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The American College of Radiology will periodically define new practice guidelines and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice guidelines and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

Each practice guideline and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review, requiring the approval of the Commission on Quality and Safety as well as the ACR Board of Chancellors, the ACR Council Steering Committee, and the ACR Council. The practice guidelines and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice guideline and technical standard by those entities not providing these services is not authorized.

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## **ACR–ASNR PRACTICE GUIDELINE FOR THE PERFORMANCE AND INTERPRETATION OF MAGNETIC RESONANCE SPECTROSCOPY OF THE CENTRAL NERVOUS SYSTEM**

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### **PREAMBLE**

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

### **I. INTRODUCTION**

This guideline was revised by the American College of Radiology (ACR) in collaboration with the American Society of Neuroradiology (ASNR).

Magnetic resonance spectroscopy (MRS) is a proven and useful method for the evaluation, assessment of severity, therapeutic planning, post-therapeutic monitoring and follow-up of diseases of the brain and other regions of the body. It should be performed only for a valid medical reason. While MRS can be useful in the diagnosis and management of patients, findings may be misleading if not closely correlated with the clinical history, physical examination, laboratory results, and diagnostic imaging studies. Adherence to these guidelines optimizes the benefit of MRS for patients.

### **II. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL**

See the [ACR Practice Guideline for Performing and Interpreting Magnetic Resonance Imaging \(MRI\)](#).

The physician supervising and interpreting MRS must understand the specific questions to be answered prior to

the procedure in order to plan and perform it safely and effectively.

### III. INDICATIONS

When conventional imaging by magnetic resonance imaging (MRI) or computed tomography (CT) is inadequate to answer specific clinical questions, indications for MRS in adults and children include, but are not limited to, the following:

1. Evidence or suspicion of primary or secondary neoplasm (pretreatment and post-treatment).
2. Grading of primary glial neoplasm, particularly high grade versus low grade glioma.
3. Evidence or suspicion of brain infection, especially cerebral abscess (pretreatment and post-treatment) and HIV-related infections.
4. Seizures, especially temporal lobe epilepsy.
5. Evidence or suspicion of neurodegenerative disease, especially Alzheimer's disease, Parkinson's disease, and Huntington's disease.
6. Evidence or suspicion of subclinical or clinical hepatic encephalopathy.
7. Evidence or suspicion of an inherited metabolic disorder such as Canavan's disease and other leukodystrophies.
8. Suspicion of acute brain ischemia or infarction.
9. Evidence or suspicion of a demyelination or dysmyelination disorder.
10. Evidence or suspicion of traumatic brain injury.
11. Evidence or suspicion of brain developmental abnormality and cerebral palsy.
12. Evidence or suspicion of other neurodegenerative diseases such as amyotrophic lateral sclerosis.
13. Evidence or suspicion of chronic pain syndromes.
14. Evidence or suspicion of chromosomal and inherited neurocutaneous disorders such as neurofibromatosis and tuberous sclerosis.
15. Evidence or suspicion of neurotoxicity disorders.
16. Evidence or suspicion of hypoxic brain injury.
17. Evidence or suspicion of spinal cord disorders such as tumors, demyelination, infection, and trauma.
18. Evidence of neuropsychiatric disorders such as depression, post-traumatic stress syndrome, and schizophrenia.
19. Differentiation between recurrent tumor and treatment related changes or radiation injury.
20. Differentiation of cystic lesions, e.g., abscess versus cystic metastasis or cystic primary neoplasm.
21. Evidence or suspicion of cerebral vasculitis, systemic lupus erythematosus (SLE), and neuropsychiatric systemic lupus erythematosus (NPSLE).

22. Evaluation of response to treatment of neurological disorders.

### IV. SAFETY GUIDELINES AND POSSIBLE CONTRAINDICATIONS

See the [ACR Practice Guideline for Performing and Interpreting Magnetic Resonance Imaging \(MRI\)](#) and the ACR Guidance Document for Safe MR Practices.

Peer-reviewed literature pertaining to MR safety should be reviewed on a regular basis.

### V. SPECIFICATIONS OF THE EXAMINATION

#### A. Written Request for the Examination

The written or electronic request for MRS of the central nervous system should provide sufficient information to demonstrate the medical necessity of the examination and allow for its proper performance and interpretation.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). Additional information regarding the specific reason for the examination or a provisional diagnosis would be helpful and may at times be needed to allow for the proper performance and interpretation of the examination.

The request for the examination must be originated by a physician or other appropriately licensed health care provider. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient's clinical problem or question and consistent with the state scope of practice requirements. (ACR Resolution 35, adopted in 2006)

Reasonable efforts should be made to ensure that all prior imaging of the region in question is available to the interpreting physician/spectroscopist at the time of the study.

#### B. Patient Selection

The physician responsible for the examination shall supervise patient selection and preparation and be available in person or by phone for consultation. Patients shall be screened and interviewed prior to the examination to exclude individuals who may be at risk by exposure to the MR environment.

Certain indications require administration of intravenous (IV) contrast media. IV contrast enhancement should be performed using appropriate injection protocols and in accordance with the institution's policy on IV contrast

utilization. (See the [ACR Practice Guideline for the Use of Intravascular Contrast Media](#).)

Patients suffering from anxiety or claustrophobia may require sedation or additional assistance. Administration of moderate sedation may be needed to achieve a successful examination. If moderate sedation is necessary, refer to the [ACR–SIR Practice Guideline for Sedation/Analgesia](#).

#### C. Facility Requirements

Appropriate emergency equipment and medications must be immediately available to treat adverse reactions associated with administered medications. The equipment and medications should be monitored for inventory and drug expiration dates on a regular basis. The equipment, medications, and other emergency support must also be appropriate for the range of ages and sizes in the patient population.

#### D. Examination Technique

Physicians and/or spectroscopists using MRS shall understand the artifacts and limitations of the MR pulse sequences. MRS involves the application of various MR pulse sequences that are designed to provide a range of capabilities. These include the following:

STEAM (stimulated echo acquisition mode) that uses three 90-degree RF pulses for volume selection.

PRESS (point-resolved spectroscopy) that uses a 90-degree excitation pulse plus two 180-degree refocusing RF pulses for volume selection.

The physician and/or spectroscopist should understand the differences between the PRESS and the STEAM techniques.

Other basic pulse sequences for spectral data acquisition are available commercially.

The physician and/or spectroscopist performing the study should understand how the history and physical examination affect the choice of technique (including location of voxel placement), repetition time (TR), and echo time (TE) for the examination and how the metabolite peaks are affected by changes in the TE. The physician and/or spectroscopist performing and the physician interpreting the examination should be knowledgeable about the normal metabolites and their relative concentrations, as well as the spectra that could be anticipated for the diagnostic entities being considered in the patient. All examinations are interpreted by physicians.

#### E. Guidelines for Performing MRS, including the Choice of Echo Time

1. Short echo time (e.g., 20 to 40 ms)  
Short TE is useful in demonstrating myoinositol (MI), glutamine/glutamate (Glx) complexes and lipids. These metabolites are useful in characterizing most neurological diseases, such as tumors, metabolic and neurodegenerative disorders, seizures, chronic pain syndrome, and disorders of myelination. They are also useful in monitoring therapy for these diseases. This is the recommended TE if only one MRS sequence is considered for the examination; however, the choice of TE would also depend on the clinical indication. For example, in the characterization of neurodegenerative disorders such as Alzheimer's disease, short TE MRS is recommended to ensure obtaining information on metabolites only detected with short TE MRS, such as myoinositol and the Glx complexes.
2. Intermediate echo (e.g., 135 to 144 ms)  
Intermediate TE has a number of advantages over short TE MRS but provides information on fewer metabolites. The recommendation is that this would be a second acquisition, time permitting, after the short TE acquisition for the following reasons:
  - a. In differentiating lactate and alanine from lipids around 1.3 to 1.4 ppm by J-modulation/inversion of the lactate and alanine doublet peaks.
  - b. Better-defined baseline and less baseline distortion compared with short TE.
  - c. No artifactual NAA. Peak in the 2.0 to 2.05 range can only be attributed to NAA rather than superimposed Glx complex peaks in the 2.05 to 2.5 ppm range.
  - d. Presence of lipids may infer more significance than at short TE.
  - e. More reproducibility and accuracy, particularly for quantifying Cho and NAA peaks.
3. Long echo time (e.g., 270 to 288 ms)  
At longer TE (longer than 144 ms) there is less signal from NAA, Cho, and Cr relative to the baseline noise, and hence the signal to noise is lower than at short and intermediate TE measurements due to the T2 decay of metabolites. The recommendation is to acquire MRS data at short TE and, time permitting, to include an intermediate echo time acquisition for the reasons stated above. Long TE can be

employed if the user has experience and normative data for comparison.

4. Chemical shift imaging (CSI) or MR spectroscopic imaging (MRSI)  
MRSI or CSI, either 2D or 3D, obtains spectroscopic information from multiple adjacent volumes over a large volume of interest in a single measurement. This technique has better resolution and samples metabolites over a larger region of interest, facilitating evaluation for focal as well as global neurological processes. CSI can be combined with conventional MR imaging, since spectral patterns and metabolite concentrations can be overlaid on grayscale conventional imaging to compare voxels containing normal parenchyma and voxels containing pathology and also to obtain distributional patterns of specific metabolites. It also allows for comparison and normalization of pathologic spectra to spectra in normal tissue. However caution must be exercised when using CSI regarding artifacts such as chemical-shift artifact, voxel bleeding, and voxel contamination when using commercially available CSI sequences.

The physician and/or spectroscopist performing the examination must understand how voxel placement affects diagnostic accuracy.

The physician and/or spectroscopist performing and the physician interpreting MRS shall recognize artifacts due to poor shimming, improper water suppression, lipid contamination, chemical shift artifact/misregistration, and/or poor voxel placement.

5. Multinuclear MRS  
Besides proton hydrogen-1 ( $^1\text{H}$ ) MRS, other nuclei for MRS that include helium-3 ( $^3\text{He}$ ), lithium-7 ( $^7\text{Li}$ ), carbon-13 ( $^{13}\text{C}$ ), oxygen-17 ( $^{17}\text{O}$ ), fluorine-19 ( $^{19}\text{F}$ ), sodium-23 ( $^{23}\text{Na}$ ), phosphorus-31 ( $^{31}\text{P}$ ), and xenon-129 ( $^{129}\text{Xe}$ ) can be used. It is recommended that multinuclear MRS be performed using a 3-tesla MR system. There are a number of reasons for this compared with  $^1\text{H}$  MRS:
  - a. Lower abundance of the nuclei.
  - b. Lower gyromagnetic ratio.
  - c. Lower sensitivity at 1.5 T resulting in poorer signal-to-noise (SNR) at 1.5 T.
  - d. Longer measurement times.
  - e. Low spatial resolution.
  - f. Lower spectral resolution.
  - g. Multiplets – needing to decouple to demonstrate the metabolites adequately.

Phosphorus-31,  $^{19}\text{F}$ , and  $^{13}\text{C}$  have demonstrated some utility in neuro-oncologic MRS. Phosphorus-31 MRS ( $^{31}\text{P}$  MRS) provides information on cellular energy metabolism, membrane phosphates and intracellular pH. Compared with proton spectroscopy ( $^1\text{H}$  MRS), the clinical utility of  $^{31}\text{P}$  MRS has been limited, due in part to the necessity for hardware modifications (coils), the relatively large volumes of tissue required (resulting in partial volume effects through necrotic regions) and the sometimes subtle metabolite changes when the spectra are reviewed visually. Cellular energy metabolism is represented by ATP, PCr, and Pi. The phosphodiester (PDE) and phosphor-monoester (PME) compounds are from membrane phospholipids. In high grade glial tumors (HGGT) such as glioblastoma multiforme, there is alkalization (pH 7.12), an increase in PME, and a decrease in PDE/ $\alpha$ -ATP with no significant changes in PCr/  $\alpha$ -ATP or PCr/Pi ratios. The metabolite resonances in HGGT may sometimes be reduced by the presence of necrosis. As expected HGGT will express higher levels of phosphatidylcholine compared with low grade glial tumors. Meningiomas are characterized by an alkalinity (pH 7.16), a decrease in phosphocreatine, and decreased phosphodiesters. Proton-decoupled  $^{31}\text{P}$  ( $^{31}\text{P}$ - [ $^1\text{H}$ ]) and  $^1\text{H}$  MRS may eventually be used in a multinuclear, multi-TE approach to neurologic diseases.

6. Ultra-high-field MRS (beyond 3-T)  
Currently MRS is FDA approved and can be performed at 3-T. The safety and clinical application of MRS for ultra-high field spectroscopy (beyond 3-T) are still under investigation. There are technical challenges; however, the ability to resolve metabolites not usually demonstrated at lower field strengths and only when using proton MRS suggests that ultra-high- field spectroscopy is likely to have a place in the near future.

## VI. DOCUMENTATION

Reporting should be in accordance with the [ACR Practice Guideline for Communication of Diagnostic Imaging Findings](#).

The report should describe the peaks visualized in the spectrum, the relative heights of the peaks, or relative concentrations of the metabolites. It should attempt to address the potential etiologies suggested by any abnormalities found.

## VII. EQUIPMENT SPECIFICATIONS

The MR equipment specifications and performance shall meet all state and federal requirements. These requirements include, but are not limited to, specifications of maximum static magnetic field strength, maximum rate of change of magnetic field strength (dB/dt), maximum radiofrequency power deposition (specific absorption rate), and maximum acoustic noise levels.

## VIII. QUALITY CONTROL AND IMPROVEMENT, SAFETY, INFECTION CONTROL, AND PATIENT EDUCATION

Policies and procedures related to quality, patient education, infection control, and safety should be developed and implemented in accordance with the ACR Policy on Quality Control and Improvement, Safety, Infection Control, and Patient Education appearing under the heading *Position Statement on QC & Improvement, Safety, Infection Control, and Patient Education* on the ACR web page (<http://www.acr.org/guidelines>).

Specific policies and procedures related to MR safety should be in place with documentation that is updated annually and compiled under the supervision and direction of the supervising MR physician. Guidelines should be provided that deal with potential hazards associated with the MR examination of the patient as well as to others in the immediate area. Screening forms must also be provided to detect those patients who may be at risk for adverse events associated with the MR examination.

Equipment monitoring should be in accordance with the [ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of MRI Equipment](#).

Follow-up pathology and laboratory results and diagnoses are needed for correlating radiology and pathology findings and should be actively sought whenever possible as part of any quality control or quality improvement program.

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**Suggested Reading** (Additional articles that are not cited in the document but that the committee recommends for further reading on this topic)

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\*Guidelines and standards are published annually with an effective date of October 1 in the year in which amended, revised, or approved by the ACR Council. For guidelines and standards published before 1999, the effective date was January 1 following the year in which the guideline or standard was amended, revised, or approved by the ACR Council.

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- Amended 2006 (Resolution 35)
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