



CLINICAL GUIDELINES

Pediatric Abdomen Imaging Policy

Version 20.0.2018
Effective May 17, 2018



eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2016 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.

Pediatric Abdomen Imaging Guidelines	
Procedure Codes Associated with Abdomen Imaging	3
PEDAB-1: General Guidelines	5
PEDAB-2: Generalized Abdominal Pain	11
PEDAB-3: Right Lower Quadrant Pain	12
PEDAB-4: Flank Pain, Renal Stone	13
PEDAB-5: Urinary Tract Infection (UTI)	14
PEDAB-6: Pediatric Acute Gastroenteritis	18
PEDAB-7: Hematuria	19
PEDAB-8: Right Upper Quadrant Pain	20
PEDAB-9: Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis	21
PEDAB-10: Abdominal Sepsis (Suspected Abdominal Abscess)	22
PEDAB-11: Postoperative Pain within 60 Days Following Abdominal Surgery	23
PEDAB-12: Constipation, Diarrhea, and Irritable Bowel Syndrome	24
PEDAB-13: Abdominal Mass	25
PEDAB-14: Renovascular Hypertension and Other Secondary Causes of Hypertension	27
PEDAB-15: Liver Lesion Characterization	30
PEDAB-16: Pediatric Liver Failure and Cirrhosis	31
PEDAB-17: Adrenal Lesions	32
PEDAB-18: Hemochromatosis	34
PEDAB-19: Indeterminate Renal Lesion	36
PEDAB-20: Hydronephrosis	37
PEDAB-21: Polycystic Kidney Disease	38
PEDAB-22: Blunt Abdominal Trauma	39
PEDAB-23: Hernias	40
PEDAB-24: Abdominal Lymphadenopathy	41
PEDAB-25: Left Upper Quadrant Pain	42
PEDAB-26: Spleen	43
PEDAB-27: Intussusception	44
PEDAB-28: Bowel Obstruction	45
PEDAB-29: Left Lower Quadrant Pain	46
PEDAB-30: Celiac Disease (Sprue)	47
PEDAB-31: Transplant	48
PEDAB-32: Gaucher Disease	49
PEDAB-33: Vomiting Infant and Hypertrophic Pyloric Stenosis	50

Procedure Codes Associated with Abdomen Imaging	
MRI	CPT®
Abdomen MRI without contrast	74181
Abdomen MRI with contrast (rarely used)	74182
Abdomen MRI without and with contrast	74183
Unlisted MRI procedure (for radiation planning or surgical software)	76498
MRA	CPT®
Abdomen MRA	74185
CT	CPT®
Abdomen CT without contrast	74150
Abdomen CT with contrast	74160
Abdomen CT without and with contrast	74170
Abdomen/Pelvis CT without contrast	74176
Abdomen/Pelvis CT with contrast	74177
Abdomen/Pelvis CT without and with contrast	74178
CT Guidance for Needle Placement (Biopsy, Aspiration, Injection, etc.)	77012
CT Guidance for and monitoring of Visceral Tissue Ablation	77013
CT Guidance for Placement of Radiation Therapy Fields	77014
Unlisted CT procedure (for radiation planning or surgical software)	76497
CTA	CPT®
Abdomen CTA	74175
Abdomen/Pelvis CTA	74174
Nuclear Medicine	CPT®
PET Imaging; limited area (this code not used in pediatrics)	78811
PET Imaging; skull base to mid-thigh (this code not used in pediatrics)	78812
PET Imaging; whole body (this code not used in pediatrics)	78813
PET with concurrently acquired CT; limited area (this code rarely used in pediatrics)	78814
PET with concurrently acquired CT; skull base to mid-thigh	78815
PET with concurrently acquired CT; whole body	78816
Adrenal Nuclear Imaging Cortex and/or Medulla	78075
Spleen Imaging Only with or without Vascular Flow	78185
Liver Imaging Static	78201
Liver Imaging with Vascular Flow	78202
Liver Imaging SPECT	78205
Liver Imaging SPECT with Vascular Flow	78206
Liver and Spleen Imaging Static	78215
Liver and Spleen Imaging with Vascular Flow	78216
Hepatobiliary System Imaging, Including Gallbladder When Present	78226

Hepatobiliary System Imaging, Including Gallbladder When Present; with Pharmacologic Intervention, Including Quantitative Measurement(s) When Performed	78227
Gastric Mucosa Imaging	78261
Gastroesophageal Reflux Study	78262
Gastric Emptying Study	78264
Schilling Test	78270
B-12 Absorption with Intrinsic Factor	78271
GI Bleeding Scintigraphy	78278
Gastrointestinal Protein Loss	78282
Intestinal Imaging	78290
Peritoneal-Venous Shunt Patency	78291
Kidney Imaging (Nuclear) Static	78700
Kidney Imaging (Nuclear) with Vascular Flow	78701
Kidney Image with Function Study (Imaging Renogram)	78704
Kidney Flow and Function, Single Study without Pharmacologic Intervention	78707
Kidney Imaging with Vascular Flow and Function with Pharmacological Intervention, Single	78708
Kidney Imaging with Vascular Flow and Function with and without Pharmacological Intervention, Multiple	78709
Kidney Imaging with SPECT	78710
Nuclear Non-imaging Renal Function	78725
Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram)	78740
Radiopharmaceutical Imaging of Inflammatory Process Limited Area	78805
Radiopharmaceutical Imaging of Inflammatory Process Whole Body	78806
Radiopharmaceutical Imaging of Inflammatory Process SPECT	78807
Ultrasound	CPT®
Ultrasound, abdomen; complete	76700
Ultrasound, abdomen; limited	76705
Ultrasound, abdominal wall	76705
Ultrasound, retroperitoneal; complete	76770
Ultrasound, retroperitoneal; limited	76775
Ultrasound, transplanted kidney (with duplex Doppler)	76776
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	93976
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete	93978
Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; limited	93979

PEDAB-1: General Guidelines

PEDAB-1.1: Pediatric Abdominal Imaging Age Considerations	6
PEDAB-1.2: Pediatric Abdomen Imaging Appropriate Clinical Evaluation and Conservative Treatment	6
PEDAB-1.3: Pediatric Abdomen Imaging Modality General Considerations	6

PEDAB-1.1: Pediatric Abdominal Imaging Age Considerations

Many conditions affecting the abdomen in the pediatric population are different diagnoses than those occurring in the adult population. For those diseases which occur in both pediatric and adult populations, differences may exist in management due to patient age, comorbidities, and differences in disease natural history between children and adults.

- Patients age < 18 years old should be imaged according to the Pediatric Abdomen Imaging Guidelines, and patients age ≥ 18 years should be imaged according to the Abdomen Imaging Guidelines, except where directed otherwise by a specific guideline section.

PEDAB-1.2: Pediatric Abdomen Imaging Appropriate Clinical Evaluation and Conservative Treatment

- A recent (within 60 days) face to face evaluation including a detailed history, physical examination, appropriate laboratory studies, and basic imaging such as plain radiography or ultrasound should be performed prior to considering advanced imaging (CT, MR, Nuclear Medicine), unless the patient is undergoing guideline-supported imaging evaluation.
- These guidelines are based upon using advanced imaging to answer specific clinical questions that will affect patient management. Imaging is not indicated if the results will not affect patient management decisions. Standard medical practice would dictate continuing conservative therapy prior to advanced imaging in patients who are improving on current treatment programs.
- Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic patients for disorders involving the abdomen is not supported. Advanced imaging should only be approved in patients who have documented active clinical signs or symptoms of disease.
- Unless otherwise stated in a specific guideline section, repeat imaging studies of the same body area are not necessary unless there is evidence for progression of disease, new onset of disease, and/or documentation of how repeat imaging will affect patient management or treatment decisions.

PEDAB-1.3: Pediatric Abdomen Imaging Modality General Considerations

- Ultrasound
 - ◆ Ultrasound should be the initial imaging study of choice in most children with abdominal conditions and should be done prior to advanced imaging.
 - ◆ For those patients who do require advanced imaging after ultrasound, ultrasound can be very beneficial in selecting the proper modality, body area, image sequences, and contrast level that will provide the most definitive information for the patient.
 - ◆ CPT® codes vary by body area and presence or absence of Doppler imaging and are included in the table at the beginning of this guideline.

➤ MRI

- ◆ MRI of the abdomen is generally performed without and with contrast (CPT® 74183) unless the patient has a documented contraindication to gadolinium or otherwise stated in a specific guideline section.
- ◆ Due to the length of time for image acquisition and the need for the patient to lie still, anesthesia is required for almost all infants and young children (age < 7 years), as well as older children with delays in development or maturity. In this patient population, MRI imaging sessions should be planned with a goal of minimizing anesthesia exposure adhering to the following considerations:
 - MRI should be performed without and with contrast unless there is a specific contraindication to gadolinium use and strict criteria for contrast agent use should be applied in all cases when the patient already has intravenous access for anesthesia.
 - Recent evidence-based literature demonstrates the potential for gadolinium deposition in various organs including the brain, after the use of MRI contrast.
 - The U.S. Food and Drug Administration (FDA) has noted that there is currently no evidence to suggest that gadolinium retention in the brain is harmful and restricting gadolinium-based contrast agents (GBCAs) use is not warranted at this time. It has been recommended that GBCA use should be limited to circumstances in which additional information provided by the contrast agent is necessary and the necessity of repetitive MRIs with GBCAs should be assessed.
 - If requesting clinicians indicate that a non-contrast study is being requested with specific concern for gadolinium retention, the exam can be approved.
 - If multiple body areas are supported by eviCore's guidelines for the clinical condition being evaluated, MRI of all necessary body areas should be obtained concurrently in the same session.
- ◆ The presence of surgical hardware or implanted devices may preclude MRI.
- ◆ The selection of best examination may require coordination between the provider and the imaging service. CT may be the procedure of choice in these cases.

➤ CT

- ◆ CT of the abdomen typically extends from the dome of the diaphragm to the upper margin of the sacroiliac joints, and CT of the abdomen and pelvis extends from the dome of the diaphragm through the ischial tuberosities.
 - In general, CT of the abdomen is appropriate when evaluating solid abdominal organs.
 - In general, CT of the Abdomen and pelvis is appropriate when evaluating inflammatory or infectious processes, hematuria, or conditions which appear to involve both the abdomen and the pelvis.
 - In some cases, especially in follow-up of a known finding, it may be appropriate to limit the exam to the region of concern to reduce radiation exposure.
- ◆ The contrast level in pediatric CT imaging is specific to the clinical indication, as listed in the specific guideline sections.

- ◆ CT of the abdomen or abdomen and pelvis may be indicated for further evaluation of abnormalities suggested on prior US or MRI studies.
 - ◆ CT may be indicated without prior MR or US, as indicated in specific sections of these guidelines.
 - ◆ CT should not be used to replace MRI in an attempt to avoid sedation unless listed as a recommended study in a specific guideline section.
 - ◆ The selection of the best examination may require coordination between the provider and the imaging service.
- Nuclear Medicine
- ◆ Nuclear medicine studies are commonly used in evaluation of the pediatric kidney and gallbladder. Other less common indications exist as well:
 - Esophageal motility study (CPT® 78258) and/or Gastroesophageal reflux study (CPT® 78262) is indicated in the evaluation of gastroesophageal reflux.
 - ◆ Gastric mucosa imaging (Meckel's scan, CPT® 78261) is indicated for the following:
 - Suspected Meckel's diverticulum.
 - Barrett's esophagus.
 - Thoracic masses suspected of containing gastric mucosa.
 - Gastric emptying study (CPT® 78264) is indicated for evaluation of either suspected delayed or rapid gastric emptying.
 - Gastric emptying study with small bowel transit (CPT® 78265) is indicated for evaluation of suspected abnormalities in both total and regional times for gastrointestinal transit in the small bowel.
 - Gastric emptying study with small bowel and colon transit (CPT® 78266) is indicated for evaluation of suspected abnormalities in both total and regional times for gastrointestinal transit to the colon.
 - Gastrointestinal bleeding scintigraphy (CPT® 78278) is indicated for evaluation of brisk active GI bleeding with indeterminate endoscopy.
 - Gastrointestinal protein loss study (CPT® 78282) is indicated for decreased serum albumin or globulins and no evidence of GI bleeding.
 - Nuclear intestinal imaging (CPT® 78290) is indicated for evaluation of ectopic gastric mucosa.
 - Peritoneal-venous shunt patency study (CPT® 78291) is indicated for evaluation of shunt patency and function in a patient with ascites.
 - ◆ Nuclear renal imaging (CPT® 78701, CPT® 78707, CPT® 78708, or CPT® 78709) is indicated for evaluation of the following:
 - Renal transplant follow-up.
 - Kidney salvage vs. nephrectomy surgical decisions.
 - Acute renal failure with no evidence of obstruction on recent ultrasound.
 - Chronic renal failure to estimate prognosis for recovery.
- 3D Rendering
- ◆ 3D Rendering indications in pediatric abdomen imaging are identical to those for adult patients. See **Preface-4.1: 3D Rendering** for imaging guidelines.

The guidelines listed in this section for certain specific indications are not intended to be all-inclusive; clinical judgment remains paramount and variance from these guidelines may be appropriate and warranted for specific clinical situations.

References

1. Bridges MD. ACR–SPR Practice parameter for the performance and interpretation of magnetic resonance imaging (MRI). Revised 2017 (Resolution 10). Accessed October 18, 2017. <https://www.acr.org/~media/ACR/Documents/PGTS/guidelines/MRI.pdf>.
2. Karmazyn BK, John SD, Siegel MJ, et al. ACR–ASER–SCBT–MR–SPR Practice parameter for the performance of pediatric computed tomography (CT). Last review date: 2014 (Resolution 3). Accessed October 16, 2017. https://www.acr.org/~media/ACR/Documents/PGTS/guidelines/CT_Pediatric.pdf
3. Ing C, DiMaggio C, Whitehouse A, et al. Long-term differences in language and cognitive function after childhood exposure to anesthesia. *Pediatrics*. 2012 Aug; 130 (3): e476-e485. Accessed October 16, 2017. <http://pediatrics.aappublications.org/content/130/3/e476>.
4. Monteleone M, Khandji A, Cappell J, et al. Anesthesia in children: perspectives from nonsurgical pediatric specialists. *J Neurosurg Anesthesiol*. 2014 Oct; 26 (4): 396-398. Accessed October 16, 2017. http://journals.lww.com/jnsa/Abstract/2014/10000/Anesthesia_in_Children_Perspectives_From.18.aspx.
5. DiMaggio C, Sun LS, and Li G. Early childhood exposure to anesthesia and risk of developmental and behavioral disorders in a sibling birth cohort. *Anesth Analg*. 2011 Nov; 113 (5):1143-1151. Accessed October 16, 2017. <https://www.ncbi.nlm.nih.gov/pubmed/21415431?dopt=Abstract>.
6. Rossi P, Gourtsoyiannis N, Bezzi M, et al. Meckel's diverticulum: imaging diagnosis, *AJR Am J Roentgenol*. 1996; 166: 567-573. Accessed October 16, 2017. <http://www.ajronline.org/doi/10.2214/ajr.166.3.8623629>.
7. Elsayes KM, Menias CO, Harvin HJ, et al. Imaging manifestations of Meckel's diverticulum, *AJR Am J Roentgenol*, 2007; 189: 81-88. Accessed October 16, 2017. <http://www.ajronline.org/doi/abs/10.2214/AJR.06.1257>.
8. Berquist TH, Nolan NG, Stephens DH, et al. Specificity of ^{99m}Tc-pertechnetate in scintigraphic diagnosis of Meckel's diverticulum: review of 100 cases. *J Nucl Med*. 1976 June 1; 17 (6): 465-469. Accessed October 16, 2017. <http://europepmc.org/abstract/med/1262963>.
9. Kumar R, Tripathi M, Chandrashekar N, et al. Diagnosis of ectopic gastric mucosa using ^{99m}Tc-pertechnetate: spectrum of scintigraphic findings. *Br J Radiol*. 2005; 78:714-720. Accessed October 16, 2017. <http://www.birpublications.org/doi/10.1259/bjr/16678420>.
10. Berquist TH, Nolan NG, Stephens DH, et al. Radioisotope scintigraphy in diagnosis of Barrett's esophagus. *AJR Am J Roentgenol*. 1975; 123 (2): 401-411. Accessed October 16, 2017. <http://ajronline.org/doi/10.2214/ajr.123.2.401>.
11. Donohoe KJ, Maurer AH, Ziessman HA, et al. Procedure guideline for adult solid meal gastric emptying study 3.0. 2009 Aug 19; 37 (3): 196-200 Accessed October 16, 2017. <http://tech.snmjournals.org/content/37/3/196#cited-by>.
12. Parkman HP, Hasler WL, and Fisher RS. American Gastroenterological Association Medical Position statement: diagnosis and treatment of gastroparesis. *Gastroenterol*. Nov 2004; 127 (5): 1589-1591. Accessed October 16, 2017. [http://www.gastrojournal.org/article/S0016-5085\(04\)01633-6/fulltext](http://www.gastrojournal.org/article/S0016-5085(04)01633-6/fulltext).
13. Abell TL, Camilleri M, Donohoe KJ, et al. Consensus recommendations for gastric emptying scintigraphy: A joint report of the American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine. *Am J Gastroenterol*. 2008; 103: 753-763. Accessed October 16, 2017. <https://pdfs.semanticscholar.org/b625/502b22dc457c0b877221f6ca37913792d043.pdf>.
14. Sarnelli G, Caenepeel P, Geypens B, et al. Symptoms associated with impaired gastric emptying of solids and liquids in functional dyspepsia. *Am J Gastroenterol*. 2003 May;98:783-788. Accessed October 16, 2017. https://www.researchgate.net/publication/10768352_Symptoms_Associated_With_Impaired_Gastric_Emptying_of_Solids_and_Liquids_in_Functional_Dyspepsia.
15. Lawal A, Barboi A, Krasnow A, et al. Rapid gastric emptying is more common than gastroparesis in patients with autonomic dysfunction. *Am J Gastroenterol*. 2007 Mar 1; 102: 618-623. Accessed October 16, 2017. <http://www.nature.com/ajg/journal/v102/n3/full/ajg2007113a.html>.
16. Chial HJ, Camilleri M, Williams DE, et al. Rumination syndrome in children and adolescents: diagnosis, treatment, and prognosis. *Pediatrics*. 2003; 111 (1): 158-62. Accessed October 16, 2017. <http://pediatrics.aappublications.org/content/111/1/158>.

17. Altailji S, Leggett J, Le Page K, et al. Utility of gastroesophageal reflux study (GER) to assess for abnormal gastric emptying in comparison to the dedicated standardized gastric emptying study (GE). *J Nucl Med*. 2007 May 1; 48(suppl. 2): 289P. Accessed October 18, 2017. http://jnm.snmjournals.org/content/48/supplement_2/289P.2.abstract?sid=390f7839-965e-4bd7-af97-7565d5b802fc.
18. Alquist D, Fennerty B, Fleischer D, et al. North American Gastroenterological Association Medical Position statement: evaluation and management of occult and obscure gastrointestinal bleeding. *Gastroenterol*. 2000;118:197-200. Accessed October 16, 2017. [http://www.gastrojournal.org/article/S0016-5085\(00\)70429-X/pdf](http://www.gastrojournal.org/article/S0016-5085(00)70429-X/pdf).
19. Raju GS, Gerson L, Das A et al. American Gastroenterological Association (AGA) Institute medical position statement on obscure gastrointestinal bleeding. *Gastroenterol*. 2007 Nov; 133 (5): 1694-1696. Accessed October 16, 2017. [http://www.gastrojournal.org/article/S0016-5085\(07\)01148-1/pdf](http://www.gastrojournal.org/article/S0016-5085(07)01148-1/pdf).
20. Zuckerman GR, Prakash C, Askin MP, et al. AGA Technical review on the evaluation and management of occult and obscure gastrointestinal bleeding. *Gastroenterol*. 2000 Jan; 118 (1): 201-221. Accessed October 16, 2017. [http://www.gastrojournal.org/article/S0016-5085\(00\)70430-6/pdf](http://www.gastrojournal.org/article/S0016-5085(00)70430-6/pdf).
21. Morton KA, Clark PB, Christensen CR, et al. Diagnostic nuclear medicine. Amirsys. 2000 1st Ed. Chapter 8, pp 122-125.
22. Thrall JH and Zeissman HA. Nuclear medicine, the requisites, Mosby. 2001 2nd Ed. pp 288-289. Remer EM, Papanicolaoui N, Casalino DD, et al. Renal Failure. ACR Appropriateness Criteria®. 2013: 1-12. Accessed October 16, 2017. <https://acsearch.acr.org/docs/69492/Narrative/>.

PEDAB-2: Generalized Abdominal Pain

- Children with generalized abdominal pain and normal physical examination and laboratory studies, including stool for blood (and stool culture if diarrhea), should initially be evaluated by ultrasound (CPT® 76700 or CPT® 76705) and treated conservatively.
 - ◆ Gastroenterology (GI) specialist evaluation is helpful in determining the need for advanced imaging.
- Children with abdominal pain that can be localized to a particular area of the abdomen should be imaged according to the relevant guideline section:
 - ◆ **PEDAB-3: Right Lower Quadrant Pain, Rule Out Appendicitis.**
 - ◆ **PEDAB-4: Flank Pain, Renal Stone.**
 - ◆ **PEDAB-8: Right Upper Quadrant Pain.**
 - ◆ **PEDAB-25: Left Upper Quadrant Pain.**
 - ◆ **PEDAB-29: Left Lower Quadrant Pain.**
- Children with generalized acute abdominal pain AND any of the following red flag signs or symptoms require additional investigation (which may include advanced imaging). CT Abdomen (CPT® 74160) or Abdomen/Pelvis (CPT® 74177) with contrast is indicated unless otherwise specified in a specific guideline section:
 - ◆ Pain that wakes the child from sleep.
 - ◆ Unexplained fever (T > 100.4°F).
 - ◆ Dysphagia.
 - ◆ GI bleeding.
 - ◆ Significant vomiting.
 - ◆ Severe chronic diarrhea or nocturnal diarrhea in a toilet-trained child.
 - ◆ Failure to thrive, involuntary weight loss, or delay in linear growth or pubertal development.
 - ◆ Family history of inflammatory bowel disease, familial polyposis syndrome, celiac disease, or peptic ulcer disease.
 - ◆ Abdominal mass, hepatomegaly, and/or splenomegaly on exam.
 - ◆ Jaundice.
 - ◆ Arthritis.
 - ◆ Costovertebral angle tenderness.
 - ◆ Perianal disease.
 - ◆ Spinal tenderness.

References

1. Sreedharan R and Liacouras CA. Major symptoms and signs of digestive tract disorders. *Nelson Textbook of Pediatrics, Chapter 306.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1758-1767.
2. Sreedharan R and Liacouras CA, Functional abdominal pain (nonorganic chronic abdominal pain). *Nelson Textbook of Pediatrics, Chapter 342.* eds Kliegman RM, Stanton BF, St. Geme JW III, Schor NF, 20th edition 2016, pp 1884-1887.
3. Cogley JR, O'Connor SC, Houslyar R, et al. Emergent pediatric US: what every radiologist should know. *RadioGraphics.* 2012 May-June; 32: 651-665. Accessed October 16, 2017. <http://www.seum-ecuador.com/pdfs/emergent.pdf>.

PEDAB-3: Right Lower Quadrant Pain

- For patients age ≤ 14 years:
 - ◆ If local expertise exists, ultrasound (CPT® 76700 or CPT® 76705) is indicated as the initial examination. If positive or negative, no further diagnostic imaging is necessary.
 - If the appendix is not visualized on ultrasound and the white blood cell count is not elevated, no further imaging is necessary in nearly all cases, although the referring physician should make the final determination of the need for advanced imaging.
 - ◆ If insufficient local ultrasound expertise exists or the ultrasound findings are inconclusive, any of the following studies are indicated for evaluation of right lower quadrant pain:
 - CT Abdomen/Pelvis with contrast (CPT® 74177).
 - CT Abdomen/Pelvis without contrast (CPT® 74176).
 - MRI Pelvis without contrast (CPT® 72195).
 - MRI Pelvis without and with contrast (CPT® 72197).
- For patients age ≥ 15 years:
 - ◆ Any of the following studies are indicated:
 - CT Abdomen/Pelvis with contrast (CPT® 74177).
 - CT Abdomen/Pelvis without contrast (CPT® 74176).
 - MRI Pelvis without contrast (CPT® 72195).
 - MRI Pelvis without and with contrast (CPT® 72197).
- If the appendix is absent, follow guidelines in: **PEDAB-2: Generalized Abdominal Pain**

References

1. Smith MP, Katz DS, Rosen MP, et al. Right lower quadrant pain – suspected appendicitis. *ACR Appropriateness Criteria®*. Date of origin: 1996. Last review date: 2013. Accessed October 16, 2017. <https://acsearch.acr.org/docs/69357/Narrative/>.
2. Aiken JJ and Oldham KT. Acute Appendicitis. *Nelson Textbook of Pediatrics, Chapter 343*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition 2016. pp 1887-1894.
3. Aspelund G, Fingeret A, Gross E et al. Ultrasonography/MRI versus CT for diagnosing appendicitis. *Pediatrics*. 2014 Apr; 133 (4): 586-593. Accessed October 16, 2017. <http://pediatrics.aappublications.org/content/133/4/586>.
4. Moore MM, Gustas CN, Choudhary AK et al. MRI for clinically suspected pediatric appendicitis: an implemented program. *Pediatr Radiol*. 2012 Sep; 42 (9): 1056-1063. Accessed October 16, 2017. <https://link.springer.com/article/10.1007/s00247-012-2412-4>.
5. Kotagal M, Richards MK, Chapman T, et al. Improving ultrasound quality to reduce computed tomography use in pediatric appendicitis: the Safe and Sound campaign, *Am J Surg*. 2015 May; 209 (5): 896-900. Accessed: October 16, 2017. [http://www.americanjournalofsurgery.com/article/S0002-9610\(15\)00078-1/fulltext](http://www.americanjournalofsurgery.com/article/S0002-9610(15)00078-1/fulltext).
6. Kotagal M, Richards MK, Flum DR et al. Use and accuracy of diagnostic imaging in the evaluation of pediatric appendicitis. *J Pediatr Surg*. 2015 Apr; 50 (4): 642-646. Accessed October 16, 2017. [http://www.jpedsurg.org/article/S0022-3468\(14\)00650-2/fulltext](http://www.jpedsurg.org/article/S0022-3468(14)00650-2/fulltext).
7. Cohen B, Bowling J, Midulla P, et al. The non-diagnostic ultrasound in appendicitis: is a non-visualized appendix the same as a negative study? *J Pediatr Surg*. 2015 June; 50 (6): 923-927. Accessed October 16, 2017. [http://www.jpedsurg.org/article/S0022-3468\(15\)00183-9/fulltext](http://www.jpedsurg.org/article/S0022-3468(15)00183-9/fulltext).
8. Bachur RG, Levy LA, Callahan MJ, et al. Effect of reduction in the use of computed tomography on clinical outcomes of appendicitis. *JAMA Pediatr*. 2015 Aug; 169 (8):755-760. Accessed October 16, 2017. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2337785>.

PEDAB-4: Flank Pain, Renal Stone

- Flank Pain imaging indications in pediatric patients are very similar to those for adult patients. See: **AB-4: Flank Pain, Rule out or Known Renal/Ureteral Stone** for imaging guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ In children, ultrasound (CPT® 76770 or CPT® 76775) is the preferred initial study
 - ◆ If ultrasound is inconclusive, CT Abdomen/Pelvis without contrast (CPT® 74176) is indicated.
 - ◆ If CT is inconclusive or there is significant concern for radiation exposure from frequent CT use for a particular patient, MRI without and with contrast of the abdomen (CPT® 74183) and pelvis (CPT® 72197) is indicated.
 - ◆ If hematuria is present, see **PEDAB-7: Hematuria** for imaging guidelines.
- Nuclear kidney imaging (CPT® 78707, CPT® 78708, CPT® 78709, or CPT® 78710) is indicated for evaluation of recurrent flank pain when CT and ultrasound are non-diagnostic, or for suspected obstructive uropathy.

References

1. Coursey CA, Casalino DD, Remer EM et al. Acute Onset Flank Pain – Suspicion of Stone Disease, *ACR Appropriateness Criteria*®, 2011: 1-9. Accessed October 16, 2017. <https://www.guideline.gov/summaries/summary/49919/acr-appropriateness-criteria--acute-onset-flank-pain---suspicion-of-stone-disease-urolithiasis>.
2. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice parameter for the performance of renal scintigraphy. Revised 2017 (Resolution 29). Accessed October 16, 2017. <https://www.acr.org/~media/1169D04DFABF4C10938D2E3DFADC4477.pdf>.
3. Tekgül S, Dogan HS, Kočvara R, et al. European Association of Urology. *European Society for Paediatric Urology. Guidelines on Paediatric Urology 2015 with limited text update March 2017*. Accessed January 15, 2018. <https://uroweb.org/guideline/paediatric-urology/?type=pocket-guidelines>.

PEDAB-5: Urinary Tract Infection (UTI)

PEDAB-5.1: Upper Urinary Tract	15
PEDAB-5.2: Lower Urinary Tract	16

PEDAB-5.1: Upper Urinary Tract

- All children with first time UTI should undergo ultrasound evaluation (CPT® 76770 or CPT® 76775), as the initial imaging modality to diagnose hydronephrosis, pyelonephritis, or congenital renal anomaly.
 - ◆ If hydronephrosis is present, this should be further evaluated with voiding cystourethrography (VCUG), to evaluate for vesicoureteral reflux. In boys, this is generally accomplished using fluoroscopic imaging and iodinated contrast to exclude urethral abnormalities. In girls, Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740) is commonly used as urethral abnormalities are rare and this technique results in lower radiation exposure.
- Diuretic renography using Tc-99m MAG 3 (CPT® 78707, CPT® 78708, or CPT® 78909) is the study of choice for the following indications:
 - ◆ Differentiating a dilated non-obstructed urinary system from a true stenosis (e.g., UPJ obstruction; ureteral-vesical junction [UVJ] obstruction),
 - ◆ Quantifying renal parenchymal function.
 - ◆ Ultrasound findings that are compatible with a multicystic dysplastic kidney to evaluate function of the affected kidney or a ureteral-pelvic junction (UPJ) obstruction of the contralateral kidney.
 - ◆ Diagnostic evaluation of upper tract dilatation when VCUG is negative.
 - ◆ Renal function evaluation in patients with hydronephrosis.
- Post-contrast CT abdomen (CPT® 71260) is sensitive in diagnosing pyelonephritis has a role in evaluation of renal abscess or unusual complications such as xanthogranulomatous pyelonephritis but has no role in the routine evaluation of UTI
- Magnetic resonance urography (MRU) (CPT® 74183 and CPT® 72197), is not a first line test for the routine evaluation of a UTI, but may be appropriate (where available) for investigation of a dilated upper urinary tract.
 - ◆ NOTE: MRU requires sedation in young children.
 - ◆ MRU can also quantitate renal function.
- Technetium-99m-dimercaptosuccinic acid (Tc-99m DMSA) scintigraphy (CPT® 78700, CPT® 78701, or CPT® 78710), is sensitive for the diagnosis of UTI but there is little benefit in using this after the first episode of a UTI:
 - ◆ DSMA is recommended for Detection of post-pyelonephritic renal scarring at least 6 months after the documented upper tract UTI in high risk patients with recurrent UTIs.
 - ◆ Note: According to the U.S. FDA, DMSA is currently not available due to manufacturing delays since 2014. Estimated return to market is 1st Quarter 2020.
- Radiopharmaceutical nuclear medicine imaging (CPT® 78805, CPT® 78806, or CPT® 78807) is indicated for evaluation of suspected pyelonephritis or diffuse interstitial nephritis.
- Nuclear non-imaging renal function study (CPT® 78725) is a quantitative study that can be used to evaluate renal function.

PEDAB-5.2: Lower Urinary Tract

- Fluoroscopic Voiding cystourethrography (VCUG) is indicated for detection of possible vesico-ureteral reflux (VUR) in neonates or young children when hydronephrosis is seen on ultrasound.
- The American Academy of Pediatrics clinical practice guidelines no longer recommend routine VCUG for infants and young children from 2 to 24 months of age after the first febrile UTI.
 - ◆ The current recommendation is to postpone the VCUG until the second febrile UTI UNLESS there are:
 - Atypical or complex clinical circumstances.
 - Renal/bladder ultrasound reveals hydronephrosis, scarring, or obstructive uropathy.
- Vesicoureteral Reflux (VUR)
 - ◆ Fluoroscopic VCUG is typically performed for diagnosis and grading of VUR, and should be the first modality used for diagnosis.
 - ◆ Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740), because of its lower radiation exposure and higher sensitivity for reflux > Grade I, is recommended for follow-up imaging of VUR, and investigation of VUR in siblings of affected patients.
- Male patients with first UTI should be evaluated with fluoroscopic VCUG studies rather than radionuclide cystography, to visualize the male urethra for possible abnormalities such as posterior urethral valves, strictures, or diverticula.
- For female patients, radionuclide cystography (CPT® 78740) may replace fluoroscopic VCUG as the initial study, since urethral anatomy is rarely abnormal except in complex malformations.
- MR urography is indicated for evaluation of ectopic distal ureteral insertion, or other complex lower urinary tract anatomy.
- Siblings of patients with known vesicoureteral reflux can undergo Ureteral Reflux Study (Radiopharmaceutical Voiding Cystogram) (CPT® 78740) if they have renal scarring on ultrasound or history of UTI and no prior evaluation for VUR.

References

1. Mandell GA, Egli DF, Gilday DL, et al. Society of Nuclear Medicine Procedure guideline for renal cortical scintigraphy in children. *Society Nuclear of Medicine Procedure Guidelines Manual*. Version 3.0, Approved June 20, 2003. pp.195-198. Accessed October 18, 2017. http://snmmi.files.cms-plus.com/docs/pg_ch32_0403.pdf
2. Subcommittee on Urinary Tract Infection, Steering Committee on Quality Improvement and Management. Urinary Tract Infection: Clinical Practice Guideline for the Diagnosis and Management of the Initial UTI in Febrile Infants and Children 2 to 24 Months. *Pediatrics*. 2011 Sep; 128 (3): 595-610. Accessed October 16, 2017. <http://pediatrics.aappublications.org/content/pediatrics/128/3/595.full.pdf>.
3. Karmazyn BK, Alazraki AL, Anupindi SA, et al. Urinary tract infection – child. *ACR Appropriateness Criteria®*. Revised 2016. Accessed January 15, 2018. <https://acsearch.acr.org/docs/69444/Narrative/>.
4. Elder JS. Urinary tract infections. *Nelson Textbook of Pediatrics, Chapter 538*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 2556-2562.
5. Jackson EC. Urinary tract infections in children: knowledge updates and a salute to the future. *Pediatr Rev*. 2015 Apr; 36 (4): 153-164. Accessed October 16, 2017. <http://pedsinreview.aappublications.org/content/36/4/153>.
6. Peters CA, Skoog SJ, Arant BS, et al. Management and screening of primary vesicoureteral reflux in children. American Urological Association. Published 2010. Reviewed and Validity Confirmed 2017. Accessed October 16, 2017. [http://www.auanet.org/guidelines/vesicoureteral-reflux-\(2010-reviewed-and-validity-confirmed-2017\)](http://www.auanet.org/guidelines/vesicoureteral-reflux-(2010-reviewed-and-validity-confirmed-2017)).
7. Fettich J, Colarinha P, Fischer S, et al. Paediatric Committee of the European Association of Nuclear Medicine: Guidelines for direct radionuclide cystography in children. Accessed January 15, 2018. http://eanm.org/publications/guidelines/gl_paed_drc.pdf.
8. Palestro CJ, Brown ML, Forstrom LA et al. Society of Nuclear Medicine Procedure guideline for ¹¹¹In-Leukocyte scintigraphy for suspected infection/inflammation, Version 3.0, approved June 2, 2004. Accessed October 17, 2017. http://interactive.snm.org/docs/Leukocyte_v3.pdf.
9. de Vries EFJ, Roca M, Jamar F et al, Guidelines for the labelling of leucocytes with ^{99m}Tc-HMPAO. *Eur J Nucl Med Mol Imaging*. 2010 Apr; 37 (4): 842-848. Accessed January 15, 2018. <https://link.springer.com/article/10.1007/s00259-010-1394-4>.

PEDAB-6: Pediatric Acute Gastroenteritis

- Imaging is not indicated in pediatric acute gastroenteritis unless there is a concern for diagnosis other than acute gastroenteritis.
- When necessary, imaging in children with suspected gastroenteritis should begin with plain x-rays of the abdomen, including supine and left lateral decubitus views. The left lateral decubitus view is useful for the detection of air-fluid levels and for detection of gas in the rectum and to exclude obstruction or bowel perforation.
- Ultrasound (CPT® 76700 or CPT® 76705) should be performed if there is organomegaly, palpable mass, or suspicion for complications in the form of intussusception. See: **PEDAB-27: Intussusception**
 - ◆ While ultrasound (CPT® 76700 or CPT® 76705) may detect findings of gastroenteritis, imaging is not necessary to make the diagnosis of uncomplicated gastroenteritis.
- CT Abdomen/Pelvis with contrast (CPT® 74177) is indicated if abdominal red flag symptoms are present as listed in **PEDAB-2: Generalized Abdominal Pain**.

References

1. Bhutta ZA. Acute gastroenteritis in children. *Nelson Textbook of Pediatrics. Chapter 340.* eds Kliegman RM, Stanton BF, St. Geme JW III, Schor NF. 20th edition. 2016, pp 1863-1874.
2. Levine A and Bechtel KA. Pediatric gastroenteritis in emergency medicine. *eMedicine*, October 31, 2016. Accessed October 17, 2017. <http://emedicine.medscape.com/article/801948-overview>.

PEDAB-7: Hematuria

Hematuria is a relatively common complaint in pediatric patients, and the imaging considerations are different than those occurring in adult patients.

- For patients with asymptomatic gross hematuria or microscopic hematuria present on separate urinalysis evaluations, ultrasound of the kidneys (CPT® 76770 or CPT® 76775) and bladder (CPT® 76856 or CPT® 76857) are indicated.
- For patients with painful hematuria and no recent trauma, any of the following studies can be approved:
 - ◆ CT Abdomen/Pelvis without contrast (CPT® 74176)
 - ◆ Ultrasound of kidneys (CPT® 76770 or CPT® 76775)
 - ◆ Ultrasound of bladder (CPT® 76856 or CPT® 76857)
- For patients with hematuria and recent trauma, the following studies are indicated:
 - ◆ CT Abdomen/Pelvis with contrast (CPT® 74177)
 - ◆ CT Cystography (CT Pelvis with bladder contrast – CPT® 72193), if gross hematuria is present and pelvic fracture or traumatic bladder injury is suspected.

References

1. Dillman JR, Coley BD, Karmazyn B, et al. Hematuria – child, *ACR Appropriateness Criteria*®. Date of origin: 1999. Last review date: 2012. Accessed January 15, 2018. <https://acsearch.acr.org/docs/69440/Narrative/>.
2. Pan CG, Avner ED. Clinical evaluation of the child with hematuria. *Nelson Textbook of Pediatrics. Chapter 509*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition 2016, pp 2494-2496.

PEDAB-8: Right Upper Quadrant Pain

- Right upper quadrant pain imaging indications in pediatric patients are very similar to those for adult patients. See: **AB-2: Abdominal Pain** for imaging guidelines.
- Pediatric-specific imaging considerations include the following:
 - ◆ In patients with complaints of RUQ pain with fever, elevated white blood cell count, positive Murphy sign with suspicion of acute cholecystitis or suspicion of acalculous, the diagnosis should be confirmed or excluded using US abdomen (CPT® 76700) and/or Nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT® 78226 or CPT® 78227).
 - MRI abdomen with and without contrast (CPT® 74183) when US or NM is equivocal.
 - CT abdomen with IV contrast (CPT® 74160) when US or NM is equivocal.
 - ◆ In patients with complaints of RUQ pain with no fever and normal white blood cell count where a diagnosis of stones and bile duct obstruction are suspected, the diagnosis should be confirmed with US abdomen (CPT® 76700) and/or Nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT® 78226 or CPT® 78227).
 - MRI abdomen with and without contrast (CPT® 74183) when US or NM is equivocal.
 - CT abdomen with IV contrast (CPT® 74160) when US or NM is equivocal.
 - ◆ In patients with complaints of RUQ pain with no fever and an ultrasound shows only gallstones, MRI abdomen without IV contrast (CPT® 74181), MRI abdomen without and with IV contrast (CPT® 74183) or Nuclear medicine imaging of the hepatobiliary system (HIDA scan, CPT® 78226 or CPT® 78227) is excluded to exclude other sources of pain.

References

1. Yarmish GM, Smith MP, Rosen MP, et al. Right upper quadrant pain. *ACR Appropriateness Criteria*®. Date of origin: 1996. Last review date: 2013. Accessed January 15, 2018. <https://acsearch.acr.org/docs/69474/Narrative/>.
2. Weissmann GS, Frank MS, Bernstein LH, et al. Rapid and accurate diagnosis of acute cholecystitis with ^{99m}Tc-HIDA cholescintigraphy. *AJR Am J Roentgenol*. 1979 Apr; 132: 523-528. Accessed October 17, 2017. <http://www.ajronline.org/doi/pdf/10.2214/ajr.132.4.523?src=recsys>.
3. Tulchinsky M, Ciak BW, Delbeke D, et al. SNM Guidelines for Hepatobiliary Scintigraphy. *J Nucl Med Technol*. 2010 Dec 1; 38 (4): 210-218. Accessed January 15, 2018. <http://tech.snmjournals.org/content/38/4/210>.
4. Gerard PS, Biyyam DR, Brown RKJ, et al. ACR-SPR practice parameter for the performance of hepatobiliary scintigraphy. *ACR Practice Parameters*. Revised 2017 (Resolution 30). Accessed January 15, 2018. <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/hepatoscint.pdf?la=en>.

PEDAB-9: Inflammatory Bowel Disease, Crohn Disease, or Ulcerative Colitis

Enterography is the most appropriate advanced imaging study for patients with inflammatory bowel disease (IBD).

- For children with suspected IBD, MR enterography (CPT® 74183 and CPT® 72197) is preferred to avoid radiation exposure.
 - ◆ CT enterography (CPT® 74177) is indicated if MR enterography is inconclusive or unavailable.
- For children with established IBD, MR enterography (CPT® 74183 and CPT® 72197) is indicated for the following:
 - ◆ Monitoring response to disease-modifying treatment on an annual basis or when treatment change is being considered.
 - ◆ Patients with new or worsening symptoms or suspected complications including abscess, perforation, fistula, or obstruction.
 - ◆ CT enterography (CPT® 74177) can be approved if MR enterography is inconclusive or unavailable.

References

1. Kim DH, Carucci LR, Baker ME, et al. Crohn Disease. *ACR Appropriateness Criteria*®. Date of origin: 1998. Last review date: 2014. Accessed October 17, 2017. <https://acsearch.acr.org/docs/69470/Narrative/>.
2. Duigenan S and Gee MS. Imaging of pediatric patients with inflammatory bowel disease. *AJR Am J Roentgenol*. 2012 Oct; 199 (4): 907-915. Accessed October 17, 2017. <http://www.ajronline.org/doi/pdf/10.2214/AJR.11.7966>.
3. Grossman AB and Baldassano RN. Inflammatory bowel disease. *Nelson Textbook of Pediatrics, Chapter 336*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1819-1831.

PEDAB-10: Abdominal Sepsis (Suspected Abdominal Abscess)

- Abdominal sepsis imaging indications in pediatric patients are identical to those for adult patients.
 - ◆ See **AB-3: Abdominal Sepsis (Suspected Abdominal Abscess)** for imaging guidelines.

PEDAB-11: Postoperative Pain within 60 Days Following Abdominal Surgery

- CT Abdomen/Pelvis with contrast (CPT® 74177) is indicated in patients with suspected postoperative complications (e.g. bowel obstruction, abscess, anastomotic leak, etc.).
 - ◆ Children can also be evaluated with ultrasound (CPT® 76700 or CPT® 76705) initially (especially in small children or in thin older children) or with MRI abdomen and pelvis without and with contrast (CPT® 74183 and CPT® 72197).
 - ◆ Because MRI may not be practical for the timely evaluation of post-operative abscesses, MRI should only replace CT when the study can be completed in a similar time frame as CT.
- Radiopharmaceutical nuclear medicine imaging (CPT® 78805, CPT® 78806, or CPT® 78807) is indicated for evaluation of any of the following:
 - ◆ Peritonitis.
 - ◆ Postoperative fever without localizing signs or symptoms.
- Beyond 60 days postoperatively, see: **PEDAB-2: Generalized Abdominal Pain.**

References

1. Katz DS, Baker MF, Rosen MP, et al. Suspected small bowel obstruction. *ACR Appropriateness Criteria*®. Date of origin: 1996. Last review date: 2013. Accessed October 17, 2017. <https://acsearch.acr.org/docs/69357/Narrative/>.
2. Yagmhai V, Rosen MP, Lalani T, et al. Acute (nonlocalized) abdominal pain and fever or suspected abdominal abscess. *ACR Appropriateness Criteria*®. Date of origin: 1996. Last review date: 2012. Accessed October 17, 2017. <https://acsearch.acr.org/docs/69467/Narrative/>.
3. Palestro CJ, Brown ML, Forstrom LA et al. Society of Nuclear Medicine Procedure guideline for ¹¹¹In-Leukocyte scintigraphy for suspected infection/inflammation, Version 3.0, approved June 2, 2004. Accessed October 17, 2017. http://interactive.snm.org/docs/Leukocyte_v3.pdf.
4. de Vries EFJ, Roca M, Jamar F et al, Guidelines for the labelling of leucocytes with ^{99m}Tc-HMPAO. *Eur J Nucl Med Mol Imaging*. 2010 Apr; 37 (4):842-848. Accessed January 15, 2018. <https://link.springer.com/article/10.1007/s00259-010-1394-4>.

PEDAB-12: Constipation, Diarrhea, and Irritable Bowel Syndrome

- Constipation and diarrhea are extremely common complaints in children. The overwhelming majority of patients do not require advanced imaging for evaluation of constipation or diarrhea.
- Irritable bowel is rare in young children, but more common in adolescents. The overwhelming majority of patients do not require advanced imaging for evaluation of irritable bowel syndrome.
 - ◆ In most cases, causes of constipation can be excluded on the basis of a careful history and physical examination. Advanced Imaging should be performed if warning signs of other diseases are present.
- Constipation associated with the following red flag signs or symptoms may require advanced imaging:
 - ◆ Red flag symptoms for abdominal pain (See **PEDAB-2: Generalized Abdominal Pain**).
 - ◆ Clinical suspicion of tethered cord based on abnormal physical findings over the spine or failure of maximal laxative therapy. (See **PEDSP-5: Tethered Cord** for imaging guidelines).
- Diarrhea that is associated with the following additional red flag signs or symptoms may require advanced imaging: (See **PEDAB-2: Generalized Abdominal Pain**).
- Irritable bowel syndrome that is associated with the following additional red flag signs or symptoms may require advanced imaging: (See **PEDAB-2: Generalized Abdominal Pain**).
- A barium enema and rectal biopsy are indicated for diagnosis of Hirschsprung disease in children with features suggestive of this disorder. MR of the pelvis without and with contrast (CPT® 72197) may be indicated in post-operative patients who have signs of complications related to treatment to assess the position of the pulled-through bowel, the sphincter muscles, and the area of the posterior urethra.

References

1. Sreedharan R and Liacouras CA. Major symptoms and signs of digestive tract disorders. *Nelson Textbook of Pediatrics, Chapter 306*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1758-1767.
2. Sreedharan R and Liacouras CA. Functional abdominal pain (nonorganic chronic abdominal pain). *Nelson Textbook of Pediatrics, Chapter 342*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1884-1887.
3. Fiorino KN and Liacouras CA. Encopresis and functional constipation. *Nelson Textbook of Pediatrics, Chapter 332.3* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016. pp 1807-1809.
4. Guarino A, Branski D, and Winter HS. Chronic diarrhea. *Nelson Textbook of Pediatrics, Chapter 341*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, p 1875-1882.
5. Zella GC, Israel EJ, Chronic Diarrhea in Children. *Pediatr Rev* 2012 May; 33 (5): 207-217. Accessed October 17, 2017. <http://pedsinreview.aappublications.org/content/33/5/207>.

PEDAB-13: Abdominal Mass

PEDAB-13.1: Abdominal Wall Mass	26
PEDAB-13.2: Intra-Abdominal Mass	26

PEDAB-13.1: Abdominal Wall Mass

- For initial imaging of a newly discovered abdominal wall mass, any of the following studies are indicated:
 - ◆ Ultrasound (CPT® 76700 or CPT® 76705).
 - ◆ MRI Abdomen without contrast (CPT® 74181) or without and with contrast (CPT® 74183).
 - ◆ If below the umbilicus, MRI Pelvis without contrast (CPT® 72195) or without and with contrast (CPT® 72197) may be added to MRI Abdomen.
- If ultrasound and/or MRI are inconclusive or insufficient for preoperative planning, any of the following studies are indicated:
 - ◆ CT Abdomen with contrast (CPT® 74160) or without contrast (CPT® 74150).
 - ◆ If below the umbilicus, CT Abdomen/Pelvis with contrast (CPT® 74177) or without contrast (CPT® 74176).

PEDAB-13.2: Intra-Abdominal Mass

- Ultrasound (CPT® 76700) should be the initial imaging study for children with an intra-abdominal mass.
- Additional imaging studies will be determined by the results of the ultrasound, and will depend on the location and organ involvement associated with the mass as well as history, physical exam, and laboratory findings. See the following sections for additional imaging guidelines:
 - ◆ **PEDONC-1: General Guidelines.**
 - ◆ **PEDONC-5: Pediatric Lymphomas.**
 - ◆ **PEDONC-6: Neuroblastoma.**
 - ◆ **PEDONC-7: Pediatric Renal Tumors.**
 - ◆ **PEDONC-10: Pediatric Germ Cell Tumors.**
 - ◆ **PEDONC-11: Pediatric Liver Tumors.**
 - ◆ **PEDONC-14: Pediatric Adrenocortical Carcinoma.**
 - ◆ **PEDAB-15: Liver Lesion Characterization.**
 - ◆ **PEDAB-17: Adrenal Lesions.**
 - ◆ **PEDAB-19: Indeterminate Renal Lesion.**
 - ◆ **PEDAB-26: Spleen.**

References

1. Allen-Rhoades W and Steuber CP. Clinical assessment and differential diagnosis of the child with suspected cancer. *Principles and Practice of Pediatric Oncology*. eds Pizzo PA and Poplack DG. 7th edition 2016. pp. 101-111.
2. Malkan AD, Loh A, Bahrami A, et al. An approach to renal masses in pediatrics. *Pediatrics*. 2015 Jan; 135 (1): 142-158. Accessed January 15, 2018. <http://pediatrics.aappublications.org/content/135/1/142>.
3. Crane GL, Hernanz-Schulman M. Current imaging assessment of congenital abdominal masses in pediatric patients. *Semin Roentgenol*. 2012 Jan; 47 (1): 32-44. Accessed January 15, 2018. [http://www.seminarsinroentgenology.com/article/S0037-198X\(11\)00065-4/fulltext](http://www.seminarsinroentgenology.com/article/S0037-198X(11)00065-4/fulltext).

PEDAB-14: Renovascular Hypertension and Other Secondary Causes of Hypertension

- Clinical evaluation for suspected hypertension should include repeated blood pressure measurements (generally ≥ 3 measurements). If these measurements are at or above the age-dependent systolic or diastolic blood pressures requiring further evaluation, as listed in the following table, further evaluation is warranted. Blood pressure may be obtained in-clinic, at home, or by using a wearable ambulatory blood pressure measurement (ABPM) device which records blood pressure at frequent intervals during normal activities and is downloaded later for computer analysis.

TABLE 6 Screening BP Values Requiring Further Evaluation

Age, y	BP, mm Hg			
	Boys		Girls	
	Systolic	DBP	Systolic	DBP
1	98	52	98	54
2	100	55	101	58
3	101	58	102	60
4	102	60	103	62
5	103	63	104	64
6	105	66	105	67
7	106	68	106	68
8	107	69	107	69
9	107	70	108	71
10	108	72	109	72
11	110	74	111	74
12	113	75	114	75
≥ 13	120	80	120	80

Above table from Flynn et al. (2017)

- Any of the following studies are indicated for initial evaluation of a pediatric patient with suspected secondary hypertension.
 - ◆ Doppler or Duplex Ultrasound (CPT® 93975 or CPT® 93976).
 - ◆ Complete retroperitoneal ultrasound (CPT® 76770).
 - ◆ Captopril renography (CPT® 78709) has largely been abandoned in clinical practice, replaced by CTA and MRA abdomen, but may be supported for unusual circumstances. All such requests should be forwarded to Medical Directors for review.
- All follow-up requests for pediatric hypertension will go to Medical Directors for review.

Other considerations for imaging evaluation:

- Abdominal MRA (CPT® 74185) or CTA (CPT® 74175) may be indicated for pediatric patients with hypertension to exclude fibromuscular dysplasia or other blood-flow restricting lesions of the renal arteries.
- Echocardiography (CPT® 93306) is indicated at initial evaluation to screen for cardiac abnormalities, coarctation of the aorta, and end-organ damage such as left ventricular hypertrophy.
- Nuclear renal imaging (CPT® 78707, CPT® 78708, or CPT® 78709) is indicated for evaluation of the following:
 - ◆ Severe hypertension with progressive renal insufficiency or failure to respond to 3 drug therapy).
 - ◆ Malignant or accelerated hypertension.
 - ◆ Acute worsening of previously stable hypertension.
 - ◆ Diastolic BP > 100 in patient < 35 years old.
 - ◆ New onset severe hypertension.
 - ◆ Hypertension in presence of asymmetric kidneys or diffuse atherosclerosis.
 - ◆ Hypertension in presence of acute elevation in creatinine either unexplained or after treatment with ACE inhibitor.
 - ◆ Abdominal bruit.
 - ◆ Recurrent acute pulmonary edema and hypertension.
 - ◆ Hypokalemia with normal or elevated plasma renin level in absence of diuretic therapy.
 - ◆ Hypertension with known neurofibromatosis.

References

1. Castelli PK, Dillman JR, Smith EA, et al. Imaging of renin-mediated hypertension in children. *AJR Am J Roentgenol.* 2013 Jun; 200 (6): W661-672. Accessed January 15, 2018. <https://www.ajronline.org/doi/10.2214/AJR.12.9427>.
2. Chhadia S, Cohn RA, Vural G, et al. Renal Doppler evaluation in the child with hypertension: a reasonable screening discriminator? *Pediatr Radiol.* 2013 Dec; 43 (12): 1549-1556. Accessed January 15, 2018. <https://link.springer.com/article/10.1007%2Fs00247-013-2741-y>.
3. Castelli PK, Dillman JR, Kershaw DB, et al. Renal sonography with Doppler for detecting suspected pediatric renin-mediated hypertension - is it adequate? *Pediatr Radiol.* 2014 Jan; 44 (1): 42-49. Accessed January 15, 2018. <https://link.springer.com/article/10.1007%2Fs00247-013-2785-z>.
4. Bolduc JP, Oliva VL, Therasse E, et al. Diagnosis and treatment of renovascular hypertension: a cost-benefit analysis. *AJR Am J Roentgenol.* 2005 Mar; 184 (3): 931-937. Accessed October 17, 2017. <http://www.ajronline.org/doi/pdfplus/10.2214/ajr.184.3.01840931>.
5. Harvin HJ, Verma N, Nikolaidis P, et al. Renovascular hypertension. *ACR Appropriateness Criteria® Revised 2017.* Accessed October 17, 2017. <https://acsearch.acr.org/docs/69374/Narrative/>.
6. Trautmann A, Roebuck DJ, McLaren CA, et al. Non-invasive imaging cannot replace formal angiography in the diagnosis of renovascular hypertension. *Pediatr Nephrol.* 2017 Mar; 32 (3): 495-502. Accessed January 15, 2018. <https://link.springer.com/article/10.1007%2Fs00467-016-3501-7>.
7. Moser M and Setaro JF. Resistant or difficult-to-control hypertension. *N Engl J Med.* 2006 July 27; 355 (4): 385-392. Accessed October 17, 2017. <http://www.nejm.org/doi/10.1056/NEJMcp041698>.
8. Lande MB. Systemic hypertension. *Nelson Textbook of Pediatrics*, Chapter 445. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition 2016, pp 2294-2303.
9. Brady TM. Hypertension. *Pediatr Rev.* 2012 Dec; 33 (12): 541-550. Accessed January 15, 2018. <http://pedsinreview.aappublications.org/content/33/12/541>.

10. Ingelfinger JR. The child or adolescent with elevated blood pressure. N Engl J Med. 2014 Jun 12; 370 (24): 2316-2325. Accessed October 17, 2017. <http://www.nejm.org/doi/full/10.1056/NEJMcp1001120>.
11. Taylor Jr AT, Blafox MD, Dubovsky EV, et al. Society of Nuclear Medicine Procedure guideline for diagnosis of renovascular hypertension, version 3.0, approved June 20, 2003 . Accessed October 17, 2017. http://interactive.snm.org/docs/pg_ch16_0403.pdf.
12. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice Guideline for the Performance of Renal Scintigraphy. Revised 2017 (Resolution 29). Accessed October 17, 2017. http://www.acr.org/~media/ACR/Documents/PGTS/guidelines/Renal_Scintigraphy.pdf.
13. Tekgül S, Dogan HS, Kočvara R, et al. European Association of Urology. European Society for Paediatric Urology. Guidelines on Paediatric Urology. 2015 with limited text update March 2017. Accessed January 15, 2018. <https://uroweb.org/guideline/paediatric-urology/?type=pocket-guidelines>.
14. Flynn JT, Kaelber DC, Baker-Smith, CM, et al. Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents. Pediatrics. 2017 Sep; 140 (3) e2017 1904. Accessed October 17, 2017. <http://pediatrics.aappublications.org/content/pediatrics/140/3/e20171904.full.pdf>.

PEDAB-15: Liver Lesion Characterization

- Liver lesion characterization imaging indications in pediatric patients are very similar to those for adult patients. See: **AB-29: Liver Lesion Characterization** for imaging guidelines.
- Nuclear medicine liver imaging (ONE of CPT® codes: CPT® 78201, CPT® 78202, CPT® 78205, CPT® 78206, CPT® 78215, or CPT® 78216) if rarely performed, but can be approved for the following when ultrasound, CT, and MRI are unavailable or contraindicated:
 - ◆ Evaluation of liver mass, trauma, or suspected focal nodular hyperplasia (FNH).
 - ◆ Differentiation of hepatic hemangioma from FNH.
 - ◆ Diffuse hepatic disease or elevated liver function tests.
 - ◆ Suspected accessory spleen (CPT® 78215 or CPT® 78216 only).
- Pediatric-specific imaging considerations includes:
 - ◆ US of the abdomen (CPT® 76700) is the initial study of choice in children. MRI is preferred over CT when possible to reduce radiation exposure.

References

1. Hegde SV, Dillman JR, Lopez MJ, et al. Imaging of multifocal liver lesions in children and adolescents. *Cancer Imaging*. 2012; 12 (3): 516–529. Accessed January 15, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3569672/>.
2. Fernandez-Pineda I and Cabello-Laureano R. Differential diagnosis and management of liver tumors in infant. *World J Hepatol*. 2014 Jul 27; 6 (7): 486–495. Accessed January 15, 2018. <https://www.wjgnet.com/1948-5182/full/v6/i7/486.htm>.
3. Siegel MJ. Liver. In: *Pediatric Sonography*. 5th ed, Philadelphia, Wolters Kluwer, 2018
4. Squires JE and Balistreri WF. Evaluation of patients with possible liver dysfunction. *Nelson Textbook of Pediatrics, Chapter 355.1*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1925-1928.
5. Chung EM, Cube R, Lewis RB, et al. Pediatric liver masses: radiologic-pathologic correlation part 1. benign tumors. *RadioGraphics*. 2010 May; 30 (3): 801–826. Accessed January 15, 2018. <http://pubs.rsna.org/doi/abs/10.1148/rq.303095173>.

PEDAB-16: Pediatric Liver Failure and Cirrhosis

- Elevated liver function testing imaging indications in pediatric patients are very similar to those for adult patients. See: **AB-30: Elevated Liver Function (LFT) Levels** for imaging guidelines.
- Causes of liver failure or cirrhosis in pediatric patients are different from adults, and are frequently idiopathic, but commonly due to one of the following:
 - ◆ Biliary dysfunction (biliary atresia, cystic fibrosis, etc.).
 - ◆ Metabolic disease.
 - ◆ Post-infectious.
- Liver ultrasound (CPT® 76700) with duplex Doppler (CPT® 93975) is indicated as an initial study for patients prior to approving CT or MRI for pediatric patients.
 - ◆ MRI Abdomen without and with contrast (CPT® 74183) is indicated for evaluation of ultrasound findings that are inconclusive or technically limited, and is preferred over CT when possible to reduce radiation exposure.
- Repeat liver ultrasound (CPT® 76705) with duplex Doppler (CPT® 93975) is indicated in pediatric patients in the following circumstances:
 - ◆ Known chronic liver dysfunction or cirrhosis of any cause.
 - ◆ New or worsening findings on history, physical exam, or laboratory results that suggest progression of liver disease.
 - ◆ Doppler ultrasound of the liver (CPT® 93975 or CPT® 93976) is indicated when portal venous congestion or portal hypertension is suspected.
- Nuclear medicine liver imaging (ONE of CPT® codes: CPT® 78201, CPT® 78202, CPT® 78205, CPT® 78206, CPT® 78215, or CPT® 78216) if rarely performed, but can be approved for the following when ultrasound, CT, and MRI are unavailable or contraindicated:
 - ◆ Diffuse hepatic disease or elevated liver function tests.

References

1. Squires JE and Balistreri WF. Evaluation of patients with possible liver dysfunction. *Nelson Textbook of Pediatrics, Chapter 355.1*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition 2016, pp 1925-1928.
2. Fusillo S and Rudolph B. Nonalcoholic fatty liver disease. *Pediatr Rev.* 2015 May; 36 (5): 198-205. Accessed October 17, 2017. <http://pedsinreview.aappublications.org/content/36/5/198>.
3. Van Rijn RR and Nievelstein RAJ. Paediatric ultrasonography of the liver, hepatobiliary tract and pancreas. *Eur J Radiol.* 2014 Sep; 83 (9): 1570-1581. Accessed October 17, 2017. <http://www.sciencedirect.com/science/article/pii/S0720048X14001636>.
4. Paranjape SM and Mogayzel Jr PJ. Cystic fibrosis. *Pediatr Rev.* 2014 May; 35 (5): 194-204. Accessed October 18, 2017. http://pedsinreview.aappublications.org/content/35/5/194?sso=1&sso_redirect_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token.
5. Royal HD, Brown ML, Drum DE, et al. Society of Nuclear Medicine Procedure guideline for hepatic and splenic imaging 3.0, version 3.0, approved July 20, 2003. Accessed October 17, 2017. http://snmmi.files.cms-plus.com/docs/pg_ch10_0403.pdf.

PEDAB-17: Adrenal Lesions

- Adrenal masses in infants and young children usually present as palpable abdominal masses or are detected on in utero US. In the neonates, the common masses are adrenal hemorrhage and neuroblastoma. Abdominal US is the initial imaging study of choice.
 - ◆ If an adrenal mass is detected, it can often be adequately evaluated with short interval follow-up retroperitoneal ultrasound (CPT® 76770) in 7 to 10 days.
 - If repeat ultrasound is concerning for neuroblastoma or there is high clinical concern for neuroblastoma, MRI Abdomen without and with contrast (CPT® 74183) or CT Abdomen without and with contrast (CPT® 74170) are indicated to confirm the diagnosis. MRI is preferred over CT when possible to reduce radiation exposure. If these studies, confirm neuroblastoma ¹²³I-Metaiodobenzylguanidine (MIBG) scintigraphy is indicated for staging.
 - ◆ Neuroblastoma is the most common primary adrenal tumor in pediatric patients between day 1 and 5 years of age. See **PEDONC-6: Neuroblastoma** for imaging guidelines.
- Additional adrenal imaging considerations include the following:
 - ◆ Adrenal Nuclear Imaging of the cortex and/or medulla (CPT® 78075) is indicated for the following:
 - Distinguishing adrenal adenoma from adrenal hyperplasia.
 - Evaluation of suspected pheochromocytoma or paraganglioma.
 - MIBG preferred (ONE of CPT® codes: CPT® 78800, CPT® 78801, CPT® 78802, CPT® 78803, or CPT® 78804).
 - For known pheochromocytoma or paraganglioma, see **ONC-15: Neuroendocrine Cancers and Adrenal Tumors** for imaging guidelines.
 - Evaluation of suspected neuroblastoma, ganglioneuroblastoma, or ganglioneuroma.
 - MIBG preferred (ONE of CPT® codes: CPT® 78800, CPT® 78801, CPT® 78802, CPT® 78803, or CPT® 78804), see **PEDONC-6: Neuroblastoma** for imaging guidelines.
 - History of multiple endocrine neoplasia syndromes: see **PEDONC-2.8: Multiple Endocrine Neoplasias (MEN)** for imaging guidelines.
 - History of neurofibromatosis: see **PEDONC-2.3: Neurofibromatosis 1 and 2 (NF1 and NF2)** for imaging guidelines.
 - History of von Hippel-Lindau disease: see **PEDONC-2.10: Von Hippel-Lindau Syndrome (VHL)** for imaging guidelines.

References

1. Gawande, R, Castenaeda, R and Daldrup-Link, H. Adrenal hemorrhage in pearls and pitfalls. *Pediatric imaging: variants and other difficult diagnoses*. eds. Heike E, Daldrup-Link, and Newman B. Cambridge University Press, Apr 24, 2014.
2. Moreira Jr SG. and Pow-Sang JM. Evaluation and management of adrenal masses. *Cancer Control*. 2002 Jul-Aug; 9 (4):326-334. Accessed October 17, 2017. <https://www.ncbi.nlm.nih.gov/pubmed/12228758?dopt=Abstract>.
3. Sharp SE, Gelfand MJ, Shulkin BL. Pediatrics: Diagnosis of Neuroblastoma. *Semin Nucl Med*, 2011; 41 (5): 345-353. Accessed October 17, 2017. <http://journals.sagepub.com/doi/10.1177/107327480200900407>.
4. Bombardieri E, Giammarile F, Aktolun C, et al. ¹³¹I/¹²³I-Metaiodobenzylguanidine (mIBG) scintigraphy: procedure guidelines for tumour imaging. *Eur J Nucl Med Mol Imaging*. 2010 Dec; 37 (12): 2436-2446. Accessed October 17, 2017. <https://link.springer.com/article/10.1007/s00259-010-1545-7>.
5. Chrisoulidou A, Kaltsas G, Ilias I, et al. The diagnosis and management of malignant pheochromocytoma and paraganglioma. *Endocr Relat Cancer*. 2007 Sep 1; 14: 569-585. Accessed October 17, 2017. <http://erc.endocrinology-journals.org/content/14/3/569.full.pdf+html>.
6. Ganguly A. Current concepts: primary aldosteronism. *New Eng J Med*. 1998 Dec 17; 339 (25): 1828-1834. Accessed January 15, 2018. <http://www.nejm.org/doi/full/10.1056/NEJM199812173392507>
7. Orth DN. Cushing's syndrome. *N Engl J Med*. 1995 Mar 23;332(12):791-803. Accessed October 17, 2017. <http://www.nejm.org/doi/full/10.1056/NEJM199503233321207>.
8. Siegel MJ and Chung EM. Adrenal gland, pancreas, and other retroperitoneal structures. In: *Pediatric sonography*. 5th ed. Philadelphia, Wolters Kluwer, 2018.
9. White PC. Congenital adrenal hyperplasia and related disorders. *Nelson Textbook of Pediatrics*, Chapter 576. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 2714-2723.

PEDAB-18: Hemochromatosis

PEDAB-18.1: Hereditary (Primary) Hemochromatosis	35
PEDAB-18.2: Transfusion-Associated (Secondary) Hemochromatosis	35

PEDAB-18.1: Hereditary (Primary) Hemochromatosis

- Hereditary hemochromatosis imaging indications in pediatric patients are identical to those for adult patients. See **AB-11.2: Hereditary (Primary) Hemochromatosis (HH) and Other Iron Storage Diseases** for imaging guidelines.

PEDAB-18.2: Transfusion-Associated (Secondary) Hemochromatosis

- Transfusion-associated hemochromatosis is a common complication of exposure to repeated red blood cell transfusions. This can occur in any patient with exposure to >20 transfusion episodes, but is most common among sickle cell disease, thalassemia, bone marrow failure (aplastic anemia, Fanconi anemia, etc.), oncology patients, and hematopoietic stem cell transplant patients.
- T2* MRI has been well established in the determination of organ iron burden in transfusion-associated hemochromatosis. Contrast use is not necessary for evaluation of iron burden. The following studies are indicated for evaluation of transfusion-associated hemochromatosis:
 - ◆ MRI Abdomen without contrast (CPT® 74181) for liver iron evaluation.
 - ◆ MRI Cardiac without contrast (CPT® 75557) for cardiac iron evaluation.
 - ◆ MRI Chest without contrast (CPT® 71550) can be approved as a single study to evaluate both heart and liver iron burden.
 - ◆ CPT® 74181 and CPT® 75557 can be approved alone, or together.
 - ◆ If requested, CPT® 71550 will evaluate both heart and liver and should not be approved with any other codes.
- Screening MRI is indicated every 12 months for chronically transfused patients at risk of hemochromatosis.
- Imaging is indicated every 3 months for treatment response in patients receiving active treatment (chelation and/or phlebotomy).

References

1. Buchanan GR, Yawn BP (Co-Chairs), Afeni-Annan A, et al. Evidence-Based Management of Sickle Cell Disease Expert Panel Report, 2014. *National Heart, Lung, and Blood Institute*. Accessed October 17, 2017. <https://www.nhlbi.nih.gov/health-topics/evidence-based-management-sickle-cell-disease>.
2. Chavhan GB, Babyn PS, Thomas B, et al. Principles, techniques, and applications of T2*-based MR imaging and its special applications. *RadioGraphics*. 2009 Sep; 29 (5):1433-1449. Accessed October 17, 2017. <https://www.medscape.com/medline/abstract/19755604>.
3. Children's Oncology Group. Long-term follow-up guidelines for survivors of childhood, adolescent, and young adult cancers. Version 4.0, Monrovia, CA: Accessed October 17, 2017. http://survivorshipguidelines.org/pdf/LTFUGuidelines_40.pdf.

PEDAB-19: Indeterminate Renal Lesion

- Indeterminate renal lesion imaging indications in pediatric patients are uncommon and are usually cysts or congenital anomalies.
- Pediatric-specific imaging considerations include the following:
 - ◆ Pediatric renal cysts have a lower risk of malignant progression than do renal cysts in adults.
 - ◆ For patients who have simple cysts but are symptomatic and surgical intervention is being considered, CT Abdomen with contrast (CPT® 74160) is indicated.
 - ◆ For pediatric patients with complex renal cyst identified on ultrasound, CT Abdomen without and with contrast (CPT® 74170) is indicated.
 - ◆ For patients with congenital anomalies, nuclear medicine studies with diuretic renography can be performed to determine function and cystography to determine presence of associated reflux.
 - ◆ Patients with solid renal masses should be imaged according to guidelines in section **PEDONC-7: Pediatric Renal Tumors**.

References

1. Karmazyn B, Tawadros A, Delaney, LR et al. Ultrasound classification of solitary renal cysts in children. *J Pediatr Urol*. 2015 Jun; 11 (3): 149. E1-149.e6. Accessed October 17, 2017. [http://www.jpurology.com/article/S1477-5131\(15\)00098-4/fulltext](http://www.jpurology.com/article/S1477-5131(15)00098-4/fulltext).
2. Kim CK, Biyyam DR, Becker MD, et al. ACR–SPR Practice parameter for the performance of renal scintigraphy. Revised 2017 (Resolution 29). Accessed October 16, 2017. <https://www.acr.org/~media/1169D04DFABF4C10938D2E3DFADC4477.pdf>.
3. Mandell GA, Egli DF, Gilday DL, et al. Society of Nuclear Medicine, Procedure guideline for renal cortical scintigraphy in children, Version 3.0, approved June 20, 2003. Accessed October 17, 2017. http://interactive.snm.org/docs/pg_ch32_0403.pdf.

PEDAB-20: Hydronephrosis

Hydronephrosis is a relatively common finding in pediatric patients, with the following imaging considerations:

- Patients with prenatal hydronephrosis can be evaluated with retroperitoneal ultrasound (CPT® 76770) within the first week of life, and again after 6 weeks of age.
- Patients with known uncomplicated hydronephrosis can be followed with retroperitoneal ultrasound (CPT® 76770) every 6 to 12 months.
- For patients with hydronephrosis associated with urinary tract infection or vesicoureteral reflux see **PEDAB-5: Urinary Tract Infection (UTI)** for imaging guidelines.
- Patients with ureteropelvic junction obstruction (UPJO) be evaluated with retroperitoneal ultrasound (CPT® 76770), and diuretic renography (CPT® 78707, CPT® 78708, or CPT® 78909) for preoperative planning and postoperatively at 6 to 12 months.
 - ◆ If hydronephrosis has resolved on postoperative imaging then no further routine imaging is indicated.
- Magnetic resonance urography (MRU) (CPT® 74183 and CPT® 72197) is rarely indicated, but can be approved in patients with inconclusive ultrasound and diuretic renography.
- CT Abdomen with contrast (CPT® 74160) is rarely indicated, but can be approved in patients with inconclusive ultrasound and a suspected vascular cause of UPJO.

References

1. Darge K and Siegel MJ. Kidney. In: Pediatric Sonography, 5th ed, Philadelphia, Wolters Kluwer, 2018
2. Sinha A, Bagga A, Krishna A, et al. Revised guidelines on management of antenatal hydronephrosis. *Indian J Nephrol.* 2013 Mar-Apr; 23: 83-97. Accessed October 17, 2017. <http://europepmc.org/articles/PMC3658301>.
3. VanDervoort K, Lasky S, Sethna C, et al. Hydronephrosis in infants and children: natural history and risk factors for persistence in children followed by a medical service. *Clin Med Pediatr.* 2009 Dec 16; 3: 63-70. Accessed October 17, 2017. <http://europepmc.org/articles/PMC3676294>.
4. Hsi RS, Holt SK, Gore JL, et al. National trends in followup imaging after pyeloplasty in children in the United States. *J Urol.* 2015 Sep; 194 (3): 777-782. Accessed October 17, 2017. [http://www.jurology.com/article/S0022-5347\(15\)03727-1/fulltext](http://www.jurology.com/article/S0022-5347(15)03727-1/fulltext).
5. Elder JS. Obstruction of the urinary tract. *Nelson Textbook of Pediatrics, Chapter 540.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 2567-2575.

PEDAB-21: Polycystic Kidney Disease

- An abdominal ultrasound (CPT® 76700) or a retroperitoneal ultrasound (CPT® 76770) is indicated if there is clinical concern for polycystic kidney disease, or for screening individuals who are at risk for autosomal dominant polycystic kidney disease (ADPKD).

References

1. Belibi FA and Edelstein CL. Unified ultrasonographic diagnostic criteria for polycystic kidney disease. *J Am Soc Nephrol*. 2009 Jan; 20(1):6-8. Accessed on October 17, 2017. <http://jasn.asnjournals.org/content/20/1/6.long>.
2. Porter CC and Avner ED. Autosomal Recessive polycystic kidney disease. *Nelson Textbook of Pediatrics, Chapter 521.2*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 2513-2514.
3. Porter CC and Avner ED. Autosomal dominant polycystic kidney disease. *Nelson Textbook of Pediatrics, Chapter 521.3*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, p 2515.

PEDAB-22: Blunt Abdominal Trauma

- Blunt abdominal trauma imaging indications in pediatric patients are identical to those for adult patients. See **AB-10.1: Blunt Abdominal Trauma** for imaging guidelines.

PEDAB-23: Hernias

- Hernia imaging indications in pediatric patients are identical to those for adult patients. See **AB-12: Hernias** for imaging guidelines.

PEDAB-24: Abdominal Lymphadenopathy

- Abdominal lymphadenopathy imaging indications in pediatric patients are identical to those for adult patients. See **AB-8: Abdominal Lymphadenopathy** for imaging guidelines.

PEDAB-25: Left Upper Quadrant Pain

- Left upper quadrant pain imaging indications in pediatric patients are identical to those for adult patients. See **AB-2: Abdominal Pain** for imaging guidelines.
- Nuclear medicine spleen imaging (CPT® 78185) is rarely performed, but can be approved for left upper quadrant pain when neither ultrasound nor CT is available.

References

1. Royal HD, Brown ML, Drum DE, et al. Society of Nuclear Medicine Procedure guideline for hepatic and splenic imaging 3.0, version 3.0, approved July 20, 2003. Accessed October 17, 2017. http://snmmi.files.cms-plus.com/docs/pg_ch10_0403.pdf.

PEDAB-26: Spleen

- Spleen imaging indications in pediatric patients are very similar to those for adult patients. See: **AB-34: Spleen** for imaging guidelines.
- Nuclear medicine spleen imaging (CPT® 78185) is rarely performed, but can be approved for the following indications when CT is unavailable:
 - ◆ Splenic trauma.
 - ◆ Evaluation of splenic function.
 - ◆ Suspected splenic mass, cyst, abscess, infarct, or metastasis.
 - ◆ Radiation treatment planning.
 - ◆ Asplenia.
 - ◆ Suspected functional accessory spleen:
 - Can approve CPT® 78215 or CPT® 78216 instead of CPT® 78185, if requested.
- Pediatric-specific imaging considerations include the following:
 - ◆ MRI is preferred over CT when possible to reduce radiation exposure.

References

1. Brandow AM and Camitta BM. Splenomegaly. Nelson Textbook of Pediatrics, Chapter 486. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp. 2408-2410.
2. Brandow AM and Camitta BM. Hyposplenism, splenic trauma, and splenectomy. Nelson Textbook of Pediatrics, Chapter 487. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp. 2410-2412
3. Royal HD, Brown ML, Drum DE, et al. Society of Nuclear Medicine Procedure guideline for hepatic and splenic imaging 3.0, version 3.0, approved July 20, 2003. Accessed October 17, 2017. http://snmmi.files.cms-plus.com/docs/pg_ch10_0403.pdf.

PEDAB-27: Intussusception

- Intussusception, telescoping of one bowel loop into another, is a frequent cause of abdominal pain in young children. It may be associated with bloody stool. Plain x-rays (supine and left lateral decubitus views) should be performed initially to exclude mass or bowel obstruction from other causes and to detect possible bowel perforation which may be an indication for emergent surgical intervention.
 - ◆ Ultrasound (CPT® 76700 or CPT® 76705) is indicated as an initial study if there is a strong suspicion for intussusception, but if negative, plain x-rays of the abdomen should follow.
 - ◆ In some institutions, Ultrasound guidance (CPT® 76942) may be used for reduction of colonic or ileocolic intussusception. Generally, this is an urgent or emergent procedure and may not require prior authorization. See Health Plan specific guidance for prior authorization requirements.

References

1. Kennedy M and Liacouras CA. Intussusception. *Nelson Textbook of Pediatrics, Chapter 333.3*. eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1812-1814.
2. Edwards EA, Pigg N, Courtier J, et al. Intussusception: past, present and future. *Pediatr Radiol* 2017 Aug;47(9):1101–1108. Accessed January 15, 2018. <https://link.springer.com/article/10.1007%2Fs00247-017-3878-x>.

PEDAB-28: Bowel Obstruction

- Bowel obstruction imaging indications in pediatric patients are identical to those for adult patients. See **AB-20: Bowel Obstruction and Gastroparesis** for imaging guidelines.

PEDAB-29: Left Lower Quadrant Pain

Diverticulitis is the most common cause of left lower quadrant pain in adults but is extremely rare in children.

Gastroenterologist evaluation is helpful in determining the appropriate diagnostic pathway in patients with left lower quadrant pain with or without heme-positive stools or rectal bleeding, since advanced imaging is rarely helpful in the initial evaluation of these patients.

- Pelvic ultrasound (CPT® 76856) is the initial imaging study of choice for children for detecting gynecologic abnormalities that may cause left lower quadrant pain.

References

1. Sreedharan R and Liacouras CA. Major symptoms and signs of digestive tract disorders. *Nelson Textbook of Pediatrics, Chapter 306.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1758-1767.
2. Sreedharan R and Liacouras CA. Functional abdominal pain (nonorganic chronic abdominal pain). *Nelson Textbook of Pediatrics, Chapter 342.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1884-1887.

PEDAB-30: Celiac Disease (Sprue)

- Celiac disease imaging indications in pediatric patients are identical to those for adult patients. See **AB-24: Celiac Disease (Sprue)** for imaging guidelines.

PEDAB-31: Transplant

- Liver and kidney transplant imaging indications in pediatric patients are identical to those for adult patients. See **AB-42: Transplant** for imaging guidelines.
- For post-transplant lymphoproliferative disorder in pediatric patients, see **PEDONC-5.3: Pediatric Aggressive Mature B-Cell Non-Hodgkin Lymphomas (NHL)** for imaging guidelines.

PEDAB-32: Gaucher Disease

See: [PEDPN-4: Gaucher Disease](#) for imaging guidelines.

PEDAB-33: Vomiting Infant and Hypertrophic Pyloric Stenosis

- Vomiting in infants is generally classified as either bilious (implying obstruction distal to the Sphincter of Oddi) or non-bilious.
- Bilious vomiting may be a true emergency, as some of the conditions causing this could result in compromise of blood supply to the intestines, a potentially life-threatening situation.
- Suspected malrotation is an indication for emergent imaging. If malrotation with mid-gut volvulus is suspected, acute abdominal series (CXR and abdominal views, including supine and upright or supine and left lateral decubitus views), followed by UGI series should be performed. If the abdominal X-rays suggest distal bowel obstruction, water soluble contrast enema should be considered.
- Hypertrophic Pyloric Stenosis is an idiopathic condition wherein the circular muscle controlling emptying of the stomach thickens, causing a relative obstruction of the gastric outlet. The condition can occur at any age (including occasionally in adults), but the typical child is male, aged 2 to 6 weeks. Projectile non-bilious vomiting is the most common presenting complaint, but the description of projectile vomiting is subjective. The differential diagnosis for non-bilious vomiting includes common conditions such as viral gastroenteritis and gastro-esophageal reflux.
 - ◆ Infants with projectile non-bilious vomiting should be evaluated with US abdomen, limited (CPT® 76705). If initial studies are not diagnostic, repeat studies should be performed, as frequently as daily, until the vomiting resolves or the diagnosis is made. UGI series may be useful as a confirmatory test, may be preferred if US expertise is not available for this condition, or if the clinical presentation is atypical for Hypertrophic Pyloric Stenosis. US is preferred when available, as it involves no contrast or ionizing radiation use.

References

1. Hunter AK and Liacouras CA. Hypertrophic pyloric stenosis. *Nelson Textbook of Pediatrics. Chapter 329.1.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1797-1799.
2. Hunter AK and Liacouras CA, Malrotation. *Nelson Textbook of Pediatrics. Chapter 330.3.* eds Kliegman RM, Stanton BF, St. Geme JW III, et al. 20th edition. 2016, pp 1803-1804.
3. Zhou L-Y, Li S-R, Wang W, et al. Usefulness of sonography in evaluating children suspected of malrotation: comparison with an upper gastrointestinal contrast study. *J Ultrasound Med.* 2015; 34: 1825–1832. Accessed January 15, 2018. <http://onlinelibrary.wiley.com/doi/10.7863/ultra.14.10017/pdf>.
4. Hwang JY. Emergency ultrasonography of the gastrointestinal tract of children. *Ultrasonography.* 2017 Jul; 36 (3):204–221. Accessed January 15, 2018. <https://www.e-ultrasonography.org/journal/view.php?doi=10.14366/usg.16052>.
5. Raske ME, Dempsey ME, Dillman JR, et al. Vomiting in infants up to 3 months of age. *ACR Appropriateness Criteria®.* Date of origin: 1995. Last review date: 2014. Accessed January 15, 2018. <https://acsearch.acr.org/docs/69445/Narrative/>.