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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.

Revised 2013 (Resolution 42)*

ACR–AAPM TECHNICAL STANDARD FOR MEDICAL NUCLEAR PHYSICS PERFORMANCE MONITORING OF GAMMA CAMERAS

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 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 technical standard was revised collaboratively by the American College of Radiology (ACR) and the American Association of Physicists in Medicine (AAPM).

All nuclear medicine imaging equipment must be tested upon installation and monitored at least annually by a Qualified Medical Physicist to ensure that it is functioning within manufacturer specifications and accepted performance standards. Additional or more frequent performance monitoring may be necessary in certain situations (e.g., after major equipment maintenance). Although it is not possible to consider all variations of equipment performance to be monitored, adherence to this technical standard will maximize image quality and help to ensure the accuracy of numerical results in clinical procedures. Key points to consider are performance characteristics to be monitored, estimated patient radiation dose, qualifications of personnel, and follow-up procedures.

The goal is to produce the highest quality diagnostic image consistent with the clinical use of the equipment and the information requirement of the examination and to establish performance standards for the imaging instruments.

II. QUALIFICATIONS AND RESPONSIBILITIES OF A QUALIFIED MEDICAL PHYSICIST

A Qualified Medical Physicist is an individual who is competent to practice independently in one or more of the subfields in medical physics. The American College of Radiology (ACR) considers certification, continuing education and experience in the appropriate subfield(s) to demonstrate that an individual is competent to practice one or more of the subfields in medical physics, and to be a Qualified Medical Physicist. The ACR strongly recommends that the individual be certified in the appropriate subfield(s) by the American Board of Radiology (ABR), the Canadian College of Physics in Medicine, or the American Board of Medical Physics (ABMP).

A Qualified Medical Physicist should meet the [ACR Practice Parameter for Continuing Medical Education \(CME\)](#). (ACR Resolution 17, adopted in 1996 – revised 2012, Resolution 42)

The appropriate subfield of medical physics for this technical standard is Nuclear Medical Physics. (Previous medical physics certification categories, including Radiological Physics and Medical Nuclear Physics, are also acceptable.)

Certification in Nuclear Medicine Physics and Instrumentation by the American Board of Science in Nuclear Medicine (ABSNM) is also acceptable.

The Qualified Medical Physicist must be familiar with the principles of radiation protection; the guidelines of the National Council on Radiation Protection and Measurements (NCRP); laws and regulations governing the use of the equipment being tested; the function, clinical uses, and performance specifications of the imaging equipment; and calibration processes and limitations of the instruments and techniques used for testing performance.

The Qualified Medical Physicist may be assisted by properly trained individuals in obtaining data for performance monitoring. These individuals must be approved by the Qualified Medical Physicist in the techniques of performing tests, the function and limitations of the imaging equipment and test instruments, the reasons for the tests, and the importance of the test results. The Qualified Medical Physicist is responsible for, and must review, interpret, and approve all data as well as provide a signed report of the conclusions.

III. PERFORMANCE CHARACTERISTICS TO BE MONITORED

A. Performance Evaluation

The following characteristics should be evaluated at least annually [1-11]:

1. Intrinsic uniformity
2. System uniformity with all commonly used collimators
3. Intrinsic or system spatial resolution/linearity
4. System sensitivity
 - a. Count rate per unit activity
 - b. Interdetector variability
5. Energy resolution
6. Count rate performance
7. Formatter/video display
 - a. Uniformity
 - b. Spatial resolution
8. Overall system performance for single photon emission computed tomography (SPECT)
 - a. Uniformity
 - b. Contrast
 - c. Spatial resolution
9. System interlocks

B. Quality Control Program

A continuous quality control (QC) program must be established for the nuclear medicine imaging equipment with the assistance of a Qualified Medical Physicist as outlined in the [ACR–SNM Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [12,13]. An on-site technologist should be identified to be responsible for conducting routine QC.

The results of the QC program must be monitored annually by the Qualified Medical Physicist. If measured values of QC parameters fall outside the control limits, the physicist should initiate appropriate investigative or corrective actions. A Qualified Medical Physicist should be available to assist in prescribing corrective actions for unresolved problems.

C. Acceptance Testing

Initial performance testing of imaging equipment must be performed upon installation and should be completed before clinical use. This testing should be more comprehensive than periodic performance testing and should be consistent with current acceptance testing practices. Electrical safety of the equipment must also be tested by appropriate personnel prior to its initial clinical use.

D. Written Survey Reports and Follow-Up Procedures

The Qualified Medical Physicist must report the findings to the physician(s), to the responsible professional(s) in charge of obtaining or providing necessary service to the equipment, and, in the case of the consulting Qualified Medical Physicist(s), to the representative of the hiring party. If appropriate, the Qualified Medical Physicist should initiate the required service. Action should be taken immediately by direct verbal communication if there is imminent danger to patients or staff using the equipment due to unsafe conditions. Written survey reports must be provided in a timely manner consistent with the importance of any adverse findings. The Qualified Medical Physicist should confirm that the unit is performing in a safe and acceptable fashion as soon as possible after the required service is performed.

IV. 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.

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).

A table of organ dose estimates should be prepared for all procedures that involve administration of radiopharmaceuticals to patients. The table should specify the radiopharmaceutical dosage schedule used at the facility. All organs that receive significant doses should be included. Separate values for standard patients of different sizes should be tabulated where applicable. The table should be reviewed at least annually and updated when any of the following occur: 1) the addition of new procedures and/or radiopharmaceuticals, 2) a change in radiopharmaceutical dosage schedules, 3) a change in the route of administration, and 4) the availability of more accurate dosimetry data [13,15-18]. For facilities performing pediatric imaging, the radiopharmaceutical dosage should be adjusted to be appropriate to the size of the patient. It is recommended that the dosages closely follow the activities as outlined in the North American Consensus Guidelines for Administered Radiopharmaceutical Activities in Children and Adolescents [19].

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- Revised 2003 (Resolution 14)
- Amended 2006 (Resolution 16g, 17)
- Revised 2008 (Resolution 5)
- Revised 2013 (Resolution 42)