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Each practice parameter 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 and approval. The practice parameters 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 parameter and technical standard by those entities not providing these services is not authorized.

2020 (Resolution 41)\*

## **ACR–ACNM–ASNR–SNMMI PRACTICE PARAMETER FOR BRAIN PET-CT IMAGING IN DEMENTIA**

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### **PREAMBLE**

This document is an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. Practice Parameters and Technical Standards are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care<sup>1</sup>. For these reasons and those set forth below, the American College of Radiology and our collaborating medical specialty societies caution against the use of these documents 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 practitioner in light of all the circumstances presented. Thus, an approach that differs from the guidance in this document, 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 this document 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 this document. However, a practitioner who employs an approach substantially different from the guidance in this document 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 the guidance in this document 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 this document is to assist practitioners in achieving this objective.

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<sup>1</sup> Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing 831 N.W.2d 826 (Iowa 2013) Iowa Supreme Court refuses to find that the *ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures* (Revised 2008) sets a national standard for who may perform fluoroscopic procedures in light of the standard's stated purpose that ACR standards are educational tools and not intended to establish a legal standard of care. See also, Stanley v. McCarver, 63 P.3d 1076 (Ariz. App. 2003) where in a concurring opinion the Court stated that "published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable in a given situation" even though ACR standards themselves do not establish the standard of care.

## I. INTRODUCTION

This practice parameter was revised collaboratively by the American College of Radiology (ACR), the American College of Nuclear Medicine (ACNM), the American Society for Neuroradiology (ASNR), and the Society of Nuclear Medicine and Molecular Imaging (SNMMI).

It is estimated that the number of people with dementia, 36.5 million worldwide in 2010, will increase to 65.7 million in 2030 and to 115 million in 2050, a result of changed demographics and increased longevity [1]. This poses great challenges for both society and health care systems [2]. Four primary neurodegenerative etiologies of dementia have been defined: Alzheimer disease (AD), vascular dementia, frontotemporal dementia (FTD), and dementia with Lewy bodies (DLB) [3]. AD is the most common form of dementia, accounting for approximately 60% – 80% of all cases [4].

The most prominent clinical feature of AD is an early impairment of episodic memory [5], which manifests as memory impairment for recent events, unusual repeated omissions, and difficulty learning new information. As the disease progresses, the symptoms often manifest in more persistent language disturbance and difficulties completing more complex tasks of daily living. The early stage of cognitive decline, namely, mild cognitive impairment (MCI), is the intermediate phase between normality and dementia, during which patients show cognitive decline confirmed on objective cognitive testing but do not meet criteria for dementia because independent function is generally preserved [6]. Those with MCI convert to AD at a rate of about 10% to 25% annually compared with healthy elders who convert at a rate of about 1% to 2% annually [3]. About 20% of MCI patients progress to other dementia types, and 30% to 40% of cases do not progress to dementia [7].

The original diagnostic criteria for AD rested on the notion that AD is a clinical-pathological entity. The diagnosis was classified as definite (clinical diagnosis with histologic confirmation), probable (typical clinical syndrome without histologic confirmation), or possible AD (atypical clinical features but no alternative diagnosis apparent; no histologic confirmation). Possible AD can be identified when there is an unusual course or atypical features versus concomitant evidence of an alternative or contributory pathology, such as prior significant head trauma, alcohol-substance abuse, cerebrovascular disease, etc. A diagnosis of definite AD was made only according to criteria of the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association (NINCDS-ADRDA) when there was histopathologic confirmation of the clinical diagnosis [8].

With research progress, distinctive biomarkers of the disease are now recognized, including structural brain changes visible on magnetic resonance imaging (MRI), molecular neuroimaging changes seen with positron emission tomography (PET), and changes in cerebrospinal fluid (CSF) biomarkers. These distinctive biomarkers have been incorporated into revised diagnostic criteria for the AD pathophysiological process. These biomarkers can be divided into 2 major categories:

- 1) the biomarkers of A-beta ( $A\beta$ ) amyloid accumulation; abnormal radiopharmaceutical retention on amyloid PET imaging and low CSF  $A\beta$ -42 peptide and
- 2) the biomarkers of neuronal degeneration or injury: elevated CSF tau protein (both total and phosphorylated tau); decreased  $^{18}F$  fluorodeoxyglucose (FDG) uptake on PET in a specific topographic pattern involving posterior cingulate/precuneus and temporoparietal cortex; and atrophy on structural MR, again in a specific topographic pattern involving medial, basal, and lateral temporal lobes and medial and lateral parietal cortices [9].

Biomarkers of  $A\beta$  amyloid are indicative of initiating upstream events that may deviate from normal before clinical symptoms manifest. Biomarkers of neuronal injury and neuronal dysfunction are indicative of downstream pathophysiological processes that temporally follow [9]. Current evidence suggests that amyloid biomarkers may become abnormal approximately 10 to 20 years before noticeable clinical symptoms. Progression of clinical symptoms closely parallels progressive worsening of neurodegenerative biomarkers [6,10,11]. Biomarkers of neurodegeneration are now being incorporated into clinical diagnostic criteria for specific disorders, in particular for AD [12-14].

In 2004, the Centers for Medicare and Medicaid Services (CMS) issued a positive coverage decision (NCD 220.6.13) for the use of FDG-PET to distinguish AD versus FTD [15]. It was determined that FDG-PET was reasonable and necessary only in patients with recent development of dementia who met diagnostic criteria for AD and FTD. The National Coverage Determination also contained a second and broader element for FDG-PET in the diagnosis of dementia under coverage with evidence development. FDA subsequently approved three amyloid PET radiopharmaceuticals (<sup>18</sup>F-florbetapir [2012], <sup>18</sup>F-Flutemetamol [2013], <sup>18</sup>F-Florbetaben [2014]) for imaging of the brain for A $\beta$ -amyloid neuritic plaque density in adult patients with cognitive impairment who are being evaluated for AD and other causes of cognitive decline.

A negative scan indicates sparse to no amyloid neuritic plaques and thus is not consistent with a neuropathological diagnosis of AD at the time of the scan. A negative scan reduces the likelihood that a patient's cognitive impairment is due to AD. A positive amyloid scan indicates moderate to severe amyloid neuritic plaques and can be seen in AD and DLB. Positive scans may also be seen in patients with mild cognitive impairment and in older people with normal cognition who are at increased risk for progressing to MCI and AD [16].

This ACR practice parameter is for both FDG and amyloid brain PET or PET/computed tomography (CT) for patients with cognitive decline.

For additional information on Definitions, see Appendix A.

## II. INDICATIONS

### A. FDG-PET

Imaging of regional glucose metabolism with the radiopharmaceutical <sup>18</sup>F FDG can provide unique neuronal metabolism information in patients with cognitive decline and dementia. Symptoms and signs of cognitive disorders are manifestations of synaptic and neuronal dysfunction and loss in neurodegenerative diseases. Regional patterns of altered glucose metabolism, as imaged with FDG-PET, can indicate the presence of a neurodegenerative process and can characterize involvement of individual cerebral structures and pathways. FDG-PET studies should be performed at the request of physicians knowledgeable in clinical diagnosis and management of dementia and under circumstances in which the results of the examination are likely to have an impact on patient care. Examples of indications for FDG-PET imaging in cognitive decline and dementia include, but are not limited to, the following:

1. Assessment of progressive dementia: Although AD is the most common cause of dementia in the elderly, several other neurodegenerative conditions exist that may be responsible for progressive dementia in the individual patient. FDG-PET can identify the underlying characteristic brain regional patterns of cerebral hypometabolism and can thereby distinguish AD from other degenerative processes such as FTD [17].
2. Assessment of neurodegeneration in subjects with MCI: Several studies support the utility of FDG-PET to identify patients with a course of progressive cognitive decline attributable to a neurodegenerative condition before the onset of clinically diagnosed dementia. Although the use of FDG-PET has not been determined to be useful for screening of asymptomatic patients who may ultimately be at risk of developing dementia, the modality can be useful in patients who meet the criteria for MCI [18-20].

### B. Amyloid-PET

Clinical molecular imaging of cerebral fibrillar A $\beta$ -amyloid deposition is based in large part on results obtained with the use of the research radiopharmaceutical 11C-Pittsburgh Compound-B (PiB; [11C] 6-HO-BTA-1). The FDA has approved radiofluorinated radiopharmaceuticals (florbetapir, flutemetamol, and florbetaben) for clinical use. The FDA approvals were based on the demonstration that in vivo tracer imaging correlated with the extent or severity of postmortem neuritic plaques in end-of-life patients [21-24]. The biodistribution and imaging characteristics of these newer radiopharmaceuticals, and the indications below, are predicated in part on the basis of findings with PiB, with the expectation that the clinical radiopharmaceuticals have similar discriminatory properties [7]. Pathological depositions of fibrillar A $\beta$ -amyloid are requisite for the pathological diagnosis of AD [25] and are also found in many instances of related neurodegenerative disorders, most frequently in cases of DLB.

Deposition of fibrillary A $\beta$ -amyloid is also found in cognitively normal elderly individuals, increasing in prevalence with age. Nonneurodegenerative disorders, such as primary cerebral amyloid angiopathy, may be amyloid PET-positive [26]. Evolving understanding of the relationships among amyloid deposition, synaptic dysfunction, and losses of neurons and synapses in AD suggest that the amyloid-driven aspects of the pathophysiology occur prior to losses of neurons and synapses, perhaps by many years [27]. Thus, it is anticipated that A $\beta$ -amyloid imaging may be more specific than FDG-PET in differentiating among degenerative dementias, but it may not necessarily provide evidence of a specific neurodegenerative cause of early cognitive complaints in nondemented patients.

The use of amyloid imaging is recommended to determine presence (or absence) of pathological fibrillar A $\beta$ -amyloid deposition in patients with progressive cognitive decline or dementia of uncertain etiology in whom AD is a possibility. Amyloid-PET studies should be performed at the request of physicians knowledgeable in clinical diagnosis and management of dementia and under circumstances in which the results of the examination are likely to impact patient care. Indications for amyloid-PET imaging in cognitive decline and dementia include, but are not limited to, the detection of amyloid plaques in cognitively impaired adults. Subjects with progressive cognitive decline who demonstrate features atypical of AD and suggestive of another neurodegenerative process, such as FTD (eg, early age of onset, prominent behavioral dysregulation, or primary progressive aphasia), may have atypical AD presentations or may have FTD. Patients with FTD do not demonstrate abnormal levels of amyloid deposition at pathology evaluation and do not have increased binding of amyloid radiopharmaceuticals in PET imaging. A negative amyloid PET scan is inconsistent with Alzheimer pathology and suggests that AD does not account for symptoms and signs of progressive cognitive decline.

Recently published primary analysis of the Imaging Dementia – Evidence for Amyloid Scanning (IDEAS) study included 11,409 participants with MCI or dementia of uncertain cause. The patient management 90 days after amyloid PET changed (compared with the pre-PET plan) in 60.2% of patients with MCI and 63.5% of patients with dementia. Hence, amyloid PET was associated with changes in the subsequent management of diagnostically challenging patient cognitive disorders [28].

At the present time, clinical amyloid-PET imaging has not been validated for screening asymptomatic subjects with genetic or other risk factors for developing AD or in subjects without a clinical diagnosis of a progressive cognitive decline or dementia as established by a clinician expert in the assessment and management of dementing disorders. In addition, amyloid PET cannot be used to establish the diagnosis of AD or monitor the response to therapy for AD in terms of disease progression or improvement, except as part of an approved clinical research trial of anti-amyloid therapy. A negative amyloid-PET study indicates absence of significant  $\beta$ -amyloid plaques at the time of the study and does not exclude the future development of these plaques.

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

#### **A. Physician**

PET/CT examinations of the brain should be performed under the supervision of and interpreted by a physician who meets qualifications outlined in the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [29]:

and

Initial Education and Experience

For brain FDG PET/CT:

1. Six hours of CME in brain FDG PET/CT interpretation for dementia
2. Thirty proctored or over-read brain FDG PET/CT scans performed for investigation of dementia prior to beginning unsupervised interpretation
3. Live or online education programs may be used to fulfill these requirements; this may also be fulfilled through a nuclear medicine residency or fellowship training program.

For brain amyloid PET/CT:

1. Three hours of CME in brain amyloid PET/CT interpretation. Live or online educational programs may be used to fulfill this requirement. Interpretation of brain PET images to estimate  $\beta$ -amyloid neuritic plaque

density should be performed only by readers who successfully complete a special training program such as one sponsored by the manufacturer of one of the FDA-approved radiopharmaceuticals. Live or online educational programs may be used to fulfill this requirement.

#### Continuing Education and Experience

For continuing education and experience, please see the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [29] and [ACR Practice Parameter for Continuing Medical Education \(CME\)](#) [30].

#### B. Qualified Medical Physicist

For qualified medical physicist qualifications, see the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of PET/CT Imaging Equipment](#) [31].

#### C. Radiologic and Nuclear Medicine Technologist

See the [ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) [32] and the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [29].

Representatives of the SNMMI and the American Society of Radiologic Technologists (ASRT) met in 2002 to discuss training technologists for PET/CT. The recommendations from that consensus conference for training technologists for PET/CT are outlined in the subsequent article published [33]. As a consequence of this conference and ensuing educational recommendations, cross-training and continuing educational programs have been developed to educate radiologic, radiation therapy, and nuclear medicine technologists in PET/CT fusion imaging.

The Nuclear Medicine Technology Certification Board (NMTCB) has developed a PET specialty examination that is open to appropriately educated and trained, certified, or registered nuclear medicine technologists, registered radiologic technologists, CT technologists, and registered radiation therapists, as defined on the NMTCB website ([www.nmtcb.org](http://www.nmtcb.org)). The American Registry of Radiologic Technologists (ARRT) offers a CT certification examination for qualified radiologic technologists and allows certified or registered nuclear medicine technologists who meet the educational and training requirements to take this examination. Eligibility criteria are located on the ARRT website ([www.arrt.org](http://www.arrt.org)).

#### D. Radiation Safety Officer

The radiation safety officer must meet applicable requirements of the Nuclear Regulatory Commission (NRC) for training as specified in 10 CFR 35.50 or equivalent state regulations.

### IV. EXAMINATION FOR THE SPECIFICATIONS

The written or electronic request for PET/CT of the brain should provide sufficient information to demonstrate the medical necessity of the examination and allow for the proper performance and interpretation of the examination.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). The provision of 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 – revised in 2016, Resolution 12-b)

## A. Patient Preparation

1. For FDG PET/CT, the major goal of preparation is to minimize radiopharmaceutical uptake in normal tissues, such as the myocardium and skeletal muscle, while maintaining high FDG uptake in the brain. The preparation should include, but not be limited to, the following:
  - a. Pregnancy testing when appropriate
  - b. Fasting instruction (a minimum of 4 hours) and no oral or intravenous (IV) fluids containing sugar or dextrose
  - c. Serum glucose analysis performed immediately prior to FDG administration (an optimal range is up to 200 mg/dL)
  - d. Oral hydration to enhance renal excretion of FDG
  - e. Focused history regarding the reason for examination (symptoms, diagnoses, and recent imaging examinations), treatments and medications, diabetes and recent exercise. Patients should be injected in the awake resting state with eyes open while sitting or lying comfortably in a dimly lit and quiet room. The uptake of FDG when the patient's eyes are closed may cause hypometabolism in the occipital lobe, possibly leading to a misdiagnosis of DLB [34].
  - f. Patients should void prior to being positioned on the PET/CT table. Patients can also be advised to void after completion of imaging to minimize radiation dose to the bladder and internal organs.
2. For a <sup>18</sup>F-amyloid binding radiopharmaceutical PET/CT scan, the preparation should include, but not limited to, the following:
  - a. Pregnancy testing when appropriate
  - b. Focused history regarding the reason for examination (symptoms, diagnoses, and recent imaging examinations) and treatments and medications. Oral hydration to enhance renal excretion of the radiopharmaceutical
  - c. Patients should be injected in the resting state while sitting or lying comfortably in a dimly lit and quiet room.
  - d. Patients should void prior to being positioned on the PET/CT table.

## B. Radiopharmaceutical

1. For FDG, the amount of administered activity should be 185 to 444 MBq (5-12 mCi) IV.
2. For <sup>18</sup>F-amyloid binding radiopharmaceuticals, the amount of administered activity should be 185 to 444 MBq (5-12 mCi) IV. The recommended doses are 10 mCi, 5 mCi, and 8.1 mCi for florbetapir, flumetamol, and florbetaben, respectively [35-37].

Note: With PET/CT, the radiation dose to the patient is the combination of the administered activity from the PET radiopharmaceutical and the dose from the CT portion of the examination. Lower administered activities may be appropriate with longer imaging times and advances in PET/CT technology.

## C. Patient Positioning

1. Careful positioning of the patient's head in the center of the camera's field of view is critical.
2. The patient should be informed of the need to remain still throughout the scan, and a head holder may diminish movement artifacts. With dementia patients, a comfortable head position, rather than straight, may reduce motion artifacts.
3. Continuous supervision of the patient during the whole scanning procedure is necessary. This is especially important for patients with cognitive impairment.
4. Conscious sedation using a short-acting benzodiazepine for agitation may be needed in selected patients. Sedating medications should be given at least 20 minutes after radiopharmaceutical injection, preferably close to PET/CT acquisition.

#### D. Protocol for CT Imaging

The CT performed as part of a PET/CT examination provides diagnostic information that may be relevant to both PET interpretation and overall patient care. A variety of protocols exist for performing the CT scan in the context of PET/CT scanning. In most cases, low-dose CT scans are utilized to provide attenuation correction and anatomic localization because the patient will often have an existing MR of the head. In patients in which an MR is contraindicated, the CT portion of the examination can be performed as an optimized brain CT with standard brain CT imaging parameters if ordered by the referring physician. Regardless of the CT technique used, a careful review of CT images is necessary for comprehensive interpretation of the PET/CT examination. Patient positioning should be optimized to minimize radiation dose to the lens.

#### E. Protocol for PET Imaging

1. A standardized acquisition protocol with a fixed acquisition start time is useful so that comparable data are obtained each time, whether from different patients or repeat scans in the same patient. PET emission acquisition should commence 35 to 60 minutes after FDG administration and 30 to 90 minutes after administration of <sup>18</sup>F-amyloid binding radiopharmaceutical. More specific details about the imaging protocol for individual amyloid PET radiopharmaceuticals can be found in the respective package inserts [35-37].
2. The duration of emission acquisition will depend on the performance characteristics of the individual scanner system, but a minimum of 10 minutes in 3-D mode is recommended.
3. PET data should be normalized for detector/geometric effects and corrected for random coincidences, dead time, scatter, and attenuation. Non-attenuation-corrected (NAC) images should also be reconstructed to assess patient motion.
4. If patient movement is a particular concern, the PET/CT scan can be performed as a dynamic acquisition (eg, five 2-minute frames). The dynamic images may be evaluated for motion and the intact data added together prior to final reconstruction. List-mode acquisitions can be used for the same purpose.
5. Images should be reconstructed so as to have a pixel size less than 2 mm in the transverse plane.
6. Iterative or analytic reconstruction methods are acceptable, although consistent technique is important.
7. Reconstruction parameters will depend on injected activity, scanner, acquisition parameters, available software, and the interpreting physician's preference.

#### F. Interpretation

1. With an integrated PET/CT system, the software packages typically provide a comprehensive platform for image review.
2. A standard brain image review is recommended to ensure rapid, accurate, and reproducible interpretations. Internal landmark reorientation should be used to achieve standardized image display.
3. The images should be critically examined prior to interpretation for technical quality, especially evidence of movement. NAC PET images should be used to assess motion between CT and PET acquisitions.
4. Fused PET/CT images are helpful to identify motion and evaluate functional-structural findings simultaneously. Fusion of PET with MRI is desirable in select individuals.
5. Review of coronal and sagittal images is highly recommended.
6. Known morphological changes, such as atrophy, must be factored into interpretation of PET data.
7. Three-dimensional display of the data set (eg, by volume rendering or surface projections, such as 3-D stereotactic surface projection (SSP), can be helpful for detection of disease patterns.
8. Comparison to an appropriate normative database obtained under similar acquisition settings may improve diagnostic accuracy.
9. For amyloid PET/CT, interpretation guidance from special training programs sponsored by the manufacturer of the FDA-approved radiopharmaceuticals need to be followed because they vary between amyloid PET radiopharmaceuticals.

## V. EQUIPMENT SPECIFICATIONS

See the [ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography \(CT\) of the Brain \[38\]](#) and the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of PET/CT Imaging Equipment \[31\]](#).

### A. Performance Parameters

For patient imaging, the PET/CT scanner should meet or exceed the following specifications:

1. For the PET scanner
  - a. In-plane spatial resolution: <6.5 mm
  - b. Axial resolution: <6.5 mm
  - c. Sensitivity (3-D): >4.0 cps/kBq
  - d. Sensitivity (2-D): >1.0 cps/kBq
  - e. Uniformity: <5%
2. For the CT scanner (if applicable)
  - a. Helical (spiral) scan time: <5 sec (<2 sec is preferable)
  - b. Slice thickness and collimation: <5 mm (<2 mm is preferable)
  - c. Limiting spatial resolution: >8 lp/cm for >32 cm display field of view (DFOV) and >10 lp/cm for <24 cm DFOV

B. 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.

C. A fusion workstation with the capability to display PET, CT, and fused images with different percentages of PET and CT blending should also be available. The workstation should ideally have the capability to fuse the PET brain images to MR. Quantification software can be a useful adjunct to visual interpretation.

## VI. DOCUMENTATION

Reporting should be in accordance with the [ACR Practice Parameter for Communication of Diagnostic Imaging Findings \[39\]](#).

## VII. EQUIPMENT QUALITY CONTROL

PET/CT performance monitoring should be in accordance with the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of PET/CT Imaging Equipment \[31\]](#).

Administered activity calibrator performance monitoring should be in accordance with the [ACR–SPR Technical Standards for Diagnostic Procedures Using Radiopharmaceuticals \[29\]](#). The accuracy of administered activity calibrators used for  $^{18}\text{F}$  should ideally be measured using Germanium-68 ( $^{68}\text{Ge}$ ) standards, cross-calibrated for  $^{18}\text{F}$  and traceable to a national metrology lab.

Specific requirements for PET/CT brain imaging include quarterly testing with an  $^{18}\text{F}$  fillable phantom, such as the ACR-approved PET phantom. Phantom images should be analyzed using the appropriate clinical workstations wherever possible. Qualitative assessment should include confirmation that PET and CT images are free from artifacts, particularly side-to-side gradients in intensity. The accuracy of the spatial registration of the PET and CT images should ideally be assessed quantitatively, although qualitative assessment is acceptable. The centers of the phantom inserts should be closely aligned on PET and CT with no systematic differences across the images. The uniform region of the PET images should have a standard uptake value in the range 0.9 to 1.1, with a target range



of 0.95 to 1.05. Resolution recovery of the phantom inserts should be stable over time, and current measurements should be consistent with previous data, eg, mean  $\pm$  2 SD of prior measurements.

A check of the performance of both the PET and CT components is required every day that the scanner is to be used and should be performed prior to patient imaging. The nature of these procedures will vary between scanner systems, and manufacturer recommendations should be followed. For PET, such tests should include verification of PET detector integrity, which involves a quantitative comparison of various detector parameters to reference values. Daily CT quality control should include a scan of a standard CT water phantom. The accuracy of the resulting CT numbers and image noise should be recorded.

When not indicated by the manufacturer's daily recommendations, a  $^{68}\text{Ge}$  cylinder phantom is recommended for periodic assessment of PET/CT system stability. Additional use of this phantom is recommended after scanner maintenance or scheduled scanner recalibration and should be performed prior to patient imaging.

The dates and results of all quality control procedures should be recorded.

## VIII. RADIATION SAFETY IN IMAGING

Radiologists, medical physicists, registered radiologist assistants, radiologic technologists, and all supervising physicians have a responsibility for safety in the workplace by keeping radiation exposure to staff, and to society as a whole, "as low as reasonably achievable" (ALARA) and to assure that radiation doses to individual patients are appropriate, taking into account the possible risk from radiation exposure and the diagnostic image quality necessary to achieve the clinical objective. All personnel that work with ionizing radiation must understand the key principles of occupational and public radiation protection (justification, optimization of protection and application of dose limits) and the principles of proper management of radiation dose to patients (justification, optimization and the use of dose reference levels) [http://www-pub.iaea.org/MTCD/Publications/PDF/Pub1578\\_web-57265295.pdf](http://www-pub.iaea.org/MTCD/Publications/PDF/Pub1578_web-57265295.pdf).

Facilities and their responsible staff should consult with the radiation safety officer to ensure that there are policies and procedures for the safe handling and administration of radiopharmaceuticals and that they are adhered to in accordance with ALARA. These policies and procedures must comply with all applicable radiation safety regulations and conditions of licensure imposed by the Nuclear Regulatory Commission (NRC) and by state and/or other regulatory agencies. Quantities of radiopharmaceuticals should be tailored to the individual patient by prescription or protocol.

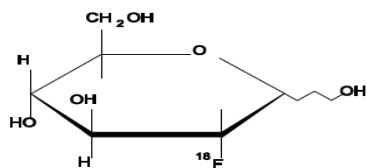
Nationally developed guidelines, such as the ACR's [Appropriateness Criteria](#)<sup>®</sup>, should be used to help choose the most appropriate imaging procedures to prevent unwarranted radiation exposure.

Additional information regarding patient radiation safety in imaging is available at the Image Gently<sup>®</sup> for children ([www.imagegently.org](http://www.imagegently.org)) and Image Wisely<sup>®</sup> for adults ([www.imagewisely.org](http://www.imagewisely.org)) websites. These advocacy and awareness campaigns provide free educational materials for all stakeholders involved in imaging (patients, technologists, referring providers, medical physicists, and radiologists).

Radiation exposures or other dose indices should be measured and patient radiation dose estimated for representative examinations and types of patients by a Qualified Medical Physicist in accordance with the applicable ACR technical standards. Regular auditing of patient dose indices should be performed by comparing the facility's dose information with national benchmarks, such as the ACR Dose Index Registry, the NCRP Report No. 172, Reference Levels and Achievable Doses in Medical and Dental Imaging: Recommendations for the United States or the Conference of Radiation Control Program Director's National Evaluation of X-ray Trends. (ACR Resolution 17 adopted in 2006 – revised in 2009, 2013, Resolution 52)

## IX. RADIOPHARMACEUTICALS

### A. FDG



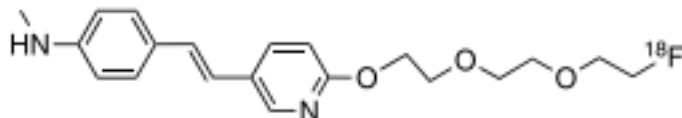
$^{18}\text{F}$  FDG refers to a positron-emitting radiopharmaceutical containing radioactive 2-deoxy-2-( $^{18}\text{F}$ ) fluoro-D-glucose, which is used for diagnostic purposes in conjunction with PET. It is administered by IV injection. The active ingredient, 2-deoxy-2-( $^{18}\text{F}$ ) fluoro-D-glucose, abbreviated  $^{18}\text{F}$  FDG, has a molecular formula of  $\text{C}_6\text{H}_{11}^{18}\text{FO}_5$  with a molecular weight of 181.26 Da.  $^{18}\text{F}$  decays by positron ( $\beta^+$ ) emission and has a half-life of 109.7 minutes. The principal photons useful for diagnostic imaging are the 511 keV gamma photons, resulting from the annihilation of the emitted positron with an electron.

$^{18}\text{F}$  FDG is taken up by cells and phosphorylated to  $^{18}\text{F}$ -FDG-6-phosphate ( $^{18}\text{F}$ -FDG-6P) at a rate proportional to the rate of glucose utilization within a given tissue.  $^{18}\text{F}$ -FDG-6-phosphate is not metabolized further in the glycolytic pathway (it is not a substrate for hexose phosphate isomerase) and is relatively trapped in the cell. In some cells,  $^{18}\text{F}$ -FDG-6-phosphate may be dephosphorylated back to  $^{18}\text{F}$ -FDG via glucose-6-phosphatase. This pathway is relatively minor in brain, skeletal muscle, and cardiac muscle, which permits PET imaging of the accumulated  $^{18}\text{F}$ -FDG-6P in these target tissues. Many neoplasms have similar high phosphorylation to dephosphorylation rates, resulting in trapping of  $^{18}\text{F}$  FDG and retention of  $^{18}\text{F}$ -FDG-6P.  $^{18}\text{F}$  FDG that is not involved in glucose metabolism is excreted unchanged in the urine.

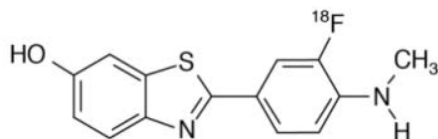
### B. Amyloid-avid Radiotracers

US FDA has approved the use of three amyloid-avid radiotracers for human imaging of fibrillar amyloid deposition in the brain. A given tracer results in similar brain images with and without deposition [7].

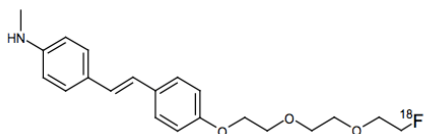
$^{18}\text{F}$  florbetapir is described as (E)-4-(2-(6-(2-(2-(2-[ $^{18}\text{F}$ ] fluoroethoxy)ethoxy)ethoxy)pyridine-3-yl(vinyl)-N-methylbenzamine. The molecular weight is 359 and the structural formula is as follows [35]:



$^{18}\text{F}$  flutemetamol is described as 2-[3-[ $^{18}\text{F}$ ]fluoro-4-(methylamino) phenyl]-6-benzothiazolol. It has the molecular formula  $\text{C}_{14}\text{H}_{11}^{18}\text{FN}_2\text{OS}$ , molecular weight 273.32, and the following structural formula [36]:



$^{18}\text{F}$  florbetaben is described as 4-[(E)-2-(4-{2-[2-(2-[ $^{18}\text{F}$ ] fluoroethoxy) ethoxy] ethoxy}phenyl)vinyl)-N-methylaniline. The molecular weight is 358.45, and the structural formula is [37]:



The time-activity curves for the amyloid tracers in the brains of subjects with positive scans are similar across the individual agents, showing continual signal increases from time zero through approximately 30 minutes post administration with stable values thereafter up to at least 90 minutes post injection. Differences in the signal intensity between portions of the brain that specifically retain the amyloid tracer and the portions of the brain with nonspecific retention form the basis of image interpretation. The specific binding of the radiotracers to A $\beta$ -amyloid aggregates was demonstrated in postmortem human brain sections using autoradiographic methods, thioflavin S, and traditional silver-staining correlation studies as well as monoclonal antibody A $\beta$ -amyloid-specific correlation studies. Radiotracer binding to tau protein aggregates and alpha-synuclein aggregates and a battery of neuroreceptors was not detected in in vitro studies. Tracer-specific binding to fibrillar A $\beta$ -amyloid aggregates in vivo was confirmed for each of the tracers in comparison to autopsy measures of amyloid burden.

## **X. 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 *ACR Position Statement on Quality Control and Improvement, Safety, Infection Control and Patient Education* on the ACR website (<https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Quality-Control-and-Improvement>).

For specific issues regarding CT quality control, see the [ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) [32].

For specific issues regarding PET and PET/CT quality control, see Section VIII on Equipment Quality Control.

Equipment performance monitoring should be in accordance with the [ACR–AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Computed Tomography \(CT\) Equipment](#) [40].

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**DEFINITIONS**

For the purpose of this practice parameter, the following definitions apply:

**PET/CT scanner:** A device that includes a single patient table for obtaining a PET scan, a CT scan, or both. If the patient stays reasonably immobile between the scans, the PET and CT data are aligned and can be accurately fused.

**PET/CT acquisition:** The process of collecting PET/CT data. In the context of brain imaging, data will be acquired from the vertex to the base of the skull. Typically this range will be encompassed by the axial field-of-view of the PET system, ie, no bed translation during PET data acquisition.

**PET/CT registration:** The process of taking PET and CT image sets that represent the same brain volume and aligning them such that there is a voxel-by-voxel match for the purpose of combined image display (fusion) or image analysis.

**PET/CT fusion:** The simultaneous display (superimposed or not) of registered PET and CT image sets. When superimposed, the image sets are typically displayed with the PET data color-coded onto the grayscale CT data.

**PET/MRI scanner:** A device that includes a single patient table for obtaining a PET scan and an MRI scan in a simultaneous manner.

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\*Practice parameters and technical 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 practice parameters and technical standards published before 1999, the effective date was January 1 following the year in which the practice parameter or technical standard was amended, revised, or approved by the ACR Council.

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