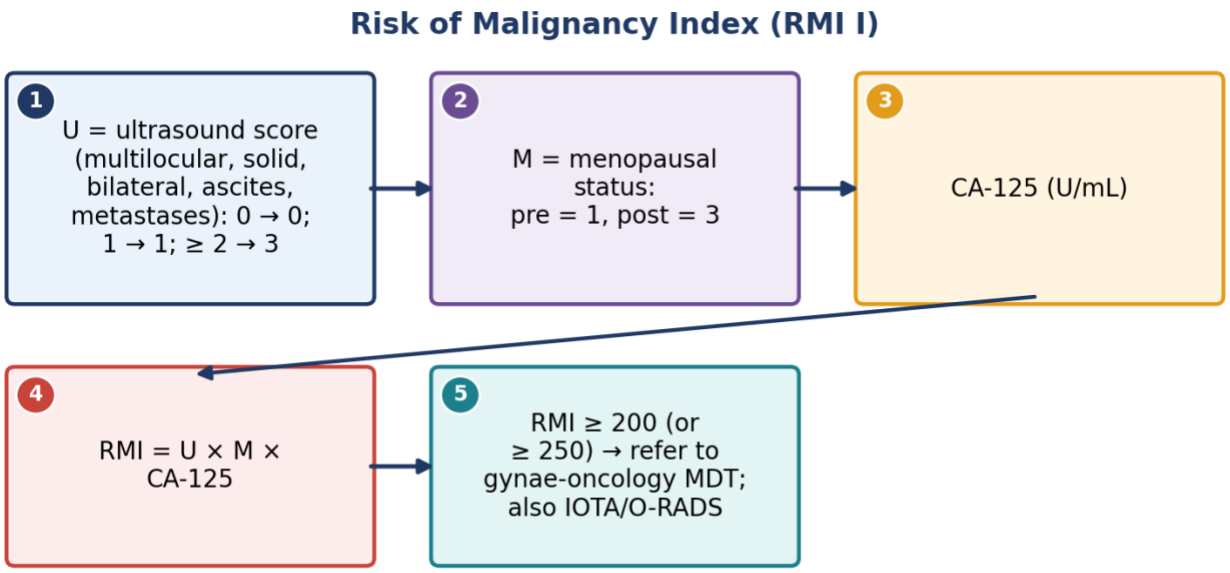


Figure 458.3 — Risk of Malignancy Index (RMI I)

■ RED FLAGS

Ovarian torsion: sudden severe unilateral pain, nausea/vomiting, tender adnexal mass; Doppler flow may be present → **urgent laparoscopy and detorsion** (conserve the ovary even if it looks dusky), ± cystectomy.

Ruptured/haemorrhagic cyst: pain, free fluid; usually conservative if stable; surgery if haemodynamic compromise.

NICE NG12: CA-125 for women (esp. ≥ 50) with persistent bloating, early satiety, pelvic/abdominal pain, urinary urgency/frequency.

■ COMMON PITFALLS

Measuring CA-125 for simple cysts in young women and causing unnecessary anxiety.

Aspirating cysts (high recurrence; risk of spill if malignant).

Delaying surgery in suspected torsion because Doppler flow is present.

458.4 Must-know summary

■ EXAM TIP

- Premenopausal simple cyst < 50 mm: no follow-up; 50–70 mm: annual USS; > 70 mm: MRI/surgery.
- < 40 with complex mass: LDH, AFP, hCG.
- Postmenopausal: CA-125 + TVS → RMI; ≥ 200 → gynae-oncology MDT; simple < 50 mm with normal CA-125 → repeat at 4–6 months.
- Torsion → urgent laparoscopic detorsion (conserve ovary).

■ MNEMONIC / MEMORY AID

Premenopausal simple cyst — '5 and 7': < 5 cm leave, 5–7 cm yearly scan, > 7 cm consider MRI/surgery.