

# Procedure Guideline for Gastrointestinal Bleeding and Meckel's Diverticulum Scintigraphy

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## PART I: PURPOSE

The purpose of this guideline is to assist nuclear medicine practitioners in recommending, performing, interpreting and reporting the results of gastrointestinal (GI) bleeding and Meckel's diverticulum scintigraphy.

## PART II: BACKGROUND INFORMATION AND DEFINITIONS

GI bleeding scintigraphy is performed in patients suspected of having active gastrointestinal bleeding using  $^{99m}\text{Tc}$ -labeled red blood cells (RBCs). Sites of active bleeding are identified by the accumulation and movement of labeled RBCs within the bowel lumen. Because activity within the lumen of the bowel can move antegrade and retrograde, frequent images (1 image every 10–60 s) will increase the accuracy of localizing the bleeding site.  $^{99m}\text{Tc}$ -sulfur colloid (SC) is rarely used today because of the short residence time within the blood.  $^{99m}\text{Tc}$ -SC is cleared from the blood by the reticuloendothelial system with a half-time as short as 2–3 min, whereas radiolabeled RBCs last for hours.

GI bleeding is either upper, originating above the ligament of Treitz, or lower, distal to the ligament of Treitz. Frequent causes of upper GI bleeding include esophageal varices, gastric and duodenal ulcers, gastritis, esophagitis, Mallory-Weiss tear or neoplasm. Causes of lower GI hemorrhage include angiodysplasia, diverticula, neoplasms and

inflammation, and, in children, Meckel's diverticulum. Endoscopy and angiography provide accurate localization of bleeding sites and potentially therapeutic control. Scintigraphy with labeled RBCs is complementary to endoscopy and angiography because it permits continuous monitoring over hours. This is a major advantage over intermittent sampling, because most GI bleeds are intermittent and therefore frequently missed.

The clinical findings for active GI hemorrhage are often unreliable and misleading. There is frequently a marked temporal lag between the onset of bleeding and the clinical findings. Although it may be clinically apparent that the patient has bled from the presence of melena or hematochezia, the blood may pool in the colon for hours before being evacuated. A drop in the hematocrit and elevated serum blood urea nitrogen also lack the temporal resolution needed to indicate active bleeding. Orthostatic hypotension and tachycardia occur more acutely but are insensitive and nonspecific.

In cases in which there is only occult bleeding detected by guaiac-positive stools, GI bleeding scintigraphy is unlikely to be useful. GI bleeding scintigraphy can detect bleeding rates as low as 0.1–0.35 mL/min. The guaiac test detects bleeds at rates well below the level necessary to be seen on GI bleeding scintigraphy.

A Meckel's diverticulum is a vestigial remnant of the omphalomesenteric duct located on the ileum about 50–80 cm from the ileocecal valve. About half of Meckel's diverticuli have gastric mucosa. Bleeding may result from ileal mucosal ulceration from acid secretion.  $^{99m}\text{Tc}$ -pertechnetate avidly accumulates in gastric mucosa and is the study of choice for identifying ectopic gastric mucosa in a Meckel's diverticulum.

## PART III: COMMON INDICATIONS

### Gastrointestinal Bleeding Scintigraphy

The goals of GI bleeding scintigraphy are to locate the bleeding site and to determine which patients require

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aggressive treatment versus those who can be treated medically. It is usually in those patients that require urgent care that the bleeding site is identified. If bleeding is detected, the site is usually localized well enough to direct the next diagnostic test (e.g., endoscopy or arteriography). In some patients, the bleeding site is identified with sufficient confidence for specific surgical intervention (e.g., right hemicolectomy in the case of a bleeding site in the ascending colon). GI scintigraphy should be done as soon as possible after the patient presents for medical care, because active bleeding is more likely at early times and is needed for correct localization.

### Meckel's Diverticulum Scintigraphy

The indication for a Meckel's scintiscan is to localize ectopic gastric mucosa in a Meckel's diverticulum as the source of unexplained GI bleeding. Bleeding Meckel's diverticula usually occur in young children. The Meckel's scintiscan should be used when the patient is not actively bleeding. Even in young children, active bleeding is best studied by radiolabeled RBC scintigraphy.

## PART IV: PROCEDURE

### Gastrointestinal Bleeding Scintigraphy

#### A. Patient Preparation

See Precautions (IV.C.) below

#### B. Information Pertinent to Performing the Procedure

1. History of past bleeding episodes
  - a. Number of transfusions in the past
  - b. Results of prior studies to localize the bleeding site
  - c. Prior therapeutic interventions
  - d. History of factors that affect RBC radiolabeling efficiency (e.g., thalassemia, chemotherapy)
2. Current blood pressure and pulse
3. Clinical signs of active bleeding
  - a. Presence of orthostatic hypotension
  - b. Change in resting pulse rate from supine to erect position
  - c. Frequency and volume of bleeding
  - d. Current hemoglobin and hematocrit
  - e. Recent hemoglobins and hematocrits
  - f. Number of recent transfusions
4. Suspected location of bleeding
  - a. Results of nasogastric aspirate or upper GI endoscopy
  - b. Results of sigmoidoscopy or colonoscopy

#### C. Precautions

1. Patients suspected of acute GI bleeding should have their blood pressure and pulse measured upon their arrival in the nuclear medicine department to confirm that they are not hypotensive. The vital signs should be monitored periodically while the patient is being imaged. The patient should have a large-bore intravenous catheter in place so that hypotension can be rapidly treated with replacement fluids or blood.

**TABLE 1**  
Radiation Dosimetry in Adults

Radiopharmaceutical	Administered activity MBq (mCi)	Organ receiving largest radiation dose* mGy (rad)	Effective dose* mSv (rem)
<sup>99m</sup> Tc-labeled red blood cells	750–1100 iv (20–30)	heart 0.023 (0.085)	0.0085 (0.031)

\*Per MBq (mCi).

iv = intravenously.

Data from reference 11, page 210.

2. The removal of blood for radiolabeling and reinjection poses the risk of misadministration to the wrong patient. The handling and administration of blood products must be subject to special safeguards and procedures, the goals of which are to eliminate any possibility of administration to the wrong patient or contamination of workers. See "Special Considerations for Labeled Blood Products" in the *Society of Nuclear Medicine Procedure Guideline for Use of Radiopharmaceuticals*.

#### D. Radiopharmaceuticals

The in vitro method for labeling RBCs is preferred because of its higher labeling efficiency. The in vivo/in vitro method can be used. The in vivo method is not recommended. See the *Society of Nuclear Medicine Procedure Guideline for Use of Radiopharmaceuticals*. (See Tables 1 and 2).

#### E. Image Acquisition

Continuous acquisition of images at a frame rate of one image every 10–60 s is important to accurately localize the bleeding site.

##### 1. Equipment

Camera: large field of view.

Collimator: a low-energy, all-purpose, parallel-hole collimator is preferred. When the study must be

**TABLE 2**  
Radiation Dosimetry in Children (5-y-old)

Radiopharmaceutical	Administered activity MBq (mCi)	Organ receiving largest radiation dose* mGy (rad)	Effective dose* mSv (rem)
<sup>99m</sup> Tc-labeled red blood cells	10–15 iv (0.3–0.4)	heart 0.062 (0.023)	0.0025 (0.093)

\*Per MBq (mCi).

iv = intravenously.

Data from reference 11, page 210.

performed at the bedside, a diverging collimator is useful to see the maximum abdominal area.

Photopeak: typically 20% window at 140 keV.

Computer: 128 × 128 matrix, single- or two-byte mode. (One byte has been called byte-mode and two-bytes, word-mode.)

2. Patient position: supine
3. Imaging field: abdomen and pelvis
4. Acquisition Protocol
  - a. Abdominal flow study

Anterior abdominal flow images (1–5 s/frame × 1 min) are recommended.
  - b. Dynamic abdominal imaging
    - i. Dynamic anterior abdominal images are acquired at a frame rate of 10–60 s/frame over a 60- to 90-min period. Acquiring these images in multiple sets of 10–15 min each may facilitate review of these images by the physician as the images are being acquired.
    - ii. If computer acquisition is not possible:

Sequential static images 1 million counts per image at least every 5 min for 60–90 min. Localization might be aided by obtaining images at a shorter interval, every 2–3 min.
  - c. Delayed imaging

For <sup>99m</sup>Tc-RBCs, if no bleeding site is identified on the initial 60–90 min dynamic images, delayed images may be acquired. These images are optional. Typically delayed images are done from 2 to 6 h and/or at 18–24 h after the injection of the radiopharmaceutical. Delayed images are useful in showing subsequent bleeding and categorizing the severity but may result in incorrect localization when identifying a bleeding site. Initiating a new dynamic study may give useful localizing information if the patient is actively bleeding at the time of imaging. This may be done while initiating a new study by radiolabeling a new RBC kit.
  - d. Additional views: Because of overlying bladder activity, activity in the rectum can be difficult to appreciate. Lateral views may be needed to see rectal bleeding. Anterior oblique and posterior views are frequently helpful in deciding if activity is located anteriorly versus posteriorly.
  - e. Region of interest counts over extravasated blood in the bowel may be used to estimate blood loss when normalized to counts obtained from a blood sample drawn simultaneously from the patient and corrected for attenuation. The precision and accuracy of such estimates should be determined by each institution making such estimates.
  - f. In cases in which extravasated blood is seen but

does not move sufficiently to determine the location or where the movement is unusual, the following may be useful: review of prior barium studies; oral <sup>99m</sup>Tc-SC to outline the upper GI and small bowel anatomy; or <sup>99m</sup>Tc-SC enema to outline the colon.

#### F. Interventions

Pharmacologic (pharmacologic intervention is controversial and is not widely used).

Glucagon has been suggested as an adjunct to GI bleeding studies. Glucagon decreases intestinal peristalsis and increases vasodilatation. Glucagon is not widely used.

Heparin also has been suggested as an adjunct to GI bleeding studies in selected patients with recurrent significant bleeding from a site that has not been localized using standard diagnostic tests. Standard procedure is to administer 6000 U heparin intravenously as a loading dose, followed by 1000 U heparin intravenously per hour. The patient's baseline coagulation status should be evaluated before giving heparin. Heparin provocation is not widely used. Surgical coverage should be immediately available as a precautionary measure. Close monitoring of the patient is necessary and protamine sulfate should be immediately available to reverse the effects of heparin.

#### G. Processing

Other than optional subtraction/contrast enhancement or blood loss estimation, there is no routine processing. If the software is available, motion correction may be used to minimize the effects of patient movement.

##### Subtraction Cine

The first frame or normalized summed set of data can be subtracted from the latter images to improve contrast. When using this technique, the patient must remain still during the examination or have appropriate motion-correction software.

#### H. Interpretation Criteria

Accurate interpretation of GI bleeding scintigraphy requires knowledge of the normal and abnormal variations in the abdominal vascular space.

Labeled RBCs rapidly reach equilibrium within the vascular space of the liver, spleen and great vessels. It is normal for some radioactivity to be excreted in the urine, and the urinary tract can be seen even when in vitro labeling is used.

Extravasated radiolabeled RBCs within the bowel lumen are identified as an area of activity that increases in intensity with time, and/or as a focus of activity that moves in a pattern corresponding to the lumen of the large or small bowel. Small bowel bleeding usually can be distinguished from large bowel bleeding by its rapid serpiginous movement.

GI bleeding scintigraphy may be used to estimate the severity of the bleeding. Factors associated with a

low bleeding rate are visualization of blood after 1 h and activity less intense than the liver. Higher bleeding rates are associated with early appearance of blood in the bowel and intense activity equal to or greater than the liver.

#### I. Reporting

Aside from patient demographics, the report should include the following information:

1. Indication for the study
2. Procedure
  - a. Radiopharmaceutical
    - i. Dose
    - ii. Radiolabeling method for RBCs (e.g., in vivo)
    - iii. Method of administration (intravenous)
  - b. Acquisition
    - i. Duration of acquisition (e.g., 1 h)
    - ii. Frame rate (e.g., 10 s/frame)
    - iii. Projections acquired (e.g., anterior, lateral)
  - c. Display (e.g., static versus cine)
  - d. Findings
    - i. Onset
    - ii. Location
    - iii. Characteristics
      - (a) Size and shape (e.g., focal, diffuse)
      - (b) Pattern of movement (e.g., moves versus stationary, serpentine small bowel pattern versus colonic, antegrade or retrograde)
      - (c) Severity (e.g., waxing or waning intensity, qualitative intensity compared with the liver, qualitative volume: large or small)
  - e. Study limitations, confounding factors
  - f. Interpretation (e.g., positive, negative, indeterminate) and location of bleeding site

#### J. Quality Control

Quality control for the gamma camera, computer system and image display are as described by the *Society of Nuclear Medicine Procedure Guideline for General Imaging*.

#### K. Sources of Error

1. Delay in implementing the procedure because bleeding may have stopped.
2. Failure to use a computer to display dynamic images as a movie. Subtle areas of bleeding may go undetected or the location of the bleeding may be inaccurately identified if images are not reviewed as a movie. Use of windowing levels and different color schemes on a computer display also facilitates the detection of subtle abnormalities.
3. It is important to continue to acquire images after abnormal activity is detected. Accurate localization of the bleeding site depends on identifying the focus of initial blood collection and on the movement of the blood away from the bleeding focus.

4. The entire abdomen must be examined before concluding that no bleeding was detected. A lateral, posterior and/or sub-pubic view is best to help in identifying activity in the rectum that would otherwise not be detected because of overlying bladder activity or soft-tissue attenuation.

5. Inexperienced readers may mistake mesenteric varices or penile blood pool for areas of bleeding. A full urinary bladder may obscure sigmoid or rectal bleeding. Radioactive urine in the renal pelvis of a transplanted kidney, in either the right or left lower quadrant of the abdomen, may look like colonic activity.

6. Gastric mucosal and renal activity is seen when free  $^{99m}\text{Tc}$ -pertechnetate is present. This potential source of error can be avoided by using an in vitro RBC labeling method and performing quality control for free pertechnetate, and by recognizing that intraluminal blood moves in a distinct pattern. Images of the thyroid and salivary glands can confirm the presence of free  $^{99m}\text{Tc}$ -pertechnetate as a source of artifact.

### Meckel's Diverticulum Scintigraphy

#### A. Patient Preparation

Pretreatment with pentagastrin, histamine  $\text{H}_2$  blockers or glucagon is reported to enhance the sensitivity of the Meckel's scan. Pentagastrin is a potent stimulator of gastric secretions and increases gastric mucosa uptake of pertechnetate. It also stimulates secretion of pertechnetate and GI motility, potentially reducing ectopic site activity. Pentagastrin is administered subcutaneously, 6  $\mu\text{g}/\text{kg}$  15–20 min before injecting  $^{99m}\text{Tc}$ -pertechnetate. Histamine  $\text{H}_2$  blockers (cimetidine, ranitidine) block secretion from the cells and increase gastric mucosa uptake. Oral cimetidine should be administered, 300 mg four times a day  $\times$  2 d in adults, 20 mg/kg/d  $\times$  2 d in children, or 10–20 mg/kg/d in neonates before starting. Intravenous cimetidine should be administered at a rate of 300 mg in 100 mL D5W over 20 min with imaging starting 1 h later. Ranitidine may be substituted for cimetidine. Ranitidine dosage is 1 mg/kg intravenously for infants, children and adults, up to a maximum of 50 mg, infused over 20 min and imaging starting 1 h later, or 2 mg/kg/dose orally for children and 150 mg/dose for adults. Glucagon relaxes the smooth muscles of the GI tract, decreasing peristalsis. The dose for glucagon is 50  $\mu\text{g}/\text{kg}$  intravenously 10 min after  $^{99m}\text{Tc}$ -pertechnetate injection.

It is not recommended that an  $\text{H}_2$  blocker and pentagastrin be combined, because  $\text{H}_2$  blockers antagonize pentagastrin.

Pharmacologic pretreatment is not considered necessary for obtaining a high-quality Meckel's scan.

Determine whether the patient has had recent in vivo RBC labeling in which all circulating RBCs were

**TABLE 3**  
Radiation Dosimetry in Adults

Radiopharmaceutical	Administered activity MBq (mCi)	Organ receiving largest radiation dose* mGy (rad)	Effective dose* mSv (rem)
<sup>99m</sup> Tc-pertechnetate	300–450 iv (8–12)	Upper large intestine 0.062 (0.23)	0.013 (0.048)

\*Per MBq (mCi).  
iv = intravenously.  
Data from reference 11, page 199, no blocking agent.

treated with stannous ion by intravenous administration of a “cold” pyrophosphate kit. If so, the Meckel’s scan may be compromised, because intravenous <sup>99m</sup>Tc-pertechnetate will label RBCs rather than concentrate in ectopic gastric mucosa. This may occur for days after the administration of stannous pyrophosphate. This is not a problem with in vitro labeling.

Patients may also be placed in a left lateral decubitus position to decrease small bowel activity arising from the stomach. Nasogastric tube suction has also been used for this purpose.

**B. Information Pertinent to Performing the Procedure**

1. History of past bleeding episodes
2. Results of prior studies to localize the bleeding site
3. Has in vivo RBC labeling been done?
4. Clinical signs of active bleeding

**C. Precautions**

None

**D. Radiopharmaceuticals (See Tables 3 and 4)**

**E. Image Acquisition**

**1. Equipment**

Camera: large field of view.

Collimator: a low-energy, all-purpose, parallel-hole collimator is preferred.

**TABLE 4**  
Radiation Dosimetry in Children (5-y-old)

Radiopharmaceutical	Administered activity MBq (mCi)	Organ receiving largest radiation dose* mGy (rad)	Effective dose* mSv (rem)
<sup>99m</sup> Tc-pertechnetate	4.0–6.0 iv (0.11–0.16)	Upper large intestine 0.21 (0.78)	0.040 (0.15)

\*Per MBq (mCi).  
iv = intravenously.  
Data from reference 11, page 199, no blocking agent.

Photopeak: typically 20% window at 140 keV.

Computer: 128 × 128 matrix, single- or two-byte mode.

2. Patient position: supine (optional: left lateral decubitus)

3. Imaging field: abdomen and pelvis

4. Acquisition protocol

a. Optional acquisition of anterior abdominal flow images (1–5 s/frame × 1 min).

b. Anterior abdominal images at a frame rate of one image every 30–60 s for at least 30 min (some favor 60 min).

c. Additional static images, anterior oblique projections, lateral and posterior projection views are recommended at the end of the dynamic acquisition. Stopping the dynamic acquisition to obtain these images when abnormal activity is first seen can be helpful to distinguish activity in a Meckel’s diverticulum from activity in the kidney, ureter or bladder. Postvoid images can also be helpful to detect activity in a Meckel’s diverticulum observed by the urinary bladder.

**F. Interventions**

See IV.A. above.

A urinary catheter to drain the bladder of activity can be helpful if the Meckel’s diverticulum is adjacent to the bladder.

Alternatively, decubitus or upright views can sometimes cause the Meckel’s diverticulum to shift away from the bladder.

**G. Processing**

None

**H. Interpretation Criteria**

Activity in the ectopic gastric mucosa should appear at the same time as activity in the normal gastric mucosa. A Meckel’s diverticulum may appear anywhere within the abdomen, although it is typically seen in the right lower quadrant. The activity that is most often mistaken for a Meckel’s diverticulum is activity in the kidneys, ureter or bladder. Activity in the urinary tract usually first appears after activity is seen in the normal gastric mucosa. Small Meckel’s diverticulum may seem to appear at a later time than the stomach.

Pertechnetate that is secreted by the gastric mucosa will gradually accumulate in the small bowel. This activity can be distinguished from a Meckel’s diverticulum by its delayed appearance and by its appearance as an area of mildly, ill-defined increased activity.

Viewing the dynamic image as a cine on a computer monitor that permits adjustment of image contrast is helpful.

**I. Reporting**

Aside from patient demographics, the report should include the following information:

1. Indication for the study

2. Procedure
  - a. Radiopharmaceutical
    - i. Dose
    - ii. Method of administration (intravenous)
  - b. Acquisition
    - i. Duration of acquisition (e.g., 1 h)
    - ii. Frame rate (e.g., 60 s/frame)
    - iii. Projections acquired (e.g., anterior, lateral)
  - c. Display (e.g., static versus cine)
  - d. Findings
    - i. Onset (e.g., early versus late, correspondence with gastric activity)
    - ii. Location
    - iii. Characteristics
      - (a) Size and shape (e.g., focal, diffuse)
      - (b) Movement (if any)
  - e. Study limitations, confounding factors
  - f. Interpretation (e.g., positive, negative, indeterminate)
- J. Quality Control
 

Quality controls for the gamma camera, computer system and image display are as enumerated by the *Society of Nuclear Medicine Procedure Guideline for General Imaging*.
- K. Sources of Error
  1. Procedures that may cause interference
    - a. False-negative result: barium enema, upper GI examination, perchlorate, recent in vivo RBC labeling
    - b. False-positive result: laxatives or endoscopy causing bowel irritation
  2. Anatomic causes of error
    - a. False-negative result: small amount of gastric mucosa in the Meckel's diverticulum, ischemia or necrosis or obscured by urinary tract activity (e.g., bladder)
    - b. False-positive result: urinary tract activity, lesions with increased blood pool, ulceration, inflammation, irritation, tumor or intussusception.

## PART V: DISCLAIMER

The Society of Nuclear Medicine has developed guidelines to promote the cost-effective use of high-quality nuclear medicine procedures. These generic recommendations cannot be applied to all patients in all practice settings. The guidelines should not be deemed inclusive of all proper procedures or exclusive of other procedures reasonably directed to obtaining the same results. The spectrum of patients seen in a specialized practice setting may be quite different than the spectrum of patients seen in a more general practice setting. The appropriateness of a procedure will depend in part on the prevalence of disease in the patient population. In addition, the resources available to care for patients may vary greatly from one medical facility to

another. For these reasons, guidelines cannot be rigidly applied.

Advances in medicine occur at a rapid rate. The date of a guideline should always be considered in determining its current applicability.

## PART VI: ISSUES REQUIRING FURTHER CLARIFICATION

### Gastrointestinal Bleeding Scintigraphy

- A. How to optimize the sequencing of examinations including angiography, endoscopy and scintigraphy
- B. How best to select patients who will benefit from this study
- C. Role of pharmacologic interventions

### Meckel's Diverticulum Scintigraphy

Role of pharmacologic interventions

## PART VII: CONCISE BIBLIOGRAPHY

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#### PART VIII: LAST HOUSE OF DELEGATES APPROVAL DATE

February 7, 1999

#### PART IX: NEXT ANTICIPATED APPROVAL DATE

2001