Results: 16/25 (64.0%) of the gynecologists were IOTA-certified. The IOTA template was used in 83/90 (92.2%) cases. 58/83 (69.9%) descriptions used IOTA terms correctly with adequate information. Conflicting use of IOTA terms were seen in 15/83 (18.1%) cases; with misclassification of uni-/multilocular lesions with solid components being the most frequent pitfall. 10/83 (12.0%) contained inadequate measures only. All 7/90 (7.8%) cases not using the IOTA template lacked information on morphology, colour score, and measures. 39/90 (43.3%) images did not document the findings described (colour score (n = 18) and lesion measures (n = 15) mostly missing). In 25/90 (27.8%) patients, the two external reviewers disagreed with the examining gynecologist on lesion classification (n = 11), cystic content (n = 8), regularity (n = 11), and shadowing (n = 3). There was no significant association between IOTA-certification status and disagreement by reviewers (22.7% in IOTA-certified vs. 29.2% in non-certified, p = 0.193).

Conclusions: Essential pitfalls in using the IOTA terms and definitions were relatively frequent, despite IOTA certification. To perform optimal evaluation and implementation of the IOTA diagnostic tools, methods to maintain IOTA competencies must be developed.

VP61.05
Efficient and customised use of IOTA ADNEX model as a clinical management tool in a tailor-made treatment of adnexal tumour suspected of malignancy

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Objectives: Validate in a reference cancer centre the ADNEX model, focusing it as an efficient tool that customises the pre-surgical approach of patients with suspicion of malignant ovarian tumour.

Methods: Prospective study, in a national health tertiary hospital, between 2018-20. Patients scanned on suspicion of malignant ovarian tumour, methodology defined by IOTA, certified explorer. IOTA ADNEX model variables were analysed, adding Doppler colour score. A threshold of 20% was considered, non-adjusted odd-ratio value is highly statistically significant (99.667) with a 95% CI. P < 0.05 considered significant. Those whose risk >20% were referred to our oncology gynecology unit. Risks 10-20% were scheduled for surgery in a general gynecology theatre, with intraoperative biopsy, counting on skilled gynecologic oncologist on alert.

Results: Malignity rate 46%. According to malignant relative risk, there was a good correlation in II-IV stage (69%) and borderline (61.9%). The worse was given in metastasis (22.2%). The cyst subtype mostly associated with II-IV tumour is the solid and multilocular solid, being for borderline tumour, multilocular solid and unilocular solid. Of 400 patients referred, were excluded malignancy risk 10% and who have no surgical indication, leaving 272 patients. Only 3 false-negatives were found in the group considered benign with surgical criteria, 3/147 (98% accuracy), all of them borderline tumours with a priori risk of 15-20% so intraoperative biopsy and optimal oncological surgery were performed in the moment. In malignant group, 33 false-positives were found (73.6% accuracy) which were: benign solid tumours (fibroma), non-gynecological malignant/benign tumours, inflammatory necrosis.

Conclusions: ADNEX model is essential for customised treatment of adnexal tumours in order to efficiency and schedule oncological surgery. The best assessment of malignancy occurs in stage II-IV tumour and borderline tumour. The worst correlation was found in metastasis, which are assessed by Doppler colour score, abdominal spread signs and patient's clinical data.

VP61.06
Abstract withdrawn

VP61.07
Portuguese multicentre external validation of the IOTA Simple Rules, LR2 risk model and ADNEX model (phase I)

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Objectives: To evaluate the performance of the IOTA Simple Rules (SR), LR2 risk model and ADNEX model in the preoperative discrimination between benign and malignant adnexal formations, when used by IOTA-certificated sonographers of two Portuguese tertiary referral hospitals.

Methods: This prospective study, conducted between January 2016 and December 2019 (phase I), included 266 non-pregnant patients (age ≥18 years) consecutively diagnosed in our institutions with clearly non-functional adnexal masses (≥ 3cm), which were

VP61.07: Table 1. Results

	Classified formations (%)	Correctly classified, benign (n/N)	Correctly classified, malignant (n/N)	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)
SR	7.9	178/180	17/22	77.3	98.9	89.5	97.3
LR2	100	198/230	27/36	75.0	86.1	45.8	95.7
ADNEX without CA125	100	171/230	Bimodal: 34/36 (a)	92.3	74.4	28.9	98.8
ADNEX with CA125	100 (#)	170/216	Bimodal: 31/35 (b)	88.6	78.7	40.3	97.7

(a) Multimodal: correctly classified BOT 7/14, invasive I 1/8, invasive II-IV 11/12, metastatic 0/2 (b) Multimodal: correctly classified BOT 7/14, invasive I 3/8, invasive II-IV 10/11, metastatic 0/2 (#) CA-125 available in 251 patients