

**American College of Radiology  
ACR Appropriateness Criteria®**

**Clinical Condition:** Breast Microcalcifications

**Variant 1:** Pleomorphic, fine, linear, branching in any distribution.

Radiologic Procedure	Rating	Comments	RRL*
X-ray mammography magnification views	9	CC and 90° lateral views preferred.	Low
Core biopsy breast	9		NS
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Excisional biopsy breast	6	If discordant needle biopsy results or concerned about sampling error. If image guided percutaneous biopsy not available.	None
US breast	4	May be useful in dense breast to look for mass component in lesion.	None
MRI breast	3	Specific indications are still being investigated.	None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 2:** Documentation of skin calcification.

Radiologic Procedure	Rating	Comments	RRL*
X-ray mammography tangential views dermal localization exam	8	Only if calcifications are not typically dermal in appearance.	Low
Fine needle aspiration breast	1		NS
Core biopsy breast	1		NS
Excisional biopsy breast	1		None
MRI breast	1		None
Sestamibi scan breast	1		High
X-ray mammography magnification views	1		Low
US breast	1		None
X-ray diagnostic mammography 6-month follow-up	1		Low
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:** Breast Microcalcifications

**Variant 3:** Milk of calcium, any distribution.

Radiologic Procedure	Rating	Comments	RRL*
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
Excisional biopsy breast	2		None
Core biopsy breast	2		NS
US breast	2		None
MRI breast	1		None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 4:** Amorphous, single cluster.

Radiologic Procedure	Rating	Comments	RRL*
X-ray mammography magnification views	9	CC and 90° lateral views preferred.	Low
Core biopsy breast	8		NS
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Excisional biopsy breast	6	If discordant needle biopsy results or concerned about sampling error. If image guided percutaneous biopsy not available.	None
X-ray diagnostic mammography 6-month follow-up	3	If present in retrospect and stable, 6-month follow-up can be considered.	Low
MRI breast	2	Specific indications are still being investigated.	None
US breast	2		None
Fine needle aspiration breast	2		NS
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 5:****Amorphous, multiple clusters, one breast.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	9	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Core biopsy breast	7	Sampling of representative grouping is recommended with further management dependent on histology.	NS
Excisional biopsy breast	3		None
MRI breast	2	Specific indications are still being investigated.	None
Fine needle aspiration breast	2		NS
US breast	2		None
Sestamibi scan breast	1		High
X-ray diagnostic mammography 6-month follow-up	No Consensus	Some would only follow-up after work-up complete and biopsy of dominant cluster benign. Others would be more conservative. If no dominant cluster, they would do 6-month follow-up.	Low
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 6:****Amorphous, multiple bilateral clusters.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
X-ray diagnostic mammography 6-month follow-up	7	Once work-up demonstrates uniform, probably benign appearance of all calcifications.	Low
MRI breast	2	Specific indications are still being investigated.	None
Excisional biopsy breast	2		None
Fine needle aspiration breast	2		NS
US breast	2		None
Core biopsy breast	2		NS
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 7:****Amorphous in a regional distribution.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Core biopsy breast	6		NS
MRI breast	2	Specific indications are still being investigated.	None
Fine needle aspiration breast	2		NS
Excisional biopsy breast	2		None
X-ray diagnostic mammography 6-month follow-up	2		Low
US breast	2		None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

**Variant 8:****Amorphous in a linear or segmental distribution.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	9	CC and 90° lateral views preferred.	Low
Core biopsy breast	8		NS
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Excisional biopsy breast	6	If discordant needle biopsy results or concerned about sampling error. If image guided percutaneous biopsy not available.	None
US breast	4	May be useful in dense breast to look for mass component in lesion.	None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
MRI breast	2	Specific indications are still being investigated	None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 9:****Coarse (popcorn), large rod-like, dystrophic, suture, lucent-centered, egg shell rim.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	2		Low
X-ray mammography orthogonal views	2		Low
US breast	2		None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
Core biopsy breast	2		NS
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

**Variant 10:****Round or punctate, clustered.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray diagnostic mammography 6-month follow-up	8	Biopsy if increasing.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
Core biopsy breast	4	Only if increasing.	NS
Excisional biopsy breast	3		None
Fine needle aspiration breast	2		NS
US breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 11:****Round or punctate, regional.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
X-ray diagnostic mammography 6-month follow-up	6	If magnification views show calcifications that are probably benign.	Low
Excisional biopsy breast	2		None
US breast	2		None
Fine needle aspiration breast	2		NS
Core biopsy breast	2		NS
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 12:****Punctate calcifications in a linear or segmental distribution.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
Core biopsy breast	8		NS
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Excisional biopsy breast	6	If discordant needle biopsy results or concerned about sampling error. If image guided percutaneous biopsy not available.	None
US breast	4	May be useful in dense breast to look for mass component in lesion.	None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 13:****Punctate and amorphous, diffuse, bilateral.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
Fine needle aspiration breast	2		NS
Core biopsy breast	2		NS
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
X-ray mammography magnification views	2		Low
X-ray mammography orthogonal views	2		Low
X-ray diagnostic mammography 6-month follow-up	2		Low
US breast	2		None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 14:****Coarse heterogeneous, single cluster.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
Core biopsy breast	6	If new or increasing.	NS
X-ray diagnostic mammography 6-month follow-up	5	If magnification views demonstrate the calcifications to be probably benign.	Low
Excisional biopsy breast	4	If suspicious and core not available.	None
Fine needle aspiration breast	2		NS
MRI breast	2	Specific indications are still being investigated.	None
US breast	2		None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 15:****Coarse heterogeneous, multiple clusters, one breast.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
X-ray diagnostic mammography 6-month follow-up	7	If magnification views demonstrate the calcifications to be probably benign.	Low
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
US breast	2		None
Fine needle aspiration breast	2		NS
Core biopsy breast	2		NS
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 16:****Coarse heterogeneous, multiple bilateral clusters.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><u>RRL*</u></b>
X-ray mammography magnification views	2		Low
X-ray mammography orthogonal views	2		Low
US breast	2		None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
Core biopsy breast	2		NS
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Clinical Condition:****Breast Microcalcifications****Variant 17:****Coarse heterogeneous, in regional distribution.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><a href="#">RRL*</a></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications.	Low
X-ray diagnostic mammography 6-month follow-up	7	If magnification views demonstrate the calcifications to be probably benign.	Low
Core biopsy breast	4	If new or increasing.	NS
US breast	3	If biopsy is contemplated and tissue is dense, may be useful to look for mass component in lesion.	None
Fine needle aspiration breast	2		NS
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

**Variant 18:****Coarse heterogeneous, in linear or segmental distribution.**

<b>Radiologic Procedure</b>	<b>Rating</b>	<b>Comments</b>	<b><a href="#">RRL*</a></b>
X-ray mammography magnification views	8	CC and 90° lateral views preferred.	Low
Core biopsy breast	8		NS
X-ray mammography orthogonal views (90° lateral and CC views if not readily available)	7	Orthogonal views may be useful in positioning for the spot compression magnification views to be sure to include the calcifications. They will also be useful for pre-stereotactic localization or localization procedure.	Low
US breast	4	May be useful in dense breast to look for mass component in lesion.	None
X-ray diagnostic mammography 6-month follow-up	2		Low
Fine needle aspiration breast	2		NS
Excisional biopsy breast	2		None
MRI breast	2	Specific indications are still being investigated.	None
Sestamibi scan breast	1		High
<b><u>Rating Scale:</u> 1=Least appropriate, 9=Most appropriate</b>			<b>*Relative Radiation Level</b>

# BREAST MICROCALCIFICATIONS

Expert Panel on Women's Imaging—Breast: Carl D'Orsi, MD<sup>1</sup>; Lawrence W. Bassett, MD<sup>2</sup>; Wendie A. Berg, MD, PhD<sup>3</sup>; Marcela Bohm-Velez, MD<sup>4</sup>; W. Phil Evans III, MD<sup>5</sup>; Dione Marie Farria, MD, MPH<sup>6</sup>; Carol Lee, MD<sup>7</sup>; Ellen Mendelson, MD<sup>8</sup>; Steven Goldstein, MD.<sup>9</sup>

## Summary of Literature Review

Currently, ductal carcinoma-in-situ (DCIS) represents 25%-30% of all reported breast cancers. Approximately 95% of all DCIS is diagnosed because of mammographically detected microcalcifications [1]. Prior to the widespread use of screening mammography, DCIS, detected as a mass on physical examination, was an uncommon disease representing less than 3% of all breast cancers. Screening mammography is the only reliable tool available for the detection of breast microcalcifications and DCIS [2].

Breast microcalcifications are detected commonly on screening mammograms. Most breast calcifications are benign and can be classified accordingly without any additional work-up [3, 4]. In women with indeterminate or malignant calcifications on screening studies, micro-focus (0.1 mm focal spot) magnification views in orthogonal projections are useful [1,4].

On magnification images, additional calcifications may be apparent, the morphology of individual calcifications can be characterized, and the distribution of calcifications can be better determined. In women with malignant calcifications, magnification images may be helpful in establishing the extent of disease [1].

Currently, the role for computer-aided detection (CAD) of calcifications [5-11] as not yet been determined. However, recent studies indicate that CAD can be clinically useful to avoid false negatives when used properly [12-14].

Stereotactically guided core biopsy using a variety of devices can sample areas of microcalcifications [15]. Stereotactically guided fine needle aspiration (FNA) of microcalcifications has been shown to be inaccurate [16]. Core biopsy specimen radiographs should be done to

establish the presence of calcifications in the core, as is done with surgically excised specimens.

## Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

Relative Radiation Level Designations	
Relative Radiation Level*	Effective Dose Estimate Range
None	0
Minimal	< 0.1 mSv
Low	0.1-1 mSv
Medium	1-10 mSv
High	10-100 mSv

\*The RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a number of factors (eg, the region of the body exposed to ionizing radiation, the imaging guidance that is used, etc). The RRLs for these examinations are designated as NS (not specified).

## Supporting Document(s)

- [ACR Appropriateness Criteria® Overview](#)
- Evidence table under review

## References

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The American College of Radiology seeks and encourages collaboration with other organizations on the development of the ACR Appropriateness Criteria through society representation on expert panels. Participation by representatives from collaborating societies on the expert panel does not necessarily imply society endorsement of the final document.

Reprint requests to: Department of Quality & Safety, American College of Radiology, 1891 Preston White Drive, Reston, VA 20191-4397.

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The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

## Appendix 1.

<b>B. CALCIFICATIONS</b>	
Analysis of calcifications includes a description of both morphology and distribution. Calcifications may be divided into those that are typically benign, those of intermediate concern, and those with a higher probability of malignancy. Distribution may be characterized as grouped or clustered, linear, segmental, regional, or diffuse/scattered.	
<b>TYPES AND DISTRIBUTION OF CALCIFICATION:</b>	
<b>1. Typically Benign</b>	
<i>Skin Calcifications</i>	These are usually lucent-centered and often pathognomonic in their appearance. Skin calcifications are most commonly seen along the intramammary fold parasternally, and in the axilla and areola. Unusual forms may be confirmed as skin deposits by performing mammographic magnification views tangential to the overlying skin.
<i>Vascular Calcifications</i>	Parallel tracks, or linear tubular calcifications that are clearly associated with blood vessels.
<i>Coarse or (“Popcorn Like” Calcifications)</i>	These are the classic large (>2-3 mm in greatest diameter) calcifications produced by an involuting fibroadenoma.
<i>Large Rod-Like Calcifications</i>	These benign calcifications with ductal ectasia may form solid or discontinuous smooth linear rods $\geq 1$ mm in diameter. They can have lucent centers; if the calcium is in the wall of the duct and will generally be solid when secretions calcify in the lumen of ectatic ducts. These follow a ductal distribution, radiating toward the nipple, are occasionally branching and usually bilateral. Secretory calcifications are most often seen in women older than 60 years.
<i>Round Calcifications</i>	Round calcifications are 0.5-1 mm in size and frequently form in acini of the terminal duct lobular unit. When smaller than 0.5 mm, the term “punctate” is used. An isolated cluster of punctate calcifications may warrant close surveillance or even biopsy if new, increasing, or ipsilateral to a cancer, though further study is warranted.
<i>Lucent-Centered Calcifications</i>	These are benign calcifications that range from smaller than 1 mm to larger than a centimeter or more. These deposits are round or oval, with smooth surfaces, and have a lucent center. The “wall” that is created is thicker than the “rim or eggshell” type of calcifications. Included are areas of fat necrosis, and calcified debris in ducts.
<i>“Eggshell” or “Rim” Calcifications</i>	These are very thin, benign calcifications that appear as calcium deposited on the surface of a sphere. These deposits are usually smaller than 1 mm in thickness when viewed on edge. Fat necrosis and calcifications in the wall of cysts are the most common “rim” calcifications.
<i>Milk of Calcium Calcifications</i>	This is a manifestation of sedimented calcifications in macro- or micro-cysts. On the craniocaudal image they are often less evident and appear as fuzzy, round, amorphous deposits, while on the 90° lateral, they are more clearly defined, semilunar, crescent-shaped, curvilinear (concave up) or linear, defining the dependent portion of cysts. The most important feature of these calcifications is the apparent change in shape of the calcific particles on different mammographic projections (craniocaudal versus oblique or 90° lateral).
<i>Suture Calcifications</i>	These represent calcium deposited on suture material. They are typically linear or tubular in appearance and when present, knots are frequently visible.
<i>Dystrophic Calcifications</i>	These usually form in the irradiated breast or in the breast following trauma. Although irregular in shape, they are coarse and usually larger than 0.5 mm in size. They often have lucent centers.
<b>2. Intermediate Concern Calcifications</b>	
<i>Amorphous or Indistinct Calcifications</i>	These are sufficiently small or hazy in appearance that a more specific morphologic classification cannot be determined. Diffuse scattered amorphous calcifications may be dismissed as benign although baseline magnification views may be helpful. Amorphous calcifications in a clustered, regional, linear or segmental distribution may warrant biopsy [17].
<i>Coarse Heterogeneous Calcifications</i>	These are irregular, conspicuous calcifications that are generally larger than 0.5 mm and tend to coalesce but are not the size of irregular dystrophic calcifications. They may be associated with malignancy but can be present in areas of fibrosis, fibroadenomas or trauma, representing evolving dystrophic calcifications. Multiplicity and bilaterality of such calcifications favors benign etiology though further study is warranted.

<b>3. Higher Probability of Malignancy</b>	
<i>Fine Pleomorphic Calcifications</i>	These are usually more conspicuous than the amorphous forms and are neither typically benign (see above) nor typically malignant (see below). They vary in size and shape and are usually smaller than 0.5 mm in diameter.
<i>Fine Linear, or Fine Linear Branching Calcifications</i>	These are thin, linear or curvilinear irregular calcifications, which may be discontinuous and are generally smaller than 0.5 mm in width. Their appearance suggests filling of the lumen of a duct involved irregularly by breast cancer.
<b>4. Distribution Modifiers</b>	
These are used to describe the arrangement of calcifications in the breast. Multiple similar groups may be indicated in the report when there is more than one group of calcifications that are similar in morphology and distribution.	
<i>Diffuse/Scattered</i>	These are calcifications that are distributed randomly throughout the breast. Punctate and amorphous calcifications in this distribution are usually benign and usually bilateral.
<i>Regional</i>	These are calcifications scattered in a large volume (>2 cc) of breast tissue not conforming to a duct distribution. Since this distribution may involve most of a quadrant or more than a single quadrant, malignancy is less likely. However, evaluation must include element shape as well as distribution.
<i>Grouped or Clustered</i>	Should be used when at least five calcifications occupy a small volume (<1 cc) of tissue.
<i>Linear</i>	Calcifications arrayed in a line. This distribution may elevate suspicion for malignancy as it suggests deposits in a duct.
<i>Segmental</i>	A segmental distribution of calcifications suggests deposits in a duct or ducts and their branches (involving a lobe or segment of the breast). Unless the calcifications are smooth and large rod-like calcifications typical of benign secretory calcifications (see above), a segmental distribution is suggestive of malignancy even if individual calcifications are punctate or amorphous in morphology.
<small>(From the American College of Radiology (ACR). ACR BI-RADS® – Mammography. 4<sup>th</sup> Edition. In: <i>ACR Breast Imaging Reporting and Data System, Breast Imaging Atlas</i>. Reston, VA: American College of Radiology; 2003.)</small>	