

The American College of Radiology, with more than 30,000 members, is the principal organization of radiologists, radiation oncologists, and clinical medical physicists in the United States. The College is a nonprofit professional society whose primary purposes are to advance the science of radiology, improve radiologic services to the patient, study the socioeconomic aspects of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and persons practicing in allied professional fields.

The American College of Radiology will periodically define new practice parameters 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 parameters and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

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.

Adopted 2017 (Resolution 25)*

ACR–ACNM PRACTICE PARAMETER FOR THE PERFORMANCE OF DOPAMINE TRANSPORTER (DaT) SINGLE PHOTON EMISSION COMPUTED TOMOGRAPHY (SPECT) IMAGING FOR MOVEMENT DISORDERS

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 care¹. 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 physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the practice parameters, 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 practice parameters 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 practice parameters. However, a practitioner who employs an approach substantially different from these practice parameters 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 practice parameters 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

¹ *Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing*, ___ N.W.2d ___ (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.

and safe medical care. The sole purpose of these practice parameters is to assist practitioners in achieving this objective.

I. INTRODUCTION

This practice parameter has been developed collaboratively by the American College of Radiology (ACR) and the American College of Nuclear Medicine (ACNM).

Application of this practice parameter should be in accordance with the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [1].

Parkinsonian syndrome (PS) consists of a group of neurodegenerative diseases including Parkinson disease (PD), progressive supranuclear palsy (PSP), multiple system atrophy (MSA), corticobasal degeneration (CBD), and dementia with Lewy bodies (DLB). Most patients with PS have movement disorders such as bradykinesia, extrapyramidal rigidity, resting tremor, and postural imbalance. PD (Parkinson disease) is the second most common neurodegenerative disorder, with a prevalence in industrialized countries of 0.3% in the entire population and about 1% in people older than 60 years and an incidence of 8 to 18 per 100,000 person-years [2-4]. PS (Parkinsonian syndrome) is associated with a twofold increase in the risk of death and is expected to impose an increasing social and economic burden on society as the population ages [5].

Accurate diagnosis of PS is critical for clinical management. Until recently, the diagnosis was based mainly on clinical presentation and often proven incorrect with further clinical follow-up. Even movement disorder specialists misdiagnose PS in up to 10% of cases [6]. Misdiagnosis can result in either a lack of effective treatment, leading to unnecessary disability, or inappropriate treatment and procedures that may expose patients to potential side effects. An important diagnostic dilemma is the differentiation of PS and non-neurodegenerative disorders, such as essential tremor (ET) or drug-induced tremor, due to the overlap of clinical symptoms. The management approach to these conditions is distinctly different. In ET, there may be asymmetry, rest tremor, cogwheeling, or subtle parkinsonian signs that are particularly common in the elderly [5,7,8]. In a study of 502 patients with presumed PD [9], 103 (26%) were found not to have PS, whereas 50 of the 103 patients (29%) met criteria for ET. Therefore, there is a need for a more accurate test that supports accurate clinical diagnosis in these patients to ensure appropriate management.

Although the exact pathological mechanism of PS is largely unknown, an important feature of this disease is the progressive degeneration of dopamine-containing cells in the substantia nigra. Dopamine transporter (DaT) is expressed exclusively on the presynaptic terminals of dopaminergic neurons and is responsible for the reuptake of dopamine from the synaptic cleft. DaT plays a critical role in the maintenance of the presynaptic neuron. In neurodegenerative PS, there is accelerated degeneration of the presynaptic terminals, resulting in reduction of DaT. In non-neurodegenerative disorders, such as ET, there is no nigrostriatal DaT loss.

A radioiodinated cocaine analogue, iodine-123 ioflupane, or iodine-123 FP-CIT (N-[omega]-fluoropropyl-1-2[beta]-carbomethoxy-3[beta] [4-iodophenyl] nortropane), binds with high affinity to presynaptic DaT in the striatum (caudate nucleus and putamen) [10]. Iodine-123 ioflupane was developed for single-photon emission computed tomography (SPECT) imaging to visualize the amount of DaT in the striatum. Therefore, iodine-123 ioflupane SPECT imaging can be used not only for the objective confirmation of presynaptic nigrostriatal degeneration but also for the early differential diagnosis of PS from non-neurodegenerative disorders, such as ET and drug-induced tremor [11]. In addition, iodine-123 ioflupane SPECT is valuable to differentiate between Alzheimer disease (AD) and DLB, with normal uptake in AD and decreased DaT uptake in DLB.

Iodine-123 ioflupane was approved by the US Food and Drug Administration (FDA) in 2011 to assist in the evaluation of adult patients with suspected PS to help differentiate ET from PS. Although this radiopharmaceutical is an adjunct to other diagnostic tools, it was not designed to distinguish among PD, MSA, and PSP. The effectiveness of the DaT scan as a screening test and for monitoring disease progression or response to therapy has not been established [12].

An abnormal iodine-123 ioflupane SPECT scan suggests a decreased amount of DaT in the striatum, that is, a diagnosis of nigrostriatal neurodegenerative PS, whereas a normal scan suggests ET or other nondegenerative parkinsonism (drug-induced, vascular, or psychogenic) [13,14].

II. INDICATIONS

A. Clinical indications for DaT SPECT imaging include, but are not limited to:

Differentiating PS from ET and drug-induced tremor in patients with:

1. Worsening ET
2. Tremor who use neuroleptics
3. Tremor “who want to know”
4. Psychogenic features
5. Dementia, to differentiate between AD and DLB

Pregnancy and known allergy to iodine-123 ioflupane are contraindications. Breastfeeding is a relative contraindication as it is not known whether iodine-123 ioflupane is excreted in breast milk. Patients should cease nursing and should pump and discard the milk for 6 days after iodine-123 ioflupane administration [12].

B. For information on radiation risks to the fetus, see the [ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation](#) [15].

III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

A. Physician

Iodine-123 ioflupane SPECT 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](#) [1].

and

Initial Education and Experience

1. Three hours of continuing medical education in brain iodine-123 ioflupane SPECT imaging interpretation.
2. Thirty proctored or over-read brain iodine-123 ioflupane SPECT imaging performed for investigation of movement disorders prior to beginning unsupervised interpretation.
3. Live or online education programs may be used to fulfill these requirements.

Continuing Education and Experience

For continuing education and experience, please see the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [1] and the [ACR Practice Parameter for Continuing Medical Education](#) [16].

B. Qualified Medical Physicist

For Qualified Medical Physicist qualifications, see the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of SPECT-CT Equipment](#) [17].

C. Radiologic and Nuclear Medicine Technologist

See the [ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) [18] and the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [1].

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. SPECIFICATIONS OF THE EXAMINATION

A. Nuclear Medicine Examination Request

The written or electronic request for DaT SPECT imaging 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)

Relevant patient data should be obtained for optimal interpretation of the examination. The data should include patient history, including the results of recent imaging examinations (eg, computed tomography [CT] or magnetic resonance imaging [MRI]) and current medications/drugs, including when last taken.

B. Radiopharmaceutical

Iodine-123 ioflupane is the nonproprietary name for N -v -fluoropropyl- 2b -carbomethoxy-3b -(4-123 I-iodophenyl) nortropane (¹²³I-FP-CIT). Iodine-123 ioflupane binds with high affinity to striatal presynaptic DaT. DaT is a sodium chloride–dependent transmembrane transport protein on the presynaptic dopaminergic nerve terminals.

The recommended dosage of iodine-123 ioflupane is 111 to 185 MBq (3 to 5 mCi). It should be administered as a slow intravenous injection (over approximately 20 seconds), followed by a saline flush. The most common adverse reactions are headache, nausea, vertigo, dry mouth, and dizziness and have been observed in fewer than 1% of patients.

C. Patient Preparation

1. Prearrival

Patients should be instructed by the referring provider to stop any medications or drugs (if possible) that might interfere with the binding mechanism of the radiopharmaceutical for at least 5 half-lives of the medication or drug [19].

Drugs that may decrease striatal iodine-123 ioflupane binding:

- Opioid: fentanyl
- Eugeroic: modafinil
- Antidepressants: bupropion, mazindol, radafaxine
- Anticholinergic: benztropine
- Anesthetics: isoflurane, ketamine, phencyclidine (PCP) (the latter 2 are of interest particularly for animal SPECT studies, although ketamine and PCP may be used illicitly)
- Central nervous system (CNS) stimulant: cocaine

Drugs that may increase or decrease striatal iodine-123 ioflupane binding:

- Adrenergic agonists: norepinephrine, phenylephrine
- Amphetamines: d-amphetamine, methamphetamine, methylphenidate
- CNS stimulants: ephedrine, phentermine

Drugs that do not increase or decrease striatal iodine-123 ioflupane binding and do not need to be stopped:

- Antiparkinsonian medication: levodopa (L-DOPA) (however, it is possible that chronic use of L-DOPA will downregulate the expression of DaT) [20]
- Dopamine agonists
- N-methyl-d-aspartate (NMDA) receptor blockers
- Monoamine oxidase type B (MAO-B) inhibitors
- Catechol-o-methyl transferase (COMT) inhibitors

2. Preinjection

- a. Evaluate the patient for his/her ability to cooperate.
- b. To minimize the uptake of free iodine-123 by the thyroid gland, administer a single dose of potassium iodide solution (SSKI) or Lugol solution (equivalent to 100 mg iodide) or potassium perchlorate (4600 mg) at least 1 hour before radiopharmaceutical injection (<http://us.datscan.com/staging/wp-content/uploads/2014/06/prescribing-information.pdf>).
- c. To minimize bladder radiation exposure, encourage patients to be well hydrated prior to and for 48 hours after the examination.

D. Image Acquisition

1. Timing

- a. SPECT imaging should be performed 3 to 6 hours following the intravascular administration of iodine-123 ioflupane.

2. Patient Positioning

- a. Place the patient's head in the center of the detector's field-of-view.
- b. Inform the patient of the importance of remaining still throughout the scan.
- c. A head holder minimizes motion artifacts.

3. Image Protocol

- a. Camera: Dual- or triple-detector gamma cameras are recommended.
- b. Collimators: Low-energy high-resolution (LEHR) collimator centered on 159 keV with a $\pm 10\%$ energy window

- c. Flexible head restraints with off-the-table headrest
- d. Use a circular orbit (360° rotation) with the smallest possible radius (typically 11 to 15 cm).
- e. Suggested matrix size is 128 × 128 with a zoom of 3.5 to 4.5 mm.
- f. Step-and-shoot acquisition mode is preferred. However, continuous mode can also be used.
- g. Collect a minimum of 4.5 million counts.
- h. Duration of the scan depends on the camera and the imaging technique used. Imaging typically requires 45 minutes.

E. Data Processing

1. Reconstruction

Iterative reconstruction using ordered-subset expectation maximization (OSEM) with 4 iterations with 8 subsets is recommended over filtered backprojection (FBP). OSEM demonstrates reliable quantification of DaT binding [21]. Software motion correction is not recommended except for minimum deletion of frames where motion occurs. It is better to reimagine after repositioning the patient to improve comfort and reduce the likelihood of motion.

2. Filtering

- a. Two-dimensional (2-D) prefiltering should be applied prior to reconstruction or three dimensional (3-D) postfiltering to reconstructed images.
- b. A low-pass filter such as a Butterworth filter is recommended, as it provides the most acceptable balance between noise and smoothing compared to other filters such as Hanning and Hamming [22]. Resolution recovery may create artifacts and is not recommended [23].

3. Attenuation

Attenuation correction has a significant effect on quantitative analysis [24]. The use of attenuation correction is recommended, either through low-dose CT or through software using linear or a zeroth-order algorithm (such as Chang's). If software attenuation correction is applied, the attenuation correction coefficient may be determined using phantoms. Alternatively, the normal value of 0.11 cm⁻¹ can be used [24,25].

4. Quantification [26]

Semiquantitative method uses the ratios of a region of interest (ROI) of highly binding DaT structures (striatum) compared to regions of low-binding DaT structures (occipital lobe) using the following formula: Striatal binding ratio = [mean counts of striatal ROI – mean counts of occipital ROI]/mean counts of occipital ROI. However, ROI determination may be achieved by a variety of methods to calculate different volumes-of-interest (VOI) [27].

- a. Manual ROIs: Manual drawing of ROI around the striatum and occipital lobe to define areas of high and low DaT bindings. To minimize inter- and intraobserver variability, the use of ROI templates is suggested.
- b. Semimanual: ROIs are drawn using coregistered anatomical imaging templates, such as MRI, or normal functional SPECT or PET (positron emission tomography) brain imaging templates. Alternatively, ROI templates may be used based on normal anatomical templates.
- c. Semiautomated and automated systems: Software packages offer different reconstructions and attenuation corrections with auto-quantification that are based on different mathematical algorithms to calculate VOI. Some software uses MRI and normal DaT scan maps for ROI templates.

F. Image Interpretation

1. Visual

- a. Allows the determination of presence of DaT based on normal striatal radiopharmaceutical uptake
- b. Images should be reviewed on a computer screen. Automated brain analysis software packages provide a comprehensive platform for image review.
- c. Examinations should be interpreted only with knowledge of the clinical data such as the patient's age, gender, and results of correlative morphological examinations such as MRI and CT scans.

- d. Image interpretation follows after confirmation that image quality is adequate. Interpretation is done in softcopy with a software platform that allows review in grayscale and color scales, including a “cool” color scale that facilitates qualitative interpretation. Level of contrast and background subtraction should be used with the knowledge of the specific reconstruction software used and the scale-normal database. Inappropriate color map may result in incorrect interpretation of the examination.
- e. Unprocessed projection images should be reviewed in a cinematic display to assess for the presence and degree of patient motion, target-to- background ratio, and potential artifacts. Specific attention should be given to maintaining straight head positioning, as head tilt may result in artifactual appearance of striatal asymmetry.

2. Quantitative

- a. Quantitative analysis and comparison with a normal database should be performed on images created using the recommended reconstruction algorithms (additional details in section IV.E.4).
- b. Primary interpretation is a qualitative review of the images, but this may be supported by quantification. Several software platforms support quantification, but it is important to recognize that multiple medications and drugs affect quantification. Quantification may be most useful when qualitative interpretation is inconclusive; FDA-approved quantitative analysis software must be used.
- c. At its simplest, quantification software may document differences between left and right basal ganglia and anterior-posterior gradients. Comparison against a database of normal patients adds another level of sophistication but may introduce errors if the patient does not match the demographics used to create the database. It is most useful when software is able to display the results for a given patient as a point in a display that shows the patient’s metric against those of normal patients, as is standard in bone densitometry.
- d. The use of quantification for monitoring response to therapy remains a subject of research and is not recommended at this time. Quantification performed on non–attenuation-corrected images is not recommended.

V. DOCUMENTATION

Reporting should be in accordance with the [ACR Practice Parameter for Communication of Diagnostic Imaging Findings](#) [28].

The report should include the radiopharmaceutical, administered activity, and route of administration, as well as any other pharmaceuticals administered, also with dosage and route of administration.

VI. EQUIPMENT SPECIFICATIONS

A. Hardware

- 1. Imaging may be done with SPECT or SPECT/CT equipment that supports the imaging protocol (IV.D.3).
- 2. The equipment must also support reconstruction using either filtered back projection (FBP) or iterative reconstruction algorithms with appropriate filters. Iterative reconstruction algorithms such as OSEM are preferred because they may result in improved image quality [21].

If SPECT/CT is performed, all additional relevant quality control (QC) procedures should be used. See the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of SPECT-CT Equipment](#) [17].

VII. RADIATION SAFETY

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

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®](#), 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® for children (www.imagegently.org) and Image Wisely® for adults (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).

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 website (<http://www.acr.org/guidelines>).

Equipment performance monitoring should be in accordance with the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of SPECT-CT Equipment](#) [17].

ACKNOWLEDGEMENTS

This practice parameter was revised according to the process described under the heading *The Process for Developing ACR Practice Parameters and Technical Standards* on the ACR website (<http://www.acr.org/guidelines>) by the Committee on Practice Parameters and Technical Standards – Nuclear Medicine and Molecular Imaging of the ACR Commissions on Nuclear Medicine and Molecular Imaging and the Committee on Practice Parameters – Neuroradiology of the ACR Commission on Neuroradiology in collaboration with the ACNM.

Collaborative Committee – members represent their societies in the initial and final revision of this practice parameter

ACR

Rathan M. Subramaniam, MD, PhD, MPH, Chair
Kirk A. Frey, MD, PhD
Christopher H. Hunt, MD
Gustavo A. Mercier, Jr., MD, PhD, MBA
Lilja B. Solnes, MD

ACNM

Patrick M. Colletti, MD
Yang Lu, MD
Bital Savir-Baruch, MD
Hadyn T. Williams, MD, FACR

Committee on Practice Parameters and Technical Standards – Nuclear Medicine and Molecular Imaging
(ACR Committee responsible for sponsoring the draft through the process)

Kevin P. Banks, MD, Co-Chair
Richard K.J. Brown, MD, FACR, Co-Chair
Twyla B. Bartel, DO
Murray D. Becker, MD, PhD, FACR
Erica J. Cohen, DO, MPH
Joanna R. Fair, MD
Perry S. Gerard, MD, FACR
Erin C. Grady, MD

Edward D. Green, MD
Jennifer J. Kwak, MD
Chun K. Kim, MD
Charito Love, MD
Joseph R. Osborne, MD, PhD
Rathan M. Subramaniam, MD, PhD, MPH
Stephanie P. Yen, MD

Committee on Practice Parameters – Neuroradiology

(ACR Committee responsible for sponsoring the draft through the process)

John E. Jordan, MD, MPP, FACR, Chair
Merita A. Bania, MD
Kristine A. Blackham, MD
Brian A. Conley, MD
H. Simms Hardin, IV, MD
Steven W. Hetts, MD
Jacqueline C. Junn, MD

Alexander M. McKinney, IV, MD
David M. Mirsky, MD
Robin J. Mitnick, MD
A. Orlando Ortiz, MD, MBA, FACR
Robert J. Rapoport, MD, FACR
Glenn H. Roberson, MD
Rathan M. Subramaniam, MD, PhD, MPH

Committee on Practice Parameters – Neuroradiology

Stephen A. Kieffer, MD, FACR
Robert McDonald, MD

Raymond K. Tu, MD, FACR
Max Wintermark, MD

M. Elizabeth Oates, MD, Chair, Commission on Nuclear Medicine and Molecular Imaging
Rathan M. Subramaniam, MD, PhD, MPH, Vice-Chair, Commission on Nuclear Medicine and Molecular Imaging
Alexander M. Norbash, MD, FACR, Chair, Commission on Neuroradiology
Jacqueline A. Bello, MD, FACR, Chair, Commission on Quality and Safety
Matthew S. Pollack, MD, FACR, Chair, Committee on Practice Parameters and Technical Standards

Comments Reconciliation Committee

Darlene F. Metter, MD, FACR, Chair
William Small, Jr., MD, FACR, Co-Chair
Kevin P. Banks, MD
Jacqueline A. Bello, MD, FACR
Richard K.J. Brown, MD, FACR
Patrick M. Colletti, MD
Kirk A. Frey, MD, PhD
William T. Herrington, MD, FACR
Christopher H. Hunt, MD
John E. Jordan, MD, MPP, FACR
Paul A. Larson, MD, FACR

Yang Lu, MD
Gustavo A. Mercier, Jr., MD, PhD, MBA
Alexander M. Norbash, MD, FACR
M. Elizabeth Oates, MD
Matthew S. Pollack, MD, FACR
Bital Savir-Baruch, MD
Lilja B. Solnes, MD
Rathan M. Subramaniam, MD, PhD, MPH
Timothy L. Swan, MD, FACR, FSIR
Hadyn T. Williams, MD, FACR

REFERENCES

1. American College of Radiology. ACR-SPR technical standard for diagnostic procedures using radiopharmaceuticals. 2016; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/RadioPharm.pdf>. Accessed September 22, 2015.
2. de Lau LM, Breteler MM. Epidemiology of Parkinson's disease. *The Lancet. Neurology*. 2006;5(6):525-535.
3. Nussbaum RL, Ellis CE. Alzheimer's disease and Parkinson's disease. *The New England journal of medicine*. 2003;348(14):1356-1364.
4. Twelves D, Perkins KS, Counsell C. Systematic review of incidence studies of Parkinson's disease. *Movement disorders : official journal of the Movement Disorder Society*. 2003;18(1):19-31.
5. Bennett DA, Beckett LA, Murray AM, et al. Prevalence of parkinsonian signs and associated mortality in a community population of older people. *The New England journal of medicine*. 1996;334(2):71-76.
6. Hughes AJ, Daniel SE, Ben-Shlomo Y, Lees AJ. The accuracy of diagnosis of parkinsonian syndromes in a specialist movement disorder service. *Brain : a journal of neurology*. 2002;125(Pt 4):861-870.
7. Cohen O, Pullman S, Jurewicz E, Watner D, Louis ED. Rest tremor in patients with essential tremor: prevalence, clinical correlates, and electrophysiologic characteristics. *Archives of neurology*. 2003;60(3):405-410.
8. Louis ED, Wendt KJ, Pullman SL, Ford B. Is essential tremor symmetric? Observational data from a community-based study of essential tremor. *Archives of neurology*. 1998;55(12):1553-1559.
9. Meara J, Bhowmick BK, Hobson P. Accuracy of diagnosis in patients with presumed Parkinson's disease. *Age and ageing*. 1999;28(2):99-102.
10. Booij J, Andringa G, Rijks LJ, et al. [123I]FP-CIT binds to the dopamine transporter as assessed by biodistribution studies in rats and SPECT studies in MPTP-lesioned monkeys. *Synapse*. 1997;27(3):183-190.
11. Catafau AM, Tolosa E. Impact of dopamine transporter SPECT using 123I-Ioflupane on diagnosis and management of patients with clinically uncertain Parkinsonian syndromes. *Movement disorders : official journal of the Movement Disorder Society*. 2004;19(10):1175-1182.
12. GE Healthcare. Quality Checks; Section 2.5. *Protocol Manual - DaTScan*; 2011.
13. Brigo F, Matinella A, Erro R, Tinazzi M. [(1)(2)(3)I]FP-CIT SPECT (DaTSCAN) may be a useful tool to differentiate between Parkinson's disease and vascular or drug-induced parkinsonisms: a meta-analysis. *European journal of neurology*. 2014;21(11):1369-e1390.

14. Gayed I, Joseph U, Fanous M, et al. The impact of DaTscan in the diagnosis of Parkinson disease. *Clinical nuclear medicine*. 2015;40(5):390-393.
15. American College of Radiology. ACR-SPR practice parameter for imaging pregnant or potentially pregnant adolescents and women with ionizing radiation. 2013; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Pregnant-Pts.pdf>. Accessed September 22, 2015.
16. American College of Radiology. ACR practice parameter for continuing medical education (CME). 2016; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CME.pdf>. Accessed February 8, 2016.
17. American College of Radiology. ACR-AAPM technical standard for medical physics performance monitoring of SPECT-CT equipment. 2014; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/SPECT-CT-Equip.pdf>. Accessed January 27, 2016.
18. American College of Radiology. ACR practice parameter for the performing and interpreting diagnostic computed tomography (CT). 2011; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CT-Perf-Interpret.pdf>. Accessed February 8, 2016.
19. Booij J, Kemp P. Dopamine transporter imaging with [(123)I]FP-CIT SPECT: potential effects of drugs. *European journal of nuclear medicine and molecular imaging*. 2008;35(2):424-438.
20. Fahn S, Oakes D, Shoulson I, et al. Levodopa and the progression of Parkinson's disease. *The New England journal of medicine*. 2004;351(24):2498-2508.
21. Koch W, Hamann C, Welsch J, Popperl G, Radau PE, Tatsch K. Is iterative reconstruction an alternative to filtered backprojection in routine processing of dopamine transporter SPECT studies? *Journal of nuclear medicine : official publication, Society of Nuclear Medicine*. 2005;46(11):1804-1811.
22. Morano GN, Seibyl JP. Technical overview of brain SPECT imaging: improving acquisition and processing of data. *Journal of nuclear medicine technology*. 2003;31(4):191-195; quiz 202-193.
23. Dickson JC, Tossici-Bolt L, Sera T, et al. The impact of reconstruction method on the quantification of DaTSCAN images. *European journal of nuclear medicine and molecular imaging*. 2010;37(1):23-35.
24. Soret M, Koulibaly PM, Darcourt J, Hapdey S, Buvat I. Quantitative accuracy of dopaminergic neurotransmission imaging with (123)I SPECT. *Journal of nuclear medicine : official publication, Society of Nuclear Medicine*. 2003;44(7):1184-1193.
25. Jarritt PH, Whalley DR, Skrypnik JV, Houston AS, Fleming JS, Cosgriff PS. UK audit of single photon emission computed tomography reconstruction software using software generated phantoms. *Nuclear medicine communications*. 2002;23(5):483-491.
26. Habraken JB, Booij J, Slomka P, Sokole EB, van Royen EA. Quantification and visualization of defects of the functional dopaminergic system using an automatic algorithm. *Journal of nuclear medicine : official publication, Society of Nuclear Medicine*. 1999;40(7):1091-1097.
27. Badiavas K, Molyvda E, Iakovou I, Tsolaki M, Psarrakos K, Karatzas N. SPECT imaging evaluation in movement disorders: far beyond visual assessment. *European journal of nuclear medicine and molecular imaging*. 2011;38(4):764-773.
28. American College of Radiology. ACR practice parameter for communication of diagnostic imaging findings. 2014; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf>. Accessed September 22, 2015.

*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.

Development Chronology for this Practice Parameter

Adopted 2017