NEW BREAST IMAGING GUIDELINES: MARCH 2022

MRI:

Please refer to the Genetic Mutation Chart for follow up guidelines. This is posted on the Iowa Rad physician page under breast imaging as well.

MRI Recommendations:

- Breast CA diagnosis under 50 y/o recommend annual Breast MRI after treatment
- Diagnosed after 50 y/o with dense/very dense tissue, consider yearly MRI

If cancelling an MRI guided biopsy, rad should ask another rad for 2nd opinion while patient is still on the table.

Ultrasound:

US Extremity: Let patient go, put exam on PACS list for anyone to pick up.

- Men: lump in axilla, not near breast tissue
- Women: Only if in obvious arm, far from breast tissue (less common)
    - If cannot discern between axilla and true breast tissue, talk to a rad and show where the lump is. Rad discretion at that time.

US Breast Females: Show a rad for both male and female US Breast

- If in axilla (not arm) continue with breast US.
    - *Under 30 y/o = US Breast only, show rad
    - *30+ y/o =
        - Diagnostic mammogram plus US breast, if baseline.
        - If previous mammogram, do contralateral mammo based on timing of last mammo.

US Breast Males:

- under 18 y/o = US breast only
- 18+ y/o = Bilat diagnostic mammogram and US to follow

Workflow for scheduling 2nd look US/US or MRI biopsy following screening MRI- when to schedule US biopsy vs MRI, blocking time on both modalities causes issues.

**Rad should call patient if biopsy is likely/recommended.

If question of whether lesion will be seen on US, will schedule directly with MRI biopsy.

If additional imaging recommended after high-risk screening MRI, do not hold biopsy spots same day as 2nd look US unless…

- If recent diagnosis of CA, try to get date of surgery so not delayed. If needed, hold biopsy spot.

High Risk Screening MRI additional imaging should be handled like added views following screening mammogram.

- First 2nd look US, then schedule another day for biopsy for most cases.

**MRI techs to include verbiage to patient at time of exam that tissue sampling may be necessary for certain findings not seen on mammogram/US (non-enhancing masses).

Mammography:

1st F/U lumpectomy:

- One diagnostic (uni or bilateral depending on timing) at 6–12-month post treatment with mag of scar---Recommend **return to screen** if no finding.

Going forward:

- After first diagnostic, **techs do not need to check**. If patient wants exam checked, can ask a radiologist, if not busy, or put on "Stat" list. Then watch for report and call the patient with results as a courtesy.

Note: If the current recommendation is a screening mammogram with mags, you do not need to do the mags anymore. Just do the screening images and let the patient go. If seeing the surgeon to follow, mark it Stat and put it out as review/stat. This goes to the top of the screening list to be picked up. If you get push back from surgeons that they aren't getting results in time, let me know.

**Patients going directly to surgeon after mammogram (screening/f/u breast CA beyond first diagnostic exam): Put on list as "stat" and let patient go.

- Stat mammograms should be read first by screening mammo readers. Do not need to show these if screening. (All offices)

If patient presents with diagnostic order and bilateral diffuse pain. Please try to call provider for screening order. Mendy or rads to help as needed. If get push back from provider, we will revisit this. Too many bilat diffuse diagnostics being done.

If see enlarged lymph nodes on mammogram, ask patient if she has had recent immunization, what that was and which arm. Document on history sheet. No longer asking this at front desk.