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.

Revised 2015 (Resolution 31) *

ACR–SAR PRACTICE PARAMETER FOR THE PERFORMANCE OF ADULT CYSTOGRAPHY AND URETHROGRAPHY

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. 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.

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.
I. INTRODUCTION

This practice parameter is intended to assist radiologists performing cystography and urethrography in adult patients. Properly performed urethrography and cystography (either conventional or CT) are diagnostic radiological imaging tests that can provide information about the urethra, bladder, and occasionally the ureters. Application of the following practice parameter will maximize the diagnostic yield of these studies. Magnetic resonance imaging (MRI) or ultrasound may occasionally provide additional diagnostic information when clinically indicated.

II. DEFINITION

Conventional cystography/urethrography:

Cystography and urethrography consist of imaging the bladder and/or urethra following administration of contrast media. The studies may be combined. These studies include cystography, cystourethrography, voiding cystourethrography, and urethrography (antegrade and retrograde). One or more scout images may be obtained before the infusion or injection of contrast for any of these studies.

Following contrast administration, images are obtained in various projections appropriate to the indication for the study (eg, oblique, lateral, during rest and strain, and/or during voiding). Abnormalities of the bladder or urethra may be detected, as well as extrinsic effects on them by adjacent abnormalities.

Fluoroscopy during the procedure may enhance diagnostic accuracy and is especially valuable in assessing the urethra, detecting contrast media extravasation from the bladder or urethra, and documenting the presence of vesicoureteral reflux.

CT cystography:

CT cystography consists of imaging the bladder following retrograde filling of the bladder to patient tolerance or a predetermined institutionally approved volume in the setting of trauma or recent surgery (usually 200–300 mL), whichever is achieved first [1,2]. Contiguous axial scans through the pelvis are then obtained [3,4]. Multiplanar reformations may be helpful in identifying leak from or tear of urinary bladder [5,6].

III. GOAL

The goal of cystography and/or urethrography is to evaluate the anatomy, function, and pathology of the lower urinary tract.

IV. INDICATIONS, CONTRAINDICATIONS, AND CAUTIONS

A. Indications

1. Indications for cystography include, but are not limited to, evaluation of the following:
   a. Recurrent urinary tract infections
   b. Vesicoureteral reflux [7]
   c. Bladder morphology and capacity
   d. Bladder diverticula [8]
   e. Leak from or tear of urinary bladder [9]
   f. Enterovesical, vesicouterine, vesicovaginal, and vesicocutaneous fistulae [10]
   g. Integrity of postoperative anastomoses or suture lines [5,11]
   h. Bladder outlet obstruction [12]
   i. Incontinence [12]
j. Hematuria
k. Neoplasia
l. Evaluation for bladder leak after pelvic surgery
m. Unexplained free intraperitoneal fluid following surgery or trauma

2. Indications for urethrography include, but are not limited to, evaluation of the following:
   a. Urethral diverticula [13]
   b. Urethral strictures [14]
   c. Bladder outlet or urethral obstruction
   d. Hematuria.
   e. Suspected urethral injury following trauma [15]
   f. Recurrent urinary tract infections
   g. Diminished urinary stream
   h. Incomplete voiding
   i. Urethral foreign bodies
   j. Urethral mucosal tumors [16]
   k. Urethral fistula
   l. Postoperative urethral injury

B. Absolute contraindications: None

C. Relative contraindications

1. Pregnancy is a relative contraindication to cystography/urethrography.
2. Urinary tract infection. Antibiotic prophylaxis should be considered in patients with a history of urinary tract infection. In patients with active urinary tract infection, consideration may be given to delaying cystography/urethrography until the infection has cleared.
3. Iodinated contrast allergy. The possibility exists for contrast media to be systemically absorbed during cystography or urethrography. This commonly occurs if there is extravasation of contrast media from the urethral or bladder lumen, and it may occur, though uncommonly, in the absence of frank extravasation.

V. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

See the ACR–SPR Practice Parameter for General Radiography [17].

VI. SPECIFICATION OF THE EXAMINATION

The written or electronic request for a cystography and/or urethrography examination 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. Appropriate history and preprocedure screening should be performed by personnel familiar with the various risk factors, preparations, and premedication strategies. See the ACR–SPR Practice Parameter for the Use of
Intravascular Contrast Media [1] and the ACR Manual on Contrast Media [2,18]. Either ionic or nonionic contrast media for injection may be used for cystography and urethrography.

B. If a urinary catheter is not in place, the urethra or bladder should be catheterized using aseptic technique. An appropriate volume of contrast should be administered to demonstrate the anatomic structures of interest. The examination should be tailored to the needs of the individual patient. Fluoroscopy can optimize diagnostic yield, especially during voiding studies. If a catheter has already been placed, another smaller catheter can be passed beside it to perform urethrography to assess urethral integrity. Combined (simultaneous) voiding cystourethrography and retrograde urethrography can provide valuable treatment planning information in male urethral strictures disease. Clinical judgment should guide decisions about contrast quantity and use of infusion or injection technique.

C. Appropriate images should be produced to demonstrate normal and abnormal findings with the minimum radiation dose necessary to achieve an optimal study. Radiologists and technologists should be trained in the correct positioning of the patient to obtain optimal images. In addition to the anteroposterior projection, bladder imaging is often enhanced by oblique and lateral views. Postvoid imaging of the bladder is helpful in assessing postvoid residual volume and can help in detecting small bladder leaks. If the examination is being performed to evaluate suspected bladder leak, particularly in a patient with pelvic trauma, it is essential to actively distend the bladder until a detrusor contraction occurs. Visualization of the male urethra is often best in a posterior oblique projection with extension of the penis to straighten the natural curve at the penoscrotal junction. AP and lateral views of the anterior urethra may offer better characterization of the extent of an abnormality. Attempt should be made to reflux contrast past the urinary sphincter to opacify the posterior urethra for a complete exam. Imaging over the kidneys facilitates visualization and documentation of vesicoureteral reflux. Fluoroscopic spot films are useful in documenting reflux and of urethral anatomy.

VII. DOCUMENTATION

Reporting should be in accordance with the ACR Practice Parameter for Communication of Diagnostic Imaging Findings [19].

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 who 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)


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.

Facilities should have and adhere to policies and procedures that require varying ionizing radiation examination protocols (plain radiography, fluoroscopy, interventional radiology, CT) to take into account patient body habitus (such as patient dimensions, weight, or body mass index) to optimize the relationship between minimal radiation dose and adequate image quality. Automated dose reduction technologies available on imaging equipment should be used whenever appropriate. If such technology is not available, appropriate manual techniques should be used.
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).

IX. 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).


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 – General, Small and Rural Practice of the Commission on General, Small, and Rural Practice, in collaboration with the SAR.

Collaborative Committee
Members represent their societies in the initial and final revision of this practice parameter.

ACR
Tammam N. Nehme, MD, Chair
Pil S. Kang, MD
Serena McClam Liebengood, MD

SAR
Nancy S. Curry, MD, FACR
Akira Kawashima, MD, PhD
Parvati Ramchandani, MD, FACR
Ron Zagoria, MD, FACR

Committee on Practice Parameters – General, Small, and Rural Practice
(ACR Committee responsible for sponsoring the draft through the process)

Matthew S. Pollack, MD, FACR, Chair
Sayed Ali, MD
Gory Ballester, MD
Lonnie J. Bargo, MD
Christopher M. Brennan, MD, PhD
Resmi A. Charalel, MD
Candice A. Johnstone, MD
Pil S. Kang, MD
Jason B. Katzen, MD
Cystography Urethrography

Serena McClam Liebengood, MD
Gagandeep S. Mangat, MD
Tammam N. Nehme, MD

Lawrence A. Liebscher, MD, FACR, Chair, Commission on General, Small and Rural Practices
Debra L. Monticciolo, MD, FACR, Chair, Commission on Quality and Safety
Jacqueline Anne Bello, MD, FACR, Vice-Chair, Commission on Quality and Safety
Julie K. Timins, MD, FACR, Chair, Committee on Practice Parameters and Technical Standards
Matthew S. Pollack, MD, FACR, Vice Chair, Committee on Practice Parameters and Technical Standards

Comments Reconciliation Committee
Joseph G. Cernigliaro, MD, FACR, Chair
Sanjay K. Shetty, MD, MBA, Co-Chair
Kimberly E. Applegate, MD, MS, FACR
Nancy S. Curry, MD, FACR
Gian Pietro Feltrin, MD
William T. Herrington, MD, FACR
Theresa T. Huang, MD
Pil S. Kang, MD
Akira Kawashima, MD, PhD
Serena McClam Liebengood, MD
Paul A. Larson, MD, FACR
Lawrence A. Liebscher, MD, FACR
Debra L. Monticciolo, MD, FACR
Tammam N. Nehme, MD
Matthew S. Pollack, MD, FACR
Parvati Ramchandani, MD, FACR
Julie K. Timins, MD, FACR
Ron Zagoria, MD, FACR

REFERENCES


*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
1992 (Resolution 13)
Amended 1995 (Resolution 24, 53)
Revised 1996 (Resolution 24)
Revised 2000 (Resolution 38)
Revised 2005 (Resolution 34)
Amended 2006 (Resolution 17, 35)
Revised 2010 (Resolution 41)
Amended 2014 (Resolution 39)
Revised 2015 (Resolution 31)