



ASNC/SNMMI POSITION STATEMENT

AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY AND SOCIETY OF NUCLEAR MEDICINE AND MOLECULAR IMAGING JOINT POSITION STATEMENT ON THE CLINICAL INDICATIONS FOR MYOCARDIAL PERFUSION PET

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PREAMBLE

Many patients with suspected or known coronary artery disease (CAD) benefit from the information

provided by a noninvasive cardiac imaging test. Cardiac imaging tests can provide information regarding the presence, extent, and severity of CAD, estimate risk for early and late major adverse cardiac events, and assist in determining the most appropriate treatment, including medical therapy and/or coronary revascularization. Valuable information can also be provided from a normal scan result that can obviate the need for further cardiac tests, reduce unnecessary medication expenses, lead to expeditious referrals for assessment of other causes of symptoms, and relieve anxiety over potential life-threatening etiologies for symptoms.

An important goal of imaging is to provide a high quality appropriate test for the right patient at the right time. There needs to be confidence and certainty in distinguishing normal from an abnormal study, and avoidance of equivocal interpretations which would result in redundant testing, delay of timely care, and increased downstream cost. This is consistent with the Centers for Medicare & Medicaid Services (CMS) implementation of quality initiatives to assure quality health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care. The imaging properties of myocardial perfusion positron emission tomography (PET) meet all of these quality goals. PET myocardial perfusion imaging is effective (high diagnostic accuracy), safe (low radiation exposure), efficient (short, 5 min image acquisition times), and patient-centered (accommodates ill or higher-risk patients as well as those with large body habitus), providing equitable (independent of patient characteristics and condition) and timely care.

Among available noninvasive cardiac imaging options, the American Society of Nuclear Cardiology and the Society of Nuclear Medicine and Molecular Imaging have noted significant underutilization of myocardial perfusion PET relative to its demonstrated advantages for patients being assessed for suspected clinically important CAD, and to its current wide availability in the United States. The purpose of this joint Society Recommendation is to succinctly summarize the properties that make myocardial perfusion PET most useful in the diagnosis and management of the CAD patient, and to provide general guidance as to when it should be considered for optimal patient care.

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IMPORTANT PROPERTIES OF MYOCARDIAL PERFUSION PET

1. **High diagnostic accuracy:** Myocardial perfusion PET has high sensitivity and specificity for angiographically significant obstructive CAD, and has been shown in meta-analyses to outperform other noninvasive approaches. Its high sensitivity improves recognition of multivessel CAD, and its high specificity improves recognition of absence of multivessel CAD. Furthermore, the combination of information gained from consistent and high-quality perfusion images, peak stress regional and global contractile function, and quantitation of myocardial blood flow permits identification of very low-risk patients that can obviate the need for further cardiac tests, reduce unnecessary medication expenses, lead to expeditious referrals for assessment of other causes of symptoms, and relieve anxiety over potential life-threatening etiologies for symptoms. The presence of coronary artery calcium can also be identified when patients are imaged using a PET/CT scanner, ensuring that an otherwise normal perfusion scan is not misinterpreted by patients, and referring physicians as indicating absence of any CAD.
2. **Consistent high-quality images:** Myocardial perfusion PET images have high myocardial counts, high spatial and contrast resolution, high signal-to-noise ratio, and accurate and reliable correction for the effects of tissue attenuation and scatter. Image quality is relatively unaffected by body shape or size, distinguishing PET from all other cardiac imaging modalities.
3. **Low radiation exposure:** A complete rest-stress myocardial perfusion PET scan routinely exposes patients to less than 5 mSv and as little as 1 mSv effective dose using 3D imaging protocols, well below levels known to be associated with long-term adverse effects, and low in comparison to most radiation-based cardiac assessments. This is an important safety concern for patients with established CAD, who are likely to be repetitively exposed over their lifetimes to radiation-based studies, and to younger patients with longer time frames for cancers to develop.
4. **Short acquisition protocols:** A complete rest/stress study can be acquired in less than one hour if rubidium-82 is used. In addition to the obvious convenience to patients, this is an advantage for acutely ill or high-risk patients, such as those in emergency departments or acute chest pain units. The 5-minute acquisition times are also helpful for those patients who find it difficult to remain still for more

than a few minutes, reducing the likelihood of nondiagnostic scans due to patient motion artifact.

5. **Quantification of myocardial blood flow:** Blood flow quantification at rest and stress is used to measure myocardial flow reserve. It allows verification of adequate stress response, further improving interpretation confidence. Regional flow reserve shows the physiological significance of epicardial CAD, analogous to invasive fractional flow reserve (FFR). In the absence of epicardial CAD, flow reserve allows the assessment of microcirculatory function. The ability to routinely quantify myocardial blood flow in ml/min/gram is unique to PET, improves accuracy, risk stratification, and patient selection for interventions.
6. **Strong prognostic power:** Myocardial perfusion PET, particularly when myocardial blood flow data are included, provides high discrimination between different levels of risk in all patient populations for whom myocardial perfusion imaging is appropriate, including obese and nonobese people, men and women, diabetics, and patients with renal dysfunction.

All of the above properties are generally applicable to both dedicated PET and PET/CT scanners. In the case of the increasingly used PET/CT scanners, in which low-dose CT is used to generate a transmission map for attenuation correction, coronary artery calcium can also be identified, without any additional radiation exposure.

CLINICAL INDICATIONS

The American Society of Nuclear Cardiology and the Society of Nuclear Medicine and Molecular Imaging have concluded that the properties of myocardial perfusion PET according to the published literature are sufficient to advance recommendations for its use in clinical practice. These recommendations are general in intent and should not be interpreted as either inclusive or exclusive of specific clinical scenarios. However, they reflect the current understanding based on extensive clinical investigations as to when myocardial perfusion PET will provide best clinical value.

- i. **Preferred:** Rest-stress myocardial perfusion PET is a first line preferred test for patients with known or suspected CAD who meet appropriate criteria for a stress imaging test and are unable to complete a diagnostic level exercise stress imaging study. There are no clinical scenarios where PET should not be considered a preferred test for patients who meet appropriate criteria for a stress imaging test and who require pharmacologic stress.

- ii. **Recommended:** Rest-stress myocardial perfusion PET is recommended for patients with suspected active CAD, who meet appropriate criteria for a stress imaging test, and who also meet one or more of the following criteria:
- Prior stress imaging study that was of poor quality, equivocal or inconclusive, affected by attenuation artifact, or discordant with clinical impressions or other diagnostic test results including findings at coronary angiography.
 - Body characteristics that commonly affect image quality. Some examples include large breasts, breast implants, obesity (BMI greater than 30), protuberant abdomen, chest wall deformities, pleural effusions, and inability for proper body positioning such as inability to position arms outside of a SPECT scanner's field of view.
 - High-risk patients in whom diagnostic errors carry even greater clinical implications. Some examples include chronic kidney disease stage 3, 4 or 5; diabetes mellitus; known or suspected potentially high-risk CAD such as left main, multivessel, or proximal LAD disease or when extensive coronary disease is known such as following coronary bypass surgery or coronary interventions; suspected transplant coronary vasculopathy; when ischemia is suspected in patients with left ventricular dysfunction; and patients for whom revascularization carries increased morbidity and mortality risk.
 - Young patients with established CAD who are anticipated to need repeated exposures to radiation-associated cardiac imaging procedures, in order to minimize accumulated life-time exposure.
 - Patients in whom myocardial blood flow quantification is identified by clinicians to be a needed adjunct to the image findings, to better identify or exclude multivessel CAD, for improved risk stratification, and when assessment of microcirculatory function is needed for clinical decision making.

CONCLUSION

The purpose of this joint Society Position Statement is to highlight the attributes that make rest/stress myocardial perfusion PET both **Preferred** and **Recommended** in the era of high value initiatives for appropriate patients. Myocardial perfusion PET image quality, high diagnostic accuracy that is relatively independent of body habitus, ability to accurately risk

stratify patients with a wide array of clinical presentations, short acquisition times, safety by virtue of low radiation exposure, and its unique ability to quantify myocardial blood flow are all significant and clinically important properties. The American Society of Nuclear Cardiology and the Society of Nuclear Medicine and Molecular Imaging encourage providers to consider this imaging option for appropriate clinical situations.

DISCLOSURES

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Consultant: Astellas, Magellan Healthcare
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SELECTED REFERENCES

Centers for Medicare and Medicaid Services. Clinical quality measures basics. <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/clinicalqualitymeasures.html>

Dilsizian V, Bacharach SL, Beanlands SR, Bergmann SR, Delbeke D, Dorbala S, Gropler RJ, Knuuti J, Schelbert H, Travin M. ASNC imaging guidelines/SNMMI procedure standard for positron emission tomography (PET) nuclear cardiology procedures. J Nucl Card 2016. doi:10.1007/s12350-016-0522-3.

Heller GV, Beanlands R, Merlino DA, Travin MI, Calnon DA, Dorbala S, Hendel RC, Mann A, Bateman TM, Van Tosh A. ASNC model coverage policy: Cardiac positron emission tomographic imaging. *J Nucl Cardiol* 2013; 20: 916-947.

Nandalar KR, Dwamena BA, Choudhri AF, Nandalur SR, Reddy P, Carlos RC. Diagnostic performance of positron emission tomography in the detection of coronary artery disease: A meta-analysis. *Acad Radiol* 2008; 15: 444-451.

McArdle, BA, Dowsley TF, deKemp RA, Wells, GA, Beanlands RS. Does Rubidium-82 have superior accuracy to SPECT perfusion imaging for the diagnosis of obstructive coronary disease? A systematic review and meta-analysis. *J Am Coll Cardiol* 2012; 60: 1828-37.

Parker MW, Iskandar A, Limone B, Perugini A, Kim H, Jones C, Calamari B, Coleman CI, Heller GV. Diagnostic accuracy of cardiac positron emission tomography versus single photon emission computed tomography for coronary artery disease; A bivariate meta-analysis. *Circ Cardiovascular Imaging* 2012; 5: 700-707.

Bateman T, Heller GV, McGhie I, et al. Diagnostic accuracy of rest/stress ECG-gated rubidium-82 myocardial perfusion PET: Comparison with ECG-gated Tc-99m-sestamibi SPECT. *J Nucl Cardiol* 2006; 12: 24-33.

Hajjiri MM, Leavitt MB, Zheng H, Spooner AE, Fischman AJ, Gewirtz H. Comparison of positron emission tomography measurement of adenosine-stimulated absolute myocardial blood flow versus relative myocardial tracer content for physiological assessment of coronary artery stenosis severity and location. *J Am Coll Cardiol* 2009; 2: 751-8

Kajander S, Joutsiniemi E, Saraste M, Pietilä M, Ukkonen H, Saraste A, Sipilä HT, Teräs M, Mäki M, Airaksinen J, Hartiala J, Knuuti J. J. Cardiac positron emission tomography/computed tomography imaging accurately detects anatomically and functionally significant coronary artery disease. *Circulation* 2010; 122: 603-613.

Dorbala S, DiCarli MF, Beanlands RS, Merhige ME, Williams BA, Veledar E, Chow BJ, Min JK, Pencina MJ, Berman DS, Shaw LJ. Prognostic value of stress myocardial perfusion positron emission tomography. *J Am Coll Cardiol* 2013; 61: 176-84.

Gould KL, Johnson NP, Bateman TM, Beanlands RS, Bengel FM, Bober R, Camici PG, Cerqueira MD, Chow

BJ, Di Carli MF, Dorbala S, Gewirtz H, Gropler RJ, Kaufmann PA, Knaapen P, Knuuti J, Merhige ME, Rentrop KP, Ruddy TD, Schelbert HR, Schindler TH, Schwaiger M, Sdringola S, Vitarello J, Williams KA Sr, Gordon D, Dilsizian V, Narula J. Anatomic versus physiologic assessment of coronary artery disease. Role of coronary flow reserve, fractional flow reserve, and positron emission tomography imaging in revascularization decision-making. *J Am Coll Cardiol* 2013; 62: 1639-53.

Herzog BA, Husmann L, Valenta I, Gaemperli O, Siegrist PT, Tay FM, Burkhard N, Wyss CA, Kaufmann PA. Long-term prognostic value of ¹³N-ammonia myocardial perfusion positron emission tomography: added value of coronary flow reserve. *J Am Coll Cardiol* 2009; 54: 150-6.

Ziadi MC, deKemp RA, Williams KA, et al. Impaired myocardial flow reserve on rubidium-82 positron emission tomography imaging predicts adverse outcomes in patients assessed for myocardial ischemia. *J Am Coll Cardiol* 2011; 58: 740-748.

Murthy VL, Naya M, Foster CR, et al. Improved cardiac risk assessment with noninvasive measures of coronary flow reserve. *Circulation* 2011; 124: 2215-2224.

Senthamizchelvan S, Bravo PE, Lodge MA, Merrill J, Bengel FM, Sgouros G. Radiation dosimetry of ⁸²Rb in humans under pharmacologic stress. *J Nucl Med* 2011; 52: 485-491.

Hunter CR, Hill J, Ziadi MC, Beanlands RS, deKemp RA. Biodistribution and radiation dosimetry of (⁸²Rb) at rest and during peak pharmacological stress in patients referred for myocardial perfusion imaging. *Eur J Nucl Med Mol Imaging* 2015; 42: 1032-42

ICRP, 2015. Radiation dose to patients from radiopharmaceuticals: a compendium of current information related to frequently used substances. ICRP Publication 128. *Ann ICRP* 44(2S). Page 143.

Einstein AJ, Johnson LL, Bokhari S, Son J, Thompson RC, Bateman TM, Hayes SW, Berman DS. Agreement of visual estimation of coronary artery calcium from low-dose CT attenuation correction scans in hybrid PET/CT and SPECT/CT with standard Agatston score. *JACC* 2010; 56: 1941-21.

Merhige ME, Breen WJ, Shelton V, Houston T, D'Arcy BJ, Perna AF. Impact of myocardial perfusion

imaging with PET and (82)Rb on downstream invasive procedure utilization, costs, and outcomes in coronary disease management. J Nucl Med 2007; 48: 1069-1076.

Note: The American Society of Nuclear Cardiology maintains a comprehensive and up-to-date listing of key references in myocardial perfusion PET that can be accessed at www.asnc.org