

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 32)*

ACR–AIUM–SRU PRACTICE PARAMETER FOR THE PERFORMANCE OF DIAGNOSTIC AND SCREENING ULTRASOUND OF THE ABDOMINAL AORTA IN ADULTS

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 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

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.

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.

I. INTRODUCTION

The clinical aspects contained in specific sections of this practice parameter (Introduction, Indications, Specifications of the Examination, and Equipment Specifications) were developed collaboratively by the American College of Radiology (ACR), the American Institute of Ultrasound in Medicine (AIUM), and the Society of Radiologists in Ultrasound (SRU). Recommendations for physician requirements, written request for the examination, procedure documentation, and quality control vary among the 3 organizations and are addressed by each separately.

These practice parameters are intended to assist in the performance and interpretation of the dedicated sonographic examination of the abdominal aorta. The examination may be performed as a diagnostic or screening study [1-3]. Although it is not possible to detect every abnormality, following this practice parameter will maximize the detection of abnormalities of the abdominal aorta.

II. INDICATIONS/CONTRAINDICATIONS

Indications for ultrasound of the abdominal aorta include, but are not limited to, the following:

A. Diagnostic Evaluation for Abdominal Aortic Aneurysm

1. Palpable or pulsatile abdominal mass or abdominal bruit
2. Unexplained lower back pain, flank pain, or abdominal pain
3. Follow-up of a previously demonstrated abdominal aortic aneurysm
4. Follow-up of patients with an abdominal aortic and/or iliac endoluminal stent graft

B. Screening Evaluation for Abdominal Aortic Aneurysm

1. Men age 65 or older
2. Women age 65 or older with cardiovascular risk factors
3. Patients age 50 or older with a family history of aortic and/or peripheral vascular aneurysmal disease
4. Patients with a personal history of peripheral vascular aneurysmal disease

Groups with additional risk include patients with a history of smoking, hypertension, or certain connective tissue diseases (eg, Marfan syndrome).

There are no absolute contraindications to ultrasound of the aorta. If aortic rupture or dissection is clinically suspected, ultrasound is usually not the examination of choice.

III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

Each organization will address this section in its document. ACR language is as follows:

See the [ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations](#) [4].

IV. WRITTEN REQUEST FOR THE EXAMINATION

Each organization addresses this requirement individually. ACR language is as follows:

The written or electronic request for ultrasound of the abdominal aorta 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)

V. SPECIFICATIONS OF THE EXAMINATION

A. Diagnostic Examination

The examination includes the following, when feasible:

1. Abdominal aorta
 - a. Longitudinal images (along the long axis of the vessel)
 - i. Proximal (below diaphragm, near the celiac artery)
 - ii. Mid (near the level of the renal arteries)
 - iii. Distal (above the iliac bifurcation)
 - iv. The aorta should be imaged in the plane that is parallel to the long axis of the lumen (for measurement of the AP dimension) and perpendicular to the long axis of the lumen (for measurement of the transverse dimension). The transverse measurement may also be obtained in the coronal plane [5].
 - b. Transverse images (perpendicular to the long axis of the vessel)
 - i. Proximal (below diaphragm, near the celiac artery)
 - ii. Mid (near the level of the renal arteries)
 - iii. Distal (above the iliac bifurcation)
 - c. Measurements
 - i. Measurements of the proximal, mid, and distal aorta should be obtained using predominantly the long axis view to measure the AP dimension. Transverse or coronal views should also be obtained to measure the width. Measurements are taken at the greatest diameter of the aorta, from outer edge to outer edge.
 - ii. If an aneurysm is present, the maximal size and location of the aneurysm should be documented and recorded. The relationship of the dilated segment to the renal arteries and to the aortic bifurcation should be determined if possible.
 - iii. At a minimum, the largest measurement should be recorded and reported. A measurement of the length of the aneurysm is not necessary.
2. Common iliac arteries
 - a. Longitudinal images of the proximal right and left common iliac arteries (along the long axis of the vessel)

- b. Transverse images (perpendicular to the long axis of the vessel) of the proximal common iliac arteries, just below the bifurcation
- c. Measurement of the widest visualized portion of each common iliac artery, from outer edge to outer edge

Color Doppler imaging and/or spectral Doppler with waveform analysis of the aorta and iliac arteries may be helpful to demonstrate patency and the presence of intraluminal thrombus.

After endoluminal graft placement, color (or power) and spectral Doppler are required to document the presence or absence of endoleaks.

Interobserver measurements of an aortic aneurysm can vary by as much as 5 mm. Visual comparison with prior studies is recommended to ensure measurements are obtained at similar locations and to assess for interval change in aneurysm size. Consistent measurements of aneurysm diameter are recommended following endograft repair to check for interval enlargement in sac size [6].

B. Screening Examination for Abdominal Aortic Aneurysm

1. Abdominal aorta

- a. Longitudinal images (along the long axis of the vessel)
 - i. Proximal (below diaphragm, near the celiac artery)
 - ii. Mid (near the level of the renal arteries)
 - iii. Distal (above the iliac bifurcation)
- b. Transverse images (perpendicular to the long axis of the vessel)
 - i. Proximal (below diaphragm, near the celiac artery)
 - ii. Mid (near the level of the renal arteries)
 - iii. Distal (above the iliac bifurcation)
- c. Measurements

AP measurements of the aorta sufficient to determine if an aortic aneurysm exists according to the criteria in section V.A. above should be obtained. If an aneurysm is present, its greatest dimension should be reported. However, if no aneurysm is identified, the largest diameter of the abdominal aorta should be reported.

C. Interpretation of the Screening Examination Should Include at Least 3 Categories

1. Positive – Infrarenal abdominal aortic aneurysm greater than or equal to 3 cm in diameter or greater than or equal to 1.5 times the diameter of the more proximal infrarenal aorta [7]. The latter definition is particularly important in women and small adults [8].
2. Negative – No infrarenal abdominal aortic aneurysm
3. Indeterminate – Aneurysmal status not defined because of nonvisualization or partial visualization of the infrarenal abdominal aorta
4. The report should also state whether or not the suprarenal aorta was seen and, if seen, should reflect whether or not it is normal. The report should also state whether dilation of the aorta above the celiac artery is noted. For the area above the celiac artery, an aneurysm may be reported if the diameter is greater than 3.9 cm for males or 3.1 cm for females.

VI. DOCUMENTATION

Each organization will address this section in its document. ACR language is as follows:

Adequate documentation is essential for high-quality patient care. There should be a permanent record of the ultrasound examination and its interpretation. Comparison with prior relevant imaging studies may prove helpful. Images of all appropriate areas, both normal and abnormal, should be recorded. Variations from normal size

should generally be accompanied by measurements. Images should be labeled with the patient identification, facility identification, examination date, and image orientation. An official interpretation (final report) of the ultrasound examination should be included in the patient's medical record. Retention of the ultrasound examination images should be consistent both with clinical need and with relevant legal and local health care facility requirements.

Reporting should be in accordance with the [ACR Practice Parameter for Communication of Diagnostic Imaging Findings](#) [9].

VII. EQUIPMENT SPECIFICATIONS

Abdominal aortic ultrasound should be performed with real-time scanners with transducers that allow for appropriate penetration and resolution, depending on the patient's body habitus. Diagnostic information should be optimized, while keeping total ultrasound exposure as low as reasonably achievable.

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

Each organization will address this section in its document. ACR language is as follows:

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 Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment](#) [10].

ACKNOWLEDGEMENTS

This practice parameter was developed 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 – Ultrasound of the Commission on Ultrasound, in collaboration with the AIUM and the SRU.

Collaborative Committee

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

ACR

John S. Pellerito, MD, FACR, Chair
Helena Gabriel, MD
Jason B. Katzen, MD
Jason Wagner, MD

AIUM

Lin Diacon, MD, RDMS, RPVI
Carl C. Reading, MD, FACR

SRU

Raymond E. Bertino, MD, FACR
Franklin N. Tessler, MD

Committee on Practice Parameters – Ultrasound

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

Beverly E. Hashimoto, MD, FACR, Chair
Teresita L. Angtuaco, MD, FACR
Marcela Bohm-Velez, MD, FACR
Maria A. Calvo-Garcia, MD
Nirvikar Dahiya, MD, MBBS
Sandra O. DeJesus Allison, MD
Helena Gabriel, MD
Gail N. Morgan, MD
Harriet J. Paltiel, MD
Maitray D. Patel, MD
Henrietta K. Rosenberg, MD, FACR
Sheila Sheth, MD, FACR
Maryellen R.M. Sun, MD
Sharlene A. Teefey, MD, FACR
Jason M. Wagner, MD

Beverly G. Coleman, MD, FACR, Chair, Commission on Ultrasound
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

Kristen K. DeStigter, MD, FACR, Chair
Catherine J. Everett, MD, MBA, FACR, Co-Chair
Kimberly E. Applegate, MD, MS, FACR
Raymond E. Bertino, MD, FACR
Douglas L. Brown MD, FACR
Beverly G. Coleman, MD, FACR
Lin Diacon, MD, RDMS, RPVI
Helena Gabriel, MD
Beverly Hashimoto, MD, FACR
William T. Herrington, MD, FACR
Jason B. Katzen, MD
Paul A. Larson, MD, FACR
Debra L. Monticciolo, MD, FACR
John Pellerito, MD, FACR
Matthew S. Pollack, MD, FACR
Carl C. Reading, MD, FACR
Franklin Tessler, MD
Theresa Tien-Ho Huang, MD
Julie K. Timins, MD, FACR
Ants Toi, MD
Jason Wagner, MD

REFERENCES

1. Adams DC, Tulloh BR, Galloway SW, Shaw E, Tulloh AJ, Poskitt KR. Familial abdominal aortic aneurysm: prevalence and implications for screening. *Eur J Vasc Surg.* 1993;7(6):709-712.

2. Ashton HA BM, Day NE, Kim LG, Marteau TM, Scott RA, Thompson SG, Walker NM; Multicentre Aneurysm Screening Study Group. The Multicentre Aneurysm Screening Study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial. *Lancet*. 2002;360:1531-1539.
3. U.S. Preventive Services Task Force. Screening for Abdominal Aortic Aneurysm 2005; <http://www.uspreventiveservicestaskforce.org/uspstf05/aaascr/aaars.htm>. Accessed September 4, 2014.
4. American College of Radiology. ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations. 2014; <http://www.acr.org/~media/13B896B9F4844E3082E7D7ED66AFC148.pdf>. Accessed October 10, 2014.
5. Pellerito J P, JF. Introduction to Vascular Ultrasonography, 6th Edition. 2012:704.
6. Comstock CE, Bluth EI, Peattie RA, Schrader T, Leslie BR. Inter-observer variability in ultrasonic evaluation of abdominal aortic aneurysms. *J La State Med Soc*. 1994;146(12):526-530.
7. Johnston KW, Rutherford RB, Tilson MD, Shah DM, Hollier L, Stanley JC. Suggested standards for reporting on arterial aneurysms. Subcommittee on Reporting Standards for Arterial Aneurysms, Ad Hoc Committee on Reporting Standards, Society for Vascular Surgery and North American Chapter, International Society for Cardiovascular Surgery. *J Vasc Surg*. 1991;13(3):452-458.
8. EM I. Contemporary Reviews in Cardiovascular Medicine: Thoracic and Abdominal Aortic Aneurysms. *Circulation*. 2005;111(816-828).
9. American College of Radiology. ACR Practice Parameter for Communication of Diagnostic Imaging Findings. 2014; <http://www.acr.org/~media/C5D1443C9EA4424AA12477D1AD1D927D.pdf>. Accessed October 10, 2014.
10. American College of Radiology. ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment. 2014; <http://www.acr.org/~media/152588501B3648BA803B38C8172936F9.pdf>. Accessed October 23, 2014.

*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

2005 (Resolution 32)

Amended 2006 (Resolution 35)

Revised 2010 (Resolution 34)

Amended 2014 (Resolution 39)

Revised 2015 (Resolution 32)