

Five Things Physicians and Patients Should Question

1

Don't do imaging for uncomplicated headache.

Imaging headache patients absent specific risk factors for structural disease is not likely to change management or improve outcome. Those patients with a significant likelihood of structural disease requiring immediate attention are detected by clinical screens that have been validated in many settings. Many studies and clinical practice guidelines concur. Also, incidental findings lead to additional medical procedures and expense that do not improve patient well-being.

2

Don't image for suspected pulmonary embolism (PE) without moderate or high pre-test probability.

While deep vein thrombosis (DVT) and PE are relatively common clinically, they are rare in the absence of elevated blood d-Dimer levels and certain specific risk factors. Imaging, particularly computed tomography (CT) pulmonary angiography, is a rapid, accurate and widely available test, but has limited value in patients who are very unlikely, based on serum and clinical criteria, to have significant value. Imaging is helpful to confirm or exclude PE only for such patients, not for patients with low pre-test probability of PE.

3

Avoid admission or preoperative chest x-rays for ambulatory patients with unremarkable history and physical exam.

Performing routine admission or preoperative chest x-rays is not recommended for ambulatory patients without specific reasons suggested by the history and/or physical examination findings. Only 2 percent of such images lead to a change in management. Obtaining a chest radiograph is reasonable if acute cardiopulmonary disease is suspected or there is a history of chronic stable cardiopulmonary disease in a patient older than age 70 who has not had chest radiography within six months.

4

Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.

Although CT is accurate in the evaluation of suspected appendicitis in the pediatric population, ultrasound is nearly as good in experienced hands. Since ultrasound will reduce radiation exposure, ultrasound is the preferred initial consideration for imaging examination in children. If the results of the ultrasound exam are equivocal, it may be followed by CT. This approach is cost-effective, reduces potential radiation risks and has excellent accuracy, with reported sensitivity and specificity of 94 percent.

5

Don't recommend follow-up imaging for clinically inconsequential adnexal cysts.

Simple cysts and hemorrhagic cysts in women of reproductive age are almost always physiologic. Small simple cysts in postmenopausal women are common, and clinically inconsequential. Ovarian cancer, while typically cystic, does not arise from these benign-appearing cysts. After a good quality ultrasound in women of reproductive age, don't recommend follow-up for a classic corpus luteum or simple cyst <5 cm in greatest diameter. Use 1 cm as a threshold for simple cysts in postmenopausal women.

How This List Was Created

The American College of Radiology (ACR) initially solicited expert opinion from physician leaders with its Board of Chancellors. A working group was then formed to further identify common clinical scenarios in which imaging may be misused and should be reconsidered. Members of the group included the physician chairs or vice chairs of seven ACR commissions such as Quality and Safety, Appropriateness Criteria and Metrics. An initial list of topics was narrowed down based on the highest potential for improvement, representing a broad range of tests and the availability of strong guidelines. Members then researched specific recommendations and evidentiary statements based on their expertise. Recommendations that were too general or were well covered by other existing measures and initiatives were eliminated to identify the final five things list. ACR's disclosure and conflict of interest policy can be found at www.acr.org.

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