1) Recognize which imaging modality to order for the evaluation of cortical bone.

2) Recognize which nuclear medicine study to order to evaluate stress fractures.

3) Recognize which nuclear medicine study to order to evaluate osteomyelitis in children versus adults.

4) Recognize when to order a nuclear medicine bone marrow scan.

5) Recognize the imaging method of choice for radiolucent soft tissue foreign bodies.

6) Recognize the imaging method of choice for acute osteomyelitis.

7) Recognize the imaging method of choice for soft tissue tumor.

8) Recognize how to adjust exposure factors when a radiograph is over or under exposed.

9) Recognize how to adjust exposure factors when evaluating soft tissues on radiographs.

10) Recognize how to position for isolated lateral digits.

11) Recognize how to position the lateral heel for a foreign body.

12) Recognize how to position for medial column or lateral column radiographs by moving the x-ray tube or the patient.

13) Recognize how to position and adjust exposure factors for a sesamoid axial view.

14) Recognize how to position a patient for a proximal tibia and fibula.

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Following this article, an answer sheet and full set of instructions are provided (pg. 134).—Editor
tumors, coalitions, or intra-articular fractures, CT without contrast (or CT plain) is indicated. Remember that plain film radiography and CT are the same imaging modality. With CT, there is an x-ray tube in the gantry, which moves circumferentially around the patient. The results are x-ray tomograms, or x-ray “slices”. The images are evaluated in the same manner as plain film radiographs. The hospital CT machines have a thinly collimated fan x-ray beam. This results in superior contrast resolution compared to plain film radiography. With this type of scanner, the x-ray tube moves circumferentially around the patient several times in order to image a volume of tissue. There is a new weight-bearing CT scanner that is appropriate for a physician’s office. This type of scanner uses a cone-shaped x-ray beam. The advantage of this is that a volume of tissue can be imaged in one circumferential pass around the patient.

Nuclear Medicine Modalities

Nuclear medicine modalities include the 99mTc MDP single phase bone scan, the 99mTc MDP triple phase bone scan, the 111In-WBC scan, the Ceretec (99mTc HMPAO [Hexamethylpropylamine-oxime]) scan, and the 99mTc Sulfur colloid bone marrow scan. The 99mTc MDP single phase bone scan is used for any process that results in increased osteoblastic activity. Suspected stress fractures that do not appear on plain film radiographs can be imaged with the single phase bone scan. The 99mTc MDP triple phase bone scan was developed to increase the specificity of bone scanning for osteomyelitis (to distinguish osteomyelitis from cellulitis). In the first phase of a triple phase bone scan, the patient is imaged immediately post-injection.

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Radiographic (from page 128)

Because musculoskeletal infection, especially with orthopedic implants, is often low grade and chronic in nature, the $^{111}$In-WBC scan is preferred over the Ceretec scan, as it allows more time for the leukocytes to migrate to the site of infection. The Ceretec scan is recommended for osteomyelitis in children. The patients can be imaged 2 and 4 hours post-injection. The radiation dose is lower than that with the $^{111}$In-WBC scan. The $^{99m}$Tc sulfur colloid bone marrow scan is usually done to supplement a labeled white blood cell scan when looking for infection in bones and joints, especially when the patient has had recent surgery or trauma to the area in question. Impacted bone can show as increased uptake on a white blood cell labelled scan even when infection is not present. In a case such as this, the $^{99m}$Tc sulfur colloid bone marrow is done in conjunction with the Ceretec scan. If the bone marrow scan shows increased uptake as well as the white blood cell labelled scan, then infection is not present. In other words, a hot white blood cell labelled scan and a hot bone marrow scan is not infection.

Diagnostic Ultrasound

For musculoskeletal diagnostic medical ultrasound in the physician’s office, one should use a linear array transducer, 10 MHz or above. Remember, increasing the frequency of sound increases the resolution but decreases the depth. This is ideal for foot and ankle imaging since most of the anatomic structures are relatively superficial. The advantages of ultrasound over MRI when evaluating soft tissue include: the ability to do guided aspiration of cystic lesions, guided injections, and foreign body localization and removal. The images are in real time, and one can take anatomic cuts in virtually any plane. Further, one can do dynamic imaging. For example, the patient can be put through a range of motion to image a dislocated tendon, which cannot be done with MRI.

Ultrasound is a valuable imaging modality for tendon pathology. Tendons can be evaluated for shape, echogenicity, and neovascularization. Diagnostic medical ultrasound increases the success rate of nerve blocks in the lower extremity. In addition, ultrasound has emerged as the imaging method of choice for the localization of radiolucent soft tissue foreign bodies.

MRI is what to order for acute osteomyelitis, soft tissue tumors, and bone contusions. Remember, for soft tissue tumors, order MRI with contrast. The reason for this is to see if there is a vascular supply to the

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99mTc MDP single phase bone scan is preferred to evaluate for stress fractures.

obtained 5 minutes post-injection. It quantifies the relative hyperemia or ischemia of the area being imaged. The third phase is called the delayed phase. The image is obtained 3 to 4 hours post-injection. It demonstrates the regional rates of bone metabolism. Sometimes, a fourth phase is done. This image is taken 24 hours post-injection. It increases the specificity for osteomyelitis. The leukocyte tagged nuclear medicine scans (the $^{111}$In-WBC scan, the Ceretec $^{99m}$Tc HMPAO [Hexamethylpropylamine-oxime]) further increase the specificity for infection imaging. The $^{111}$In-WBC scan is recommended for osteomyelitis in adults. Patients can be scanned at 3 and 24 hours post-injection.

Figure 6: Positioning for an isolated lateral digit using a folded piece of silk tape (top), and the resultant radiograph (bottom). Since a lower kVp was used for the single digit, the area of the metatarsals is underexposed. This is acceptable if we are only interested in the digit.
tumor. Although MRI is the imaging method of choice for acute osteomyelitis, chronic osteomyelitis and an active Charcot joint should be imaged with a white blood cell labelled scan.

Radiography, by definition, is using the x-ray beam, and its ability or inability to penetrate different types of tissues to produce an image to aid in the diagnosis and treatment of injury or disease. Radiopaque structures appear white, radiolucent structures appear black, and other structures appear as different shades of gray. When film is exposed, it turns black. An overexposed image will appear too black, and an underexposed will appear too white. Recall that the primary exposure factors are the milliamperes (or the mA), the kilovolt peak (or the kVp) and the time in seconds, (or s). The exposure factors can be manipulated to influence the quantity and the quality of the radiation coming out of the x-ray tube (Figure 1).

**If a radiograph is too black, the radiograph is overexposed, and the exposure factors need to be decreased.**

The Quantity of Radiation

Electrons are formed on the cathode side of the x-ray tube when one presses the exposure button. The mA controls the amount of current going to the filament on the cathode side of the tube. The higher the current, the more electrons will be produced. The electrons will travel across the x-ray tube and bombard the anode target. The collision of the electrons with the anode target produces x-radiation. Therefore, the more electrons, the more radiation. A lower mA will produce fewer electrons, and therefore, less radiation. The mA controls the quantity of radiation coming out of the x-ray tube. The time (s), on the other hand, also controls the quantity of radiation coming out of the x-ray tube, but in a different way. The timer on the control panel controls the amount of time the current is applied to the filament on the cathode side of the tube. The longer the time the current is applied to the filament, the more electrons will be produced. Again, more electrons produced means more electrons will hit the anode target. More...
diograph with software if it is overexposed or underexposed. However, this is only possible in a narrow range. If a radiograph is too overexposed, imaging software will not compensate for this (Figure 3). Similarly, if a radiograph is too underexposed, imaging software will not compensate for this either (Figure 4).

When needing to evaluate soft tissues on radiographs, one should use a low kVp, similar to that of mammography. This may be necessary for foreign body localization, or for evaluating gas in the tissues. When evaluating the digits for foreign bodies, an isolated lateral radiograph is useful. This positioning technique will free the digit from superimposition of the other digits. Since we are only interested in a single digit, the kVp can
to be decreased, whether it is the mA, time, or kVp. One way to adjust exposure factors to compensate for an overexposed or underexposed radiograph is to adjust the kVp by 4. For example, 58 kVp was used for the radiograph for the midfoot in Figure 1. The digits, however, are overexposed. When decreasing the kVp to 54, the digits can now be seen (Figure 1). If one desires an even lighter radiograph to evaluate soft tissue, the kVp can be decreased by 4 more, bringing it to 50 kVp (Figure 2). With the advent of digital imaging, there is an ability to manipulate a ra-

**Radiographic** (from page 130)
electrons hitting the anode means more radiation will be produced. Therefore, the mA and the time control the amount, or quantity, of radiation coming out of the x-ray tube.

**Quality of the X-ray Beam**

There is a difference in potential between the negative cathode and positive anode. Raising the kilovolt peak, or kVp, will increase the difference in potential across the x-ray tube. In other words, raising the kVp will increase the negativity of the cathode and the negativity of the anode. This will cause the electrons to hit the anode with a much greater force. The result will be an x-ray beam with a greater penetrating power. Turning the kVp down will have the opposite effect: an x-ray beam will be produced that has a lower penetrating power. A low kVp technique is better for evaluating soft tissue. This is why a very low kVp is required for mammography.

**Adjusting the Exposure Factors**

If one wants the image to appear darker, the exposure factors need to be increased, whether it is the mA, the time, or the kVp. If one wants the image to appear lighter, the exposure factors would need

**Figure 9c:** Positioning for a medial column radiograph, angling the patient’s foot.

**Figure 9d:** Positioning for a medial column radiograph, angling the x-ray tube.

**Figure 10a:** A close-up of the shadow and the radiograph, medial side down, similarly showing the lateral column.

**Figure 10b:** Positioning for a lateral column radiograph, angling the patient’s foot.

**Figure 10c:** Positioning for a lateral column radiograph, angling the x-ray tube.

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be lowered by 4 from what is used for a complete foot radiograph (Figure 6). In addition, one should always use the smallest exposure field possible to reduce patient exposure. For radiographs of the heel when looking for a soft tissue foreign body, the patient does not need to be weight-bearing. Therefore, the heel can be elevated (e.g., with cast padding), so that the soft tissue is not obscured (Figure 6). One should remember that diagnostic medical ultrasound has emerged as the imaging method of choice for radiolucent soft tissue foreign bodies.

Kager’s Triangle
Kager’s triangle and Kager’s fat pad can be used to evaluate pathology of the posterior ankle, such as edema, infection, hemorrhage, inflammation, neoplasm, tendonitis, and Achilles tendon rupture. However, if the kVp is too high, Kager’s triangle won’t be visible (Figure 8a). Even if computer software is used to make the image lighter, Kager’s triangle can’t be identified because the image is still overexposed (Figure 8b). If the kVp is low enough, the structures delineating Kager’s triangle can be identified (Figure 8c).

There is some confusion over the terminology concerning medial oblique radiographs and lateral oblique radiographs. With oblique radiographs, one should remember that the images are basically shadows, and they behave like shadows. When taking an oblique radiograph with the lateral side of the foot down closest to the cassette, one can see the medial column with little superimposition (Figure 9a). A shadow of a skeleton model with the lateral side down, and the actual radiograph of the foot with the lateral side down, are similar images (Figure 9b).

There are two different maneuvers that can produce the medial column radiograph. One can have the patient angle the foot (Figure 9c), or one can angle the x-ray tube (Figure 9d). When taking an oblique radiograph with the medial side of the foot down closest to the cassette, one can see the lateral column with little superimposition (Figure 9a). A shadow of a skeleton model with the lateral side down, and the actual radiograph of the foot with the lateral side down, are similar images (Figure 9b).

Diagnostic ultrasound modality has emerged as the imaging method of choice for radiolucent soft tissue foreign bodies.
Radiographic (from page 132)

and the actual radiograph of the foot are similar images (Figure 10a). There are two different maneuvers that can produce the lateral column radiograph. One can have the patient angle the foot (Figure 10b), or one can angle the x-ray tube (Figure 10c).

When performing the sesamoid axial, one can use the same exposure factors as used for the calcaneal axial, with the kVp increased by 4 (Figure 11).

When there is a need to take radiographs of the proximal tibia and fibula, one can do this by having the patient hold the cassette. For the AP proximal tibia and fibula, one should shield the patient first, before positioning. Then, have the patient hold the cassette behind the knee (Figure 12a). For the lateral radiograph of the proximal tibia and fibula, have the patient hold the cassette between the legs (Figure 12b). One can use the same exposure factors used for the ankle, with the kVp increased by 4. PM

References


CME EXAMINATION

SEE ANSWER SHEET ON PAGE 135.

1) What is the imaging method of choice to evaluate cortical bone pathology after plain film radiography?
   A) MRI
   B) Diagnostic ultrasound
   C) Nuclear medicine
   D) CT

2) What imaging modality should be ordered to evaluate intra-articular calcaneal fractures?
   A) MRI plain
   B) MRI with contrast
   C) CT plain
   D) CT with contrast

3) Which nuclear medicine study is preferred to evaluate stress fractures?
   A) 99mTc MDP single phase bone scan
   B) 99mTc MDP triple phase bone scan
   C) 111In-WBC scan.
   D) 99mTc Sulfur colloid bone marrow scan

4) Which nuclear medicine study is preferred to evaluate osteomyelitis in children?
   A) Ceretec (99mTc HMPAO [Hexamethylpropylamine-oxime]) scan
   B) 99mTc MDP single phase bone scan
   C) 99mTc MDP triple phase bone scan
   D) 111In-WBC scan

5) Which nuclear medicine study is preferred to differentiate between osteomyelitis and bone impaction?
   A) 99mTc MDP single phase bone scan
   B) 99mTc MDP triple phase bone scan
   C) Ceretec (99mTc HMPAO [Hexamethylpropylamine-oxime]) scan
   D) 99mTc Sulfur colloid bone marrow scan in conjunction with a 111In-WBC scan

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6) Which imaging modality is the gold standard for evaluating acute osteomyelitis?
   A) CT
   B) Nuclear medicine
   C) Diagnostic ultrasound
   D) MRI

7) Which imaging modality should be ordered to evaluate a soft tissue tumor?
   A) CT plain
   B) CT with contrast
   C) MRI
   D) MRI with contrast

8) Which imaging modality has emerged as the imaging method of choice for radiolucent soft tissue foreign bodies?
   A) CT
   B) MRI
   C) Diagnostic ultrasound
   D) Plain film radiography

9) If a radiograph is too black, how do the exposure factors need to be adjusted?
   A) The radiograph is overexposed, and the exposure factors need to be decreased.
   B) The radiograph is overexposed, and the exposure factors need to be increased.
   C) The radiograph is underexposed, and the exposure factors need to be decreased.
   D) The radiograph is underexposed, and the exposure factors need to be increased.

10) If 10mA .1s and 70kVp is used for a radiograph, and one wanted to see more soft tissue, how do the exposure factors need to be adjusted?
    A) Double the mA
    B) Double the time
    C) Increase kVp
    D) Decrease the kVp

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Over, please
EXAM #9/17
Radiographic Fundamentals Review
(Armstrong)

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