**Appropriate Use Criteria for Gastrointestinal Transit Scintigraphy**

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**EXECUTIVE SUMMARY**

The appropriate use of scintigraphy for studying gastrointestinal (GI) motility requires not only an understanding of the normal physiology and pathophysiology of the various disorders that can affect the GI tract but also an understanding of the numerous methods and associated technical details of the current clinically available modalities for studying GI motility. Developing recommendations on the appropriate use of GI transit scintigraphy requires input from experts in the fields of nuclear medicine, radiology and gastroenterology. This document has been prepared therefore with input from representatives with this expertise from various professional societies (Appendix A). These experts reviewed the current literature with the methodology described below and established appropriateness ratings for a wide range of clinical scenarios experienced by patients who have symptoms associated with suspected abnormal GI function. The appropriate use criteria(AUC) delineated in this report is intended to assist referring medical practitioners in the diagnosis and management of patients with symptoms thought to arise from altered GI motility including the esophagus, stomach, small bowel and colon.

**INTRODUCTION**

Direct measurement of GI motility is classically performed by a gastroenterologist by placing a tube or catheter-based probe within the GI tract to directly measure pressure changes within a lumen, electrical signals, or pH. Recently, less invasive wireless motility capsules have been introduced (x). The advantages of scintigraphy for studying GI motility have remained the same since the first application of a radiolabeled meal to measure gastric emptying. Scintigraphy is noninvasive, does not disturb normal physiology and can provide accurate quantification of the bulk transit of an orally administered radiolabeled solid or liquid meal. Compared to radiographic methods, scintigraphy involves low radiation exposure to the patient, is quantifiable and uses commonly ingested foods rather than barium or nonphysiologic radiopaque markers.

Gastroenterologists and primary care physicians are often faced with a wide range of symptoms in a patient including: early satiety, pain, nausea, vomiting, bloating, diarrhea, constipation or difficulty with passing a bowel movement. Patient GI symptoms often overlap and may or may not be associated with meal ingestion. It is difficult to assess whether patient’s symptoms are due to an underlying structural pathology or are functional. The authors of this AUC document recognize that management of these patients is complex and the decision to perform any diagnostic study must take into consideration the entire patient presentation. The recommendations in this AUC document do not preclude the use of other testing. Referring health care providers should always consider the patient history, physical findings, and results of previously acquired tests before utilizing GI scintigraphy studies. This AUC document is presented to assist health care practitioners in the appropriate use of GI scintigraphy in evaluating patients with GI tract symptoms. It is not intended to replace good clinical judgment.

As scintigraphy does not provide detailed anatomic images of the GI tract it is particularly important to make sure an anatomic cause for the patient’s symptoms has been excluded before assuming the patient has a nonstructural, primary motility disorder. This is typically performed using radiographic imaging or endoscopic methods.

After reviewing the literature on GI transit scintigraphy, it is apparent that while some studies such as gastric emptying and esophageal transit have been available for over 50 years, the use of scintigraphy to image and quantify GI motility continues to undergo modernization and advancement. Methods such as esophageal transit scintigraphy while established many years ago have become replaced in many centers by more advanced manometric techniques but remain in limited use in select institutions where there is clinical expertise often not available in other institutions. Gastric emptying studies continue to evolve with advances that permit simultaneous measurement of other indices of gastric motility such as accommodation and antral contractions(x). Because of such advancements, this AUC report may need updates as newer and more specialized techniques are developed.

As with many imaging studies there have been few multicenter studies looking at clinical outcomes. Our appropriateness ratings are influenced by the clinical experience of the expert panel which included both imaging specialist and gastroenterologist who perform and order and use these studies in the diagnosis and management of patients with a wide range of GI symptoms.

It should be emphasized that these AUC recommendations are intended to apply primarily to adults. Since no well-defined radiolabeled meal normal values have been established in children (due to concerns of radiation exposure to children involved in research) and established GI transit protocols require development of normal values, this committee felt there was insufficient pooled data on normal values in children in the literature to confirm the validity of GI transit studies performed in children. Many sites however have developed institutional experience which may be utilized to validate their local study procedures.

This document may also be useful for nuclear medicine physicians, radiologists, and technologists, as well as for developers of clinical decision support (CDS) tools as guidance in validating requests for imaging patients with GI tract symptoms. Radiology benefits managers and other third-party payer may also use this AUC. It is our intention that the AUC be used to help ensure the appropriate ordering of GI motility scintigraphic testing in patients with GI symptoms who lack appropriate diagnosis and treatment.

**METHODOLOGY**

**Expert Workgroup Selection**

The experts of the AUC workgroup were convened by SNMMI to represent a multidisciplinary panel of health-care providers to determine the appropriate use of scintigraphy for studying gastrointestinal (GI) motility. In addition to nuclear medicine physicians representing the SNMMI, physicians from the American College of Physicians, the American Gastroenterological Association, and the American College of Nuclear Medicine were included in the workgroup. Twelve physicians were ultimately selected as content experts to participate and contribute to the resulting AUC. A complete list of workgroup participants can be found in Appendix A. Appendix B is a summary of definitions of terms and acronyms, and Appendix C provides the disclosures and conflicts-of-interest statement.

**AUC Development**

The process for AUC development was modeled after the RAND/UCLA Appropriateness (Fitch K, 2001 #101;Hendel, 2013 #102) and included the development of a list of common indications for the use of scintigraphy for studying gastrointestinal (GI) motility, a systematic review of evidence related to these indications, and the development of an appropriateness score for each indication using a modified Delphi process. This process strove to adhere to the standards of the Institute of Medicine of the National Academies for developing trustworthy clinical guidance (Academy, 2011 #99).

**Scope and Development of Clinical Indications**

To begin this process, the workgroup discussed various potential clinical indications for the use of scintigraphy for studying gastrointestinal (GI) motility. For all indications, the relevant patients were the populations of interests for esophageal transit, gastric emptying, small bowel transit and colon transit, of all genders, ages, races and geographic locations.

The workgroup identified 42 clinical indications for the use of scintigraphy for studying gastrointestinal (GI) motility. The indications are intended to be as representative of the relevant patient population as possible for development of AUC. The resulting AUC are based on evidence and expert opinion regarding diagnostic accuracy and effects on clinical outcomes and clinical decision making as applied to each indication. Other factors affecting the AUC recommendations were potential harm— including long-term harm that may be difficult to capture—costs, availability, and patient preferences.

**Systematic Review**

To inform the workgroup, a systematic review of the relevant evidence was commissioned by an independent group, the Pacific Northwest Evidence-Based Practice Center of Oregon Health and Science University (Center, 2008 #104). The primary purpose of the systematic review was to synthesize the evidence on the accuracy of esophageal transit scintigraphy for diagnosing esophageal dysmotility, gastroesophageal reflux disease (GERD), and pulmonary aspiration; the proportion of patients undergoing scintigraphy that meets criteria for abnormal (delayed or rapid) gastric, small bowel, or colon transit; and effects of GI transit scintigraphy on clinical decision-making (i.e., use of therapies, additional testing). The workgroup selected the following key questions to guide the review:

**Esophageal transit scintigraphy**

1. In adults undergoing evaluation of dysphagia, what is the accuracy of esophageal transit scintigraphy versus esophageal manometry for diagnosis of esophageal dysmotility?
2. In adults undergoing evaluation for potential GERD, what is the accuracy of esophageal transit scintigraphy versus 24-hour pH monitor, esophageal manometry, barium contrast radiography, and/or endoscopy for diagnosis of GERD?
3. In adults undergoing evaluation for potential pulmonary aspiration, what is the accuracy of esophageal transit scintigraphy versus modified barium swallow (video fluoroscopic swallow study) for diagnosis of pulmonary aspiration?
4. In adults undergoing evaluation of a) dysphagia, b) GERD, or c) pulmonary aspiration, what is the impact of esophageal transit scintigraphy versus no scintigraphy on clinical decision-making (use of therapies, additional testing)?
5. In adults who have undergone treatment (pharmacological therapies, gastric stimulator, balloon dilatation) for dysphagia, GERD, or pulmonary aspiration, what is the impact of esophageal transit scintigraphy versus no scintigraphy on clinical decision-making (use of therapies, additional testing)?

**Gastric emptying scintigraphy**

1. In adults with suspected gastric dysmotility disorder who undergo gastric emptying scintigraphy, what is the proportion diagnosed with abnormal (delayed or rapid) gastric emptying?
2. In adults with suspected gastric dysmotility disorder who undergo gastric emptying scintigraphy, what is the effect on clinical decision-making?
3. In adults who have undergone treatment (pharmacological therapies, gastric stimulator, balloon dilatation) for delayed gastric emptying, what is the impact of gastric emptying scintigraphy versus no scintigraphy on clinical decision-making (use of therapies, additional testing)?

**Small bowel transit scintigraphy**

1. In adults with suspected small bowel dysmotility who undergo small bowel transit scintigraphy, what is the proportion diagnosed with abnormal small bowel transit?
2. In adults with suspected small bowel dysmotility who undergo small bowel transit scintigraphy, what is the effect on clinical decision-making?

**Colon transit scintigraphy**

1. In adults with symptoms of constipation who undergo colon transit scintigraphy, what is the proportion diagnosed with delayed colonic transit?
2. In adults with symptoms of constipation who undergo colon transit scintigraphy, what is the effect on clinical decision-making?

The inclusion and exclusion criteria for papers for this review were based on the study parameters established by the workgroup, using the PICOTS (population, intervention, comparisons, outcomes, timing, and setting) approach. The studies Included in the review were of patients undergoing esophageal transit that evaluated diagnostic accuracy for esophageal dysmotility, GERD, or pulmonary aspiration against a reference standard as pre-specified in the questions, and studies (imaging series) of gastric emptying, small bowel transit, or colon transit scintigraphy that reported the proportion of patients with abnormal (delayed or rapid) emptying. The review also included studies that reported effects of GI transit scintigraphy on clinical decision-making (use of therapies, subsequent testing). Non-English language articles and studies published only as conference abstracts were excluded.

Searches were conducted on the following databases: Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and Ovid MEDLINE® (through January 2018) for relevant studies and systematic reviews. These searches were supplemented by reviewing the reference lists of relevant publications.

Two investigators independently assessed the quality (risk of bias) of each study as “good,” “fair,” or “poor” using pre-defined criteria specific for each study design. The criteria from QUADAS-2 (Quality Assessment of Diagnostic Accuracy Studies-2) (Whiting, 2011 #103) was adapted for studies of diagnostic accuracy. For studies reporting the proportion of patients meeting criteria for abnormal GI transit in imaging series, QUADAS-2 was modified by excluding criteria that addressed use of a reference standard. Discrepancies were resolved through a consensus process. The strength of overall evidence was graded as high, moderate, low, or very low using GRADE methods based on quality of evidence, consistency, directness, precision, and reporting bias.

Database searches resulted in 2128 potentially relevant articles. After dual review of abstracts and titles, 340 articles were selected for full-text dual review and 72 studies were determined to meet inclusion criteria and were included in this review. Fifteen studies evaluated diagnostic accuracy of esophageal transit scintigraphy against a reference standard of esophageal manometry, pH monitoring, and/or endoscopy (including biopsy findings), 56 studies reported the proportion of patients who met criteria for abnormal GI transit scintigraphy (gastric emptying, small bowel, or colon scintigraphy), and four studies reported effects of GI transit scintigraphy studies on clinical decision-making.

**Rating and Scoring Process**

In developing this AUC for gastrointestinal (GI) motility, the workgroup members used the following definition of appropriateness to guide their considerations and group discussions: “The concept of appropriateness, as applied to health care, balances risk and benefit of a treatment, test, or procedure in the context of available resources for an individual patient with specific characteristics” (AQA, 2009 #100).

At the beginning of the process, workgroup members convened via webinar to develop the initial clinical indications. On evaluating the evidence summary of the systematic literature review, the workgroup further refined its draft clinical indications to ensure their accuracy and facilitate consistent interpretation when scoring each indication for appropriateness. Using the evidence summary, workgroup members were first asked individually to assess the appropriateness and provide score for each of the identified indication. Workgroup members then convened in a group setting for several successive webinars to discuss each indication and associated scores from the first round of individual scoring. After deliberate discussion, a consensus score was determined and then assigned to the associated appropriate use indication. For this scoring round, the expert panel was encouraged to include their clinical expertise in addition to the available evidence in determining the final scores. All members contributed to the final discussion, and no one was forced into consensus. After the rating process was completed, the final appropriate use ratings were summarized in a format similar to that outlined by the RAND/UCLA Appropriateness Method.

The workgroup scored each indication as “appropriate,” “may be appropriate,” or “rarely appropriate” on a scale from 1 to 9. Scores 7–9 indicate that the use of the procedure is appropriate for the specific clinical indication and is generally considered acceptable. Scores 4–6 indicate that the use of the procedure may be appropriate for the specific indication. This implies that more research is needed to classify the indication definitively. Scores 1–3 indicate that the use of the procedure is rarely appropriate for the specific indication and generally is not considered acceptable.

As stated by other societies that develop AUC, the division of these scores into 3 general levels of appropriateness is partially arbitrary, and the numeric designations should be viewed as a continuum. In addition, if there was a difference in clinical opinion for an indication such that workgroup members could not agree on a common score, that indication was given a ‘may be appropriate’ rating to indicate a lack of agreement on appropriateness based on the available literature and the members’ collective clinical opinion, indicating the need for additional research.

**ESOPHAGEAL TRANSIT** **SCINTIGRAPHY (ETS)**

**Introduction/ Background**

There are several tests of esophageal motor function. The decision on which diagnostic study to use for esophageal dysmotility depends on the patient’s symptoms. If dysphagia is present, a barium swallow or endoscopy is usually performed first to exclude an anatomic lesion. Manometry is considered the gold standard for diagnosis of the primary esophageal motility disorders, which include: achalasia, scleroderma, diffuse esophageal spasm, impaired lower esophageal sphincter(LES) relaxation, hypertensive lower esophageal sphincter, and nonspecific esophageal motility disorders. Manometry, however, has limitations. It provides only an indirect measure of peristalsis, as the pressure waves recorded do not always correlate with the aboral forces applied to a solid or liquid bolus in the esophagus. In addition, the presence of a manometric tube itself may affect normal physiology and quantification of the volume of retained solids or liquids in the esophagus is not possible.

Early scintigraphy studies of esophageal transit demonstrated a high sensitivity for detecting a wide range of esophageal motility disorders but a low sensitivity for disorders with intact peristalsis but high-amplitude contractions or isolated elevated pressures in the lower esophageal sphincter (Drane, 1987 #1;RH, 1989 #2;Jorgensen, 1992 #3). The use of manometry potentially supplemented by esophageal transit scintigraphy for equivocal manometry results will, in large part, be determined by local expertise and availability.

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores gastrointestinal transit are presented in Table 1.

*Scenario 1: Dysphagia (e.g. symptoms of: achalasia, scleroderma, DES, hypertensive LES, nonspecific motility disorder, esophageal outflow obstruction) (7 - Appropriate)*

The use of ETS for evaluation of dysphagia is typically limited to when results of barium swallow, endoscopy and manometry are nondiagnostic or equivocal. It has been shown that as many as 50% of patients with dysphagia and normal manometry and barium studies demonstrate esophageal dysmotility on scintigraphy (Maurer, 2006 #4). From the systematic review of the literature, the sensitivity and specificity of ETS ranged from 44-95% and 47-96%, respectively (Maurer, 2006 #4;RH, 1989 #2;Blackwell, 1983 #5;Caestecker, 1986 #6;Gilchrist, 1987 #7;Mughal, 1986 #8;Parkman, 1996 #9;Tatsch, 1996 #10). This indication, obtaining ETS in evaluation of dysphagia, was considered appropriate by unanimous agreement of the panel.

*Scenario 2: Quantification of response to therapy (treatment for Achalasia) (7 - Appropriate)*

Response to treatment of esophageal disorders, such as achalasia, is often assessed by improvement in symptoms. Improvement in esophageal transit and emptying may also be helpful. Although few studies were found that use ETS to quantitate the response of therapy for esophageal motility disorders such as achalasia, the expert panel considered by unanimous agreement that ETS is appropriate when there is a need to quantitate objectively the response to some therapy (Maurer, 2006 #4;P, 2002 #11).

*Scenario 3: Aspiration (4 – May be Appropriate)*

Limited studies have evaluated the accuracy of ETS compared with modified barium swallow as the reference standard to detect aspiration (Isaacs, 1990 #12). From the systematic review of the literature, the sensitivity and specificity of ETS ranged from 65-88% and 62-95%, respectively (11). One study of patients with known pulmonary aspiration who underwent ETS found that 89% of patients had liquid diet restrictions reduced following scintigraphy (Silver, 1994 #13) . There was unanimous agreement of the panel that ETS may be appropriate in the evaluation of patients with suspected pulmonary aspiration by unanimous agreement of the panel.

*Scenario 4: Rumination (4 – May be Appropriate)*

Rumination is an eating disorder in which a person brings back up partially digested food that has already been swallowed. No studies were found from the systematic review for evaluating ETS for the evaluation of rumination. However, this indication was considered as may be appropriate by unanimous agreement of the panel based on their clinical experience.

*Scenario 5: Gastroesophageal Reflux (GER) (e.g. symptoms of: regurgitation (liquid or solid), heartburn) (5 – May be Appropriate)*

Currently esophageal pH probe monitoring is the gold standard used to confirm the presence of GER using either a nasally based catheter or pH capsule attached to the esophagus. The systematic review of the literature revealed a sensitivity and specificity ranging from 43-90% and 64-100%, respectively(Parkman, 1996 #9;P, 2002 #11;Isaacs, 1990 #12;Kjellen, 1987 #14;Styles, 1984 #15). The expert panel considered by unanimous agreement that ETS may be appropriate in the assessment of patient with gastroesophageal reflux.

*Scenario 6: Pre and post fundoplication (5 – May be Appropriate)*

One study found in the systematic review evaluated findings following fundoplication (Falk, 2015 #16). This indication, using ETS to assess patients following fundoplication, was considered as may be appropriate by unanimous agreement of the panel.

**TABLE 1**

Clinical Scenarios for Esophageal Transit (often performed with GER studies)

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Dysphagia (e.g. symptoms of: achalasia, scleroderma, DES, hypertensive LES, nonspecific motility disorder, esophageal outflow obstruction) | Appropriate | 7 |
|  | Quantification of response to therapy (treatment for Achalasia) | Appropriate | 7 |
|  | Aspiration | May be Appropriate | 4 |
|  | Rumination | May be Appropriate | 4 |
|  | Gastroesophageal Reflux (GER) (e.g. symptoms of: regurgitation (liquid or solid), heartburn) | May be Appropriate | 5 |
|  | Pre and post fundoplication | May be Appropriate | 5 |

**Summary of Recommendations**

Esophageal manometry, barium swallow radiography and pH monitoring are typically used for first line evaluation of patients with suspected esophageal dysmotility and gastroesophageal reflux. Use of esophageal transit scintigraphy is limited by the availability of local expertise with experience in the methodology, but when available, is most commonly used when there are equivocal or non-diagnostic findings from the first line studies.

**GASTRIC EMPTYING SOLIDS (SOLID NUTRIENT OR EQUIVALENT\*)**

**Introduction/Background**

Gastric emptying (GE) studies are usually ordered to confirm or exclude whether gastroparesis (delayed GE) is a cause of a patient’s symptoms. Gastroparesis is usually associated with upper gastrointestinal symptoms, which include nausea (92% of patients), vomiting (84%), abdominal fullness or distention (75%), or early satiety (60%)(Cuomo, 2001 #17). Etiologies for gastroparesis include diabetes, postgastric surgical conditions, infections(especially post viral), neuromuscular, autoimmune, and connective tissue diseases, or idiopathic.

Patients often do not have well-defined gastrointestinal symptoms and present with complaints of dyspepsia (symptoms of any pain or discomfort thought to originate in the upper gastrointestinal tract). The goal of diagnosing delayed GE is to identify patients who will benefit from a prokinetic drug or other treatment to alleviate symptoms. A GE study is indicated for patients with suspected gastroparesis or dyspepsia after an anatomic cause for symptoms has been excluded. A GE study may also be indicated in the absence of dyspeptic symptoms such as: those with severe gastroesophageal reflux disease not responding to acid suppressants(to see if delayed GE contributes to reflux); those requiring a work-up to identify a diffuse gastrointestinal motility disorder; and those who are diabetic and have poor glycemic control. GE studies can also be used to assess patients for dumping syndrome, where there is rapid GE. Classically, this occurs postsurgery, but is now being described in patients with autonomic dysfunction, cyclic vomiting syndrome, and functional dyspepsia.

Gastric emptying scintigraphy (GES) currently is the gold standard method for measuring GE and is the standard to which other diagnostic tests have been compared. It should be performed using the currently accepted, standardized low-fat solid meal that is endorsed by the American Neurogastroenterology and Motility Society and the Society of Nuclear Medicine and Molecular Imaging(Abell, 2008 #18;Donohoe, 2009 #19;Tougas, 2000 #20). Advantages of this test include good tolerability of the meal by the majority of patients, validated multicenter normal values, and a reproducible methodology. Patients who cannot tolerate the current egg based solid meal can be tested with the nutritional supplement Ensure® PLUS (Knight, 2012 #21). This substitute meal has advantages of the same imaging protocol and similar normal GE values as the solid egg-based meal. A rice-based, solid meal substitute that is gluten free and vegan has documented normal values but may not be widely available (Somasundaram, 2014 #22). While many variations of solid and liquid GE meals are used by some diagnostic facilities, these are not recommended until they have had sufficient validation in the literature.

Recently, a non-nutrient water only GE test was compared to the standard solid meal and showed a delay in water GE in 32% of patients with normal solid GE(Ziessman, 2009 #23). A water only meal has potential advantages including: meal tolerability, a shorter acquisition time and added sensitivity. Currently there is very limited clinical data to support the use of a non-nutrient, water meal.

To fully integrate the results of a GES test into patient management, it is important to document GI symptoms, prior surgical procedures, and all drugs in use(Camilleri, 2013 #24). An abbreviated list of interfering medications includes anticholinergics, calcium channel blockers, clonidine, proton pump inhibitors, tricyclic antidepressants, lithium, exenatide, liraglutide, pramlintide, dopamine agonists, progesterone containing agents, nicotine by smoking and/or use of containing agents, medications containing opioids, octreotide or other somatostatin analogues, tetrahydrocannabinol by smoking and/or its ingestible derivatives. Interfering medications should be stopped for 3 days or 6-10 half-lives of the drug. Concealed use of illicit drug can be an overlooked reason for GI symptoms and GE dysfunction. In diabetics blood glucose must be checked and documented immediately before the test to avoid slowing of GE due to hyperglycemia (Fraser, 1990 #25;Bharucha, 2015 #26;Schvarcz, 1997 #27).

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores in gastric emptying solids are presented in Table 2.

*Scenario 1: Symptoms of gastroparesis (e.g. symptoms of: diabetic or idiopathic). (9 - Appropriate)*

Studies examining GES findings in relationship to gastrointestinal complaints show that symptoms correlating best with delayed GE at 4 hours are early satiety, nausea, vomiting, post prandial fullness and loss of appetite (Pathikonda, 2012 #28). The 4-hour value is the most sensitive and specific indicator of gastric dysfunction. A pivotal investigation showed 37% of patients with normal GE at 2 hours were delayed at 4 hours (Guo, 2001 #29). All time points must be considered as a delay in GE at 2 hours may show normalization at 4 hours (Guo, 2001 #29). While no distinct pattern distinguishes diabetic (the most common cause) from idiopathic or other gastroparesis; diabetic patients on average have greater delayed GE at 4 hours when compared to non-diabetics. Delayed GE documented on GES fulfills one of the three criteria for establishing the diagnosis of gastroparesis (Chantadisai, #344) in combination with the other two – symptoms of GP and absence of gastric outlet obstruction or ulceration (Camilleri, 2013 #24). This indication was considered appropriate by unanimous agreement of the panel.

Scenario*2: Functional dyspepsia (e.g. symptoms of: upper abdominal pain/discomfort, early satiety, nausea, vomiting, bloating, postprandial fullness). (9 –Appropriate)*

While the pathophysiology of functional dyspepsia (FD) is multifactorial, recent studies suggested that it includes a gastric motility disorder. The main pathophysiology in FD appear to include: delayed GE, impaired fundal accommodation and/or visceral hypersensitivity (Farre, 2013 #30;Asano, 2017 #31;Simren, 2018 #32). Delayed GE has been considered as a mechanism of dyspeptic symptoms, especially in the FD category of postprandial distress syndrome (early satiety and abdominal fullness after meals) rather than the epigastric pain syndrome subgroup (abdominal pain/discomfort symptoms present at night while fasting as well as post prandial). However, correlations between severity of FD and delayed GE have been weak with approximately 40% of patients with a working diagnosis of FD also showing delayed GE (Quartero, 1998 #33).

The documentation of delayed GE is a starting point for treatment strategies in this clinically heterogeneous group, which includes patients where accelerated GE can be an unexpected finding. In the future it may be of use to combine proximal stomach or fundal emptying analyses during standard GES, as well as employing dynamic antral scintigraphy to assess antral contractions. It may unmask a new subset of FD patients with normal GE results but impaired fundal accommodation or impaired antral motility (Troncon, 2006 #34). This indication was considered appropriate by unanimous agreement of the panel.

*Scenario 3: Post-surgical induced symptoms of dyspepsia, questionable rapid gastric emptying (e.g. symptoms of: postsurgical gastroparesis, postvagotomy). (9 –Appropriate)*

Some patients who have an accidental vagotomy during a standard fundoplication surgery for gastroesophageal reflux develop symptoms of post-vagotomy gastroparesis or alternatively, “dumping”. These may be clinically indistinguishable. The subtle differentiating characteristics are more post prandial abdominal pain, less vomiting and more urge to defecate or experience post-prandial early diarrhea in “dumping syndrome” (Berg, 2015 #35). In addition, late dumping symptoms (hypoglycemia, weakness and fainting) may also help in differentiating between the two complications. Post-vagotomy gastroparesis can result in severe delayed GE because pyloric relaxation is impaired and there is often bezoar formation that can block GE (McCallum, 2015 #36). This indication was considered appropriate by unanimous agreement of the panel.

*Scenario 4: Poorly controlled diabetes, without dyspeptic symptoms. (5 – May be Appropriate)*

Gastroparesis diabeticorum is a term that described diabetic patients who have no symptoms of gastroparesis but are noted to have retained food in the stomach. This observation has been extrapolated to mean that when poorly controlled diabetes cannot be explained by non-adherence to treatment regimen then gastroparesis may be the reason for excessive swings in blood glucose. The lack of GI symptoms may be related to concomitant neuropathy causing impaired gastric sensations. GES is able to objectively resolve this working diagnosis of gastroparesis without GI symptoms and was considered as may be appropriate by the consensus panel.

*Scenario 5: Poorly controlled GER, without dyspeptic symptoms. (6 – May be Appropriate)*

Delayed GE has been reported in the 28-56% of patients with gastroesophageal reflux disease (GERD) and its presence can explain poor control of symptoms, particularly nocturnal symptomatology (Buckles, 2004 #37). Delayed GE is correlated with poor nocturnal control of GERD and may guide management to combining prokinetic agents with proton-pump inhibitors therapy. In addition, objective delay in GE gives credence to adjusting evening meal timing and content, elevation of the head of the bed and/or sleeping on the left side measures to improve symptoms of GERD. This indication was considered as may be appropriate by the consensus panel.

*Scenario 6: Suspected generalized GI motility disorder (Intestinal pseudo obstruction). (6 – May be Appropriate)*

A suspected generalized motility disorder, so called “intestinal pseudo obstruction”, can be from neuropathic, myopathic causes. This can be seen in connective tissue disorders, typically systemic sclerosis, where the esophagus, small intestine and colon are commonly affected (Sridhar, 1998 #38). Dyspeptic symptoms including nausea, vomiting and epigastric fullness are often observed in scleroderma patients. A range of 47-66% of patients with scleroderma have delayed GE of solids (Marie, 2012 #39). It is hypothesized that collagen replacement of the gastric smooth muscle may lead to subsequent stomach hypomotility. Evidence of delayed GE supports initiation of promotility therapy. This indication of obtaining a gastric emptying study in patients with suspected generalized GI motility disorder including intestinal pseudoobstruction was considered as may be appropriate by the consensus panel.

*Scenario 7: Cyclic vomiting syndrome. (6 – May be Appropriate)*

GE studies in cyclic vomiting syndrome (CVS) can be crucial in separating this entity from gastroparesis and, hence, change course of treatment as well as long term prognosis. In the largest published study examining GE in nearly 100 CVS patients there was rapid GE in 30% and normal GE in 70% (Hejazi, 2010 #40); whereas the gastric emptying is delayed in patients with gastroparesis.

The key to studying GE in CVS is the timing of the study. It should be performed during the remission phase of CVS. A major confusion in past literature is performing a GE in the hospital where CVS patients typically receive narcotics for their abdominal pain. This results in delayed GE and the misdiagnosis of gastroparesis. In addition, marijuana use is common in a subset of CVS patients termed “Cannabis Hyperemesis Syndrome” and here GE may also be slow as recent marijuana use will slow GE (Pattathan, 2012 #41). The finding of normal or rapid GE is regarded as a specific finding for CVS and separates this entity from gastroparesis. This is very important especially when CVS is occurring in the setting of diabetes mellitus. This indication was considered as may be appropriate by the consensus panel.

*Scenario 8: Anorexia nervosa. (5 – May be Appropriate)*

Anorexia nervosa in childhood or early adulthood can result in altered GE function, where despite subsequent improvement of eating habits, there is no recovery of the gastric atrophy. Another possible explanation for delayed GE could be secondary to endocrine dysfunction (i.e. hypoadrenalism) observed in patients with eating disorders. Anorexia and bulimia have been associated with dyspeptic symptoms and delayed GE. In a study of 16 female patients with anorexia nervosa, GE of solid food phase was significantly delayed in 80% of patients (McCallum, 1985 #42). With improvement of the eating disorder and recovery of normal body weight, the gastric emptying can improve. This indication was considered as may be appropriate by the consensus panel.

*Scenario 9: Suspected impaired gastric accommodation (e.g. symptoms of: early satiety, postprandial fullness and/or abdominal pain). (7 – Appropriate)*

Studies have shown an association between symptoms of nausea, early satiety, abnormal distention and gastroesophageal reflux with proximal gastric retention, whereas vomiting may be more associated with distal gastric retention (Gonlachanvit, 2006 #43). Two methods for performing GES measurement of gastric accommodation have been reported. One uses standard planar (2 dimensional) GES and looks at the intragastric meal distribution immediately post meal ingestion. The second utilizes a 3-dimensional SPECT acquisition and estimates gastric volume by imaging the gastric mucosa. The SPECT method is therefore not influenced by GE, is independent of intragastric content, and can assesses both fasting and postprandial gastric volume during the first 10 minutes after meal ingestion.

Measurements of gastric volume by SPECT differ significantly from the estimates of gastric accommodation based on intragastric meal distribution measured immediately after food ingestion by the 2-dimensional method (Chedid, 2019 #44).

Measurements of gastric volume by SPECT differ significantly from the estimates of gastric accommodation based on intragastric meal distribution measured immediately after food ingestion by the 2-dimensional method (Chedid, 2019 #44). The current literature shows that both methods independently correlate with symptoms. There is significant evidence that the SPECT method measures gastric volume changes comparably to the intragastric barostatically-controlled balloon (Bouras, 2002 #45) and has excellent the performance characteristics (Breen, 2011 #46). In addition, improvement in functional dyspepsia symptoms with low dose antidepressants has recently been associated with increased SPECT-measured gastric accommodation (Lacy, 2018 #47). Current evidence supporting that measuring gastric accommodation based on 2-dimensional scintigraphy improves diagnosis and provides for specific treatment of impaired accommodation is more limited (Orthey, 2018 #48;Maurer, 2019 #49). This indication was considered as appropriate by the consensus panel.

*Scenario 10: Pre- and/or Post-bariatric surgery. (5 – May be Appropriate)*

Gastric bypass surgery may result not only in weight loss but also reverse type 2 diabetes. Objective measurement of a delay in GE can be taken to support the recommendation for gastric bypass surgery rather than the laparoscopic sleeve gastrectomy. In patients who develop vomiting post gastric bypass, a GE study can identify significant delay in GE from the pouch, an indication of stenosis at the gastric-jejunal anastomosis. If the gastric pouch emptying shows expected rapid GE, then the explanation for ongoing vomiting is either from over eating or rumination syndrome. Therefore, GES before bariatric surgery may guide selection of surgical technique while in patients with symptoms of post-surgical vomiting it may disclose an actionable surgical complication. The evidence for using GES before or after bariatric surgery, however, is currently limited (Ardila-Hani, 2011 #50). When employed it should be combined with an endoscopic and or radiographic assessment. This indication was considered as may be appropriate by the consensus panel.

*Scenario 11: Post-surgical evaluation (for: neurosimulator, pyloroplasty, pyloromyotomy, partial gastric resection) (6 – May be Appropriate)*

Oral contrast radiographic studies are routinely performed to document uncomplicated gastric surgeries. Assessing symptoms that may still be present in a GP patient who has undergone surgical treatment can be very important. Gastric electrical neurostimulation does not predictably change GE (McCallum, 2011 #51). Pyloroplasty will accelerate GE (Davis, 2017 #52). If GE is not sufficiently accelerated, then incomplete pyloromyotomy or presence of a gastric bezoar should be suspected. In the future endoscopic pyloromyotomy may become another indication for GES as one recent study has already shown acceleration of GE by endoscopic pyloroplasty (Mekaroonkamol, 2019 #53). This indication was considered as may be appropriate by the consensus panel.

*Scenario 12: Post-surgical treatment. (6 – May be Appropriate)*

A recent study suggests that GE rate from a gastric pouch has inverse correlation with weight loss after Roux-en-Y gastric bypass (ReYGB) surgery (Deden, 2017 #54). Therefore, rapid dumping was correlated with failed ReYGB in achieving target weight loss. Several studies show patients with failed ReYGB benefit from salvage banding, which applies an adjustable band on either over the gastric pouch to control excessive dilation or over the gastrojejunostomy to control dilation of the opening (Vijgen, 2012 #55). GES results may help to guide where to place the salvage band; however, currently no evidence exists to support this strategy. This indication was considered as may be appropriate by the consensus panel.

*Scenario 13: Post-surgical Neurostimulator placement. (6 – May be Appropriate)*

GES may provide supportive evidence for surgical success. If GE is abnormal after surgery aimed to treat gastroparesis additional therapy to promote GE may be helpful. Neurostimulator is one such option. It has worked synergistically with pyloroplasty (Davis, 2017 #52).

Hence, addition of neurostimulator would be reasonable if GES remains abnormal in a patient with GP who remains symptomatic after pyloroplasty. Other complications from gastrointestinal surgery that result in slow GE may benefit from neurostimulator placement. Case-reports anecdotally support such intervention in those patients. This indication was considered as may be appropriate by the consensus panel.

*Scenario 14: Post-surgical pyloroplasty. (6 – May be Appropriate)*

Since GES objectively documents effectiveness of surgery, it may also guide further management when GE remains abnormal in patient with persistent symptoms. Such patients are known to benefit from combination therapy of adding neurostimulator (Davis, 2017 #52). This indication was considered as may be appropriate by the consensus panel.

*Scenario 15: Following Surgical or Endoscopic Pyloromyotomy. (6 – May be Appropriate)*

Surgical pyloromyotomy is performed in infants with hypertrophic pyloric stenosis. When these patients were studied as adults, the GE of nutrient liquid meal was found to be overall normal (Sun, 2000 #56). However, pyloric motility in the same patients was abnormal, as would be expected. This observation is consistent with the concept that stomach has the capacity to compensate for changes in pyloric motility to minimize effects on GE. This mechanism may fail in some patients and manifest in gastrointestinal symptoms. There are no published studies on using GE study in such patient population. Never the less, performance of GE study was considered reasonable and may be appropriate in relating abdominal complaints to the development of GE dysfunction in these patients. Another patient population treated with surgical pyloroplasty or pyloromyotomy can be combined with electrical stimulation for the treatment for severe gastroparesis. These patients can have a significant improvement in their symptoms and show improved GE (Davis, 2017 #52). GES serves as objective evidence for successful treatment by this combined surgical procedure. Recently, endoscopic pyloromyotomy was also found to effectively treat severe gastroparesis with marked improvement in symptoms and GE (Mekaroonkamol, 2019 #53).

*Scenario 16: Post-surgical Partial gastric resection. (6 – May be Appropriate)*

Partial gastric resections, either Billroth I (antrectomy) or Billroth II (gastro-jejunal anastomosis), have unpredictable effects on GE. When these procedures are performed in the context of the peptic ulcer disease, the GE is generally expected to be accelerated after surgery. However, as many as 50% of these patients may later display abdominal symptoms of gastroparesis after Billroth I surgery. Demonstration of delayed GE is diagnostic of gastroparesis when the stomach is patent by endoscopy. These patients may benefit from completion gastrectomy (McCallum, 1991 #57). An antral resection without a pyloroplasty may not change GE and may delay GE in a significant proportion of these patients. This procedure is typically done in patients with gastric cancer resection. It is a standard of care in these patients to follow-up with endoscopy for early detection of cancer recurrence. However, there is often significant residual food after standard preparation of patients after Billroth I, which interferes with diagnostic endoscopy. Delayed GE in these patients predicted interference of significant food remnant with endoscopy and correlates well with development of postsurgical abdominal symptoms of gastroparesis (Michiura, 2006 #58;Takahashi, 2009 #59). This indication was considered as may be appropriate by the consensus panel.

**TABLE 2**

Clinical Scenarios for Gastric Emptying Solids (including post-infectious symptomatology)

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Symptoms of gastroparesis (e.g. symptoms of: diabetic vs. idiopathic) | Appropriate | 9 |
|  | Functional dyspepsia (e.g. symptoms of: upper abdominal pain/discomfort, early satiety, nausea, vomiting, bloating, postprandial fullness) | Appropriate | 9 |
|  | Post-surgical induced symptoms of dyspepsia, questionable rapid gastric emptying (e.g. symptoms of: postsurgical gastroparesis, postvagotomy) | Appropriate | 9 |
|  | Poorly controlled diabetes, without dyspeptic symptoms | May be Appropriate | 5 |
|  | Poorly controlled GER, without dyspeptic symptoms | May be Appropriate | 6 |
|  | Suspected generalized GI motility disorder (Intestinal pseudo obstruction) | May be Appropriate | 6 |
|  | Cyclic vomiting syndrome | May be Appropriate | 6 |
|  | Anorexia nervosa | May be Appropriate | 5 |
|  | Suspected impaired gastric accommodation (e.g. symptoms of: early satiety, postprandial fullness and/or abdominal pain) | Appropriate | 7 |
|  | Pre- and/or Post-bariatric surgery | May be Appropriate | 5 |
|  | Post-surgical evaluation (all specific items: neurosimulator, pyloroplasty, pyloromyotomy, partial gastric resection) | May be Appropriate | 6 |
|  | Post-surgical treatment | May be Appropriate | 6 |
|  | Post-surgical Neurostimulator placement | May be Appropriate | 6 |
|  | Post-surgical pyloroplasty | May be Appropriate | 6 |
|  | Post-surgical Endoscopic Pyloromyotomy | May be Appropriate | 6 |
|  | Post-surgical Partial gastric resection | May be Appropriate | 6 |

**Summary of Recommendations**

GES remains the standard for measuring both solid and liquid gastric emptying. Recent advances in GES now permit additional measurements of gastric motility including intragastric meal distribution, gastric accommodation response, and antral contraction frequency and amplitude. While current treatments for gastroparesis are limited it is anticipated that these newer measures of gastric dysmotility may lead to improved treatment.

**GASTRIC EMPTYING LIQUIDS (NUTRIENT AND NON-NUTRIENT/WATER MEALS)**

**Introduction/Background**

Determining GE rates of a non-nutrient, water meal at this time is not well established. Use of a water meal dates back to the early use of saline load test for gastric outlet obstruction. There is limited evidence for existence of a subset of gastroparesis patients with normal solid GE but an abnormal GE of water (Ziessman, 2009 #60;Ziessman, 2009 #23). Use of a water meal has not been validated in multicenter studies. Since water by definition has no caloric value, it is clinically of greater pertinence to address the GE of a nutrient liquid meal. A nutrient liquid meal is indicated for patients referred for GES who have egg and/or gluten allergies or other reasons for intolerance of the standard solid meal. The GE characteristics of a validated liquid nutrient meal is similar to the standard solid meal but with a slightly faster emptying rate (Knight, 2012 #21;Sachdeva, 2013 #61).

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores in gastric emptying liquids (non-nutrient/water meal) (including post-infectious symptomatology) are presented in Table 3.

*Scenario 1:* Symptoms of gastroparesis (e.g. symptoms of: diabetic vs. idiopathic), if solid emptying is normal. *(7 – Appropriate)*

A retrospective study of combined tap water and standard solid-meal GES evaluated 21 patients with GI symptoms.

Investigators found that of 17 patients with normal solid GE, the water GE was abnormal. The same group then initiated another prospective study of 101 patients with the key difference that water and solid GES were done consecutively to eliminate simultaneous liquid and solid meal ingestion as in the first investigation. Delayed GE was found in 36% of plain water and 16% of the solid GES. Similar to the first study, water GE was delayed in 32% of all patients with normal solid emptying (Ziessman, 2009 #60;Ziessman, 2009 #23). While advantages of plain water include availability and a short acquisition (30 minutes) time, there is currently insufficient evidence to support routine clinical use. In patients who cannot tolerate the standard solid meal, this indication was considered as appropriate by the consensus panel.

*Scenario 2: Functional dyspepsia (e.g. symptoms of: upper abdominal pain/discomfort, early satiety, nausea, vomiting, bloating, postprandial fullness). (7 – Appropriate)*

Non nutrient, plain water GES may be useful especially when other validated nutritional meals cannot be tolerated. See Scenario 1.

*Scenario 3: Poorly controlled diabetes, without dyspeptic symptoms. (4 – May be Appropriate)*

Plain water GES may be useful if other validated meals with nutritional value cannot be tolerated. A non-caloric meal may be useful to avoid the known physiologic effects of hyperglycemia which can slow GE. This indication was considered as may be appropriate by the consensus panel.

*Scenario 4: Poorly controlled GER, without dyspeptic symptoms. (3 – Rarely Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. This indication was considered as rarely appropriate by the consensus panel.

*Scenario 5: Suspected generalized GI motility disorder (Intestinal pseudo obstruction). (3 – Rarely Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. This indication was considered as rarely appropriate by the consensus panel.

*Scenario 6: Cyclic vomiting syndrome. (3 – Rarely Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. This indication was considered as rarely appropriate by the consensus panel.

*Scenario 7: Anorexia nervosa. (4 – May be Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful in this patient population especially if other validated nutritional meals cannot be tolerated. This indication was considered as may be appropriate by the consensus panel.

*Scenario 8: Gastrostomy evaluation. (5 – May be Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. This indication was considered as may be appropriate by the consensus panel.

*Scenario 9: Unable to tolerate solid meal. (8 –Appropriate)*

There is no literature evidence for validity of plain water GES in this indication. Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. This indication was considered as may be appropriate by the consensus panel.

*Scenario 10: After normal solid meal when symptoms suggest gastric motility disorder. (8 –Appropriate)*

Non nutrient, plain water GES may be useful especially if other validated nutritional meals cannot be tolerated. Recently, a non-nutrient water only GE test was compared to the standard solid meal and showed a delay in water GE in 32% of patients with normal solid GE(Ziessman, 2009 #23). A water only meal has potential advantages including: meal tolerability, a shorter acquisition time and added sensitivity. Currently there is very limited clinical data to support the use of a non-nutrient, water meal but the consensus panel felt the existing data show that it’s use is appropriate for this clinical scenario.

*Scenario 11: Small bowel transit study (When combined with liquid gastric emptying). (7 –Appropriate)*

For some patients with vague symptoms consistent with a functional GI disorder, it can be challenging to diagnose whether the abnormality involves the stomach, small bowel, or colon. In such instances, transit of a water meal may disclose a small bowel transit abnormality. While combing liquid (water) and solids using a dual isotope technique to measure both solid and liquid GE and then following the liquid transit thru the small bowel has been previously confined to the research setting, it has recently become a clinically validated study to assess small bowel motility (Bonapace, 2000 #62;Maurer, 2015 #63;Ning, 2016 #64). This indication was considered as appropriate by the consensus panel.

**TABLE 3**

Clinical Scenarios for Gastric Emptying Liquids (non-nutrient/water meal)

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Symptoms of gastroparesis (e.g. symptoms of: diabetic vs. idiopathic), if solid emptying is normal | Appropriate | 7 |
| 2. | Functional dyspepsia (e.g. symptoms of: upper abdominal pain/discomfort, early satiety, nausea, vomiting, bloating, postprandial fullness) | Appropriate | 7 |
| 3. | Poorly controlled diabetes, without dyspeptic symptoms | May be Appropriate | 4 |
| 4. | Poorly controlled GER, without dyspeptic symptoms | Rarely Appropriate | 3 |
| 5. | Suspected generalized GI motility disorder (Intestinal pseudo obstruction) | Rarely Appropriate | 3 |
| 6. | Cyclic vomiting syndrome | Rarely Appropriate | 3 |
| 7. | Anorexia nervosa | May be Appropriate | 4 |
| 8. | Gastrostomy evaluation | May be Appropriate | 5 |
| 9. | Unable to tolerate solid meal | Appropriate | 8 |
| 10. | After normal solid meal when symptoms suggest gastric motility disorder | Appropriate | 8 |
| 11. | Small bowel transit study(when combined with liquid gastric emptying study) | Appropriate | 7 |

**Summary of Recommendations**

GES of solids remains the gold standard for measuring GE. There is limited data on the clinical value of liquid GE alone. Liquid GE however is typically combined with solids when additional small bowel or colonic transit studies are needed. A substitute liquid meal however can be of clinical value for patients who cannot tolerate the standard radiolabeled egg meal.

**SMALL BOWEL TRANSIT**

**Introduction / Background**

The function of the small bowel is to transport food as it empties from the stomach and to mix it with bile and with pancreatic and intestinal secretions to facilitate absorption over the bowel mucosal surface. Measurement of small-bowel transit is complex because entry of a meal into the small intestine depends on GE and because small-bowel chyme spreads over a large distance as it progresses toward the colon. There is no simple small-bowel peristaltic pattern. Antegrade and retrograde movements of intestinal chyme occur in the jejunum and ileum, with some areas progressing rapidly and others slowly. Jejunal peristaltic activity is typically more rapid and intense, with slowing of peristalsis seen in the ileum (Seidl, 2012 #65).

The simplest approach to scintigraphic measurement of small-bowel transit is to measure orocecal transit time by imaging the leading edge of radiotracer transit through the bowel. Accurately defining the leading edge (the first visualized arrival of activity in the cecum), however, requires frequent (every 10–15 min) and prolonged imaging because of the stasis in the terminal ileum.

An alternative scintigraphic method of measuring small-bowel transit does not attempt to characterize the complex temporal or spatial peristaltic small-bowel patterns or leading-edge transit but simply measures the overall bulk movement of radiotracer as it progresses distally into the terminal ileum. Typically, the radiolabeled meal collects in a terminal ileal reservoir. This region is also referred to as the ileocolonic junction. The recent SNMMI/EANM guideline on small-bowel transit recommends use of the percentage of administered liquid meal that has accumulated in the terminal ileum at 6 h after meal ingestion as a simple index of small-bowel transit (Maurer, 2013 #66). Small-bowel transit is considered normal if more than 40% of administered activity has progressed into the terminal ileum or passed into the cecum and ascending colon at 6 h. Small-bowel transit is delayed if activity persists in multiple loops of small bowel at 6 h and little (<40%) activity arrives in the terminal ileum reservoir. The amount of colon filling at 6 h has also been used as an index of small-bowel transit. The wireless motility capsule has been shown to correlate well with scintigraphy for measuring small bowel transit (Maqbool, 2009 #67) .

Indications for small bowel transit testing have been proposed in prior consensus publications. Authors of a review article by the American and European Neurogastroenterology and Motility Societies proposed that small bowel transit testing should be considered for those with unexplained nausea, vomiting, bloating, distention, or other manifestations of small intestinal bacterial overgrowth (SIBO) or dysmotility (Rao, 2011 #68). An older review commented that symptoms of small bowel dysmotility are similar to those of gastroparesis and that small bowel transit testing could be considered for those patients with persistent symptoms despite normal GE rates (Camilleri, 1998 #69).

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores in small bowel transit are presented in Table 4.

*Scenario 1: Symptoms of small bowel dysmotility (e.g. symptoms of: Nausea, Vomiting, Bloating, constipation, diarrhea, abdominal distention)*. *(7 - Appropriate)*

Scintigraphy has been employed to measure small bowel transit in several retrospective studies with varying designs relating to patient symptom profiles. In one study of 55 patients undergoing whole gut scintigraphy, small bowel transit was abnormal in 3/14 (21%) of those with dyspepsia while delays in small bowel transit were found in 7/27 (26%) of individuals with constipation and 3/14 (21%) with diarrhea, respectively (Balan, 2010 #70). In a second investigation of 108 patients with functional symptoms, 4/35 (11%) with dyspepsia exhibited small bowel transit delays and 5/69 (7%) with constipation had small bowel delays (Bonapace, 2000 #62). Changes in management were directed by whole gut scintigraphy (WGTS) which combines GE, small bowel and colon transit measurements, findings in 74% of patients with dyspepsia and 64% of those with constipation, although no mention was made of the specific impact of small bowel transit findings on management decisions. A third report focused on complaints of unexplained constipation in 212 patients (Shahid, 2012 #71). Nine individuals (10%) with slow transit constipation had delayed small bowel transit, while 2/25 (8%) with dyssynergic defecation had associated small bowel delays. Seven of 53 (13%) with combined slow transit constipation and dyssynergia and 2/43 (5%) with normal coloanal testing exhibited small bowel transit slowing. The authors of this investigation postulated that the extracolonic transit delays could be a potential explanation for failed responses to appropriate therapies of constipation. In another study, small bowel transit was delayed in 2/8 (25%) of patients with constipation (Stivland, 1991 #72). Moderately high intra and intersubject variability in scintigraphic small bowel transit times have been proposed by some investigators to limit discrimination of transit delays in some patients with small intestinal motility disorders (Miller, 1997 #73;Camilleri, 1998 #69).

Small bowel scintigraphy was employed to document responsiveness to treatment in one study of functional gastrointestinal patients (Prather, 2000 #74). Percent scintigraphic colonic filling at 6 hours (reflecting orocecal transit) was significantly accelerated by oral administration of the serotonin 5-HT4 receptor agonist prokinetic medication (tegaserod) in 24 patients with constipation-predominant irritable bowel syndrome.

Other tests including barium contrast radiography, radioopaque markers, video capsule endoscopy, and magnetic resonance imaging have been proposed to quantify small bowel transit, however no case series using these methods to document transit delays have been published (Rao, 2011 #68;Szarka, 2012 #75). This indication was considered appropriate by unanimous agreement of the panel.

*Scenario 2: Suspected small intestinal bacterial overgrowth (SIBO). (5 – May be Appropriate)*

Literature on use of scintigraphy to document small bowel transit delays in patients with SIBO is very limited. In a study of patients undergoing concurrent lactulose breath testing and WGTS, there were no differences in breath test positivity overall in those with and without small bowel transit delays (Suri, 2018 #76). However, patients with positive methane production exhibited slower small intestinal transit compared to hydrogen producers. A second investigation employing simultaneous lactulose breath testing and scintigraphy conferred a diagnosis of SIBO when the hydrogen rise from bacterial fermentation of the substrate was detected before 5% of the radiolabeled tracer passed into the cecum (Zhao, 2014 #77). Using these rigorous criteria from combined testing, those with SIBO reported significantly better symptom responses to antibiotic treatment with rifaximin than those who did not meet these criteria.

Using lactulose breath tests, prolonged orocecal transit has been observed in patients with inflammatory bowel disease, acromegaly, diabetes, and scleroderma in association with SIBO (Cuoco, 2002 #78;Rana, 2013 #79;Wegener, 1994 #80). Wireless motility capsule testing and small intestinal manometry are also useful for demonstrating abnormal small bowel transit associated with SIBO. Patients with SIBO diagnosed by lactulose breath testing exhibit delayed small bowel transit on wireless motility capsule testing compared to those with negative breath tests (Wegener, 1994 #80;Cuoco, 2002 #78).

Based on the above evidence the committee concluded that small bowel scintigraphy may be appropriate to measure transit in patients with suspected SIBO. It must be emphasized that documentation of transit delays cannot make a diagnosis of SIBO, but such testing may offer insight into the pathogenesis of SIBO and may stratify patients into those who may need different treatments. It is anticipated that documentation of delayed transit using scintigraphy may direct use of prokinetic medications with the intention of expelling organisms trapped in a sluggish intestine.

*Scenario 3: Suspected generalized GI motility disorder (e.g. drug induced, idiopathic, or genetic). (8 - Appropriate)*

WGTS permits quantification of GE, small bowel transit, and colon transit in a single test. There is literature which confirms the utility of small bowel scintigraphy to confirm or refute the presence of a generalized dysmotility disorder with abnormal transit in at least two of these three gastrointestinal organs. In the previously described study of 108 patients with functional gastrointestinal symptoms, 3 of the 4 patients with dyspepsia and delayed small bowel transit also exhibited delayed GE by scintigraphy (Bonapace, 2000 #62). All 5 patients with constipation and delayed small bowel transit also showed GE delays. In another investigation of 212 constipated patients, 9 individuals with slow transit constipation and delayed small bowel transit also had slow GE confirming generalized impairments throughout the alimentary tract (Shahid, 2012 #71). Findings of these scintigraphy studies parallel investigations using the wireless motility capsule which is also able to measure whole gut transit in a single diagnostic test. Small bowel transit delays were observed in 16% of 209 patients with suspected gastroparesis (Hasler, 2018 #81).

These findings support the unanimous endorsement of the committee for use of small bowel transit scintigraphy as an appropriate diagnostic test in patients with a suspected generalized gastrointestinal motility disorder. The evidence is convincing that scintigraphy can document small bowel transit delays in combination with delays in other gut regions. However, it is again uncertain if such capability will have significant impact on defining management decisions or determining outcomes from treatments directed by documenting small bowel transit delays. Very few prokinetic therapies are available to correct small intestinal motor impairments. Agents which act in the small bowel include erythromycin, pyridostigmine, prucalopride, and octreotide, but the benefits of any of these agents to specifically treat small bowel transit delays in patients with functional symptoms without pseudoobstruction are unproved.

*Scenario 4: Suspected Intestinal pseudo obstruction (e.g. unexplained small bowel dilation). (8 – Appropriate)*

Chronic intestinal pseudoobstruction presents with symptoms mimicking mechanical obstruction with generalized dilation of small bowel (and usually colon) loops in the absence of physical blockage. The diagnosis usually is made with plain or cross-sectional radiography with or without documentation of contractile abnormalities on intestinal manometry. Small bowel transit measurements can be informative in cases where luminal dilation is minimal and when motor impairments in this gut region are uncertain. In an early report of 8 patients with chronic intestinal pseudoobstruction established by small bowel manometry, transit in this gut region on scintigraphy was delayed compared to healthy controls for both solid (131I-fiber) and liquid (99mTc-DTPA-water) meals (Camilleri, 1986 #82). The prokinetic drug cisapride normalized small bowel transit delays for both solid and liquids in these patients. In another study of 14 patients who had undergone small intestinal manometry to confirm dysmotility including documentation of neuropathic findings in 8 and myopathic patterns in 6 individuals, scintigraphic small bowel transit was markedly prolonged compared to healthy controls (median 328 vs. 218 minutes, P<0.01) (Camilleri, 1991 #83).

Regional transit abnormalities have also been documented by scintigraphy in the distal small intestine in chronic intestinal pseudoobstruction. In a comparative study of patients with pseudoobstruction and healthy controls, 6 patients with myopathic findings on intestinal manometry exhibited passage of solid radiolabeled boluses from the ileum into the colon that were smaller in size and occurred less frequently than in 14 patients with neuropathic disease and 10 normal volunteers (Greydanus, 1990 #84).

These observations support the unanimous endorsement of the committee for use of small bowel scintigraphy as an appropriate diagnostic test in patients with suspected intestinal pseudoobstruction. Scintigraphic measures of small intestinal transit clearly can demonstrate delays in this patient population. The regional bolus findings suggest the potential to provide pathophysiologic information distinguishing neuropathic from myopathic variants. Although the method can detect treatment responses, there is inadequate information to show that performance of small bowel scintigraphy can alter treatment decisions, predict outcomes from prokinetic therapy, or provide prognostic information to determine if a given patient should be considered for parenteral nutrition.

**TABLE 4**

Clinical Scenarios for Small Bowel Transit

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Symptoms of small bowel dysmotility (e.g. symptoms of: Nausea, Vomiting, Bloating, constipation, diarrhea, abdominal distention) | Appropriate | 7 |
|  | Suspected small intestinal bacterial overgrowth (SIBO) | May be Appropriate | 5 |
|  | Suspected generalized GI motility disorder (e.g. drug induced, idiopathic, or genetic) | Appropriate | 8 |
|  | Suspected Intestinal pseudo obstruction (e.g. unexplained small bowel dilation) | Appropriate | 8 |

**Summary of Recommendations**

The investigations cited in this systematic review, support the endorsement of the panel for use of small bowel scintigraphy as an appropriate diagnostic test in patients with symptoms of small bowel dysmotility and SIBO. The available data suggest that a subset of patients with symptoms of presumed upper and/or lower gut origin will exhibit delayed small bowel transit. However, there is not yet convincing literature that specifically documenting small bowel transit delays will influence additional management decisions or affect outcomes of any treatments for patients with functional gastrointestinal disorders.

**COLON TRANSIT**

**Introduction/Background**

Colonic motility regulates slow mixing and movement of its contents so the colon can absorb water and electrolytes and transform liquid chyme to semisolids or solids in the sigmoid colon. Rhythmic phasic contractions aided by tonic contractions cause slow distal propulsion and mixing of colonic contents. Additionally, infrequent high amplitude (>100 mm Hg) propagating contractions produce mass movements that deliver a large column of stool into the rectum. Thereafter, in healthy individuals, controlled evacuation of stool occurs normally between 2-3 times a day up to once in 3 day. A key question in patients with chronic constipation is to identify whether there is colonic inertia, generalized slow colon transit, pelvic floor dysfunction, functional outlet obstruction, or irritable bowel syndrome (Gibson, #52). Colonic motility and transit time are tested to determine whether a patient with symptoms of constipation has abnormal colonic transit and whether a specific area of the colon is involved.

Colon transit can be imaged using serial radiographs and after ingestion of radiopaque markers with a meal.

Radiographs are obtained for several days (up to 7) to count the number of markers remaining in segments of the colon (right, left and rectosigmoid regions) or throughout the colon. The radiopaque marker test is however not physiologic for the assessment of transit of intestinal chime. In contrast, two scintigraphic methods that have been most commonly applied to provide a more dynamic assessment of colonic transit use oral In-DTPA to measure colonic transit. These methods are described in detail in a consensus practice guideline (62). The wireless motility capsule is a newer technique that has been shown to correlate well with scintigraphy and radiopaque markers for measuring colon transit (Maqbool, 2009 #67).

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores in colon transit are presented in Table 5.

*Scenario 1:* Symptoms of large bowel (colon) dysmotility (e.g. symptoms of: constipation, bloating, abdominal pain, non-diarrhea dominant IBS). *(8 – Appropriate)*

Chronic constipation is a very prevalent condition. Based on studies using validated questionnaires, it is estimated to affect approximately 14% of the global population (NC, 2011 #60). Ruling out structural problems with colonoscopy or radiologic imaging is of primary importance, particularly for ruling out colonic malignancy or extrinsic luminal obstruction. Three types of constipation have been identified – normal transit, slow transit (colonic inertia or chronic colonic pseudo-obstruction) and evacuation disorders. Considerable overlap exists between the three groups (Camilleri, 2017 #86). Normal transit constipation includes those with IBS with constipation and IBS with mixed symptoms and in these patients abdominal pain and bloating is associated with constipation. Some patients with mixed constipation and diarrhea actually have underlying constipation and the diarrhea is caused by overflow of stool material around hard impacted stool in the rectosigmoid region (overflow incontinence). Therefore, assessing large bowel motility is helpful to determine an approach to treatment in all these patient groups, once obstructive lesions have been ruled out.  It is also important to assess the role of the pelvic floor function, as it relates to constipation before performing scintigraphy.  Pelvic floor dysfunction, especially dyssynergic defecation, has been shown to affect colonic transit (i.e. secondary slowing of colonic transit from distal functional obstruction) (Chitkara, 2004 #87). Once obstruction and pelvic floor dysfunction have been eliminated then colon transit scintigraphy is indicated and has proven to be a reliable test to distinguish slow transit from normal transit constipation (Camilleri, 2010 #88). In addition to distinguishing constipated patients with slow transit constipation, it can also differentiate patients who have delayed transit isolated to the rectosigmoid area. This indication was considered appropriate by unanimous agreement of the panel.

*Scenario 2:* *Suspected generalized GI motility disorder. (8 – Appropriate)*

The discussion and evidence supporting the use of colon transit imaging for this indication is essentially the same as those supporting the use of WGTS which includes GE, small bowel and colon transit studies. See Scenario 3: Suspected generalized GI motility disorder, Small Bowel Transit; Scenario 3 Suspected Intestinal pseudo obstruction, Colon Transit; and Scenario 1: Suspected pan gastrointestinal motility disorder, Whole Gut Transit.

*Scenario 3: Suspected Intestinal pseudo obstruction (e.g. unexplained megacolon). (8 – Appropriate)*

Intestinal pseudo-obstruction is a severe motility disorder where patients present with clinical signs of bowel obstruction. Radiographs will show dilated loops of bowel and air-fluid levels suggesting an obstruction, but no mechanical occluding lesion can be found. As discussed under Gastric Emptying *Scenario 6: Suspected generalized GI motility disorder (Intestinal pseudo obstruction)* intestinal pseudo-obstruction is commonly seen with systemic sclerosis, where the esophagus, stomach, small intestine and colon are commonly affected (Sridhar, 1998 #38). The presence of slow colon transit confirmed with WGTS as well as the demonstration of delayed GE and delayed small bowel transit helps to establish a diagnosis of intestinal pseudo-obstruction (Panganamamula, 2005 #89). This indication was considered appropriate by unanimous agreement of the panel.

**TABLE 5**

Clinical Scenarios for Colon Transit

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Symptoms of large bowel (colon) dysmotility (e.g. symptoms of: constipation, bloating, abdominal pain, non-diarrhea dominant irritable bowel syndrome) | Appropriate | 8 |
|  | Suspected generalized GI motility disorder | Appropriate | 8 |
|  | Suspected Intestinal pseudo obstruction (e.g. unexplained megacolon) | Appropriate | 8 |

**Summary of Recommendations**

Colonic transit scintigraphy can be used to distinguish motility disorders that affect colonic transit from those that affect the whole gut.   Also, disorders of colonic transit that cause constipation can be further differentiated into slow intestinal transit and normal transit constipation. In addition, this test may identify patients who have intestinal pseudo-obstruction and distal colonic disorders such as delayed rectosigmoid transit or dysfunction and disorders of the pelvic floor.

**WHOLE GUT TRANSIT**

**Introduction/Background**

Whole gut transit scintigraphy (WGTS) refers to a combined study which includes measurement of GE, small bowel and colonic transit after administration of a dual-isotope, solid-liquid meal (Maurer, 2013 #66). These studies are helpful for evaluating patients whose symptoms cannot be classified as either upper or lower GI in origin or where a functional and not an organic cause is suspected (Maurer, 1995 #90). The wireless motility capsule has been shown to correlate well with scintigraphy for measuring whole gut transit (Maqbool, 2009 #67) .

**Clinical Scenarios and AUC Scores**

Clinical scenarios for the use of nuclear medicine and final AUC scores in whole gut transit are presented in Table 6.

*Scenario 1: Suspected pan gastrointestinal motility disorder (e.g. unable to differentiate upper from lower gastrointestinal motility disorder). (8 - Appropriate)*

As discussed in both of the above sections on small bowel and colon transit, it is often difficult to determine whether a patient’s symptoms are functional or organic and, if organic, caused by upper or lower GI tract dysmotility. WGTS is therefore appropriate for use in such patients. In a study of patients referred for upper GI symptoms, constipation, or diarrhea, 40% were found to have an organic cause of symptoms but 60% were diagnosed as functional (Charles, 1995 #91).In a study to evaluate the clinical utility of WGTS, organic disease was found in many patients with an initial suspected functional disorder and the initial diagnosis was changed in 45% patients and patient management was changed in 67% patients (Bonapace, 2000 #1).

Patients with diarrhea-predominant IBS have faster small bowel transit and rapid colonic filling, whereas constipated patients have slower small bowel transit and delayed colonic filling (Read, 1986 #92). Gastrointestinal symptoms in patients with untreated celiac disease is associated with a wide range of dysmotility involving esophageal transit, gastric and gallbladder emptying, orocecal transit (small bowel) and colon transit (Tursi, 2004 #93). WGTS therefore can play an important role in evaluating patients with suspected symptoms from celiac disease.

Many patients with severe idiopathic constipation may have prominent upper GI symptoms. WGTS is most helpful for evaluating patients with constipation. Colon transit is slowed more commonly in patients with organic disease and normal in patients with functional constipation. It is important to exclude significant upper GI dysmotility in such patients before surgery because subtotal colectomy may not correct their symptoms (Kamm, 1988 #94). In a study of patients with severe idiopathic constipation with upper gastrointestinal symptoms, 3 of 4 with upper gastrointestinal symptoms had abnormal GE and small bowel transit in addition to delayed colon transit (VanDerSijp, 1993 #95). Another study of patients with chronic diverse GI symptoms referred for WGTS over a 5-year period documented delayed colon transit in 63% of patients with constipation compared to only 29% with dyspepsia (Kottekkattu, 2010 #96). This indication was considered appropriate by unanimous agreement of the panel.

Scenario 2: *Presurgical evaluation of colonic inertia*

In patients with chronic constipation, WGTS is useful to identify if there are abnormalities of gastric emptying and small bowel transit. These upper GI transit delays may be playing a role in the symptoms of constipation. For patients being considered for surgical treatment of chronic refractory constipation, such as total colectomy, obtaining WGTS is useful to ensure colonic transit is delayed and that transit of the upper GI tract is relatively normal. Pelvic floor dysfunction should also be excluded. Better outcomes are achieved for total colectomy if there is isolated colonic inertia (McCoy, 2012 #97). This indication was considered appropriate by unanimous agreement of the panel.

**TABLE 6**

Clinical Scenarios for Whole Gut Transit

|  |  |  |  |
| --- | --- | --- | --- |
| Scenario no. | Description | Appropriateness | Score |
|  | Suspected pan gastrointestinal motility disorder (e.g. unable to differentiate upper from lower gastrointestinal motility disorder) | Appropriate | 8 |
|  | Presurgical evaluation of colonic inertia | Appropriate | 8 |

**Summary of Recommendations**

Substantial evidence exists that WGTS helps localizing a site or sites of abnormal GI motility and thus helps yield a diagnosis and aids in directing therapy in patients with a wide range of both upper and lower GI tract symptoms.

**BENEFITS AND HARMS OF IMPLEMENTING THE AUC GUIDANCE**

The goal of this document is to aid and benefit referring physicians using clinical decision support (CDS) tools so they may achieve efficient and cost-effective use of scintigraphic gastrointestinal motility studies for the wide range of clinical scenarios described in this report. The recommendations presented are not meant to replace clinical judgment but rather are presented so that they can be incorporated into CDS tools to both educate referring physicians about the appropriate use of these studies and permit efficient ordering of scintigraphic GI motility studies.

It is recognized that it is not possible to cover all patient symptoms scenarios where GI scintigraphy studies may aid the referring physician in diagnosis and treatment. There are instances where no literature is available to support the use of such studies in a particular clinical scenario. Thus, there is concern that reliance on CDS tools may diminish the appropriate use of an imaging study for a clinical indication not described in this document. At this time, the future impact on patient outcomes of CDS tools based on use of AUC is unknown.

**QUALIFYING STATEMENTS**

**Study/Evidence Limitations**

After reviewing the available literature on GI transit scintigraphy, it is apparent that many studies describing tests such as gastric emptying and esophageal transit are more than a decade old. Methods such as esophageal transit scintigraphy while established many years ago have become replaced in many centers by more advanced manometric techniques and thus it’s use is limited to only select institutions where there is procedural expertise often not available at other institutions.  GI motility scintigraphy, however, continues to undergo modernization and advancement in other areas.  For example, gastric emptying studies continue to evolve with advances that permit simultaneous measurement of other indices of gastric motility such as accommodation and antral contractions (Orthey, 2019 #98).  This AUC will need updates as advancements of new, more specialized techniques occur.

Another limitation of the literature on GI transit studies is the lack of a gold standard to establish sensitivity and specificity values. Much of the literature, especially on measurement of gastric emptying and small bowel transit was established without comparison to another standard since no other methodology was available to look at solid and liquid transit of a physiologic meal within the GI tract.

As with many imaging studies, there have been few multicenter studies looking at clinical outcomes.  Our appropriateness ratings are heavily influenced by the clinical experience of the expert panel which included both imaging specialist s and gastroenterologists who perform , order and use these studies in the diagnosis and management of patients with a wide range of GI complaints.

It should be emphasized that these AUC recommendations are intended to apply primarily to adults.  Since no well-defined radiolabeled meal normal values have been established in children (due to concerns of radiation exposure to children involved in research) and GI transit protocols require development of normal values, this committee felt there was insufficient pooled data on normal values in children in the literature to confirm the validity of GI transit studies done in children.  Many sites however have developed institutional experience which may be utilized to validate their local study procedures.

**IMPLEMENTATION OF THE AUC GUIDANCE**

To develop broad-based multidisciplinary clinical guidance documents, SNMMI has been working with several other medical specialty societies. It is hoped that this collaboration will foster the acceptance and adoption of this guidance by other specialties. SNMMI has developed a multipronged approach to disseminate this AUC for GI transit scintigraphy to all relevant stakeholders including: referring physicians, nuclear medicine physicians, and patients. The dissemination and implementation tactics will include a mix of outreach and educational activities targeted to each of these audiences. SNMMI will create case studies for its members, as well as for referring physicians, and make them available via online modules and webinars. These cases will cover the appropriate clinical scenarios for the use of GI transit scintigraphy studies. Related resources such as the systematic review supporting the development of these AUC, a list of upcoming education events on the AUC, factsheets, and other didactic materials will be made available on the SNMMI web site. Live sessions will be held at the SNMMI annual and midwinter meetings, as well as at relevant other professional society meetings of referring physicians to highlight the importance and application of this AUC. SNMMI also aims to create a mobile application for this AUC for both Apple and Android platforms.

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**APPENDIX A: WORKGROUP MEMBERS AND EXTERNAL REVIEWERS**

**Workgroup**

The members of the workgroup are Alan Maurer, MD (chair), Temple University Hospital, Philadelphia, PA (SNMMI, #63); Thomas L. Abell, MD, University of Louisville, Louisville, KY (AGA); Paige Bennett, MD, Wake Forest University Baptist Medical Center, Winston-Salem, NC (SNMMI, #63); Jesus R. Diaz, MD, Texas Tech University Health Sciences Center, El Paso, TX (SNMMI, RSNA, ACR, AUR, ARRS); Lucinda A. Harris, MD, Mayo Clinic, Scottsdale, AZ (AGA, ACP, ACG, ANMS); William Hasler, MD, University of Michigan Health System, Ann Arbor, MI (AGA); Andrei Iagaru, MD, FACNM, Stanford University, Stanford, CA (SNMMI, #63); Kenneth L. Koch, MD, Wake Forest University Baptist Medical Center, Winston-Salem, NC (AGA); Richard McCallum, MD, Texas Tech University Health Sciences Center, El Paso, TX (ANMS, SNMMI); Henry Parkman, MD, Temple University School of Medicine, Philadelphia, PA (ANMS, AGA, SNMMI); Mark Tulchinsky, MD, FACNM, CCD, Milton S. Hershey Medical Center, Hershey, PA (SNMMI, #63).

**External Reviewers**

The external (peer) reviewers are [*fill in names, institutions and locations*].

**SNMMI**

The staff support from SNMMI is Sukhjeet Ahuja, MD, MPH, director, Evidence & Quality Department; Teresa Ellmer, MIS, CNMT, senior program manager, Evidence & Quality Department; Julie Kauffman, program manager, Evidence & Quality Department.

**APPENDIX B: DEFINITION OF TERMS AND ACRONYMS**

[*fill in definitions of all acronyms and terms*]

ACG= American College of Gastroenterology

ACNM = American College of Nuclear Medicine

ACP =American College of Physicians

ACR =American College of Radiology

AGA = American Gastroenterological Association

ANMS = American Neurogastroenterology and Motility Society

ARRS =American Roentgen Ray Society

AUR =Association of University Radiologists

AUC = Appropriate Use Criteria

CDS = Clinical decision support

COI = Conflicts of interest

CVS = Cyclic vomiting syndrome

ETS = Esophageal transit scintigraphy

FD = Functional dyspepsia

GE = Gastric emptying

GES = Gastric emptying scintigraphy

GI = Gastrointestinal

IBS = Irritable bowel syndrome

ReYGB = Roux-en-Y gastric bypass

RSNA = Radiological Society of North America

SIBO = Suspected small intestinal bacterial overgrowth

SNMMI = Society of Nuclear Medicine and Molecular Imaging

UCLA = University of California Los Angeles

WGTS = Whole gut transit scintigraphy

**APPENDIX D: DISCLOSURES AND CONFLICTS OF INTEREST (COI)**

SNMMI rigorously attempted to avoid any actual, perceived, or potential COIs that might have arisen as a result of an outside relationship or personal interest on the part of the workgroup members or external reviewers. Workgroup members were required to provide disclosure statements of all relationships that might be perceived as real or potential COIs. These statements were reviewed and discussed by the workgroup chair and SNMMI staff and were updated and reviewed by an objective third party at the beginning of every workgroup meeting or teleconference. The disclosures of the workgroup members can be found in Table [*fill in table number*]. A COI was defined as a relationship with industry—including consulting, speaking, research, and nonresearch activities—that exceeds $5,000 in funding over the previous or upcoming 12-mo period. In addition, if an external reviewer was either the principle investigator of a study or another key member of the study personnel, that person’s participation in the review was considered likely to present a COI. All reviewers were asked about any potential COI. A COI was also considered likely if an external reviewer or workgroup member was either the principal investigator or a key member of a study directly related to the content of this AUC. All external reviewers were asked about any potential COI.

**TABLE ##**

Relationships with Industry and Other Entities

|  |  |
| --- | --- |
| Workgroup member | Reported relationships |
| Abell, Thomas |  |
| Bennett, Paige |  |
| Diaz, Jesus |  |
| Harris, Lucinda |  |
| Hasler, William |  |
| Iagaru, Andrei |  |
| Koch, Kenneth |  |
| Maurer, Alan |  |
| McCallum, Richard |  |
| Parkman, Henry |  |
| Rao, Satish |  |
| Tulchinsky, Mark |  |

**APPENDIX E: PUBLIC COMMENTARY**

The workgroup solicited information from all communities through the SNMMI website and through direct solicitation of SNMMI members. The comments and input helped to shape the development of these AUC on the use of nuclear medicine in gastrointestinal transit.

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