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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.

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## **ACR–SPR PRACTICE PARAMETER FOR THE PERFORMANCE OF PARATHYROID SCINTIGRAPHY**

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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, \_\_\_ 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.

## I. INTRODUCTION

This practice parameter was revised collaboratively by the American College of Radiology (ACR) and the Society for Pediatric Radiology (SPR). It is intended to guide physicians performing and interpreting parathyroid scintigraphy in adult patients.

The goal of parathyroid scintigraphy is to produce images of diagnostic quality to assist in the detection and localization of enlarged and hyperfunctioning parathyroid tissue in normal or ectopic locations in patients with clinical hyperparathyroidism as shown by elevated levels of serum ionized calcium and parathyroid hormone. When properly performed, imaging with radiopharmaceuticals that localize in parathyroid tissue is a sensitive means of detecting parathyroid adenomas. These examinations may also detect parathyroid carcinomas in patients with known hyperparathyroidism. Although multigland hyperplasia may also be detected on this examination, it is more often associated with negative or equivocal examination. As with all nuclear medicine examinations, scintigraphic findings must be correlated with clinical information and other imaging modalities.

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

## II. INDICATIONS AND CONTRAINDICATIONS

Parathyroid scintigraphy is used to identify and localize hyperfunctioning parathyroid tissue prior to surgery and in so doing to facilitate and expedite surgical excision. It may also be used in postoperative patients with persistent or recurrent hyperparathyroidism to detect residual or ectopic parathyroid tissue and to help reduce surgical time at the time of repeat excisional surgery.

Parathyroid imaging is not to be used as a screening test for hyperparathyroidism but is used to localize the source of excess parathyroid hormone production in a patient with clinically proven hyperparathyroidism (persistently elevated serum calcium and parathyroid hormone in the appropriate clinical setting). Technetium-99m sestamibi uptake is not specific for parathyroid adenoma or hyperplasia but may localize to benign or malignant tumor in any organ or tissue, including adenoma (thyroid or parathyroid), carcinoma, lymphoma, sarcoma, bone tumor benign (brown tumor, osteitis fibrosa cystica), and malignant (primary or metastatic, including multiple myeloma and plasmacytoma).

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](#).

## III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

See the [ACR–SNM Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#).

## IV. SPECIFICATIONS OF THE EXAMINATION

The written or electronic request for parathyroid scintigraphy 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's scope of practice requirements. (ACR Resolution 35, adopted in 2006)

## A. Radiopharmaceuticals

### 1. Radiopharmaceuticals localizing in both thyroid and parathyroid tissues

The principal agent for parathyroid scintigraphy is currently technetium-99m sestamibi. Although technetium-99m tetrofosmin and thallium-201 chloride have been used for this purpose historically, sestamibi is the more widely accepted radiopharmaceutical [1-4].

- a. Technetium-99m sestamibi given intravenously in an administered activity of 20 to 30 millicuries (740 to 1,110 MBq) localizes in both thyroid and parathyroid tissues in proportion to local blood flow and metabolism. The rate of clearance from hyperplastic and neoplastic parathyroid tissue is usually slower than from the normal thyroid and parathyroid tissues [1-4].
- b. Thallium-201 chloride should no longer be used for parathyroid scintigraphy [1-3].
- c. Administered activity for children should be determined based on body weight and should be as low as reasonably achievable for diagnostic image quality. For children, the recommended administered activity of technetium-99m sestamibi is 0.3 mCi/kg, with a minimum administered activity of 1 mCi and maximum administered activity of 20 mCi.

### 2. Radiopharmaceuticals localizing in the thyroid in proportion to thyroid function (see the [ACR-SPR Practice Parameter for the Performance of Scintigraphy and Uptake Measurements for Benign and Malignant Thyroid Disease](#)).

- a. Technetium-99m pertechnetate given intravenously in an administered activity of 1 to 10 millicuries (37 to 370 MBq) is trapped by the follicular cells of the thyroid.
- b. Iodine-123 sodium iodide given orally in an administered activity of 200 to 600 microcuries (7.5 to 22 MBq) is trapped and organified by the follicular cells of the thyroid.

## B. Imaging

There are 2 different strategies for imaging: 1) single radiopharmaceutical dual-phase imaging and 2) dual radiopharmaceutical imaging. For both strategies, it is important to image the neck and mediastinum to evaluate for ectopic parathyroid tissue. Single-photon-emission computed tomography (SPECT) imaging separately or together with computed tomography (SPECT/CT) has been shown to increase sensitivity and greatly improve anatomic localization for the surgeon, especially in cases of ectopic parathyroid tissue. SPECT or SPECT/CT imaging is most sensitive and accurate when performed immediately after the initial planar images [2,4].

### 1. Single radiopharmaceutical with single-phase or dual-phase imaging

Technetium-99m sestamibi is given intravenously. Anterior planar images of the neck and thorax are obtained at 10 to 30 minutes and again at 90 to 180 minutes. Because abnormal parathyroid tissue usually retains the radiopharmaceutical for a longer period of time than normal thyroid or parathyroid tissue, abnormal tissues appear as foci of increased activity on the delayed images. Although the single radiopharmaceutical with dual-phase imaging technique relies on differential wash-out, some parathyroid lesions with more rapid radiopharmaceutical wash-out may be difficult to detect. SPECT/CT, SPECT, and dual radiopharmaceutical imaging have increased sensitivity and may improve detection of abnormal parathyroid tissue with rapid wash-out. If SPECT or SPECT/CT is not performed as part of the protocol, pinhole-collimated images of the neck can improve resolution and permit anterior oblique images for lesion depth estimation.

## 2. Dual radiopharmaceutical

In this strategy, an image acquired after the administration of a radiopharmaceutical that accumulates only in thyroid tissue (technetium-99m pertechnetate or iodine-123 sodium iodide) is subtracted digitally or by qualitative visual comparison from an image acquired after administration of a radiopharmaceutical that localizes in both thyroid and parathyroid tissue (technetium-99m sestamibi). Imaging relies on using different photopeaks of the 2 radiopharmaceuticals administered or different administered activities of the 2 radiopharmaceuticals. Two approaches are used: 1) the thyroid-seeking radiopharmaceutical is given first or 2) the parathyroid radiopharmaceutical is given first.

## V. EQUIPMENT SPECIFICATIONS

Any gamma camera may be used. Parallel-hole collimation is the standard for imaging the neck and mediastinum. Pinhole collimation may improve resolution of the neck and permit anterior oblique and lateral images for lesion depth determination.

Various methodologies for SPECT/CT and SPECT imaging with single- and dual-phase technetium-99m parathyroid scintigraphy are in clinical use. These include performing SPECT/CT (or SPECT) immediately after the early planar images, after the delayed planar images, or after both sets of images. One large investigation showed that early SPECT/CT (or SPECT) imaging in combination with any delayed imaging method (planar, SPECT, or SPECT/CT) had the highest accuracy for parathyroid adenoma localization. This is thought to be related to the rapid sestamibi wash-out from some parathyroid adenomas and many hyperplastic parathyroid glands [2,4].

SPECT data are optimally acquired over a 360 degree elliptical body-contouring orbit. The SPECT acquisition requires approximately 25 minutes and ranges from 120 to 60 projections obtained at 15 to 25 seconds per projection at 3 to 6 degree angles depending on the sensitivity of the detector and number of projections. The SPECT data are acquired into a 128 x 128 matrix corrected for attenuation and reconstructed using an ordered subset expectation maximization (OSEM) iterative technique. A 3-D postprocessing filter is usually applied to the SPECT data, as per the manufacturer's specifications.

CT acquisition parameters vary according to individual patient, laboratory, and equipment manufacturer. Typically, a tube current ranging from 100 to 200 mAs and a voltage of 120 kVp (ranging from 100 to 140 kVp) are used. Intravenous contrast is usually not administered for SPECT/CT parathyroid scintigraphy.

The reconstructed data are ideally displayed as separate SPECT, CT, and fusion image sets in the 3 standard projections (axial, coronal, and sagittal). These image sets should be coregistered so that the body regions are displayed by the number slices of any given projection.

At some centers, surgeons increasingly utilize hand-held gamma probe devices to enhance their intraoperative identification of parathyroid lesions after administration of technetium-99m sestamibi at the same administered activity used for preoperative diagnostic examination. In such cases, skin marking may be done by the radiologist preoperatively, ie, within a few hours before the patient goes to surgery [1].

## VI. DOCUMENTATION

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

The report should include the radiopharmaceutical(s) used, the administered activity(ies), and route(s) and time(s) of administration.

## VII. 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).

## 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 Nuclear Physics Performance Monitoring of Gamma Cameras](#).

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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 Pediatric Radiology in collaboration with the SPR.

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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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