

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 2021(Resolution 19)*

ACR–ACNM–SNMMI–SPR PRACTICE PARAMETER FOR THE PERFORMANCE OF SINGLE-PHOTON EMISSION BRAIN PERFUSION IMAGING (INCLUDING SPECT AND SPECT/CT)

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

¹ *Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing*, 831 N.W.2d 826 (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 has been revised collaboratively by the American College of Radiology (ACR), the American College of Nuclear Medicine (ACNM), the Society of Nuclear Medicine and Molecular Imaging (SNMMI), and the Society for Pediatric Radiology (SPR).

Nuclear medicine imaging, including single-photon emission computed tomography (SPECT) brain perfusion imaging, using lipophilic radiopharmaceuticals that cross the blood-brain barrier and localize in brain tissue is a proven and useful procedure to define the regional distribution of brain perfusion, evaluate a variety of brain abnormalities, and corroborate the clinical diagnosis of brain death in appropriate situations [1-3]. The radiotracers technetium-99m (Tc-99m) exametazime (hexamethyl propylene amine oxime [HMPAO]) and Tc-99m bicisate (ethyl cysteinate dimer [ECD]), have high first-pass extraction across the blood-brain barrier and are significantly trapped in the brain by conversion to polar metabolites that do not readily cross intact cell membranes.

Application of this practice parameter should be in accordance with the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [4].

The goal of brain perfusion imaging is to detect abnormalities in cerebral perfusion.

II. INDICATIONS

A. Clinical indications for brain perfusion imaging examinations include, but are not limited to:

1. Evaluating patients with suspected dementia [3,5]
2. Localizing seizure foci [6,7]
3. Mapping of brain perfusion during interventions [2,3,8]
4. Detecting and evaluating cerebrovascular disease [1-3,9]
5. Corroborating the clinical diagnosis of brain death (note that these examinations can be performed with SPECT or planar imaging; see section IV.H) [10-18]

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](#) [21].

III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

See the [ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals](#) [4].

IV. SPECIFICATIONS OF THE EXAMINATION

A. Nuclear Medicine Examination Request

The written or electronic request for a brain perfusion 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 scope of practice requirements. (ACR Resolution 35 adopted in 2006 – revised in 2016, Resolution 12-b)

In addition to data needed to document medical necessity, optimal interpretation often requires additional relevant patient data. These data should include additional patient history, such as past and current drugs and medication use (including when last taken); traumatic, neurologic, and psychiatric findings (eg, clinical evaluations or neuropsychological test, etc); neurodiagnostics (eg, electroencephalography); and results of recent anatomic brain imaging examinations (eg, CT, magnetic resonance imaging [MRI] [10]).

B. Radiopharmaceuticals

Either Tc-99m ECD or Tc-99m HMPAO (stabilized or unstabilized) is used.

1. Radiopharmaceutical preparation
 - a. Use fresh generator eluate (<2 hours old) for optimal results with Tc-99m HMPAO [22].
 - b. Use only eluate from a Tc-99m generator that was previously eluted within 24 hours.
 - c. Radiochemical purity determinations should be performed on each vial prior to patient administration by using the method outlined in the package insert.
2. Radiopharmaceutical administration
 - a. Tc-99m ECD: radiopharmaceutical should be injected intravenously no more than 6 hours after reconstitution.
 - b. Tc-99m HMPAO: stabilized radiopharmaceutical should be injected intravenously no more than 4 hours after reconstitution; unstabilized radiopharmaceutical should be injected no more than 30 minutes after reconstitution.
 - c. When examinations are performed to localize a seizure focus during a seizure, ideally the radiopharmaceutical should be injected within 30 seconds from the seizure onset.
3. Interval between injection and imaging
 - a. Tc-99m ECD: for best image quality, a minimum interval of 45 minutes is recommended.
 - b. Tc-99m HMPAO: Images should be obtained >90 minutes after injection.
 - c. If possible, patients should be instructed to void within 2 hours postinjection to minimize radiation exposure.
4. Administered Activity
 - a. Adult: 555 to 1110 MBq (15 to 30 mCi)
 - b. Pediatric: 11.1 MBq/kg (0.3 mCi/kg); minimum 185 MBq (5.0 mCi), maximum 740 MBq (20 mCi) [23]

C. Patient Preparation

1. Prearrival

Patients should be instructed to avoid caffeine, alcohol, and other drugs known to affect intracranial perfusion for at least 24 hours and to avoid smoking cigarettes for at least the day of the examination.
2. Preinjection
 - a. Evaluate the patient for ability to cooperate.
 - b. Explain the procedure to the patient or to the responsible family member or health care proxy.
 - c. Achieve a consistent environment at the time of injection and during uptake:
 - i. Place the patient in a quiet, dimly lit room with no direct light source facing the patient's eyes. Whether the eyes are covered or the patient is instructed to open or close their eyes should be according to department policy and should be followed consistently.
 - ii. Ensure that the patient is sitting or reclining comfortably.
 - iii. Place intravenous access at least 10 minutes prior to injection.
 - iv. Instruct the patient not to speak, read, or move prior to, during, and up to 5 minutes after injection.
3. Precautions
 - a. Cognitively impaired patients must be closely observed at all times.

- b. Patients undergoing epilepsy evaluation should have electroencephalogram (EEG) monitoring during injection as seizure activity can alter scan appearance.

D. Intervention: Acetazolamide Administration for Identification of Cerebrovascular Reserve

Cerebral perfusion imaging examinations may be performed both before and after the administration of acetazolamide in patients with cerebrovascular disease to evaluate cerebrovascular reserve [1,3]. The indications include evaluation of cerebrovascular reserve in transient ischemic attack (TIA), completed stroke, and/or vascular anomalies (eg, arteriovenous malformation) and to aid in distinguishing vascular from neuronal causes of perfusion defects.

1. Contraindications and adverse reactions

- a. Known sulfa allergy (skin rash, bronchospasm, and anaphylactic reaction) and advanced liver disease. In case of sulfa allergy contraindication, an alternative method is to use 5% carbon dioxide by inhalation to evaluate cerebrovascular reserve. Usually the Tc-99m ECD or Tc-99m HMPAO is administered intravenously (IV) during the first 1 to 2 minutes of a 5-minute inhalation. Carbon dioxide inhalation can cause side effects of headache and nausea.
- b. May induce migraine in patients with migraine history.
- c. Generally avoid within 3 days of acute stroke or recent TIA.
- d. Mild vertigo, tinnitus, paresthesias, and, rarely, nausea may be experienced. These are generally self-limited and do not require specific treatment. Patients may experience postural hypotension when rising from a supine or sitting position and should be appropriately warned and assisted, if necessary.

2. Protocols

Various protocols have been used. The 2-day technique is simple and preferable. Typically, the acetazolamide challenge examination is performed first. If this examination is normal, consideration may be given to omitting the baseline examination. If a baseline examination is performed, allow sufficient time for residual activity to clear (at least 24 hours).

3. Administered Dose (injected IV slowly)

- a. Adult: Acetazolamide 1,000 mg
- b. Pediatric: Acetazolamide 14 mg/kg

Wait 15 to 20 minutes after administering acetazolamide before injecting radiopharmaceutical.

4. Acetazolamide is a diuretic. The patient should be instructed to void immediately before image acquisition begins. Acquisition and processing are identical to those of a non-acetazolamide-enhanced examination.

E. Refractory Epilepsy Ictal/Interictal Evaluations

Cerebral perfusion imaging performed at onset of a focal epileptic seizure may be used to localize the refractory seizure focus for consideration of surgical resection. Imaging performed at onset (ictal imaging) is compared with repeated imaging without seizure activity or effect (interictal imaging) to specifically identify functional changes attributable to the seizure and distinguish from static changes that may be attributable to underlying brain developmental or structural features.

1. Patient Preparation and Management – Ictal Imaging

For ictal imaging, the patient should be monitored clinically and with continuous EEG. Anticonvulsants may be reduced or discontinued to increase likelihood of seizure episode (tracer at bedside). After tracer injection and initial uptake, the patient should be medically stabilized and appropriate medication administered to terminate prolonged or repetitive seizure activity.

2. Interictal Examination

Interictal perfusion imaging should be performed with the patient at neurological baseline and without recent seizure activity. Although evidence-basis is not available, a 24-hour interval after last seizure is recommended, if possible.

3. Procedural Considerations

- a. Administered radiopharmaceutical and dosage should be the same for both ictal and interictal studies.
- b. Time from tracer administration to imaging should be the same for both ictal and interictal studies.
- c. To the extent possible, the ambient environment and patient state (other than seizure activity) should be comparable for ictal and interictal studies (eg, eyes open or closed for both injections, etc).

F. Image Acquisition

1. The patient should void prior to imaging for maximum comfort during the examination.
2. The patient should be positioned for maximum comfort. Minor obliquity of head orientation can be corrected in most systems during processing or image review.
3. The patient's head should be positioned in the middle of the field of view with the intercanthal line at a 90° angle to the axis of rotation and parallel to the horizontal plane. If the patient cannot be positioned with the intercanthal line at a 90° angle to the axis of rotation and parallel to the horizontal plane, images can be realigned during postprocessing. The entire brain (cerebrum and cerebellum) should be included in the field of view. The head should be lightly restrained to facilitate patient cooperation in minimizing motion during acquisition.
4. Sedation should be avoided if possible. If sedation is required, it should be given at least 5 minutes after injection of radiopharmaceutical and preferably just prior to image acquisition. In rare circumstances, sedation may need to be administered prior to radiopharmaceutical administration to obtain an interpretable examination, particularly in young children.
5. Ensure that there is no patient movement during image acquisition.

See equipment specifications below in section VI.

G. Data Processing

1. Iterative reconstruction is preferred to filtered back projection.
2. Attenuation correction should be performed in all cases unless a specific application or circumstance dictates otherwise [24]. If calculated attenuation correction is used, the contours should include the scalp and should be defined individually for each transaxial slice. If slice-specific attenuation correction software is not available, it is acceptable to review non-attenuation-corrected images. If SPECT/CT imaging is performed, the low-dose, noncontrast CT images may be used for attenuation correction and image fusion.
3. Transaxial data should be reformatted into at least 3 orthogonal planes. Transaxial sections should be generated relative to a repeatable anatomic orientation (eg, the anterior commissure–posterior commissure [AC-PC] line) and coronal and sagittal sections orthogonal to the transaxial [24]. Additional sections along a plane parallel to the long axis of the temporal lobes may be useful, particularly in assessment of temporal lobe epilepsy [24].
4. Image fusion with anatomical imaging (MRI or CT) is highly desirable, and it may be considered essential for the localization of functional abnormalities detected on perfusion SPECT.

H. Image Interpretation

1. All examinations should be interpreted with the knowledge of all clinical data, including EEG and results of other imaging studies, especially MRI and CT.
2. The extent of normal variability must be appreciated during the scan interpretation. Substantial variability may be noted between normal individuals and between examinations of a single subject obtained at different times.
3. Images should be viewed on a computer display so as to permit interactive adjustment of contrast, background subtraction, and color table.
4. Unprocessed projection images should be assessed in cinematic display prior to viewing of tomographic sections for the presence and degree of patient motion, target-to-background ratio, and other potential artifacts. Inspection of the projection data in sinogram form may be useful [28]. It is important that the brain SPECT is corrected for motion and 3-D image be aligned along the orthogonal planes.
5. Three-dimensional volume or surface renderings may be useful in appreciating overall patterns of disease.
6. Caution must be used in selecting levels of contrast and background subtraction. Noncontinuous color scales may be confusing or misleading if abrupt color changes occur in the range of expected gray matter activity. Thresholding, if used, must be based upon knowledge of a normal database for specific radiopharmaceuticals and instruments used in acquiring the examination. Artifacts can be created when inappropriate thresholding is performed.
7. Quantitative analysis and comparison with normal database values can be used to detect asymmetry in cerebral perfusion or other focal or diffuse abnormalities and is recommended for adults [25].
 - a. Images obtained as part of a seizure evaluation should be correlated with the relevant EEG data and clinical observations. The timing of radiopharmaceutical injection relative to observed seizure activity should be noted [3,6]. Image characteristics and the extent of seizure foci may change dramatically, depending on the exact timing of radiopharmaceutical injection relative to seizure onset. Ictal and interictal examinations should be compared for optimal patient evaluation. The ictal and interictal scans should be reviewed, with visual assessment initially, to evaluate for areas of increased uptake on the ictal scan that reverse on the interictal scan.
 - b. Ictal-interictal subtraction images should ideally be computed employing dedicated commercial software by registering and normalizing the ictal to the interictal SPECT images. The seizure focus will “stand out” on the subtraction images.
 - c. The ictal, interictal, and subtraction images must be registered and overlaid to the patient’s CT or MRI for anatomic localization of the seizure focus.

I. Brain Death Imaging

1. Goal
To corroborate the clinical diagnosis of brain death by determining the presence or absence of intracranial perfusion [10]
2. Indications
 - a. As part of a standardized institutional protocol for establishing brain death
 - b. In situations in which hypothermia or coma caused by barbiturates or other medications impedes evaluation by other modalities
 - c. In situations in which the referring and interpreting physicians agree that evidence for the presence or absence of intracranial perfusion would be helpful
 - d. In compliance with local hospital and government regulatory requirements.

3. Administered Activity
 - a. Tc-99m ECD and Tc-99m HMPAO
 - i. Adhere to package insert and quality control instructions to ensure optimal image quality
 - ii. Adult: 555 to 1,110 MBq (15-30 mCi)
 - iii. Pediatric: 11.1 MBq/kg (0.3mCi/kg); minimum 185 MBq (5.0 mCi), maximum 740 MBq (20 mCi) [23]
 - b. Tc-99m diethylenetriaminepentaacetic acid (DTPA) and Tc-99m pertechnetate
 - i. Agents that cross the blood-brain barrier (eg, Tc-99m ECD or HMPAO) are preferred. If they are not available, Tc-99m DTPA or pertechnetate may be used for cerebral vascular imaging.
 - ii. Adult (DTPA/pertechnetate): 555 to 1,110 MBq (15-30 mCi)
 - iii. Pediatric (DTPA): 7.4 MBq/kg (0.2 mCi/kg); minimum 37 MBq (1.0 mCi), maximum 740 MBq (20 mCi)

4. Patient

Injection of the radiopharmaceutical must be made directly into a vein or through an IV line that is not being used for infusion of vasoactive medications or transfusion of blood. If available, a central venous line is preferable for injection.

5. Examination

Dynamic blood flow imaging is required for use of Tc-99m DTPA, and it is recommended, but optional, for Tc-99m ECD and Tc-99m HMPAO. Acquisition should be in the anterior projection with the skull vertex (permitting potential visualization of the sagittal sinus) and the common carotid arteries in the field of view (FOV).

For Tc-99m HMPAO and Tc-99m ECD, planar static image acquisition for 500,000 to 1,000,000 counts in the anterior view is recommended. Additional lateral or posterior images depicting the cerebellum are required. SPECT or SPECT/CT imaging may be performed.

6. Other considerations

The President's Council on Brain Death (1982) [26] determined that of the 4 examinations available to establish the presence or absence of brain death, 2 (clinical examination and properly performed 4-vessel cerebral angiography) are diagnostic and 2 (electroencephalography and cerebral scintigraphy) are confirmatory of the clinical examination. Thus, one may corroborate the clinical diagnosis by determining the absence of intracranial perfusion with cerebral scintigraphy. According to an evidence-based review, radiopharmaceutical examinations remain an acceptable confirmatory test [18,27].

For Tc-99m HMPAO and Tc-99m ECD, the absence of demonstrable radiopharmaceutical activity within the brain is consistent with the absence of intracranial perfusion (cerebral and cerebellar), but is not sufficient by itself to make the diagnosis of brain death and should be corroborated with other clinical, neurodiagnostic, and imaging findings.

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 radiopharmaceutical administration, as well as any other pharmaceuticals administered, also with dosage and route of administration.

Direct communication of the results of the examination to a physician from the referring clinical service is mandatory for brain death examinations.

VI. EQUIPMENT SPECIFICATIONS

Equipment performance monitoring should be in accordance with the [ACR–AAPM Technical Standard for Nuclear Medical Physics Performance Monitoring of Gamma Cameras](#) [29].

For planar imaging, any gamma camera equipped with a low-energy all-purpose/general all-purpose (LEAP/GAP) or high-resolution collimator may be used.

For SPECT imaging, a multiple-detector instrument or a dedicated brain imaging system is preferred to a single-head gamma camera system. A SPECT/CT system may be used, if available.

The following is recommended for SPECT imaging:

- A. The smallest radius of rotation possible with appropriate patient safeguards should be used [24].
- B. Low-energy high-resolution or ultrahigh-resolution collimators may be used. Fan-beam or other focused collimators are preferable to parallel-hole collimators because they provide improved resolution and higher count rates. However, care must be taken to ensure that the entire brain is visualized in all projections to avoid the problem of “incomplete” views. When parallel-hole collimation is used, care should be taken to ensure that adequate counts are obtained.
- C. A 128×128 or greater acquisition matrix is preferred. Camera zoom should be set to produce a pixel size of 3.5 mm or less.
- D. Continuous acquisition may provide shorter total scan duration when compared with a step-and-shoot technique. When continuous acquisition is used, angular sampling should be 3° or less.
- E. If SPECT/CT imaging is performed, all additional relevant quality control procedures should be used. See the [ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of SPECT-CT Equipment](#) [30].
- F. Segmentation of data acquisition into multiple sequential acquisitions will permit exclusion of bad data, eg, removing segments of projection data with patient motion. The scan may be repeated if there is excessive patient motion.

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 [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 *ACR Position Statement on Quality Control & Improvement, Safety, Infection Control, and Patient Education* on the ACR website (<https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Quality-Control-and-Improvement>).

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 (<https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards>) by the Committee on Practice Parameters and Technical Standards - Nuclear Medicine and Molecular Imaging of the ACR Commission on Nuclear Medicine and Molecular Imaging and the Committee on Practice Parameters – Pediatric Radiology of the ACR Commission on Pediatric Radiology, in collaboration with the ACNM, the SNMMI, and the SPR.

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

ACR

Kirk A. Frey, MD, PhD, Chair
Omar Khan, MD
Nadine Mallak, MD
Andrew T. Trout, MD

ACNM

Somali Gavane, MD
Darko Pucar, MD, PhD
David Wan, MD

SNMMI

Michael D. Devous, Sr., PhD, FSNMMI
Alan D. Waxman, MD

SPR

Hollie A. Lai, MD
Maria R. Ponisio, MD
S. Ted Treves, MD

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

Munir V. Ghesani, MD, FACR, Co-Chair
Rathan M. Subramaniam, MD, PhD, MPH, Co-Chair
Esma A. Akin, MD, FACR
Alexandru C. Bageac, MD, MBA
Twyla B. Bartel, DO, MBA
Elizabeth H. Dibble, MD

Andrew Kaiser, MD
Jeffrey S. Kempf, MD, FACR
Justin G. Peacock, MD
Syam P. Reddy, MD
Eric M. Rohren, MD, PhD
Levi Sokol, MD

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

K. Elizabeth Hawk, MD, MS, PhD
Eric Hu, MD

Andrew T. Trout, MD

Committee on Practice Parameters – Pediatric Radiology
(ACR Committee responsible for sponsoring the draft through the process)

Terry L. Levin, MD, FACR, Chair
John B. Amodio, MD, FACR
Jesse Berman, MD
Tara M. Catanzano, MB, BCH
Harris L. Cohen, MD, FACR
Kassa Darge, MD, PhD
Dorothy L. Gilbertson-Dahdal, MD
Lauren P. Golding, MD
Safwan S. Halabi, MD
Jason Higgins, DO

Jane Sun Kim, MD
Jennifer A Knight, MD
Jessica Kurian, MD
Matthew P. Lungren, MD, MPH
Helen R. Nadel, MD
Erica Poletto, MD
Richard B. Towbin, MD, FACR
Andrew T. Trout, MD
Esben S. Vogelius, MD

Don C. Yoo, MD, FACR, Chair of the Commission Nuclear Medicine and Nuclear Medicine
Richard A. Barth, MD, FACR, Chair, Commission on Pediatric Radiology
David B. Larson, MD, MBA, Chair, Commission on Quality and Safety
Mary S. Newell, MD, FACR, Chair, Committee on Practice Parameters and Technical Standards

Comment Reconciliation Committee

Taj Kattapuram, MD, Chair
K. Elizabeth Hawk, MD, MS, PhD Co-Chair
Helena R. Balon, MD
Twyla B. Bartel, DO, MBA
Richard A. Barth, MD, FACR
Larry Binkovitz, MD
David Brandon, MD
Michael D. Devous, Sr., PhD, FSNMMI
Richard Duszak Jr., MD, FACR
Saeed Elojeimy, MD, PhD
Kirk A. Frey, MD, PhD
Somali Gavane, MD
Munir V. Ghesani, MD, FACR
Arnold Jacobson, MD
Omar Khan, MD
Amy Kotsenas, MD, FACR

Hollie A. Lai, MD
David B. Larson, MD, MBA
Paul A. Larson, MD, FACR
Terry L. Levin, MD, FACR
Nadine Mallak, MD
Mary S. Newell, MD, FACR
Maria R. Ponisio, MD
Darko Pucar, MD, PhD
Barry Shulkin, MD
Rathan M. Subramaniam, MD, PhD, MPH
S. Ted Treves, MD
Andrew T. Trout, MD
David Wan, MD
Alan D. Waxman, MD
Don C. Yoo, MD, FACR

REFERENCES

1. Camargo EE. Brain SPECT in neurology and psychiatry. J Nucl Med 2001;42:611-23.
2. Catafau AM. Brain SPECT in clinical practice. Part I: perfusion. J Nucl Med 2001;42:259-71.
3. Holman BL, Devous MD, Sr. Functional brain SPECT: the emergence of a powerful clinical method. J Nucl Med 1992;33:1888-904.
4. American College of Radiology. ACR–SPR technical standard for diagnostic procedures using radiopharmaceuticals. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Radiopharmaceuticals.pdf?la=en>. Accessed January 27, 2020.

5. Borghesani PR, DeMers SM, Manchanda V, Pruthi S, Lewis DH, Borson S. Neuroimaging in the clinical diagnosis of dementia: observations from a memory disorders clinic. *J Am Geriatr Soc* 2010;58:1453-8.
6. Markand ON, Spencer SS, Anderson AR. SPECT in epilepsy. *J Neuroimaging* 1995;5 Suppl 1:S23-33.
7. Treves ST, Chugani HT, Bourgeois FD, Kuruc A. Central nervous system: the brain and cerebrospinal fluid, Chapter 4. In: Treves ST, ed. *Pediatric Nuclear Medicine and Molecular Imaging*. New York: Springer; 2014:47-99.
8. Juni JE. Taking brain SPECT seriously: reflections on recent clinical reports in *The Journal of Nuclear Medicine*. *J Nucl Med* 1994;35:1891-5.
9. Ueda T, Yuh WT. Single-photon emission CT imaging in acute stroke. *Neuroimaging Clin N Am* 2005;15:543-51, x.
10. Al-Shammri S, Al-Feeli M. Confirmation of brain death using brain radionuclide perfusion imaging technique. *Med Princ Pract* 2004;13:267-72.
11. Harding JW, Chatterton BE. Outcomes of patients referred for confirmation of brain death by 99mTc-exametazime scintigraphy. *Intensive Care Med* 2003;29:539-43.
12. Lu G, Shih WJ, Ryo UY. Findings on Tc-99m HMPAO brain imaging in brain death. *Clin Nucl Med* 1996;21:891-3.
13. Munari M, Zucchetta P, Carollo C, et al. Confirmatory tests in the diagnosis of brain death: comparison between SPECT and contrast angiography. *Crit Care Med* 2005;33:2068-73.
14. Nakagawa TA, Ashwal S, Mathur M, Mysore M. Clinical report-Guidelines for the determination of brain death in infants and children: an update of the 1987 task force recommendations. *Pediatrics* 2011;128:e720-40.
15. Okuyaz C, Gucuyener K, Karabacak NI, Aydin K, Serdaroglu A, Cingi E. Tc-99m-HMPAO SPECT in the diagnosis of brain death in children. *Pediatr Int* 2004;46:711-4.
16. Sinha P, Conrad GR. Scintigraphic confirmation of brain death. *Semin Nucl Med* 2012;42:27-32.
17. Spieth M, Abella E, Sutter C, Vasinrapee P, Wall L, Ortiz M. Importance of the lateral view in the evaluation of suspected brain death. *Clin Nucl Med* 1995;20:965-8.
18. Wijdicks EF, Varelas PN, Gronseth GS, Greer DM. Evidence-based guideline update: determining brain death in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology* 2010;74:1911-8.
19. Ethical clinical practice of functional brain imaging. Society of Nuclear Medicine Brain Imaging Council. *J Nucl Med* 1996;37:1256-9.
20. Lewis DH, Mayberg HS, Fischer ME, et al. Monozygotic twins discordant for chronic fatigue syndrome: regional cerebral blood flow SPECT. *Radiology* 2001;219:766-73.
21. American College of Radiology. ACR–SPR practice parameter for imaging pregnant or potentially pregnant adolescents and women with ionizing radiation. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Pregnant-Pts.pdf?la=en>. Accessed January 27, 2020.
22. Hung JC, Corlija M, Volkert WA, Holmes RA. Kinetic analysis of technetium-99m d,l-HM-PAO decomposition in aqueous media. *J Nucl Med* 1988;29:1568-76.
23. Treves ST, Gelfand MJ, Fahey FH, Parisi MT. 2016 Update of the North American Consensus Guidelines for Pediatric Administered Radiopharmaceutical Activities. *J Nucl Med* 2016;57:15N-18N.
24. Devous MD. SPECT functional brain imaging. Technical considerations. *J Neuroimaging* 1995;5 Suppl 1:S2-13.
25. Imabayashi E, Matsuda H, Asada T, et al. Superiority of 3-dimensional stereotactic surface projection analysis over visual inspection in discrimination of patients with very early Alzheimer's disease from controls using brain perfusion SPECT. *J Nucl Med* 2004;45:1450-7.
26. Guidelines for the determination of death. Report of the medical consultants on the diagnosis of death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *JAMA* 1981;246:2184-6.
27. Greer DM, Shemie SD, Lewis A, et al. Determination of Brain Death/Death by Neurologic Criteria: The World Brain Death Project. *JAMA* 2020.
28. American College of Radiology. ACR practice parameter for communication of diagnostic imaging findings. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf?la=en>. Accessed January 27, 2020.
29. American College of Radiology. ACR–AAPM technical standard for nuclear medical physics performance monitoring of gamma cameras Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Gamma-Cam.pdf>. Accessed September 14, 2020.

30. American College of Radiology. ACR–AAPM technical standard for medical physics performance monitoring of SPECT-CT equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/SPECT-CT-Equip.pdf?la=en>. Accessed January 27, 2020.

*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

2007 (Resolution 21)

Revised 2012 (Resolution 25)

Amended 2014 (Resolution 39)

Revised 2016 (Resolution 26)

Revised 2021 (Resolution 19)