Commenter	Section	Line #	Priority	Issue	Proposal	Committee Discussion	Owner (opt.)	Resolution (w Rationale if rejected)	Status	Post-resolution Reviewer	Reviewed	Post-review
IMPORTANT: Use ***File->Make a copy...*** to copy this template into a new file for your comments and edit the name (upper left) to rename it.								1	TBD	To be decided		
See http://qibawiki.rsna.org/index.php/Public_Comment_Process for more guidance on the comment resolution process								0	OK	No action requested		
								0	Discuss	Need to decide resolution		
								0	TODO	Resolution decided		
								59	Done	Profile update completed		
		Use PDF lines, they're stable		Describe your issue. Don't write a book, but do include enough to indicate what you see as a problem.	Suggest new wording or describe a way to address the issue. The committee may simply accept your suggested text. Even if they don't, it gives a good sense of what you're looking for. Leaving this blank means you can't imagine how to resolve the issue	<Cmte Notes as needed.> <Optionally, use the Owner column to divide up the work and assign rows to a committee member who will lead discussion and resolution>	<Delete this column if not used>	Describe how the comment was/will be resolved. May be simply accepted & changed as proposed, may be accepted & resolved differently, or may be rejected with a rationale for why.	TBD			
Fernando Calamante | fernando.calamante@sydney.edu.au	3.10.1	656	M	As far as I could see, section 3.10 is where the analysis method is described, but I've found the description "Post-Bolus Baseline: The Image Analyst shall visually identify the first point after the change in signal due to bolus passage" very vague and unclear as to how someone would accurately define that point based on the description provided (I wouldn't be able to know exactly what data point to choose based on that description!). Is this clarified better somewhere else that I missed?	I believe this section needs a more clear description of how that data point is defined. It would be helpful to add a figure to show this more clearly, if figures are allowed. If the definition is not very clear, it will lead to variability and subjectivity on how users interpret how the point should be selected.	Identify point of maximum drop, calculate baseline (from ~1 min of collection) mean and standard deviation. Work backwards from point of max drop to within std. deviation, step back a few (~3) timepoints. Difficult to capture algorithmically. Can be s/w-specific. Present above as an _example_ of how to approach? Ona: Perhaps limit duration to be 2 minutes maximum for AUC-TN estimates	Brad Erickson &Ona	Resolved by adding section 4.5 to provide details for post-bolus calculation	Done	Chad Quarles	Edits were made to 4.5 and not 4.3; otherwise resolved	Update 4.3 to 4.5 in spreadsheet/OW
Fernando Calamante | fernando.calamante@sydney.edu.au	3.10	626	M	I couldn't find where the AUC calculation is described. I would expect this should be included in section 3.10 (which describes the Image Data Reconstruction") . In particular, I couldn't find if the AUC is meant to be computed numerically (and if so by which approach?), by fitting, etc, what happens to the recirculation, etc? All these factors will play a role in the value measured, and thus would need to be clarified (or at least discussed what the various approaches are, and what the implications of choosing one vs the other are). Otherwise, again, if this is left 'vague', the risk is that this will be a source of variability and subjective choice.	-None provided-	Identify point of maximum drop, calculate baseline (from ~1 min of collection) mean and standard deviation. Work backwards from point of max drop to within std. deviation, step back a few (~3) timepoints. Difficult to capture algorithmically. Can be s/w-specific. Present above as an _example_ of how to approach?	Brad Erickson	Resolved by adding detailed explanation to 4.6	Done	Chad Quarles	resolved	
Fernando Calamante | fernando.calamante@sydney.edu.au	3.10	626	L	I found confusing the choice of "Image Data Reconstruction" for this heading, as I thought it was going to refer to the image reconstruction of the MRI data, while what it actually is describing is the image analysis to compute the maps.	I would therefore suggest it would be better to refer to "Analysis" (or something like that) rather than "Reconstruction", which in MRI has a very specific meaning.	3.10 contains quite a bit of analysis, majority of this section should be incorporated/merged into 3.13, specificaiton table adjusted accordingly (which may mean its elimination).	Ona	Rejected. The organization of profiles typically has 3.10 focusiing on how to make the maps. Section 3.13 focuses on how to measure regions of interest in the tumors which are the focus of the Aims.	Done	Chad Quarles	resolved	
Fernando Calamante | fernando.calamante@sydney.edu.au	2	146	L	Should somewhere have a explicit statement to indicate that the effect of AIF is not taken into consideration in this QIBA? I kept on looking through the document to see where the AIF was discussed, and then I realised it is never used or discussed. I have no issue with the decision of not using the AIF information, but it seems odd not to mention it up front.	-None provided-	Again avoiding proscribing s/w approach in an effort to allow for different s/w packages, pending conforming performance with DRO Might be useful to have some explanatory text in the Profile addressing this.	Brad Erickson	Resolved by adding to discussion of 3.10 that AIF is used by some software, but beyond the scope of the profile due to lack of reproducibility data	Done	Chad Quarles	resolved	

Kyrre Emblem | Kyrre.Eeg.Emblem @rr-research.no				In our clinical trials, we observe quite some variation when using multiple expert readers (radiologists) to outline the lesion volumes (both for enhancing and non-enhancing). The profile recognizes the potential advantage of automatic routines, as well as the limiting factor of not all centers having access to such specialized to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one software. Have you considered suggesting one dedicated radiologist as a 'local centralized review' to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one expert reader on study, but in our experience, using one dedicated reader as final approval seems to be of big help vis-à-vis outline reproducibility.		not best practices document. perhaps can mention something about "ideal" world, but not practical. we already mention inter and intra rater reproducibily - Smit paper. that you need to account for that in your estimation of wCV	Mark Shiroishi	Resolved by adding to discussion of Section 3.13	Done	Chad Quarles	resolved	
Kyrre Emblem | Kyrre.Eeg.Emblem @rr-research.no				The profile discusses the SS-EPI spatial distortion issue on page 32. Owing to a long-time collaboration with fellow Norwegian Anders Dale, we've had the multi-phase DSC setup going for quite some years. Having this data, impact of the artifact can be quite dramatic, especially when coregistered to non-EPI anatomical scans. This is just as much a focus for EPI-based diffusion MRI, and I know vendors like GE have already started implemented automatic correction algorithms in some of their sequences (multi shell, etc). The literature on the impact of this for DSC is limited, but may it be of relevance to mention that adding a simple non-bolus opposite-phase encoding scheme (~acquisition time in seconds) may provide imaging studies with the necessarily tools to compensate for this artifact post-scan?		this is a very specific technique - need special sequences so likely not generalizable in the clinics	Ona	Resolved by adding to discussion of 3.6 about alternate sequences and adding reference to review article Reference 25.	Done	Chad Quarles	I couldn't find text about alternate sequence	Corrected section from 3.10 to 3.6 in spreadsheet / Ona
Kyrre Emblem | Kyrre.Eeg.Emblem @rr-research.no	3.13	757-760	M	Inter- and intra-observer variations versus centralized review	In our clinical trials, we observe quite some variation when using multiple expert readers (radiologists) to outline the lesion volumes (both for enhancing and non-enhancing). The profile recognizes the potential advantage of automatic routines, as well as the limiting factor of not all centers having access to such specialized software. Have you considered suggesting one dedicated radiologist as a 'local centralized review' to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one expert reader on study, but in our experience, using one dedicated reader as final approval seems to be of big help vis-à-vis outline reproducibility.	see 12		Resolved by adding to discussion of Section 3.13	Done	Chad Quarles	resolved	
Kyrre Emblem | Kyrre.Eeg.Emblem @rr-research.no	3.11	711-715	M	The need for EPI spatial distortion correction	We've had an opposite-phase DSC setup going for quite some years. Having this data, impact of the artifact can be quite dramatic, especially when coregistered to non-EPI anatomical scans. This is just as much a focus for EPI-based diffusion MRI, and I know vendors like GE have already started implemented automatic correction algorithms in some of their sequences (multi shell, etc). The literature on the impact of this for DSC is limited, but may it be of relevance to mention that adding a simple non-bolus opposite-phase encoding scheme (~acquisition time in seconds) may provide imaging studies with the necessarily tools to compensate for this artifact post-scan?	see 13		Resolved by adding to discussion of 3.10	Done	Chad Quarles	resolved	
Todd Jensen |todd@jenseninformatics.com	1	123-125	H	AUC-TN seems to be equivalent to what is typically referred to as normalized rCBV (nrCBV) in vendor products and journal articles. I understand the desire to differentiate that the biomarker called rCBV may not actually be a 1:1 measure of CBV, but it has become very common-place and will be difficult to explain what AUC-TN is to clinicians not interested in reading the QIBA profiles.	Replace AUC-TN with nrCBV and include black box type warning. Or at least make clear in this section that AUC-TN why that term is being used versus nrCBV.	rCBV is often assumed to be proportional to AUC-TN. software component that converts AUC-TN to nrCBV.	Ona/Brad	Resolved by updating Executive Summary to explain why we use the term AUC-TN instead of rCBV	Done	Chad Quarles	resolved	
Todd Jensen |todd@jenseninformatics.com	Title	5	M	As a number of biomarkers can be derived from DSC-MRI, but only one is discussed in this profile.	Include biomarker in profile title or as a subtitle.	keep title as is		Reject since there will be future profiles to cover other biomarkers	Done	Chad Quarles	resolved	

Todd Jensen |todd@jenseninformatics.com	1	132-133	L	Where did the magic numbers 0.31 and 0.40 come from for the 95% CI?	Add something like "see Section 2.2 for more information about how these CI were derived".	agree to edit		Resolved by adding to Executive Summary	Done	Chad Quarles	resolved	
Todd Jensen |todd@jenseninformatics.com	2, 3.10.1	168-176, 644-648	H	Unsure where definition of K2 was obtained. Most K2 values derived from DSC MRI are based on the Weisskoff model which is more involved than the slope of the line (J. L. Boxerman, K. M. Schmainda, and R. M. Weisskoff, "Relative cerebral blood volume maps corrected for contrast agent extravasation significantly correlate with glioma tumor grade, whereas uncorrected maps do not," AJNR Am J Neuroradiol, vol. 27, no. 4, pp. 859–867, Apr. 2006.).	Add reference(s) for K2. Update K2 definition to be correct or that it may have multiple ways of being calculated.	add jerry's paper as ref for K2 calc	ona	Resolved by updating K2 calculation description and references to Section 4.6	Done	Chad Quarles	resolved	
Todd Jensen |todd@jenseninformatics.com	2.2	279-306	H	The magic numbers 0.31 and 0.40 are somewhat empirical due to the variability of acquisition and post-processing techniques and this is noted as a limitation. Therefore, the claims for the biomarker are not very strong. As Section 3 leaves a lot of variability for acquistion types and post-processing methods, the numbers reported for a specific acquistion type and post-processing method may not generalize.	Recommend to make the numbers in the claims parameters (i.e., 0.31 becomes wCV_tumor and 0.40 becomes wCV_nawm) that are not hard-coded but can be adjusted as more evidence becomes available (either globally for all or at a specific site) as is discussed in lines 330-353. Then add the recommendation to use 0.31 and 0.40 for wCV_tumor and wCV_nawm, respectively, if not known or measured with references to where these numbers originated.	Edit 2.2 qualifier to move paragraph to beginning of discussion and also add to executive summary	ona	Resolved by added to Executive Summary that values may change if future studies warrant it. The order of the discussion with respect to the claims cannot be swapped since Profile organization have Discussion after.	Done	Chad Quarles	resolved	
Kim.van.de.Ven@philips.com	Exec Summary	None provided	NA	Goal & target users of the document: to me this is very technical & vague. An executive summary should be much clearer. Is this document targeted towards clinical users, or researchers? Should it be used for optimal clinical data acquisition, or for DSC in research studies? Brain tumor only (apparent from section 2, clinical context). Do you target vendors to implement according to these guidelines?	I believe the executive summary should be more clear on the goal and target users – technical details should follow later.	edit executive summary	ona	Resolved with edits to executive summary	Done	Chad Quarles	resolved	
Kim.van.de.Ven@philips.com	NA	None provided	NA	I'm a bit confused wrt the chosen biomarker. As you say in L156 rCBV is most commonly used. So this is what commercial software shows (corrected for leakage and tissue normalized). I understand AUC-TN is mathematically more correct, but what do you expect of vendors. Should we report AUC-TN in addition to rCBV? And how do you envision interpretation of data by researchers and clinicians? Should they look at AUC-TN or rCBV?	Not provided	edit executive summary	ona	Resolved with edits to executive summary	Done	Chad Quarles	resolved	
Kim.van.de.Ven@philips.com	NA	None provided	NA	-Acquisitions (p47-48, p66-68): you nicely propose a standard protocol.	I suggest to better explain the critical parameters (TR should be below XX, voxelsize in plane should be smaller than YYxZZ, etc) and the tolerance/ranges of parameter settings that are acceptable. Not on every scanner type the exact same protocol can be achieved. We are looking into putting these standardized protocols in our protocol database, but some flexibility is required. I want to specifically point out that Compressed SENSE is now approved by FDA and can be used in these protocols as well.	clarify that these are parameters for DSC phantom studie in the appendix	ona	Resolved by clarifying that the parameters in Appendix F are for DSC phantom studies in the appendix	Done	Chad Quarles	resolved	
Ho-Ling (Anthony) Liu | hlaliu@mdanderson.org	3.6.2	535	H	Acquisition time has to be at least 180 s. What's the evidence that 180 s is needed? We scan for 120 s which is consistent with the ASFNR white paper (AJNR 2015).	120-180 s.	change to at least 120 s	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Ho-Ling (Anthony) Liu | hlaliu@mdanderson.org	3.6.3	535	H	TE=30 s. Slightly shorter TE help with susceptibility artifact while preserve enough contrast (e.g. > 10% described on this page).	25-35 ms.	make changes	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Ho-Ling (Anthony) Liu | hlaliu@mdanderson.org	3.10.1	644	H	K2 is determined based on slope of post-bolus time point, which seems different than the widely used Weisskoff model.	Provide an equation and the basis with reference of this method.	fix to reference boxerman paper	ona	See response to 19.	Done	Yuxiang Zhou	OK	
Ho-Ling (Anthony) Liu | hlaliu@mdanderson.org	3.4.1	458	M	"20c.c. saline chaser" the amount doesn't need to be exact.	At least certain c.c. of saline chaser. The saline should be injected as the same rate as the contrast agent.	accept changes	ona	Resolved with edits to Section3.9	Done	Yuxiang Zhou	OK	

Ho-Ling (Anthony) Liu | hlaliu@mdanderson.org	3.5.2	484	M	Physicist being Actor for Contrast Injector.	Physicist or Biomedical Engineer (or Technologist)	leave as is	ona	Reject. Having multiple actors can lead to confusion on who is responsible for carrying out checklist items.	Done	Yuxiang Zhou	Suggest to assign to Technologist because they use it everyday and for others.	Resolved. Changed to technologist./OW
Brian Taylor | bataylor2@vcu.edu	NA	Not provided	H	Acceptance and QA testing of the power injector should be the responsibility of a biomedical engineer (preferably) or technologist and not the medical physicist.	Assign the power injector actor (acceptance testing and QA) to biomedical engineer or technologist	see comment 28	ona	See reponse to 28.	Done	Yuxiang Zhou	Same as above	Resolved. Changed to technologist./OW
Brian Taylor | bataylor2@vcu.edu	NA	563 – 571	M	Lines 563 – 571 pertains to MR safety. Many implants are MR conditional at 1.5T cylindrical bore only. At some point can QIBA provide guidance at 1.5T for (1) patients with 1.5T MR-conditional implants and (2) facilities with no 3T systems.	Not provided	we focus on 3T.	ona	Resolved by adding 3T specifications to 3.2	Done	Yuxiang Zhou	OK	
Brian Taylor | bataylor2@vcu.edu	Page 48	Not provided	M	For the Philips acquisition, why is the flip angle “60 (or 30)”? 60 only may be more appropriate and is consistent with the other vendors.	Not provided	accept changes	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Brian Taylor | bataylor2@vcu.edu	NA	Not provided	L	For multiple lesions, care must be done if there are lesions in both hemispheres in selecting an ROI in normal appearing white matter. In addition, multiple lesions involving the same side of cerebral and cerebellar hemispheres can affect perfusion in the contralateral hemisphere if used for a reference (crossed cerebellar diaschisis)	Not provided	make comment in the profile discussion.	brad	Resolved by adding to discussion of 2.2 and 3.13	Done	Yuxiang Zhou	OK	
Lisa Cimino | lcimino@acr.org	3.9.1	615	M	cover as much of the brain as possible	cover the entire tumor (have had multiple sites cover full brain and double the acquisition, causing them to double the temporal resolution.So possibly mention not to go over the allotted slices?	priority is the keep TR at 1.5 ms and focus on covering the tumor	ona	Resolved by editing 3.9 specifications	Done	Yuxiang Zhou	OK	
Jim Gimpel | jgimpel@acr.org	3.6.2	535	L	Pixel Spacing parameter (8th row in table) is repeated at bottom of table	Fix typo	agree to edit	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Jim Gimpel | jgimpel@acr.org	3.6.1	522	M	There is reference to the use of a Preload Dose within the table (and a minor reference in line 528) in this section, but I did not find any guidance or instructions regarding the use of a preload; particularly in the checklists.	Remove reference to preload or elaborate on instructions for preload injections.	agree	brad	Resolved by editing Section 3.8 and described 2 methods, either by RT doing manual injection or via power injector and specifiyg appropriate delay (minimum time 5 min) (ona to prepopulate table)	Done	Yuxiang Zhou	OK	
Jim Gimpel | jgimpel@acr.org	3.2.2	424	L	What is meant by "Site Image Header" (see second row of table) as opposed to "Image Header" (in rows 3 and 4)?	Elaborate or fix typo	typo	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Jim Gimpel | jgimpel@acr.org	3.7.1	579	L	I was a little confused by the wording here. I think "scan timing" can be confused with scan time (e.g. sequence timing, temporal res, etc.). In this context, I might recommend "scan scheduling".	Change wording as described.	agree	ona	Accepted and changed as proposed	Done	Yuxiang Zhou	OK	
Jim Gimpel | jgimpel@acr.org	3.9.1	615	M	There is no mention regarding feasibility at 1.5T or why the profile is limited to 3T. Literature cited (Bell), states that, "when normalized...CBV does not differ across field strengths".	Reconsider use of term | Recommend a brief statement in the discussion on the rationale for limiting focus to 3T.	no data on 1.5T is why we focused on 3T. Paper cited is based on simulatiions.	ona	Resolved by editing Section 2.2 explaining why we focus on 3T in claims	Done	Yuxiang Zhou	OK	
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	12	N/A	N/A	Remove template notation. It’s a profile now. That being said, per the “Example text” entry, all the grey text throughout your profile should have been edited and color changed to black/Automatic	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	97	N/A	N/A	If you don’t have anything you are seeking feedback from reviewers on, you can remove Open Issues section	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	105	N/A	N/A	-That first row in the closed Issues table can be removed -Consolidate Actors row – since we can see what you did and there is no rationale here, can remove the row -Every specification row – seems like a todo that’s done. Can remove. -Just saw this row – seems like it’s done. Can remove -Table 1 row – seems like it’s done. Can remove.	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	112	N/A	N/A	“initial draft” -> “public comment”	agree	ona	Accepted and changed as proposed	Done	Mike Boss		

Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	126	N/A	N/A	if the sentence is a useful summary to readers, it should match your actor list from Table 1	the sentence should match actor list in Table 1	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	127	N/A	N/A	if the sentence is a useful summary to readers, it should match your activity list from Table 1	the sentence should match activity list in Table 1	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	140	N/A	what is the disclaimer disclaiming? And does this belong in the executive summary?	N/A	remove disclaimer	ona	Resolved by removing sentence from Executive Summary	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	148	N/A	this section is intended to be a paragraph or two stating what you think AUC-TN is used for (clinically) so readers can confirm we're on the same page.	Consider if it could be shortened.	agree should be shortened	brad	Resolved by editing Section 2	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	221	N/A	N/A	all these bullets should be requirements in the requirement tables down in the profile. Once there, they don't need to be repeated here. Skipped Section 2.1 and 2.2.	not sure whether we need to remove these sections	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	362	N/A	N/A	can tidy up some of the cell merges for the leftmost column (e.g. merge 3 Acquisition Device cells)	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	391	N/A	N/A	has staff lacking the certifications or qualifications listed here been found to be a common source of variability in AUC-TN measurements? If not, might consider dropping this section. If it has, focus the requirements in on the specific actors and qualifications that were found to affect variability.	suggesting drop section	ona	Rejected. Some sites may have technologists serving the role of physicists or vice versa. This section clarifies that the Actor roles may not be filled with someone with the job title. For example, a technologist may be fulfilling the role of the Physicist Actor for setting up protocols if qualified without having the MR Physicist job title at a site.	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	N/A	remove bullets. Just use sentences.	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	when copying into checklist tables, try not to put two requirements in the same cell.	Make two rows.	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	N/A	"SiteImage Header" -> "Image Header"?	fixed		Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	Contrast Media – avoid the slippery slope of embedding an incomplete MR safety/best-practices guide inside the profile.	Recommend removing this since it doesn't affect the claim.	remove safety language. change to focus on field effect size, paramagnetic agent	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	N/A	"Shall be confirmed that performance is linear" -> "Shall demonstrate linear performance" – and should likely reference an assessment procedure unless you let everyone choose their own method.	Point to 4.6 assessment procedure		Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	N/A	"Shall record volume of regions of interests uses." -> "Shall record the volume of each region of interest."	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	424	N/A	do you want to include a requirement that the MR be 3T?	N/A	yes	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	427	N/A	N/A	Given that you have a Periodic QA activity, it seems like you can perhaps drop the Pre-Delivery and Installation sections as redundant.	copy from DWI profile	ona	Resolved by modifying 3.3 and 3.4 to be consistent with DWI profile	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	468	N/A	just a reminder that all the stuff in Discussion is helpful background or clarification, but there are not actual requirements here. All the requirements are in the Specification requirement tables.	N/A	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	484	N/A	N/A	make text black, remove bullets, put one requirement per row.	ok	ona	Accepted and changed as proposed	Done	Mike Boss		

Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	484	N/A	it requires documenting upgrades but that information is never used. So how does it affect the claim?	If just best practice, consider dropping.	We need to know if software version has changed since longitudinal study.	ona	Resolved by adding discussion to 3.5.1 to explain how changes in software version can affect longitudinal results with reference	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	484	N/A	has assessing performance within vendor model benchmarks proven to be a common source of AUC-TN measurement variability?	If not, could drop.	Yes scanner stability for longitudinal claims can affect meeting the claim.	ona	See response to 60	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	484	N/A	“Scanner Operator Stability”	Gotta watch out for those unstable scanner operators. ;-)	typo	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	484	N/A	“Shall confirm Temporal SNR is <within some range?>"	See 4.4. Assessment Procedure: Temporal SN”, requirement to use QIBA-NIST DSC phantom should go inside the assessment procedure. And the procedure does not mention linearity.	specify range of temporal SNR based on phantom experiments from round table	ona	Resolved by expanding discussion in section 4.4 to deal with phantom measurements	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	501	N/A	uh oh. Hiding “shalls” in the discussion section.	See Profile Writing Guideline #1 (http://qibawiki.rsna.org/index.php/How_to_Write_a_Profile#Follow_Profile_Writing_Guidelines_)	see 58	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	505	N/A	and another shall…	See Profile Writing Guideline #1 (http://qibawiki.rsna.org/index.php/How_to_Write_a_Profile#Follow_Profile_Writing_Guidelines_)	see 58	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	535	N/A	“Physicist Shall confirm number of slice locations provides optimal coverage of tumor” Isn’t that going to be patient specific?	Probably belongs in Image Data Acquisition and probably not the Physicist?	agree	ona	Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	535	N/A	“Bolus Drop” – is there a procedure for evaluating this?	If its obvious to all physicists and none of the methods they might use are likely to generate results that differ in any significant way then it’s fine to have no procedure specified. Check the other procedures in section 4 and consider removing any that also fall into that category.	Expand 4.3 and have pointer to 4.3 in this table	ona	Resolved by adding pointer to 4.3	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	536	N/A	onward – mostly did not have time to review	N/A			no actions	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	582	N/A	“contraindications” and “venous access” sound like more safety/best practice rather than AUC variability.	Can likely drop.	Replace with making sure IV line is in the same arm as baseline study as applicable and remove safety concerns. Mention right arm is better. Put in Subject Handling as well.		Resolved by removing table, but kept Discussion	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	582	N/A	N/A	prescribing protocol consistent with baseline might go better in subject handling rather than selection (which was more clinical trial oriented) allowing this selection activity to be dropped.	agree		Accepted and changed as proposed	Done	Mike Boss		
Kevin O'Donnell | kodonnell@mru.medical.canon	N/A	839	N/A	N/A	“will” -> “shall”?	agree		Accepted and changed as proposed	Done	Mike Boss		