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ACR PRACTICE GUIDELINE FOR THE PERFORMANCE OF AN ULTRASOUND EXAMINATION OF THE ABDOMEN AND/OR RETROPERITONEUM

PREAMBLE

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They 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 cautions against the use of these guidelines 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 guidelines, 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 guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations on available resources, or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines 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 guidelines 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 guidelines is to assist practitioners in achieving this objective.

I. INTRODUCTION

The clinical aspects of this guideline (Indications, Specifications of the Examination, and Equipment Specifications) were developed collaboratively by the American College of Radiology (ACR) and the American Institute of Ultrasound in Medicine (AIUM). Recommendations for physician requirements, written request for the examination, procedure documentation, and quality control vary between the two organizations and are addressed by each separately.

This guideline has been developed to assist practitioners performing ultrasound studies of the abdomen and/or retroperitoneum. Ultrasound examination is a proven and useful procedure for the evaluation of many structures

within these anatomic areas. Depending on the clinical indications, an examination may include the entirety of the abdomen and/or retroperitoneum, a single organ, or several organs. A combination of structures may be imaged because of location (e.g., upper abdominal scan, right upper quadrant organs) or function (e.g., biliary system [liver, gallbladder, and bile ducts], both kidneys). For some patients, more focused examinations may be appropriate for evaluating specific clinical indications or to follow up a known abnormality. In some cases, additional and/or specialized examinations may be necessary (e.g., spectral, color, and/or power Doppler). While it is not possible to detect every abnormality using ultrasound examination of the abdomen and/or retroperitoneum, adherence to the following guideline will maximize the probability of detecting abnormalities.

Throughout this guideline, references to Doppler evaluation may include spectral, color, or power Doppler individually or in any combination. Whenever a long axis view is indicated, it could be either a sagittal or coronal plane.

(For specific pediatric considerations, see sections V.A.2., V.A.5, V.B.3, and VII.)

II. QUALIFICATIONS AND RESPONSIBILITIES OF THE PHYSICIAN

See the [ACR Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations](#).

III. INDICATIONS/CONTRAINDICATIONS

Indications for ultrasound examination of the abdomen and/or retroperitoneum include, but are not limited to:

- A. Abdominal, flank, and/or back pain.
- B. Signs or symptoms that may be referred from the abdominal and/or retroperitoneal regions such as jaundice or hematuria.
- C. Palpable abnormalities such as an abdominal mass or organomegaly.
- D. Abnormal laboratory values or abnormal findings on other imaging examinations suggestive of abdominal and/or retroperitoneal pathology.
- E. Follow-up of known or suspected abnormalities in the abdomen and/or retroperitoneum.
- F. Search for metastatic disease or occult primary.
- G. Evaluation of suspected congenital abnormalities.
- H. Abdominal trauma.
- I. Pre-transplantation and post-transplantation evaluation.
- J. Planning and guidance for an invasive procedure.
- K. Search for the presence of free or loculated peritoneal and/or retroperitoneal fluid.

Abdominal and/or retroperitoneal ultrasound should be performed when there is a valid medical reason. There are no absolute contraindications.

IV. WRITTEN REQUEST FOR THE EXAMINATION

The written or electronic request for an abdomen and/or retroperitoneum ultrasound examination should provide sufficient information to demonstrate the medical necessity of the examination and allow for the proper performance and interpretation of the examination.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). The provision of 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. 2006 (Res. 35)

V. SPECIFICATIONS FOR INDIVIDUAL EXAMINATIONS

Doppler may be useful to differentiate vascular from nonvascular structures in any location. Measurements should be considered for any abnormal area.

A. Abdomen

1. Liver

The examination of the liver should include long axis and transverse views. The liver parenchyma should be evaluated for focal and/or diffuse abnormalities. If possible, the echogenicity of the liver should be compared with that of the right kidney. In addition, the following should be imaged:

- a. The major vessels in the region of the liver, including the inferior vena cava (IVC), the hepatic veins, the main portal vein, and, if possible, the right and left branches of the portal vein.
- b. The hepatic lobes (right, left, and caudate) and, if possible, the right hemidiaphragm and the adjacent pleural space.
- c. For vascular examinations of the native or transplanted liver, Doppler evaluation

should be used to document blood flow characteristics and blood flow direction in the hepatic artery, hepatic veins, portal veins, intrahepatic portion of the IVC, collateral venous pathways, and transjugular intrahepatic portosystemic shunt (TIPS) stent, when appropriate.

2. Gallbladder and biliary tract

The gallbladder evaluation should include long-axis and transverse views obtained in the supine position; other positions, such as left lateral decubitus, erect, or prone positions, may be necessary to evaluate the gallbladder and its surrounding area completely, particularly when stones and/or sludge are observed. Measurements may aid in determining gallbladder wall thickening. If the patient presents with pain, tenderness to transducer compression should be assessed.

The intrahepatic ducts can be evaluated by obtaining views of the liver demonstrating the right and left branches of the portal vein. Doppler may be used to differentiate hepatic arteries and portal veins from bile ducts. The intrahepatic and extrahepatic bile ducts should be evaluated for dilatation, wall thickening, intraluminal findings, and other abnormalities. The size of the bile duct in the porta hepatis should be documented. When visualized, the distal common bile duct in the pancreatic head should be evaluated.

Routine gallbladder examination should be conducted on an adequately distended gallbladder. In most cases, fasting for 8 hours prior to examinations will permit adequate distension of a normally functioning gallbladder in adults and children. In infants and some adults, adequate distention may be achieved in less time.

3. Pancreas

Whenever possible, all portions of the pancreas — head, uncinate process, body, and tail — should be identified. Orally administered water or contrast agent may afford better visualization of the pancreas. The following should be assessed in the examination of the pancreas:

- a. Parenchymal abnormalities.
- b. The distal common bile duct in the region of the pancreatic head.

- c. The pancreatic duct for dilatation and any other abnormalities, with dilatation confirmed by measurement.
- d. The peripancreatic region for adenopathy and/or fluid.

4. Spleen

Representative views of the spleen in long-axis and transverse projections should be obtained. Doppler may be used to determine the presence and direction of flow in the splenic vein and artery. Splenic measurement may be helpful in assessing enlargement. Echogenicity of the left kidney should be compared to splenic echogenicity when possible. An attempt should be made to demonstrate the left hemidiaphragm and the adjacent pleural space.

5. Bowel

The bowel may be evaluated for wall thickening, dilatation, muscular hypertrophy, masses, and other abnormalities. Sonography of the pylorus and surrounding structures may be indicated in the evaluation of the vomiting infant. Compression sonography may be necessary to visualize the appendix or other bowel loops. Measurements may aid in determining bowel wall thickening. Color Doppler imaging may be done to assess blood flow.

6. Peritoneal fluid

Evaluation for free or loculated peritoneal fluid should include documentation of the extent and location of any fluid identified.

7. Abdominal wall

The examination should include images of the abdominal wall in the location of symptoms or signs. The relationship of any identified mass to the peritoneum should be demonstrated. Any defect in the peritoneum and abdominal wall musculature should be documented. The presence or absence of bowel, fluid, or other tissue associated within any abdominal wall defect should be noted. Images obtained in upright position and/or with use of the Valsalva maneuver may be helpful. Doppler examination may be useful to define the relationship of blood vessels to a detected mass.

B. Retroperitoneum

1. Kidneys

The examination should include long-axis and transverse views of the upper poles, mid portions, and lower poles of the kidneys. The cortex and renal pelvis should be assessed. A maximum measurement of renal length should be recorded for both kidneys. Decubitus, prone, or upright positioning may provide better images of the kidneys. When possible, renal echogenicity should be compared to the adjacent liver or spleen. The kidneys and perirenal regions should be assessed for abnormalities.

For vascular examination of the kidneys, Doppler can be used:

- a. To assess renal arterial and venous patency.
- b. To evaluate adults suspected of having renal artery stenosis. For this application, angle-adjusted measurements of the peak systolic velocity should be made proximally, centrally, and distally in the extrarenal portion of the main renal arteries when possible. Peak systolic velocity of the adjacent aorta (or iliac artery in transplanted kidneys) should also be documented for calculating the ratio of renal to aortic peak systolic velocity. Spectral Doppler evaluation of the intrarenal arteries from the upper and lower portions of the kidneys, obtained to evaluate the early systolic peak, may be of value as indirect evidence of proximal stenosis in the main renal artery.

2. Urinary bladder and adjacent structures

When performing a complete ultrasound evaluation of the urinary tract, transverse and longitudinal images of the distended urinary bladder and its wall should be included, if possible. Bladder lumen or wall abnormalities should be noted. Dilatation or other distal ureteral abnormalities should be documented. Transverse and longitudinal scans may be used to demonstrate any post-void residual, which may be quantitated and reported.

3. Adrenal glands

When possible, usually in the newborn or young infant, long-axis and transverse images of the adrenal glands may be obtained. The adrenal glands are infrequently seen in adults. When visualized, the size of the gland should be documented as well as the presence of hemorrhage, masses, or other abnormalities.

4. Aorta

As a minimum, abdominal aorta screening criteria should be met for the abdominal sonogram.

See the [ACR Practice Guideline for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta](#).

5. Inferior vena cava

Transverse and longitudinal images of the inferior vena cava (IVC) should be obtained. Patency and abnormalities may be evaluated with Doppler. Vena cava filters, interruption devices, or catheters may need to be localized with respect to the hepatic and/or renal veins.

VI. DOCUMENTATION

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 the side (right or left) of the anatomic site imaged. 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 Guideline for Communication of Diagnostic Imaging Findings](#).

VII. EQUIPMENT SPECIFICATIONS

Abdomen and/or retroperitoneum studies should be conducted with real-time scanners, preferably using sector or linear (straight or curved) transducers. The equipment should be adjusted to operate at the highest clinically appropriate frequency, realizing that there is a trade-off between resolution and beam penetration. For most preadolescent pediatric patients, mean frequencies of 5 MHz or greater are preferred, and in newborns and small infants a higher frequency transducer is often necessary. For adults, mean frequencies of 3.5 or 5 MHz are most commonly used. Occasionally, very large patients may require a lower frequency transducer. When Doppler studies are performed, the Doppler frequency may differ from the imaging frequency. 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 CONCERNS

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 Concerns appearing elsewhere in the ACR Practice Guidelines and Technical Standards book.

Equipment performance monitoring should be in accordance with the [ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment](#).

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