



Style Definition: TOC 1
Style Definition: TOC 3

QIBA Profile:

Ultrasound Measurement of Shear Wave Speed for Estimation of Liver Fibrosis

Stage: 2. Consensus

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1. Executive Summary

The goal of a QIBA Profile is to help achieve a useful level of performance for a given biomarker.

85 Profile development is an evolutionary, phased process; this Profile is in the consensus stage. The performance claims represent expert consensus and will be empirically demonstrated at a subsequent stage. Users of this Profile are encouraged to refer to the following site to understand the document's context: http://qibawiki.rsna.org/index.php/QIBA_Profile_Stages.

The **Claim** (Section 2) describes the biomarker performance.

90 The **Activities** (Section 3) contribute to generating the biomarker. Requirements are placed on the **Actors** that participate in those activities as necessary to achieve the Claim.

Assessment Procedures (Section 4) for evaluating specific requirements are defined as needed.

Conformance (Section 5) regroups Section 3 requirements by Actor to conveniently check Conformance.

95 This QIBA Profile (Ultrasound Measurement of Shear Wave Speed for Estimation of Liver Fibrosis) addresses estimation of liver fibrosis, which is often used to determine when and how to treat patients with diffuse liver disease, and also monitor progression or response to treatment. It places requirements on ultrasound scanners (acquisition devices), Scanner Manufacturer/Vendor, Technologists/Sonographers, QA (Quality Assurance) Manager, Radiologists, and Image Analysis Tools
100 involved in pre-delivery steps, scanner installation, periodic QA procedures, subject selection and handling, SWS image acquisition, image QA, and image analysis. The requirements are focused on achieving sufficient accuracy and avoiding unnecessary variability of the estimation of liver fibrosis. Estimates of liver fibrosis are based on a measurement of shear wave speed (SWS) in the tissue using ultrasound, which in turn is based on the stiffness of the liver tissue.

105 The clinical performance target is to achieve SWS measurements with a bias of the mean value of $\leq 5\%$ and an overall coefficient of variation (SD/mean) of $\leq 5\%$. The standard against which to measure bias has not yet been fully defined, so currently there is no bias claim. At the present time, bias is determined by comparison to the measured SWS and stiffness using a Verasonics ultrasound system in a calibrated QIBA SWS phantom. Currently bias and precision depend on the magnitude of measured SWS (as
110 determined in phantom studies) so bias and variance claims are given for three ranges of measured SWS values. Also, bias and precision depend on the conditions under which the measurements are made. Bias and precision claims are therefore also given for various measurement conditions.

115 This document is intended to help clinicians basing decisions on this biomarker, imaging staff generating this biomarker, vendor staff developing related products, purchasers of such products, and investigators designing trials with imaging endpoints.

Note that this document only states requirements to achieve the claim, not "requirements on standard of care." Conformance to this Profile is secondary to properly caring for the patient.

QIBA Profiles addressing other imaging biomarkers using CT, MRI, PET and Ultrasound can be found at https://qibawiki.rsna.org/index.php/Main_Page

120

Commented [WKA1]: Checklist 3.5 says "periodic QA"

Commented [WKA2]: Checklist says "SWS Image Acquisition"

Commented [WKA3]: The checklist and Section 3.11 just say "Image QA"

Commented [WKA4]: Consider rewrite: Estimates of liver fibrosis are based on measurements of ultrasound shear wave speed (SWS), which are related to tissue stiffness.

Commented [WKA5]: Isn't bias defined as the difference between the mean value and the true value? If so, then "of the mean value" is unnecessary.

Commented [MS6R5]: want to retain this definition "bias of the mean" as there are alternative definitions

2. Clinical Context and Claims

Elastography is a technique for measuring tissue stiffness or elasticity. Stiffness or elasticity of all materials including tissue is defined by a parameter known as the elastic (or Young's) modulus typically given in units of pressure (Pascals or kilopascals). The elastic modulus may be measured directly by mechanical testing where stress (mechanical pressure) is applied to a sample of material and the deformation (change ΔL of original thickness L) is measured. The slope of the plot of relative deformation ($\Delta L/L$) vs. stress is the elastic modulus. For a given amount of stress, the fractional deformation (change in thickness over original thickness) of the overall block of material, or at any location in the material, is defined as the "strain". Samples of tissue are not usually available for mechanical testing, so elastography was developed as a means to estimate tissue elasticity non-invasively. Tissue elasticity may be calculated in two ways: 1) From an image of the strain of a region of tissue in response to external or internal compression force (known as strain elastography), and 2) by measuring the speed of propagation of a shear wave as it traverses a region of tissue (known as shear wave elastography). For the second technique, the (SWS) may be used as a surrogate for tissue stiffness which serves as a biomarker for amount of fibrosis since it has been shown that fibrosis is the primary cause of increased liver stiffness.

Clinical Context

~~SWS is aserves as a biomarker of liver fibrosis, to identify patients with moderate but though significant liver fibrosis is, defined as \geq F2 stage of fibrosis in the METAVIR staging system (or equivalent for other scoring systems), while cirrhosis is defined as F4 stage of fibrosis of staging liver fibrosis. Recently updated Consensus statements¹ recommend using SWS to convey a likelihood of compensated advanced chronic liver disease (cACLD), categorizing patients as either high probability of being normal (i.e., no fibrosis); low probability of cACLD; suggestive of having cACLD with other clinical signs; and high probability of cACLD (i.e., cirrhosis). This might be used to monitor progression or regression (due to therapy) of fibrosis.~~

~~SWS SWS also serves as a biomarker for the evaluation of cirrhosis, defined as F4 stage of fibrosis of the METAVIR system of staging liver fibrosis. This might may further be used to monitor progression or regression (due to therapy) of fibrosis.~~

As noted in the discussion below, the SWS biomarker may be referred to as the "measurand" elsewhere in this document.

Intended Clinical Application: SWS is measured in the liver of patients with suspected diffuse liver disease, with or without ~~fatty infiltration~~steatosis of the liver and with suspected fibrosis or cirrhosis.

Multiple Claims: Groundwork studies conducted by the QIBA SWS Biomarker Committee have indicated that the key measures of biomarker performance, Bias and Precision, depend on the level of fibrosis present and upon other variables such as whether or not the measurements are taken with a single machine at a single site (hospital or clinic) or not. Accordingly, several claims for bias and precision are made depending on the situation and estimated level of fibrosis. Strictly speaking, the claims of the

Commented [WKA7]: SWS already defined.

Commented [WKA8]: In the previous paragraph, you say "F2 fibrosis". Here you say "F4 stage of fibrosis". You might want to be consistent regarding whether you say "stage of" or not.

Commented [WKA9]: Groundwork is one word.

¹ Barr, R. G., Wilson, S. R., Rubens, D., Garcia-Tsao, G., & Ferraioli, G. (2020). Update to the society of radiologists in ultrasound liver elastography consensus statement. *Radiology*, 296(2), 263-274.

profile only apply to purely elastic materials and phantoms. This is because visco-elastic phantoms are generally not available at this time for sites to verify the profile claims. In addition, the committee must perform further work to verify the profile claims for a clinically relevant range of visco-elastic materials. Claims for visco-elastic phantoms and tissues are expected to appear in the next version of the profile. The claims are presented below.

In the claims presented below, the term “imaging system” refers to both the ultrasound scanner (machine) and the operator using the machine to perform SWS measurements. Changing either the operator or ultrasound scanner therefore results in a different imaging system.

Conformance to this Profile by all relevant staff and equipment supports the following claim(s):

Claim 1 (technical performance claim): A shear wave speed measurement has a within-subject coefficient of variation (wCV) depending on the measured SWS and depth of acquisition according to Table 2-1.

Table 2-1 Within-Subject Coefficient of Variation (wCV)

Measured SWS (m/s)	Depth=4.5cm*	Depth=7.0cm
0.9 < SWS ≤ 1.2	5%	8%
1.2 < SWS ≤ 2.2	4%	5%
2.2 < SWS ≤ 5.0	10%	12%

*For measurements taken at depths other than the two listed, the SWS Committee has determined that linear interpolation of the Coefficients of Variation (wCV) is appropriate. Although large changes in wCV are seen between the middle and high SWS ranges, those ranges have different clinical uses. The committee has insufficient phantom data to make a recommendation regarding interpolation of wCV based on SWS.

Claim 2 (cross-sectional claim): A 95% confidence interval for the true SWS is $Y \pm (1.96 \times Y \times wCV/100)$, where Y is the measured SWS and wCV is the within-subject coefficient of variation from Table 2-1.

Note: Claims 3a and 3b hold when the same technologist and same ultrasound scanner are used at the two time points.

Claim 3a (longitudinal claim): A true change in SWS measurements (Y1 and Y2) over two time points has occurred with 95% confidence if the measured % change, defined as $\frac{|Y_2 - Y_1|}{(Y_1 + Y_2)/2} \times 100$, is equal to or greater than the repeatability coefficient (RC) given in Table 2-2.

Table 2-2 Repeatability Coefficient (RC)

Measured SWS (m/s)	Depth=4.5cm*	Depth=7.0cm

Commented [WKA10]: I find the second half of this sentence (beginning with “and the committee”) to be confusing. Is it necessary?

Commented [WKA11]: Change “<=” to “≤” throughout document?

Commented [WKA12]: I don’t understand this. Maybe it’s just me. Same clause appears in many table captions.

Commented [MS13R12]: deleted from table caption

Commented [MS14]: if changed is agreed to, apply same caption change to all tables as applicable

Commented [MS15R14]: agreed to at 19 Jan 2022 call

Commented [MS16]: Review w/ group

Formatted: Body Text

Commented [WKA17]: What if Y1 is in one SWS range (say, 1.2 – 2.2 m/s) and Y2 is in a different SWS range (say, 2.2 – 5.0 m/s). Which RC value should be used? The average? The lower value? The higher value? The conservative approach might be to use the higher value.

This ambiguity exists for multiple claims below.

Or am I missing something?

0.9 < SWS ≤ 1.2	14%	22%
1.2 < SWS ≤ 2.2	11%	14%
2.2 < SWS ≤ 5.0	28%	33%

*For measurements taken at depths other than the two listed, the SWS Committee has determined that linear interpolation of the Repeatability Coefficient (RC) is appropriate. ~~Although large changes in RC are seen between the middle and high SWS ranges, those ranges have different clinical uses. The committee has insufficient phantom data to make a recommendation regarding interpolation of RC based on SWS.~~

Claim 3b (longitudinal claim): A 95% confidence interval for the true change over two time points (Y1 and Y2) is:

$$(Y_2 - Y_1) \pm 1.96 \times \sqrt{(Y_1 \times wCV_1/100)^2 + (Y_2 \times wCV_2/100)^2}, \text{ where } wCV \text{ is based on Table 2-1.}$$

~~Claims 3a and 3b hold when the same technologist and same ultrasound scanner are used at the two time points.~~

Note: Claims 4a and 4b hold when a different technologist and/or a different ultrasound scanner is used at the same site at the two time points.

Claim 4a (longitudinal claim): A true change in SWS measurements (Y1 and Y2) over two time points has occurred with 95% confidence if the measured % change, defined as $\frac{|Y_2 - Y_1|}{(Y_1 + Y_2)/2} \times 100$, is equal to or greater than the reproducibility coefficient (RDC) given in Table 2-3.

Table 2-3 Reproducibility Coefficient (RDC) (Same Site)

Measured SWS (m/s)	Depth=4.5cm	Depth=7.0cm
0.9 < SWS ≤ 1.2	19%	25%
1.2 < SWS ≤ 2.2	14%	17%
2.2 < SWS ≤ 5.0	33%	39%

*For measurements taken at depths other than the two listed, the SWS Committee has determined that linear interpolation of the Reproducibility Coefficient (RDC) is appropriate. ~~Although large changes in RDC are seen between the middle and high SWS ranges, those ranges have different clinical uses. The committee has insufficient phantom data to make a recommendation regarding interpolation of RC based on SWS.~~

Claim 4b (longitudinal claim): A 95% confidence interval for the true change over two time points (Y1 and Y2) is

$$(Y_2 - Y_1) \pm 1.96 \times \sqrt{(Y_1 \times U_1/100)^2 + (Y_2 \times U_2/100)^2}, \text{ where } U \text{ is from Table 2-3b.}$$

Commented [WKA18]: Change wCV to wCV_1 and wCV_2 in case SWS jumps from one SWS range to another?

Commented [WKA19]: Should this line appear BEFORE claims 3a and 3b?

Commented [MS20R19]: moved before 3a and 3b

Commented [WKA21]: Should this line appear BEFORE claims 4a and 4b?

Table 2-3b Values of U (wCV from different technologist and/or scanner at same site)

Measured SWS (m/s)	Depth=4.5cm	Depth=7.0cm
0.9 < SWS ≤ 1.2	7%	9%
1.2 < SWS ≤ 2.2	5%	6%
2.2 < SWS ≤ 5.0	12%	14%

*For measurements taken at depths other than the two listed, the SWS Committee has determined that linear interpolation of U is appropriate. ~~Although large changes in U are seen between the middle and high SWS ranges, those ranges have different clinical uses. The committee has insufficient phantom data to make a recommendation regarding interpolation of U based on SWS.~~

~~Claims 4a and 4b hold when a different technologist and/or a different ultrasound scanner is used at the same site at the two time points.~~

Commented [WKA22]: Should this line appear BEFORE claims 4a and 4b?

Claims 5a and 5b hold when a different technologist and/or a different ultrasound scanner is used at different sites at the two time points.

Commented [WKA23]: Should this line appear BEFORE claims 5a and 5b?

Claim 5a (longitudinal claim): A true change in SWS measurements (Y1 and Y2) over two time points has occurred with 95% confidence if the measured % change, defined as $\frac{|Y_2 - Y_1|}{(Y_1 + Y_2)/2} \times 100$, is equal to or greater than the reproducibility coefficient (RDC) given in Table 2-4.

Table 2-4 Reproducibility Coefficient (RDC) (Different Sites)

Measured SWS (m/s)	Depth=4.5cm	Depth=7.0cm
0.9 < SWS ≤ 1.2	22%	28%
1.2 < SWS ≤ 2.2	17%	19%
2.2 < SWS ≤ 5.0	33%	39%

Claim 5b (longitudinal claim): A 95% confidence interval for the true change (in m/sec) over two time points (Y1 and Y2) is

$$(Y_2 - Y_1) \pm 1.96 \times \sqrt{(Y_1 \times H_1\%/100)^2 + (Y_2 \times H_2\%/100)^2}, \text{ where H is from Table 2-4b.}$$

Table 2-4b Values of H (wCV from different technologist and/or scanner at different sites)

Measured SWS (m/s)	Depth=4.5cm	Depth=7.0cm
0.9 < SWS ≤ 1.2	8%	10%
1.2 < SWS ≤ 2.2	6%	7%
2.2 < SWS ≤ 5.0	12%	14%

~~Claims 5a and 5b hold when a different technologist and/or a different ultrasound scanner is used at different sites at the two time points.~~

Commented [WKA24]: Should this line appear BEFORE claims 5a and 5b?

240 The above claims were developed based on phantom studies conducted by the Ultrasound Shear Wave Speed Biomarker Committee and may not accurately reflect performance in patients. The expectation is that during the Claim Confirmation and Clinical Confirmation stages, data on the actual field performance will be collected and changes made to the claims or the details accordingly. At that point, this caveat may be removed or re-stated.

245

2.1 Clinical Interpretation

QIBA Claims describe the technical performance of quantitative measurements. The clinical significance and interpretation of those measurements is left to the clinician. Some considerations are presented in the following text.

250 Currently the only consensus standard for interpretation in the United States is that formulated by the Society of Radiologists in Ultrasound in October 2014². According to that standard, measurements are used to classify a patient into one of the three categories below:

Example Table of Liver Fibrosis Categories and Corresponding Representative Shear Wave Speed Values. *

Ultrasound System	No Fibrosis or Minimal Fibrosis (METAVIR F0-F1)	Moderate Fibrosis (METAVIR F2 ⁱ and F3 ⁱⁱ)	Severe Fibrosis/Cirrhosis (METAVIR F3 – F4)
System A	SWS < 1.37 m/s (< 5.7kPa) ⁱⁱⁱ	1.37 < SWS < 2.2 m/s (> 5.7 kPa, < 15 kPa)	SWS > 2.2 m/s (> 15 kPa) ^{iv}
System B	SWS < 1.66 m/s (<8.29 kPa)	1.66 ≤ SWS < 1.88 m/s (≥8.29 kPa, < 10.60 kPa)	SWS ≥1.88 m/s (≥10.60 kPa)

255 *Considerable changes have been adopted by the clinical community since this table was developed. Some of the changes are described below:

i. Metavir F2 currently is often classified as “significant fibrosis” and is no longer grouped with F3.

ii. F3 is no longer classified as moderate cirrhosis but instead both F3 and F4 are classified as “Compensated advanced chronic liver disease” for clinical management.

260 iii. [Some systems estimate elasticity in kPa rather than SWS in m/s.](#) After acquisition of additional data with newer software, the values for this system have been revised upward. Currently the cutoff value for F2 is approximately 7kPa for both ARFI systems such as this one and Fibroscan.

iv. This value is high for the F4 cutoff and carries a significant risk of misclassification of F4 patients as F3. This value was used as it was associated with a nearly 100% specificity which was considered desirable by the consensus panel. It may be revised in the next consensus panel statement.

265

Further guidance regarding interpretation of SWS values for chronic diffuse liver disease may be found in the updated guidelines for liver ultrasound elastography published in September 2018 by the World

² Richard G. Barr, Giovanna Ferraioli, Mark L. Palmeri, Zachary D. Goodman, Guadalupe Garcia-Tsao, Jonathan Rubin, Brian Garra, Robert P. Myers, Stephanie R. Wilson, Deborah Rubens, and Deborah Levine. Elastography Assessment of Liver Fibrosis: Society of Radiologists in Ultrasound Consensus Conference Statement. Radiology 2015 276:3, 845-861

Commented [WKA25]: This table gives the first appearance of kPa in the Profile. So I added some explanation of kPa.

Federation of Ultrasound in Medicine and Biology³.

270 For cutoff values for some specific ultrasound systems, please refer to the Manufacturer Specific Protocols in Appendix D.

275 Tests (see References (Inflammation affects SWS)) have shown that active inflammation in the liver affects SWS measurements. When a patient has severe acute/chronic active hepatitis (including short-term flare-ups), SWS may OVERESTIMATE the degree of fibrosis (increased positive bias). Similarly, SWS may OVERESTIMATE the degree of fibrosis in a non-fasting state and in conditions that cause congestion of the liver, such as congestive heart failure, renal failure with volume overload, etc.

Clinical interpretation with respect to progression or response:

280 For measurements at multiple points in time, a patient may be reclassified clinically if the newer measurement falls into a different clinical category AND if the difference between the new measurement and prior measurement are statistically different from one another, according to claims 3-5.

2.2 Discussion

285 Groundwork studies conducted by the QIBA SWS Biomarker Committee have indicated that the key measures of biomarker performance, Bias and Precision, depend on the level of fibrosis present and upon other variables such as whether or not the measurements are taken by a single technologist with a single machine at a single site (hospital or clinic). Accordingly, several claims for bias and precision are made dependent on the use of the same or different technologist and scanner, and on the measured shear wave speed (SWS).

290 In shear wave elastography (SWE), the biomarker is, as noted above, SWS which is the speed of a shear wave generated in a patient's liver by an acoustic radiation force impulse (ARFI) "push pulse". One device measuring propagation of shear waves using ultrasound is the non-imaging FibroScan® device which applies force by means of a mechanical piston pressing against the skin instead of an ARFI push pulse. Measurement using the FibroScan® device is not covered by this profile. A table for comparing FibroScan® and magnetic resonance elastography (MRE) values with ARFI SWS values obtained
295 according to this profile will be listed at the end of this section when validated comparisons become available. The SWS biomarker is used for measurement at a single point in time intended to classify liver tissue according to fibrosis grade and also for monitoring SWS (and corresponding fibrosis) changes over time.

300 Claim 1 describes the expected variability in terms of the within-subject coefficient of variation (%wCV) of measurements made at approximately the same time in the same patient and acquisition depth for several depths and for several ranges of SWS. These two variables (depth and SWS range) have been determined by the committee to have significant effects on technical performance but which can be controlled for by acquisition technique and data analysis. The claim is based on results from a phantom

Commented [WKA26]: Consider changing "Another" to "One" since the antecedent is SWE, which is a technology, not a device.

³ Ferraioli, Giovanna & Wong, Vincent & Castera, Laurent & Berzigotti, Annalisa & Sporea, Ioan & Dietrich, Christoph & Choi, Byung Ihn & Wilson, Stephanie & Kudo, Masatoshi & Barr, Richard. (2018). Liver Ultrasound Elastography: An Update to the World Federation for Ultrasound in Medicine and Biology Guidelines and Recommendations. Ultrasound in Medicine & Biology. 10.1016/j.ultrasmedbio.2018.07.008.

study, where 10 repeat measurements were performed at each depth within a phantom at each site.

305 Claim 2 is a cross-sectional claim describing the 95% confidence interval of the true SWS measurement for several depths and for several ranges of SWS. ~~These two variables (depth and SWS range) have been determined by the committee to have significant effects on technical performance but which can be controlled for by acquisition technique and data analysis.~~ The claim is based on two results from the phantom study: first, that the within-subject CV is as described in Claim 1; second, that the bias is negligible for most systems.

310 Claims 3a and 3b describe the confidence interval for differences between two measurements of SWS made on the same patient at different points in time when the same operator makes the measurement on the same scanner using the technique described in this profile. These claims make the following assumptions:

- 315 a. ~~SWS measurements have the property of linearity~~ are proportional to true SWS
b. The slope of a line between the SWS measurements and the true value is 1.0.

320 Claims 4a and 4b describe the confidence interval for differences between two measurements of SWS made on the same patient at different points in time when a different operator and/or a different scanner at the same imaging site is used to make the measurements using the technique described in this profile. These claims make the following assumptions:

- a. SWS measurements ~~have the property of linearity~~ are proportional to true SWS
b. The slope of a line between the SWS measurements and the true value is 1.0.

325 Claims 5a and 5b describe the confidence interval for differences between two measurements of SWS made on the same patient at different points in time when a different operator and/or a different scanner at a different imaging site is used to make the measurements using the technique described in this profile. These claims make the following assumptions:

- a. SWS measurements ~~have the property of linearity~~ are proportional to true SWS
b. The slope of a line between the SWS measurements and the true value is 1.0.

Commented [WKA27]: Is it necessary to repeat this sentence that appeared in the previous paragraph?

Commented [MS28R27]: Deleted

Commented [WKA29]: Consider rephrasing: Measured SWS is linearly related to true SWS. Otherwise, readers may ask, "linear with respect to what?" This applies to several instances below.

Commented [MS30R29]: could replace linearity with proportional? or say "SWS are proportional to the true SWS"?

330 **3. Profile Activities**

The Profile is documented in terms of “Actors” performing “Activities”. Equipment, software, staff or sites may claim conformance to this Profile as one or more of the “Actors” in the following table.

Conformant Actors shall support the listed Activities by conforming to all requirements in the referenced Section.

335 **Table 1: Actors and Required Activities**

Actor	Activity	Section
Ultrasound Scanner	Periodic QA	3.5
Technologist/Sonographer	Staff Qualification	3.1
	Subject Handling	3.8
	SWS Image Acquisition and Point SWS Measurement	3.9
	Image QA	3.11
Radiologist	Subject Selection	3.7
	Subject Handling	3.8
	Image QA	3.11
	Image Analysis	3.13
QA Manager	Site Conformance	3.0
	Installation	3.4
	Periodic QA	3.5
Manufacturer	Pre-delivery	3.3
	Installation	3.4

The requirements in this Profile do not codify a Standard of Care; they only provide guidance intended to achieve the stated Claim. Failing to conform to a “shall” in this Profile is a protocol deviation. Although deviations invalidate the Profile Claim, such deviations may be reasonable and unavoidable and the radiologist or supervising physician is expected to do so when required by the best interest of the patient or research subject. How study sponsors and others decide to handle deviations for their own purposes is entirely up to them.

340

345 A detailed sequencing of all the Activities specified in this Profile is given in the Excel spreadsheet “Checklist” in Appendix E in a format that can be reproduced for use on site during the generation of the biomarker.

3.0. Site Conformance Check

This activity involves establishing the overall conformance of an imaging site to this Profile. It includes criteria to confirm the conformance of each of the participating Actors at the site.

350 3.0.1 DISCUSSION

A site conforms to the Profile if each relevant ~~actor~~Actor conforms to each requirement assigned in the Activities of the Profile.

The requirements in section 3.0.2 are that a site-designated QA Manager confirm all the relevant Actors at the site have conformed to the Profile.

355 For a discussion of Conformance, see Section 5.

3.0.2 SPECIFICATION

Parameter	Actor	Requirement
3.0.2.1 Ultrasound Scanner	QA Manager	Shall confirm requirements for performance and installation are met, and US scanners conform to Profile
3.0.2.2 Technologist / Sonographer / Radiologists	QA Manager	Shall confirm that each potential operator (technologist/sonographer and Radiologist) conforms to this Profile with respect to training, documented acquisition performance, and proper conduct of SWS acquisitions. <u>If a site has ultrasound systems from multiple manufacturers, conformance shall be confirmed for each model / scanner type at the site.</u>

3.1. Staff Qualification

360 This activity involves evaluating the human Actors (Radiologist, Physicist, and Technologist) prior to their participation in the Profile. It includes training, qualification or performance assessments that are necessary to reliably meet the Profile Claim.

3.1.1 DISCUSSION

These requirements, as with any QIBA Profile requirements, are focused on achieving the Profile Claim. Evaluating the medical or professional qualifications of participating actor/Actors is beyond the scope of this profile.

3.1.2 SPECIFICATION

Parameter	Actor	Requirement
3.1.2.1 Operator Training	Technologist/Sonographer Radiologist	Shall be trained and approved for SWS acquisition, meeting performance requirements on subjects based on site-specific protocol. Patient case review with IQR/median ≤ 0.30 if in kPa, or < 0.15 if in m/s.

An example of a possible site-specific protocol:

After performing approximately 20 supervised SWS acquisitions on patients, the operator’s examination images and SWS quality in terms of IQR/median are reviewed by the QA Manager or Radiologist. If 90% of examinations are within the specification above then the operator may be qualified to perform the SWS measurements from a technique standpoint.

Commented [MS31]: The ~20 figure should probably appear in the checklist
Commented [MS32]: Should include this in the checklist too?

Other parameters related to good clinical practice such as patient-operator interactions, image labeling etc. may also be assessed in the usual manner for clinical personnel.

3.2. Product Validation

This activity involves evaluating the product Actors (Acquisition Device and Image Analysis Tool) prior to their use in the Profile (e.g. at the factory). It includes validations and performance assessments that are necessary to reliably meet the Profile Claim.

For ultrasound scanners, each system has unique software and means of display plus validation methods internal to the Manufacturer. For this reason, no requirements regarding product validation are provided here. Manufacturer performance testing is covered in the pre-delivery section.

3.3. Pre-delivery

This activity involves calibrations, phantom imaging, performance assessments or validations prior to delivery of equipment to a site (e.g. performed at the factory by the scanner manufacturer/Manufacturer) that are necessary to reliably meet the Profile Claim.

3.3.2 SPECIFICATION

Parameter	Actor	Requirement
3.3.2.1 System Conformance	Manufacturer	Shall certify system specifications conform to the Profile, including acoustic output, focusing, and measurement consistency.
3.3.2.2 Hardware and transducer Manufacturer specified parameters	Manufacturer	Shall ensure the equipment intended for use is listed in Appendix D as a compliant combination of System, Software Revision and Transducer.
3.3.2.3 SWS Measurement Consistency	Manufacturer	Shall confirm SWS measurements are within +/- 5% in a calibrated phantom that the SWS Measurement Consistency of the Ultrasound Scanner is within ± 5%. See 4.2 Assessment Procedure: SWS Measurement Consistency.

Commented [WKA33]: I suggest deleting "transmit power", and just call it "acoustic output." "Acoustic Output" is the common term used in IEC standards and FDA guidance. It includes not only power but also pressure measurements. Same comment applies to checklist, section 3.3.2.1

3.4. Installation

390 This activity describes calibrations, phantom imaging, performance assessments or validations following installation of equipment at the site that are necessary, or after relevant software or hardware upgrades, to reliably meet the Profile Claim.

3.4.1 DISCUSSION

395 The QA Manager is responsible for several of these requirements being met. The QA Manager may delegate actual performance of certain steps, e.g., to a scanner vendor engineer, and confirm the results.

400 The testing procedure in section 4.3 compares the SWS measured by the scanner in a phantom to the calibration values obtained by using the Verasonics system. These results **do not yet represent a formal claim for the profile** but could become one in a future edition. If the scanner does not meet the specifications in the table below (table 3.4.2), then the scanner may still be used, but the Manufacturer should be contacted about the discrepancy to determine possible causes. For example, the acquisition procedure provided by the Manufacturer in Appendix D may be incomplete or the site may not be following the procedure as intended by the Manufacturer. The site should record and report a discrepancy found here with their results reporting until the issue is resolved (in conjunction with the Manufacturer).

3.4.2 SPECIFICATION

Parameter	Actor	Requirement / (Recommendation)
3.4.2.1 Software verification	QA Manager	Shall confirm the software version equals the version specified in the products QIBA Conformance Statement or one listed in Appendix D.
3.4.2.2 SWS	QA Manager	Recommendation: Shall confirm that SWS Measurement

Measurement Concordance	Concordance is within $\pm 5\%$. See 4.3 Assessment Procedure: SWS Measurement Concordance
-------------------------	--

3.5. Periodic QA

410 This activity describes calibrations, phantom imaging, performance assessments or validations performed periodically at the site, but not directly associated with a specific subject, that are necessary to reliably meet the Profile Claim.

3.5.1 DISCUSSION

415 The QA Manager is shown as being responsible for much of the phantom-based testing. The QA Manager may delegate actual performance of certain steps to a selected Technologist and confirm the results.

3.5.2 SPECIFICATION

Parameter	Actor	Requirement / (Recommendation)
3.5.2.1 US Imaging QA	QA Manager	Shall perform standard ultrasound system QA checks and conform to quality criteria as specified in ACR, AIUM, or other accreditation guidelines.
3.5.2.2 SWS Measurement Consistency & System QA Testing	QA Manager	<i>(Recommendation) Shall confirm that measurements of SWS on a QIBA elastic phantom using standard instrument settings and acquisition procedures annually, and after any software change, are within $\pm 5\%$ of the values of the Elastic SWS phantom specifications as determined by testing with a Verasonics system. If the system is already known to give results more than 5% different from the phantom values, the system should give values within $\pm 5\%$ of the previously obtained results.</i> <i>See Measurement Concordance Test Procedure in section 3.4 above.</i>
3.5.2.3 Operator training and qualification testing	QA Manager	Shall confirm that each operator continues to meet qualification criteria (as listed in 3.1 Staff Qualification)
3.5.2.4 US Imaging and SWS Phantom Characterization and Stability Testing	QA Manager	<i>(Recommendation) Shall confirm SWS Phantom Acoustic and Mechanical Properties at Independent Test Site Using QIBA procedures after construction and if a weight change of $>0.5\%$ has occurred.</i>

Commented [WKA34]: Extra space should be deleted.

Commented [MS35]: Need to align with checklist

Commented [WKA36]: Extra space should be deleted

420 **3.6. Protocol Design**

This activity involves designing acquisition protocols for use in the Profile. It includes constraints on protocol acquisition parameters that are necessary to reliably meet the Profile Claim.

425 Modern Ultrasound scanners use fully automated internal protocols for SWS acquisition with little or no user modification capability. The parameters that may be adjusted are those used during the acquisition process. Those are described in the acquisition sections along with the general principles underlying the acquisition procedure. Because each scanner has its own internal acquisition design, custom acquisition procedures are often needed. These are placed in Appendix D and are to be used in place of the more general procedures in the profile whenever possible.

3.7. Subject Selection

430 This activity describes criteria and procedures related to the selection of appropriate imaging subjects that are necessary to reliably meet the Profile Claim.

3.7.1 DISCUSSION

The profile is intended to be used in patients who require clinical assessment of liver fibrosis. The following factors affect patient selection.

435 *Prior Surgery*

Prior liver surgery can interfere with SWS data acquisition. If subjects have had a surgical resection of all or portions of right lobe of the liver that prevents an intercostal measurement in the right liver lobe, then the patient should be considered for exclusion. Consider MRE as an alternative. The claims in this profile have not been validated for measurements other than the right lobe of the liver, but may be validated in later versions of the profile.

Breathing

Excessive motion during SWS data acquisition may degrade SWS measurement accuracy. Patient should suspend breathing during data acquisition. Manufacturer guidelines for the time needed for each breath hold/acquisition are listed in Appendix D.

445 3.7.2 SPECIFICATION

Parameter	Actor	Recommendation
3.7.2.1 Prior Surgery	Radiologist or Technologist/Sonographer	Shall confirm the presence of the right liver lobe & the absence of surgical/other scars that could cause shadowing. Lack of optimal acoustic window should be communicated to interpreting radiologist for case review.
3.7.2.2 Breathing	Radiologist or Technologist/Sonographer	Shall confirm the ability of the patient to follow the breath hold instructions. Inability of patient to follow instructions should be communicated to interpreting radiologist for case review.

Commented [MS37]: Align w/ checklist

3.8. Subject Handling

This activity describes details of handling imaging subjects that are necessary to reliably meet the Profile Claim.

450 **3.8.1 DISCUSSION**

Subject handling for quantitative SWS measurement with ultrasound focuses on proper preparation of the patient for the acquisition of high reliability data.

455 An information/instruction sheet supplied to the patient prior to acquisition may be very helpful. The sheet could describe the technology, explain why it is useful, and give instructions to the patient on how to fast prior to the procedure (see Fasting State in 3.8.2.1). It may also provide information on maneuvers such as breath holding that will occur during the procedure.

In some cases (for example elastography research), an informed consent may be needed.

460 *Fasting State.* A recent meal increases portal flow into the liver and has been shown to elevate liver stiffness estimates in some patients. If the patient presents non-fasting, options include rescheduling the patient, or waiting a sufficient amount of time to qualify for fasting, as scheduling resources allow. Non-fasting status must be communicated to the interpreting radiologist who may recommend proceeding with the examination with the knowledge that the examination would not fulfill requirements for meeting Profile Claims, however SWS results within the expected range for a normal liver may still be a clinically valid result.

465 *SWS Acquisition System.* Even though efforts have been made to reduce variation in SWS measurements by different ultrasound systems, such variation still exists and it may be significantly higher when acquisitions are performed in patients vs. phantoms. For this reason, every effort should be made to acquire successive SWS measurements with the same system or with a system from the same Manufacturer. This guideline cannot be followed in many clinics with systems from multiple
470 Manufacturers because it results in scheduling difficulties. In cases where more than one system is used on a given patient on different exam dates, then the system should be identified and the median values the system gave using the calibration phantom should be given to aid the reader in determining if a difference in median/mean value between two systems should be taken into account during interpretation of the results.

475 **3.8.2 Specification**

Parameter	Actor	Requirement
3.8.2.1 Fasting State ⁱ	Technologist/Sonographer or Radiologist	Shall confirm patient has fasted for at least 4 hours . Non-fasting status must be communicated to interpreting radiologist
3.8.2.2 SWS Acquisition	Technologist/Sonographer or Radiologist	Shall perform measurements on the same equipment/manufacturer Manufacturer when successive

Parameter	Actor	Requirement
System		measurements are made on the same patient

3.9. SWS Image Acquisition and Point SWS Measurement

480 This section describes details of the data acquisition processes that are necessary to reliably meet the Profile Claim. It includes technique, performance assessments or validations during acquisition that are necessary to reliably meet the Profile Claim.

3.9.1 DISCUSSION

485 *Patient position.* For SWS acquisition, this appears to vary somewhat between institutions. Supine or slight (<30°) left decubitus positions are thought to be similar enough⁴ so as not to induce variation in liver stiffness even though there is evidence that full left lateral decubitus positioning significantly affects measured SWS.

490 *Respiration.* Suspended tidal (normal or quiet) respiration is recommended to avoid the additional pressure that a deep inspiration (or Valsalva maneuver) by have on the liver, increasing measurements of liver stiffness. In addition, this form of suspended respiration may result in less movement of the liver during acquisition since the diaphragm may move less than during a deep inspiration.

495 Instruction on how the patient should suspend respiration should be given immediately prior to data acquisition. Practice runs should be performed to allow the patient to learn how to suspend respiration. This will provide the patient or subject with useful information on what the ultrasound probe feels like and how long they will be asked to hold their breath.

500 *Transducer Position.* Intercostal transducer positioning has been shown to reduce variability in measurements. However, there are situations where intercostal acquisition is not feasible. For example, smaller patients may not have wide enough intercostal spaces to allow intercostal positioning of the transducer without partial blockage of transducer elements resulting either in obvious shadowing or loss of transmit power on the shear wave push and detection pulses. Either will likely result in poor quality SWS estimates. Another problem arises when the subject has COPD and the hyper-expanded lung pushes the liver below the costal margin. Consider subcostal only if intercostal is not feasible. The claims in this profile have not been validated for a subcostal approach. Where necessary, consider excluding the subject, and using MRE and/or liver biopsy for evaluation.

505 To avoid additional power loss of acoustic push for SWE acquisitions, keep the liver capsule parallel to the transducer face in both planes (transverse and elevational planes). For the same reason, the acquisition region of interest (ROI) placement should be in the center of the image.

Please refer to Manufacturers' instructions on acquisition techniques, procedures and machine specific pitfalls for additional information. Appendix D contains this material for a number of Manufacturers.

Commented [WKA38]: This is the first appearance of "SWEI." Some readers might be confused. Should this be "Shear Wave Elasticity Image Acquisition (SWEI)" so that it matches the acronym, SWEI? Also in checklist.

Commented [WKA39]: First occurrence of ROI

⁴ Barr et.al. Elastography assessment of Liver Fibrosis: SRU Consensus Conference Statement. Radiology 2015; 276(3): 845-861.

510 *Liver Movement.* Absence of motion during SWS acquisition is critical to obtain accurate and precise SWS measurements. Even though challenging in some patients, it is critical to ensure that no appreciable motion occurs during acquisition. Otherwise, the acquisition should not be included in the analysis. Having the patient practice breath holds (suspended tidal respiration) may be helpful but avoid practicing so much that patient becomes fatigued.

515 *Number of Measurements.* **Ten consecutive measurements shall be obtained from the same region of liver parenchyma.** Although recent publications suggest fewer measurements may provide similar accuracy, the claims in this profile have not yet been validated for fewer than 10 measurements. The minimum number of measurements required remains an active area of research and may be addressed in future versions of the Profile.

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520 Each measurement should be associated with an independent image acquisition in both Point and 2D shear wave elastography. Multiple measurements should not be made from a single acquisition. Although some manufacturers offer techniques that provide multiple measurements per image acquisition, the claims in this profile have not yet been validated for these techniques.

525 Point Shear Wave Speed Measurement

The above considerations in image acquisition also apply to the measurement of shear wave speed from a single location with or without SWS imaging, often referred to as point SWS measurement. The following are some additional specifics to point SWS measurement.

Commented [WKA40]: Here you call it SWS imaging. Previously, it was SWEI. Should the profile be consistent about this?

530 *Measurement Region of Interest (ROI) Placement.* ROI placement with respect to depth and lateral positioning is critical. Positioning the ROI center at a **depth** greater than 2 cm deep to the liver capsule will avoid the slight overestimation of stiffness near the liver capsule. A depth < 7.0 cm will help to ensure that the shear wave amplitude is sufficient for reliable estimates of shear wave speed. Positioning away from discrete structures (e.g., vessels) is important as the algorithms used to estimate SWS assume homogeneous isotropic tissue, not heterogeneous tissue containing specific structures or lesions. An image should be acquired to document the ROI location relative to vessels so as to allow future acquisition at the same location for additional measurements, either at the same time or on follow-up examinations.

Commented [WKA41]: See my comment for 3.9.2.4 in the Table below.

Positioning the ROI away from the **centerline** of the image may introduce variation in SWS estimates as may changing the ROI size. The effects of changing ROI size have not yet been systematically examined.

540 Please refer to Manufacturer specific instructions and specifications for guidance on additional steps to take during point SWS acquisition (see Appendix D).

545 Positioning the ROI at a **constant depth** as close as practicable from measurement to measurement and from one patient visit to another is important because SWS estimates are known to decline as a function of depth with many current SWS software implementations. Measuring at a constant depth will help to minimize variations.

~~*Ten consecutive measurements shall be obtained from the same region of liver parenchyma.* Although recent publications suggest fewer measurements may provide similar accuracy, the claims in this profile have not yet been validated for fewer than 10 measurements. The minimum number of measurements required remains an active area of research and may be addressed in future versions of the Profile.~~

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550 ~~Each measurement should be associated with an independent image acquisition. Multiple measurements should not be made from a single acquisition. Although some manufacturers offer techniques that provide multiple measurements per image acquisition, the claims in this profile have not yet been validated for these techniques.~~

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555 Shear Wave Speed Imaging (2D SWE)

This section describes criteria and procedures related to obtaining SWS images (also known as 2D shear wave elastography) and producing quantitative measurements from the images that are necessary to reliably meet the Profile Claim.

Commented [WKA42]: Previously in the document, this was referred to as SWEI.

560 *SWS Imaging Quality Assessment.* The measure box fill and consistency for the SWS image are critical for obtaining reliable estimates of the SWS. Only measurement boxes with more than 50% color fill should be considered to be a successful image. Manufacturer guidance regarding quality and/or confidence images should be followed as detailed in Appendix D to ensure the most reliable estimates.

565 *SWS Imaging Measurement ROI Placement.* The location in the SWS image for performing measurements may impact the SWS estimates. To ensure reliable measurements, the measurement ROI should be placed in the most homogeneous region that is consistent with ~~manufacturer~~ Manufacturer recommendations, especially taking into consideration interpretation of quality or confidence images.

3.9.2 SPECIFICATION

Parameter	Actor	Requirement
3.9.2.1 Patient Position	Technologist/Sonographer or Radiologist	Shall ensure patient is comfortable, positioned in supine or 30 degree left lateral decubitus
3.9.2.2 Transducer Position	Technologist/Sonographer or Radiologist	Shall position transducer at intercostal space wide enough to accommodate transducer and at level to image mid to upper right liver lobe. Shall position transducer face long axis parallel to the intercostal space and check for correct positioning by inspecting the image for shadowing at the image edges. Shall position the transducer parallel to liver capsule so acoustic waves travel perpendicular to capsule.
3.9.2.3 Ultrasound Image	Technologist/Sonographer or Radiologist	Shall optimize B-mode image. Shall confirm absence of focal structures near image center; no acoustic shadowing from the lung or ribs
3.9.2.4 Measurement Region of Interest (ROI) Use and	Technologist/Sonographer or Radiologist	Shall use the standard ROI size specified by the ultrasound vendor as the default for their system; ROI center positioned 2 cm deep to liver capsule; <7.0 cm from transducer face; near center of image sector, away from liver margins and from discrete structures

Commented [WKA43]: Delete extra space

Commented [WKA44]: To be consistent with wording in "Measurement Region of Interest (ROI) Placement" above. Same comment in checklist

Parameter	Actor	Requirement
Placement		
3.9.2.5 Respiration	Technologist/Sonographer or Radiologist	Shall confirm patient has successfully suspended tidal respiration during acquisition. Inability of patient to follow instructions shall be communicated to interpreting radiologist.
3.9.2.6 Liver Movement	Technologist/Sonographer or Radiologist	Shall acquire only when minimized visible liver motion. Presence of liver motion during measurements should be communicated to interpreting radiologist.
3.9.2.7 Measurement Location Consistency	Technologist/Sonographer or Radiologist	Shall make follow-up acquisitions and ROI placements consistent with the baseline measurement in terms of the Transducer Position and Measurement Region of Interest (ROI) Placement. ROI placement and measurement at consistent depth and location from baseline across all subsequent acquisitions
3.9.2.8 Number of Measurements	Technologist/Sonographer or Radiologist	Shall take the number of independent measurements specified by the Manufacturer (see Appendix D) or if not specified, 10 independent measurements.
3.9.2.9 SWS Imaging – Quality Assessment	Technologist/Sonographer or Radiologist	Shall consider successful color map acquisition as at least 50% color fill. Shall measure in regions of high consistency, quality, and/or confidence, following manufacturer Manufacturer specifications
3.9.2.10 SWS Imaging Measurement ROI Placement	Technologist/Sonographer or Radiologist	Shall place the measurement ROI location in most consistent, reproducible region of SWS color map or other images related to SWS variability as specified by MANUFACTURER (Appendix D).

Commented [MS45]: maybe this should get moved into the checklist?

570 **3.10. Image Data Reconstruction**

This activity describes criteria and procedures related to producing images from the acquired data that are necessary to reliably meet the Profile Claim.

Reconstruction protocols are preset by the Manufacturers and not user modifiable or selectable. Image display parameters are user selectable but do not affect quantification of SWS or the profile claims.

575 Therefore, this section is not applicable to this profile on SWS.

3.11. Image QA

This activity describes criteria and evaluations of the images that are necessary to reliably meet the Profile Claim.

Besides checking that clinical study is performed following those requirements in sections 3.8 and 3.9,

Commented [MS46]: Section not in checklist Pre-Acquisition or Subjects & Data Acquisition sections, but appears in the Profile Conformance-by-Section?

580 sites shall all complete period QA as specified in 3.5.

3.12. Image Distribution

This activity describes criteria and procedures related to distributing images that are necessary to reliably meet the Profile Claim.

There are no relevant requirements for image distribution.

585

3.13. Image Analysis

This activity describes criteria and procedures related to producing quantitative measurements from the images that are necessary to reliably meet the Profile Claim.

590 No actual image analysis is needed to meet the Profile claim. See section 3.9. SWS Image Acquisition (SWEI) and Point SWS Measurement for requirements on producing the SWS measurements.

3.14. Image Interpretation

This activity describes criteria and procedures related to clinically interpreting the measurements and images that are necessary to reliably meet the Profile Claim.

No clinical interpretation is required to meet the Profile Claim

595

4. Assessment Procedures

600 Most of the requirements described in Section 3 can be assessed for conformance by direct observation, however some of the performance-oriented requirements are assessed using a procedure. When a specific assessment procedure is required or to provide clarity, an example of these procedures are provided in subsections here in Section 4, and the subsection is referenced from the corresponding requirement in Section 3.

4.1. Assessment Procedure: Imaging Performance

605 This procedure can be used by a scanner vendor or an imaging site to assess the imaging performance of an ultrasound system. Imaging performance is assessed in terms of change compared to specifications and/or initial testing of most recent prior QA testing when imaging a phantom.

4.1.1 OBTAINING AND MAINTAINING THE IMAGING PHANTOMS

Ultrasonic Imaging and SWS Phantoms Used for Testing:

610 A commercially available standard ultrasound imaging phantom may be used to confirm imaging performance of the ultrasound systems used for SWS acquisition. See section 4.2.1.1.B below for details regarding the phantom's use as a site assessment tool.

For testing of instrument (scanner) SWS performance, an elastic phantom will be used since it is both

affordable and practical. A viscoelastic phantom may be used for testing in later versions of the profile to better address possible bias (bias is not part of the claims in this version).

615 A simple homogeneous phantom rather than a complex structured phantom will be used since the liver is a relatively homogenous organ.

The phantoms selected for instrument pre-delivery testing by Manufacturer should meet the following specifications:

620

Ultrasonic Imaging Phantom Specifications:

- a. Attenuation: 0.5 ± 0.1 dB/cm/MHz; in 1-9MHz range
- b. Backscatter: Approximately $10^{-4} - 10^{-3}$ cm⁻¹Str⁻¹ at 3 MHz or sufficient to create mean speckle brightness comparable to a human liver-mimicking phantom (± 3 dB)
- 625 c. Speed of Sound: 1540 ± 30 m/sec
- d. Volume and Shape:
 - i. Cylindrical or rectangular
 - ii. Height: 15 ± 3 cm
 - iii. Diameter: 12.5 ± 3 cm in inner diameter (ID)

630

Shear Wave Speed Phantom Specifications:

- a. Attenuation: 0.5 dB/cm/MHz (± 0.1 dB/cm/MHz)
- b. Backscatter: Approximately $10^{-4} - 10^{-3}$ cm⁻¹Str⁻¹ at 3 MHz or sufficient to create mean speckle brightness comparable to a human liver-mimicking phantom (± 3 dB)⁵
- 635 c. Speed of Sound: $1520-1540 \pm 30$ m/s
- d. Stiffness: Two phantoms can be used or a single phantom with two different components: Normal Liver Equivalent & Fibrotic F3 Liver equivalent. $\pm 5\%$ of the specified values. Stiffness verified using Verasonics system and software from Duke University and Mayo Clinic. See <https://github.com/RSNA-QIBA-US-SWS/QIBA-DigitalPhantoms>.
- 640 e. Volume and Shape – Cylindrical, 20 cm tall, 12.5 cm in diameter. (Cylindrical preferred, rectangular is acceptable if width and depth are 12.5 cm and 20 cm tall)

Ultrasonic Imaging Phantom Characterization:

Phantom is weighed upon construction. It is then tested following procedures in the AIUM Guidance document.⁶

645 Pass Fail Tolerances for Site-Phantom Characterization and/or Retesting (these are the same specifications as the phantoms used for pre-delivery instrument testing)

Testing to be performed at 21 ± 1 °C.

650

- Method to verify temperature of phantoms prior to testing. Temperature measurement method: TBD [open issue]

Commented [WKA47]: Specify a frequency range, e.g. frequencies up to 6 MHz? Same comment for SWS Phantom Specifications.

Commented [MS48R47]: is 1-6MHz ok? 1-9?

Commented [MS49]: Change suggested by Rik Hansen @ Radboud

⁵ Reference - IEC 61391-2: Ultrasonics – Pulse-echo scanners – Part 2: Measurement of maximum depth of penetration and local dynamic range. 2010, Int Electrotechnical Comm: Geneva.

⁶ Methods for Specifying Acoustic Properties of Tissue-Mimicking Phantoms and Objects 2nd Edition. AIUM Technical Standards Committee. American Institute of Ultrasound in Medicine. 2015.

Attenuation: $\pm 20\%$

- $0.5 \text{ dB/cm/MHz} \pm 0.1 \text{ dB/cm/MHz}$

Back Scatter: $\pm 3\text{dB}$

- Approximately $10^{-4} - 10^{-3} \text{ cm}^{-1}\text{Str}^{-1}$ at 3 MHz or sufficient to create mean speckle brightness comparable to a human liver-mimicking phantom ($\pm 3 \text{ dB}$)

Speed of Sound: $\pm 2\%$

- $1540 \pm 30 \text{ m/s}$ [1510-1570 m/s]

***Phantoms failing these tolerance tests shall be refused or replaced if already acquired.**

Ultrasonic Imaging Phantom Temporal Stability testing:

The phantoms should be re-weighed every six months (using a scale with accuracy of $\pm 0.1\%$ or better) and if the phantom weight changes by more than 0.5%, the phantom should be retested to confirm that acoustic properties are within the specifications above prior to next use.

If the phantom Manufacturer has other criteria for stability testing prior to acoustic property testing, those should be used instead.

Commented [WKA50]: I don't know why Manufacturer and Actor are often capitalized, but maybe that is QIBA style.

Testing of phantom acoustic properties shall be as specified by the AIUM guidelines noted previously and the phantom supplier's recommendations.

**If the values are changing faster than the rates above, sites should consider replacement or testing more frequently than every 6 months.*

SWS Phantom (pre-delivery and on-site phantoms)

The initial characterization of the phantoms should be performed and verified by the QIBA committee, the phantom Manufacturer, Verasonics or another party using measurements obtained from Verasonics research ultrasound systems. Independent verification of phantom properties to ensure that the phantom meets the SWS Phantom specifications above is strongly recommended. If a newly procured phantom has already been independently tested within six months of the date of manufacture and those results are available then additional independent testing prior to use is not necessary. The phantom Manufacturer may be contacted for assistance in finding a site that will perform independent testing.

SWS Phantom Temporal Stability Testing (pre-delivery and site-phantoms)

The SWS phantom should be weighed monthly and if the weight changes more than 0.5% over a six-month period the following parameters will be checked by sending the phantom to a testing facility capable of performing the tests using a Verasonics system. The phantom Manufacturer may be contacted for assistance with obtaining the tests. Alternatively, a calibrated replacement phantom may be procured.

SWS Phantom Stability Tolerances:

- (1) SWS: <5% change in both hard and soft components over 6 months.
- (2) Speed of Sound: <1% change over 6 months.

If SWS Phantom stability is demonstrated at six months, then the timeline can be changed to annual testing.

SWS Phantom Temperature Sensitivity and Shipping Considerations

SWS Phantom stiffness may change as a function of temperature. For this reason, the temperature of the phantom should be recorded at the time of use. The phantom should be used at the temperature specified by the Manufacturer. Very cold or hot temperatures may damage the phantom and permanently change its acoustic and mechanical properties. Please ship according the Manufacturer's recommendations and contact the Manufacturer if shipping in extreme heat or cold is not discussed in the instructions.

Ultrasound System Phantom Testing

a. Grayscale imaging tests as normally conducted by the ultrasound system Manufacturer or as described in the AIUM document "AIUM Quality Assurance Manual for Gray Scale Ultrasound Scanners"⁷.

b. SWS Estimations are obtained from the SWS phantom using the Manufacturer specified procedures as defined in Appendix D of the QIBA SWS Profile.

SWS Tolerance: $\pm 5\%$ of the Verasonics system calibration value for the phantom as determined by the QIBA calibration site.

4.1.2 ASSESSING IMAGING PERFORMANCE

The assessor shall perform grayscale imaging tests as normally conducted by the ultrasound system ~~manufacturer~~ Manufacturer or as described in the AIUM document "AIUM Quality Assurance Manual for Gray Scale Ultrasound Scanners"⁸.

A link to the QA Tests and expected results recommended by AIUM is given here:

<http://aium.s3.amazonaws.com/resourceLibrary/14qa.pdf>

4.2. Assessment Procedures: SWS Measurement Consistency

This section describes a group of procedures for assessing the performance of a site or of individual ~~actor~~ Actors to determine if pre-established quantification performance specifications are met. For a

⁷ AIUM Quality Assurance Manual for Gray Scale Ultrasound Scanners, AIUM Technical Standards Committee, American Institute of Ultrasound in Medicine, www.aium.org, 2014 (ISBN 1-932962-31-X)

⁸ AIUM Quality Assurance Manual for Gray Scale Ultrasound Scanners, AIUM Technical Standards Committee, American Institute of Ultrasound in Medicine, www.aium.org, 2014 (ISBN 1-932962-31-X)

725 site, those pre-established quantification performance specifications are the claims made in the claims
section of the profile. For the individual ~~actor~~Actors, the performance specifications are those that have
been shown, or are likely to be necessary for the site to meet the performance claims of the profile. The
performance specifications for ~~actor~~Actors are based on the results of the technical and claims
confirmation studies performed during the QIBA profile development process (see the QIBA wiki:
730 <https://qibawiki.rsna.org/index.php/Process>) and/or on typical acceptable performance achieved in
clinical practice worldwide.

The overall performance of a site (and its ability to meet the profile claims) depends upon multiple
~~actor~~Actors meeting or exceeding their performance specifications, even if they already meet the
procedural performance expectations of the profile (checklist compliance – see section 5). Clearly if an
735 ~~actor~~Actor's performance does not meet specification, the profile claim may be invalidated for that site
but inadequate performance on the part of one ~~actor~~Actor may be compensated for by better-than-
expected performance of another ~~actor~~Actor. The described assessment procedures are designed to
test the hypothesis that an Actor's wCV meets the Profile requirement at a specified type I error rate
(usually 5%). It is not sufficient to show that the observed wCV is <10% for only a sample of cases.

Commented [WK451]: Should actor be capitalized like it is 4 lines below?

740 Therefore, two types of assessment procedures and performance specifications are described: A) those
for assessment of composite performance of a site and B) those for testing individual ~~actor~~Actors. The
assessment procedures for types A and B may be the same or very similar to one another but different
performance specifications will be given.

745 Cross-sectional claims (for a given patient at a single time point) require testing of within subject
precision, often termed "repeatability" as well as bias. Longitudinal claims (for a given patient at
different time points or for different imaging methods at one or more time points require testing of
repeatability, bias, linearity and regression slope. As this profile makes multiple longitudinal claims and
one cross-sectional claim, numerous testing procedures are described below along with the claim that
750 each applies to.

755 4.2.1 SITE ASSESSMENT TOOLS AND TESTS.

4.2.1.0 Site assessment dataset.

The dataset (or "parts being measured" in six sigma measurement system analysis) are livers of patients
and two test phantoms, a b-mode imaging test phantom and a calibrated elastography phantom.

4.2.1.1. Site assessment data acquisition

4.2.1.1.A. B-mode imaging:

760 For Ultrasound b-mode imaging assessment a standard ultrasound test phantom shall be used to acquire
test images and measurement values that will be evaluated according to the methods described in the
guidelines of AIUM quality assurance manual or other accrediting body.

4.2.1.1.B. Phantom SWS:

765 For assessment of SWS performance and conformance in phantoms, calibrated SWS phantoms shall be
used. These phantoms can be obtained from phantom manufacturers and consist of either two
phantoms, one with stiffness approximating normal liver and the other with a stiffness approximating a
liver with F3 fibrosis, or a single two-part phantom containing regions with each of the two stiffnesses.
770 The specifications of the phantoms are given in section 4.1.1 above along with instructions for periodic
phantom stability checks.

The site assessment phantom data will consist of SWS acquisitions obtained by each operator who has
been qualified by training and testing to acquire SWS data according to the following criteria:

- Twenty (20) distinct SWS measurements will be collected from each of the two phantoms at both
4.5 cm and 7 cm depths, by each operator. For these tests a measurement is defined as
775 completed when the scanner outputs a SWS to the screen or to the data collection table within
the machine. A system may acquire multiple SWS values and then report an overall SWS value
(i.e., mean and median). The individual SWS values are the measurements, not this summary
result. So, for each operator a total of 80 measurements, 20 for each of the two phantoms and for
each of two different depths.
- If a site has ultrasound systems from more than one ~~manufacturer~~ Manufacturer, the test
780 measurements must be performed for each ~~manufacturer~~ Manufacturer's system (only one set of
test measurements per ~~manufacturer~~ Manufacturer unless the ~~manufacturer~~ Manufacturer notes
that different models of their systems give different SWS results). So, for multiple different
ultrasound systems being used to acquire SWS, the total number of measurements taken per
785 operator will be $80 \times n$ where n = the number of ultrasound systems. It is expected that
acquisition of these phantom measurements will take approximately 20 minutes per machine.
- Depth is defined as the distance from the transducer surface to the center of the region of interest
from which the point SWS is acquired.
- Between each measurement, the transducer will be removed from contact with the phantom and
790 the phantom will be shifted so that each measurement is performed with the transducer oriented
differently relative to the phantom in a random manner. NO effort to reposition the transducer in
the same exact spot as the previous measurement should be made.
- The temperature at which the testing was performed at should be recorded. It is strongly
recommended that the measurements be performed at the temperature at which the phantom
795 was calibrated by the QIBA test site or ~~manufacturer~~ Manufacturer using approved QIBA
instrumentation and methodology.
- Each ultrasound scanner will have different specific instructions that should be followed as noted
above, but one important requirement is that the transducer should remain motionless during
each measurement. If transducer movement is detected by any method during measurement,
800 that value should be discarded and another measurement taken.
- The operators will be blinded with respect to the actual SWS values represented in the
phantom(s). The operator will however see a large number of SWS measurements from each
phantom since the phantom(s) will be used repeatedly. Therefore, the operator must NOT discard
805 a SWS measurement solely because it appears different from the others or from the assumed
"true" value for the phantom

Commented [WKA52]: In this document, "manufacturer" is sometimes capitalized and other times not capitalized.

Commented [MS53R52]: Changed all instances referring to ultrasound system manufacturer to be capitalized

4.2.1.1.C. *In-vivo SWS data:*

An example of possible site-specific in-vivo SWS assessment testing:

* Six volunteers having no history of liver disease and with normal AST, ALT, Alkaline Phosphatase and Total Bilirubin values will be recruited. Ideally the volunteers should cover a range of BMI values from 20 to 35 and ideally will be available for at least several rounds of testing (months to years). The site assessment in-vivo data set will consist of ten (10) measurements by each operator on each of the six volunteers and at two different depths made according to the following criteria:

* Ten (10) distinct SWS measurements at each of two depths (4.5 cm and 7 cm) will be made from each volunteer by each operator. Depth is defined as the distance from the transducer face to the center of the region of interest used for acquisition of the SWS value (not the region defined for shear wave imaging display).

* The measurements will be performed with the volunteer having fasted for at least six hours.

Commented [WKA54]: Note period added at end of sentence.

* The measurements will be made according to the instructions provided by the scanner ~~manufacturer~~ Manufacturer and according to the guidelines in section 3.9 of this profile.

* The measurements should be performed for each brand of ultrasound scanner if scanners from multiple ~~manufacturer~~ Manufacturers are used to acquire SWS data. All scanners from a given ~~manufacturer~~ Manufacturer are assumed to give identical results unless otherwise specified by the ~~manufacturer~~ Manufacturer.

* Between each measurement, the transducer should be removed from contact with the volunteer, and the volunteer should get up from the scan table between each measurement. If this is not feasible due to time limitations or physical condition of the volunteer, the measurements should be divided into groups of five (5) measurements and the volunteer should get up from the scan table before lying down for the next measurement group.

* As for the phantom data collection, a SWS measurement is defined as whenever a SWS value appears on the scanner screen, NOT the mean value or median value reported by the scanner after several measurements.

* As for phantom SWS measurement, values obtained during visible patient or transducer movement should be discarded and repeated.

* SWS values that appear different from the others by a sizeable amount should never be discarded unless there was movement during the measurement, or another error occurred. Errors in measurement are defined as measurements where the ~~manufacturer~~ Manufacturer instructions were not followed. If a SWS is discarded, a repeat SWS measurement should be collected.

4.2.1.2. Site Conformance - Quality Metrics and Computation

As a number of distinct claims are made that depend on the depth that SWS is estimated and the stiffness of the tissue being examined, separate performance analysis will be performed for each combination of the two parameters, depth and material stiffness. The test data will contain data from the exact same two depths as specified in the claims but only two test phantoms will be used to assess performance at the three different stiffness ranges specified in the claims. The two phantoms are high and low stiffness and are expected to have stiffness values that will result in SWS values in the low (0.9-

1.2 m/s) and at the lower bound of the high stiffness range. Performance will therefore be judged using the claims for these two stiffness ranges.

4.2.1.2.A. Within Subject Measurement Variation.

SWS claims use within subject coefficient of variation (wCV) as an important quality metric, wCV computation from the test dataset (dataset as described under 4.2.1.1.B above) is as follows (next paragraph):

For each case (corresponding to the liver of a single patient where the variable i denotes the case number), the first measured SWS as described in 4.2.1.1 represents the first replicate measurement (denoted Y_{i1}) and the second measured SWS represents the second replicate measurement (Y_{i2}) for that case. For phantoms, there is only a single phantom for each of the two stiffness values being analyzed separately so i takes on the single value $i=1$. For patient data, there are six volunteer subjects so the variable i ranges from 1 to 6. For each case and for each combination of depth and stiffness range, the assessor shall first calculate the mean and variance of the measurements (five per operator per machine for phantoms and three per operator per machine for human volunteers). From these values, the variance divided by the square of the mean (mean^2) will be calculated for each case and the results for each case will be summed and the total divided by the number of cases (one for the phantom and 6 for the human data). The square root of this value is the wCV. The equations for these computations are:

$$\widehat{wCV} = \sqrt{\sum_{i=1}^N \left\{ \frac{\text{Variance}_i}{\text{Mean}_i^2} \right\} / N}$$

where $N=6$ for the patient data and $N = 1$ for phantom data.

As noted in the preceding paragraph, if data were acquired from more than one brand of machine and more than one operator, the measurements from all machines and all operators should also be pooled for the computation to accurately reflect these sources of variability.

4.2.1.2.A-1 Maximum Allowable Variance.

To assure site conformance to the profile claims, the upper 95% confidence bound of the wCV computed above must be less than the wCV reported in the claim to ensure that the calculated wCV for a site meets the claim with 95% confidence.

[Data available for maximum allowable wCV and RC:

Phantoms: 20 per operator, per phantom stiffness value (2 values), per depth (two different depths)

Patients: 10 per operator, per depth (two depths), per patient (6 patients).]

With 6 subjects and 10 replicates per subject per depth, and with claims stating wCV of 4% and 5% for depths of 4.5 and 7.0 for moderate SWS values, the maximum allowed wCVs are 3.3 and 4.1 for depths

of 4.5 and 7.0, respectively.

4.2.1.2.B Site Percentage Bias Estimation:

Although bias claims are not made in the current version of the profile, this calculation is provided for use in later versions of the profile where bias claims will be made. At the present time, bias claims for phantoms only are expected as no verified clinical methods for estimation of true SWS in patients are available. Currently the values obtained using a standard acquisition procedure in phantoms (using a Verasonics research system) are considered the “gold standard” for bias and linearity estimation.

As the claims are stratified by acquisition depth and SWS range, bias estimates will also be estimated by the same categories.

For each of the four measurement situations (3.5 cm depth, soft phantom; 7 cm depth soft phantom; 3.5 cm depth stiff phantom, 7 cm depth stiff phantom), the data available are 20 x N where N is the number of operators.

For each measurement, the assessor shall calculate the value of the SWS (denoted Y_i), where i denotes the i -th acquisition. The assessor shall calculate the % bias: $b_i = [(Y_i - X_i)/X_i] \times 100$, where X_i is the true value of the measurand. Over N acquisitions estimate the population bias: $\hat{b} = \sum_{i=1}^N b_i / N$. The estimate of variance of the bias is $\widehat{var}_b = \sum_{i=1}^N (b_i - \hat{b})^2 / N(N - 1)$. The assessor shall calculate the 95% CI for the bias as $\hat{b} \pm t_{\alpha=0.025, (N-1)df} \times \sqrt{\widehat{var}_b}$, where $t_{\alpha=0.025, (N-1)df}$ is from the Student's t-distribution with $\alpha=0.025$ and (N-1) degrees of freedom. The lower bound of the 95% CI must be $> -5\%$ and the upper bound of the 95% CI must be $< +5\%$.

4.2.1.2.C Site Linearity Estimation and Slope Estimation.

The phantom data set will be used. Since the longitudinal claims specify using the same operator and ultrasound system at each point in time the measurements from each operator and US system will be analyzed separately. The test data for each operator and machine consist of 20 measurements for each of two different measurement depths and for two different stiffness values.

For each operator and ultrasound system combination calculate linearity as follows:

For each measurement, the assessor shall calculate the SWS (denoted Y_i), where i denotes the i -th measurement. Let X_i denote the true value for the i -th measurement. The assessor shall fit an ordinary least squares (OLS) regression of the Y_i 's on X_i 's. A quadratic term is first included in the model to rule out non-linear relationships: $Y = \beta_0 + \beta_1 X + \beta_2 X^2$. If $|\beta_2| < 0.5$, then the assessor shall fit a linear model: $Y = \beta_0 + \beta_1 X$, and estimate R^2 .

The absolute value of the estimate of β_2 should be < 0.50 and R-squared (R^2) should be > 0.90 .

For the linear model fit, let $\hat{\beta}_1$ denote the estimated slope. The assessor shall calculate its variance as $\widehat{var}_{\beta_1} = \{\sum_{i=1}^N (Y_i - \hat{Y}_i)^2 / (N - 2)\} / \sum_{i=1}^N (X_i - \bar{X})^2$, where \hat{Y}_i is the fitted value of Y_i from the regression line and \bar{X} is the mean of the true values. The assessor shall calculate the 95% CI for the slope

as $\hat{\beta}_1 \pm t_{\alpha=0.025, (N-2)df} \sqrt{\widehat{var}_{\beta_1}}$.

Allowable Slope Range: For most Profiles it is assumed that the regression slope equals one. Then the

920 95% CI for the slope should be completely contained in the interval 0.95 to 1.05. These thresholds should be specified in Section 3 of the Profile.

4.2.2 ASSESSING SWS CONSISTENCY COMPARED WITH PHANTOM SPECIFICATIONS--- SEE THIS TOPIC IN SECTION 3.4.1

4.2.3 INDIVIDUAL ACTOR TOOLS AND TESTS

925 As this profile was created based on considerable preliminary phantom data testing designed to assess the contribution of various ~~actor~~Actors to overall imprecision and bias, a “top-down threshold selection” approach is used to assess the bias and imprecision attributable to each ~~actor~~Actor. Phantom studies have shown that the site and observer are small contributors to variability in phantoms. This finding may not generalize to patients however since the potential for operator errors and operator-patient
930 interaction variation is much greater. Analysis of the test data using six sigma measurement systems analysis methods such as crossed gauge r and r with ANOVA are expected to provide sufficient information on relative contribution of the various ~~actor~~Actors to overall variance so that appropriate corrective measures may be taken to reduce overall imprecision to levels consistent with the profile claims (further discussion in next version).

4.2.3.1. Technologist/Operator Qualification Testing

935 The test data set for phantoms and for in-vivo [patients] are described in sections 4.2.1.1.B and 4.2.1.1.C. The test data are acquired by each Technologist/Operator so are suitable for qualification testing. A similar data set acquired only in-vivo would also suffice. See section [3.1.2 Staff Qualification](#) for the test and test criteria for qualification.

4.3. Assessment Procedure: SWS Measurement Concordance

940 This procedure can be used by a ~~manufacturer~~Manufacturer or an imaging site to assess the concordance of SWS measurements for an ultrasound system. Measurement concordance is assessed in terms of the difference between the measurement made on a phantom by the ultrasound system and a reference value for that phantom.

945 The assessor shall obtain an elastic SWS phantom as described in section 4.1.1.

The assessor shall have someone else measure the shear wave speed on the phantom using the instrument settings and acquisition procedures specified by the Scanner Vendor in Appendix D and according to the phantom acquisition protocol defined in section 4.2.1.1.B. Phantom SWS data acquisition.

950 The assessor may obtain for the same phantom the most recent shear wave speed using the Verasonics system that were determined by the QIBA calibration site (which may be the phantom manufacturer). If the phantom specifications and independent test values are slightly different, the average of the two values will be used.

955 The assessor shall compute the SWS Measurement Consistency as the percentage difference between the ultrasound and MRE SWS measurements. This computation may be made according to the instructions given in section 4.2.1.2.B, Site Percentage Bias Estimation.

To keep the individual acquiring the data blinded to the true phantom values, the computation of Measurement Consistency (measurement bias) should be conducted by **someone different** than the individual acquiring the data.

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5. Conformance

To conform to this Profile, participating staff and equipment (“Actors”) shall support each activity assigned to them in Section 3 and in the Checklist. Activities represent steps in the chain of preparing for and generating biomarker values (e.g., product validation, system calibration, patient preparation, image acquisition, image analysis, etc.).

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To support an activity, the ~~actor~~Actor shall conform to the requirements (indicated by “shall language”) listed in the Specifications table of the activity. Each activity has a dedicated subsection in Section 3.

For convenience, the Specification table requirements have been duplicated and organized in two ways.

1. In chronological order to help users follow the steps needed to properly check their acquisition systems and to properly acquire SWS data. These are termed “execution checklists”. 2. By section and by ~~actor~~Actor for use in establishing conformance of the site and each individual ~~actor~~Actor to the requirements of the QIBA profile. These are called “conformance checklists”.

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All checklists are located in an Excel workbook with the filename “Appendix E – QIBA SWS Checklists.xlsx”. The checklists are organized under five tabs in the excel workbook. The execution checklists are divided into Pre-Acquisition and Subjects & Data Acquisition (each under its own tab) corresponding to the main sections covered by the profile. At any given time, an ~~actor~~Actor will likely be concentrating exclusively on one of these two sections of the profile so can retrieve just the corresponding worksheet for use to help ensure that no steps are forgotten. These checklists are intended to work best for actual acquisition of quantitative image data and be easy to follow in a clinical or research environment.

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Note: Execution Checklists are limited to parameters necessary to achieve the performance in the Claims. Requirements can be easily identified by the use of the word “shall”. Checklists may not contain items considered best clinical or research practices as they are not requirements to conform to the profile.

Two types of conformance checklists are included. One is organized by profile sections and may be useful for determination of site conformance. The second is organized by ~~actor~~Actor so that the conformance of each ~~actor~~Actor can be evaluated. The conformance checklists have a column labeled “Conforms” where each step or activity is scored as either conformant (yes) or non-conformant (no). Technically, to be fully conformant all activities must be conformant. However, in the real world, this is not always possible. The scoring column is for an ~~actor~~Actor or profile section to be scored as fully conformant (all activities conformant = 3 points), non-conformant in one activity = 2 pts, non-conformant in 2-3 activities = 1 pt, or non-conformant in more than three activities = 0 pts. The scores for all ~~actor~~Actors or all profile sections may be tallied for use in determining site conformance. This scoring allows for the possibility of scoring a site as “conformant” even though a few activities may be non-conformant. At the present time no threshold score for determining that a site is “conformant” has been established. Some requirements reference a specific assessment procedure in section 4 that shall

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be used to assess conformance to that requirement.

Formal claims of conformance by the organization responsible for an Actor shall be in the form of a published QIBA Conformance Statement.

1000 If a QIBA Conformance Statement is already available for an ~~actor~~Actor (e.g., your analysis software), you may choose to provide a copy of that statement rather than confirming each of the requirements in that Actors checklist yourself.

1005 Vendors publishing a QIBA Conformance Statement shall provide a set of “Model-specific Parameters” (as shown in Appendix D) describing how their product was configured and is to be used to achieve conformance. Vendors shall also provide access or describe the characteristics of the test set used for conformance testing.

Appendix A: Acknowledgements and Attributions

This document is proffered by the Radiological Society of North America (RSNA) Quantitative Imaging Biomarker Alliance (QIBA), The QIBA Ultrasound Coordinating Committee and the QIBA Ultrasound Shear Wave Speed Biomarker Committee* (US SWS BC). The original complete version was written under the BC founding leadership of Brian Garra, Tim Hall, and Andy Milkowski, with Brian Garra serving as primary profile editor and leading coauthor. Manish Dhyani, M.D. was a major coauthor and initial editor, while Paul Carson served as QIBA Ultrasound Coordinator. This published version was finalized by current US SWS BC co-chairs David Fetzer, Steven McAleavey, and Stephen Rosenzweig.

Special contributions in conduct of groundwork studies and their publication were made by Mark Palmeri and his colleagues at Duke University. Other leaders of groundwork studies included Anthony Samir and colleagues at Massachusetts General Hospital, Tim Hall and colleagues at the Univ. of Wisconsin, Matthew Urban and colleagues at the Mayo Clinic, Stephen McAleavey and colleagues at The University of Rochester, and Jingfeng Jiang and colleagues at Michigan Technical University. Andy Milkowski performed an initial analysis. Discussions and contributions from Nancy Obuchowski greatly improved the statistical methods used in the analysis. Proofreading and guidance on structure of the profile were provided by Kevin O'Donnell. Cooperation of the MR Elastography Biomarker Committee, through Richard Ehman's team at the Mayo Clinic, was much appreciated for their testing in phantoms for comparison with ultrasound. The 15 ultrasound system companies mentioned below were helpful in their contributions. In particular, those included in Appendix D provided systems and/or performed studies for the groundwork. Also participating were companies producing phantoms, test equipment, contrast agents and drug studies and volunteers from government and many academic and clinical institutions.

*Biomarker Committee members at the time of this publication:

David Fetzer, MD (co-chair)	UT Southwestern Medical Center
Stephen McAleavey, PhD (co-chair)	University of Rochester (NY)
Stephen Rosenzweig, PhD (co-chair)	Siemens Healthineers USA, Inc.
S. Kaiser Alam, PhD	Institute of Electrical and Electronics Engineers (IEEE)
Maryam Alysedalhashem, PhD	King Fahad Specialist Hospital Dammam
Karen Alton, BS, RDMS, RVT	Karen Alton Consulting, LLC
Michael André, PhD	San Diego VA Healthcare/University of California, San Diego (UCSD)
Brian Anthony, PhD	MIT
John J. Antol	BK Ultrasound
Michalakis (Mike) A. Averkiou, PhD	University of Washington, Seattle
Paul Barbone, PhD	Boston University
Felipe Barjud Pereira do Nascimento, MD	Albert Einstein Hospital (São Paulo, Brazil)
Richard G. Barr, MD, PhD	Northeastern Ohio Medical University
Tharakeswara K. Bathala, MBBS, MD	University of Texas, MD Anderson Cancer Center
Parviz Behfarin, MD	Plainview Hospital
Matt Berger, BS	Samsung Electronics Co., Ltd. (South Korea)
Laura Brattain, PhD	Massachusetts General Hospital

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1055	<u>Elizabeth Carini, RDMS, RDCS, RVT, CCRC</u>	<u>Siemens Healthineers USA, Inc.</u>
	<u>Paul L. Carson, PhD</u>	<u>University of Michigan Medical Center</u>
	<u>Huan Wee Chan, MB ChB</u>	<u>The National Hospital for Neurology and</u> <u>Neurosurgery</u>
	<u>Peter Chang, PhD, PMP</u>	<u>Hologic, Inc.</u>
1060	<u>Anil Chauhan, MD</u>	<u>University of Pennsylvania</u>
	<u>Jun Chen, PhD</u>	<u>Mayo Clinic</u>
	<u>Shigao Chen, PhD</u>	<u>Mayo Clinic</u>
	<u>Yuling Chen, PhD</u>	<u>Mindray Medical</u>
	<u>Hyo-Min Cho, PhD</u>	<u>Korea Research Institute of Standards and Science</u>
1065	<u>Wui K. Chong, MD</u>	<u>University of Texas, MD Anderson Cancer Center</u>
	<u>Yi Hong Chou, MD</u>	<u>Taipei Veterans General Hospital</u>
	<u>A Jung Chu, MD</u>	<u>Seoul National University Hospital (South Korea)</u>
	<u>Claude Cohen-Bacrie, MS</u>	<u>e-Scopics</u>
	<u>Elaine Collins, RDMS</u>	<u>CALYX</u>
1070	<u>Ron Daigle, PhD</u>	<u>Verasonics</u>
	<u>Manish Dhyani, MD</u>	<u>Lahey Hospital & Medical Center</u>
	<u>Jonathan R. Dillman, MD, MSc</u>	<u>Cincinnati Children's Hospital</u>
	<u>Marina Doliner, MD</u>	<u>Ann and Robert H. Lurie Children's Hospital</u> <u>of Chicago</u>
1075	<u>John Donlon</u>	<u>Philips</u>
	<u>Marvin M. Doyle, PhD</u>	<u>University of Rochester (NY)</u>
	<u>Shuyan Du, PhD</u>	<u>Bristol-Myers Squibb</u>
	<u>Richard L. Ehman, MD</u>	<u>Mayo Clinic</u>
	<u>Todd Erpelding, PhD, MSE</u>	<u>Canon Medical Systems USA</u>
1080	<u>Alex Exposito</u>	<u>SuperSonic Imagine</u>
	<u>Giovanna Ferraioli, MD</u>	<u>University of Pavia (Italy)</u>
	<u>Steven E. Fick, PhD</u>	<u>National Institute of Standards and Technology</u> <u>(NIST)</u>
1085	<u>J. Brian Fowlkes, PhD</u>	<u>University of Michigan</u>
	<u>Caterina M. Gallippi, PhD</u>	<u>University of North Carolina at Chapel Hill</u>
	<u>Brian Garra, MD</u>	<u>Washington DC VA Medical Center/FDA</u>
	<u>Joel Gay, MSc</u>	<u>Supersonic Imagine (SSI) - (Aix-en-Provence, France)</u>
	<u>Albert Gee</u>	<u>Mindray Medical</u>
1090	<u>Gilles Guenette, RDMS, RDCS, RVT</u>	<u>Siemens Healthineers USA, Inc.</u>
	<u>Zaegyoo (Jay) Hah, PhD, MBA</u>	<u>Samsung Electronics Co., Ltd. (South Korea)</u>
	<u>Tim J. Hall, PhD</u>	<u>University of Wisconsin, School of Medicine &</u> <u>Public Health</u>
1095	<u>Aiguo Han, PhD</u>	<u>University of Illinois (UIC) Chicago</u>
	<u>Christopher Hazard, PhD</u>	<u>GE Corporate R&D (NY)</u>
	<u>Anis Hadj Henni, PhD</u>	<u>Rheolution, Inc. (Montréal, Canada)</u>
	<u>Yasunori Honjo, PhD</u>	<u>Canon Medical Systems</u>
	<u>Kenneth (Ken) Hoyt, PhD</u>	<u>University of Texas at Dallas</u>
	<u>Yu Igarashi, PhD</u>	<u>Canon Medical Systems</u>
	<u>Jingfeng Jiang, PhD</u>	<u>Michigan Technical University</u>

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1100	Thiago Julio, MD	Hospital Israelita Albert Einstein (São Paulo, Brazil)
	Muneki Kataguchi, PhD	Canon Medical Systems
	Tetsuya, Kawagishi, PhD	Canon Medical Systemes
	So Yeon Kim, MD	Adan Medical Center, Korea
	Riwa Kishimoto, MD, PhD	National Institute of Radiological Sciences
1105	Sonal Krishan, MD	Medanta (India)
	Viksit Kumar, PhD	Massachusetts General Hospital
	Koichiro Kurita, PhD	Canon Medical Systems
	Ogonna Kenechi Nwawka, MD	Hospital for Special Surgery (HSS)
	Safeer Hyder Laghari, PhD	Sukkur IBA University (Pakistan)
	Hyoung Ki Lee, PhD	Samsung Electronics Co., Ltd. (South Korea)
1110	Julian Lee	Alpinion Medical Systems
	Mi-Jung Lee MD, PhD	Severance Children's Hospital, Yonsei University College of Medicine
	Eleni Liapi, MD, MSc	Johns Hopkins University
	Ken Linkhart	Verasonics
1115	Jianwen Luo, PhD	Tsinghua University (China)
	Ted Lynch, PhD	Computerized Imaging Reference Systems, Incorporated (CIRS, Inc.)
	Andrej Lyshchik, MD, PhD	Thomas Jefferson University Hospital
	Jerry Mabary	Echosens (US operations)
1120	Michael MacDonald, PhD	GE Healthcare (Ultrasound)
	Ravi A. Managuli, PhD, RDMS	Fujifilm Healthcare Americas Corporation
	Glen McLaughlin, PhD	Mindray Medical
	Martha G. Menchaca, MD	University of Illinois (UIC) Chicago
	Steve Metz, PhD	Siemens Healthineers USA, Inc.
1125	Andy Milkowski, MS	Siemens Healthineers USA, Inc.
	Wayne L. Monsky, MD, PhD	University of Washington
	Jaime Morales, MD	Instituto Nacional de Perinatología (INPER) (Mexico)
	Cara E. Morin, MD, PhD	St. Jude Children's Research Hospital
	Thomas (Tom) R. Nelson, PhD	Retired
1130	Kathryn Nightingale, PhD	Duke University
	Svetoslav Nikolov, PhD	BK Ultrasound
	Marcello H. Nogueira-Barbosa, MD, PhD	University of São Paulo - Ribeirão Preto School of Medicine (Brazil)
	Adrian D. Nunn, PhD	Bracco Research USA
1135	Nancy Obuchowski, PhD	Cleveland Clinic Foundation
	James O'Callaghan, PhD	Alimentiv
	Arinc Ozturk, MD	Harvard-Massachusetts General Hospital
	Hugo José Paladini, MD	Hospital Universitario Fundación Favaloro
	Mark Palmeri, MD, PhD	Duke University
1140	Seong-Hoon Park, MD	Wonkwang University School of Medicine (South Korea)
	Kevin Parker, PhD	University of Rochester (NY)
	Patrick Ploc	Gammex, Inc.

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1145	<u>Michelle L. Robbin, MD, MS, FACR, FAIUM, FSRU</u>	<u>University of Alabama at Birmingham</u>
	<u>Nicolas Rognin, MSc, PhD</u>	<u>Moffitt Cancer Center</u>
	<u>Jonathan Rubin, MD, PhD</u>	<u>University of Michigan</u>
	<u>Anthony Samir, MD, MPH</u>	<u>Massachusetts General Hospital</u>
	<u>Leah E. Schafer, MD</u>	<u>Partners Healthcare</u>
1150	<u>Mark Schafer II, PhD</u>	<u>Sonic Tech, Inc.</u>
	<u>Cedric Schmitt, PhD</u>	<u>Rheolution, Inc. (Montréal, Canada)</u>
	<u>Vijay Shamdasani, PhD</u>	<u>Philips</u>
	<u>James Shin, MD</u>	<u>Stony Brook University Medical Center</u>
	<u>Claude Sirlin, MD</u>	<u>University of California, San Diego (UCSD)</u>
1155	<u>Gale Sisney, MD</u>	<u>University of Wisconsin</u>
	<u>Bob Spaulding</u>	<u>ATS Laboratories, Inc.</u>
	<u>Daniel C. Sullivan, MD</u>	<u>Duke University</u>
	<u>Joon Sunwoo, MD, MBA</u>	<u>Samsung Electronics Co., Ltd. (South Korea)</u>
	<u>Mihra S. Taljanovic, MD, PhD</u>	<u>University of Arizona</u>
1160	<u>Kai E. Thomenius, PhD</u>	<u>Consultant</u>
	<u>Ronald Tosh, PhD</u>	<u>National Institute of Standards and Technology</u> <u>(NIST)</u>
	<u>Gregg Trahey, PhD</u>	<u>Duke University</u>
	<u>Yao-Sheng Tung, PhD</u>	<u>Verasonics</u>
	<u>Theresa Tuthill, PhD</u>	<u>Pfizer</u>
1165	<u>Matthew Urban, PhD</u>	<u>Mayo Clinic College of Medicine</u>
	<u>Tomy Varghese, PhD</u>	<u>University of Wisconsin, Dept of Medical Physics</u>
	<u>Sudhakar Venkatesh, MD</u>	<u>Mayo Clinic</u>
	<u>Michael Wang, PhD, MAsc</u>	<u>GE Healthcare (Ultrasound)</u>
	<u>Masaki Watanabe, PhD</u>	<u>Canon Medical Systems</u>
1170	<u>Keith A. Wear, PhD</u>	<u>U.S. Food and Drug Administration (FDA)</u>
	<u>Thaddeus (Thad) Wilson, PhD, MS*</u>	<u>The University of Tennessee Health Science Center</u>
	<u>James Wiskin, PhD</u>	<u>QT imaging Inc.</u>
	<u>Russ Witte, PhD</u>	<u>University of Arizona</u>
	<u>Hua Xie, PhD</u>	<u>Philips</u>
1175	<u>Tadashi Yamaguchi, PhD</u>	<u>Chiba University, Graduate School of Engineering</u> <u>Dept. of Medical Engineering</u>
	<u>Shuji Yamamoto, PhD</u>	<u>National Cancer Center (Japan)</u>
	<u>Zhi Yang</u>	<u>Binzhou Medical University Hospital</u>
	<u>Terry S. Yoo, PhD</u>	<u>Center for Drug Evaluation and Research (CDER)</u>
1180	<u>Kwon-Ha Yoon, MD, PhD</u>	<u>Wonkwang University School of Medicine</u> <u>(South Korea)</u>
	<u>James A. Zagzebski, PhD</u>	<u>University of Wisconsin, School of Medicine &</u> <u>Public Health</u>
	<u>Heng Zhao, MS, PhD</u>	<u>GE Healthcare (Ultrasound)</u>
1185	<u>Haoyan Zhou, MS</u>	<u>Case Western University</u>
	<u>Brian Garra, MD (co chair)</u>	<u>Center for Devices and Radiological Health, FDA</u>
	<u>Tim J. Hall, PhD (co chair)</u>	<u>University of Wisconsin, School of Medicine & Public Health</u>
	<u>Andy Milkowski, MS (co chair)</u>	<u>Siemens Healthineers USA, Inc.</u>

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- 1190 — S. Kaiser Alam, PhD — Institute of Electrical and Electronics Engineers (IEEE)
- Karen Alton, MS, RDMS, RVT — Karen Alton Consulting, LLC
- Michael André, PhD — San Diego VA Healthcare/University of California, San Diego (UCSD)
- Brian Anthony, PhD — MIT
- John J. Antol — BK Ultrasound
- 1195 — Michalakis (Mike) A. Averkiou, PhD — University of Washington, Seattle
- Paul Barbone, PhD — Boston University
- Felipe Barjud Pereira de Nascimento, MD — Albert Einstein Hospital (São Paulo, Brazil)
- Richard G. Barr, MD, PhD — Northeastern Ohio Medical University
- Tharakeswara K. Bathala, MBBS, MD — University of Texas, MD Anderson Cancer Center
- Parviz Behfarin, MD — Plainview Hospital
- 1200 — John Benson — Siemens
- Matt Berger, BS — Samsung Electronics Co., Ltd. (South Korea)
- Laura Brattain, PhD — Massachusetts General Hospital
- Paul L. Carson, PhD — University of Michigan Medical Center
- Huan Wee Chan, MB ChB — The National Hospital for Neurology and Neurosurgery
- 1205 — Anil Chauhan, MD — University of Pennsylvania
- Jun Chen, PhD — Mayo Clinic
- Shigao Chen, PhD — Mayo Clinic
- Yuling Chen, PhD — Mindray (Zonare)
- Hyo-Min Cho, PhD — Korea Research Institute of Standards and Science
- 1210 — Wui K. Chong, MD — University of Texas, MD Anderson Cancer Center
- Yi Hong Chou, MD — Taipei Veterans General Hospital
- A Jung Chu, MD — Seoul National University Hospital (South Korea)
- Claude Cohen-Bacrie, MS — e-Scopies
- Elaine Collins, RDMS — PAREXEL International
- 1215 — Ron Daigle, PhD — Verasonics
- Jonathan R. Dillman, MD, MSc — Cincinnati Children's Hospital
- Marina Doliner, MD — Ann and Robert H. Lurie Children's Hospital of Chicago
- John Donlon — Philips
- Marvin M. Doyley, PhD — University of Rochester (NY)
- 1220 — Shuyan Du, PhD — Bristol-Myers Squibb
- Richard L. Ehman, MD — Mayo Clinic
- Todd Erpelding, PhD, MSE — Canon Medical Systems USA
- Alex Exposito — SuperSonic Imagine
- Steven E. Fick, PhD — National Institute of Standards and Technology (NIST)
- 1225 — Caterina M. Gallippi, PhD — University of North Carolina at Chapel Hill
- Joel Gay, MSc — Supersonic Imagine (SSI) — (Aix-en-Provence, France)
- Albert Gee — Zonare Medical Systems
- Gilles Guenette, RDMS, RDCS, RVT — Siemens
- Alexander Guimaraes, MD, PhD — Oregon Health & Science University
- 1230 — Zaegyoo (Jay) Hah, PhD, MBA — Samsung Electronics Co., Ltd. (South Korea)
- Hendrik Hansen, PhD — Radboud University Medical Center (Nijmegen, The Netherlands)
- Alpana Harisinghani, MD — PAREXEL International
- Peggy Harrigan, PhD — PAREXEL International

- 1235 — Christopher Hazard, PhD — GE Corporate R&D (NY)
- Anis Hadj Henni, PhD — Rheolution, Inc. (Montréal, Canada)
- Yasunori Honjo, PhD — Canon Medical Systems
- Kenneth (Ken) Hoyt, PhD — University of Texas at Dallas
- Yu Igarashi, PhD — Canon Medical Systems
- 1240 — Edward F. Jackson, PhD — University of Wisconsin, School of Medicine & Public Health
- Jingfeng Jiang, PhD — Michigan Technical University
- Thiago Julio, MD — Hospital Israelita Albert Einstein (São Paulo, Brazil)
- Muneki Kataguchi, PhD — Canon Medical Systems
- Tetsuya, Kawagishi, PhD — Canon Medical Systems
- So Yeon Kim, MD — Adan Medical Center, Korea
- 1245 — Riwa Kishimoto, MD, PhD — National Institute of Radiological Sciences
- Sonal Krishan, MD — Medanta (India)
- Viksit Kumar, PhD — Massachusetts General Hospital
- Koichiro Kurita, PhD — Canon Medical Systems
- Hyoung Ki Lee, PhD — Samsung Electronics Co., Ltd. (South Korea)
- 1250 — Julian Lee — Alpinion Medical Systems
- Mi Jung Lee MD, PhD Severance Children's Hospital, Yonsei University College of Medicine
- Eleni Liapi, MD, MSc — Johns Hopkins University
- Ken Linkhart — Verasonics
- Jianwen Luo, PhD — Tsinghua University (China)
- 1255 — Ted Lynch, PhD — Computerized Imaging Reference Systems, Incorporated (CIRS, Inc.)
- Andrej Lyshchik, MD, PhD — Thomas Jefferson University Hospital
- Jerry Mabary — Echosens (US operations)
- Michael MacDonald, PhD — GE Healthcare (Ultrasound)
- Ravi A. Managuli, PhD, RDMS Hitachi Medical Corporation; University of Washington
- 1260 — Stephen McAleavey, PhD — University of Rochester (NY)
- Glen McLaughlin, PhD Zonare Medical Systems
- Martha G. Menchaca, MD — University of Illinois (UIC) Chicago
- Wayne L. Monsky, MD, PhD — University of Washington
- Jaime Morales, MD — Instituto Nacional de Perinatología (INPER) (Mexico)
- 1265 — Thomas (Tom) R. Nelson, PhD — Retired
- Kathryn Nightingale, PhD — Duke University
- Svetoslav Nikolov, PhD — BK Ultrasound
- Marcello H. Nogueira Barbosa, MD, PhD — University of São Paulo — Ribeirão Preto School of Medicine (Brazil)
- 1270 — Adrian D. Nunn, PhD — Bracco Research USA
- Nancy Obuchowski, PhD — Cleveland Clinic Foundation
- Arinc Ozturk, MD — Harvard Massachusetts General Hospital
- Hugo José Paladini, MD — Hospital Universitario Fundación Favaloro
- Mark Palmeri, MD, PhD — Duke University
- 1275 — Seong Hoon Park, MD Wonkwang University School of Medicine (South Korea)
- Kevin Parker, PhD — University of Rochester (NY)
- Patrick Ploc — Gammex, Inc.
- Nicolas Rognin, MSc, PhD — Moffitt Cancer Center

- Stephen Rosenzweig, PhD — Siemens
- Jonathan Rubin, MD, PhD — University of Michigan
- Anthony Samir, MD, MPH — Massachusetts General Hospital
- Leah E. Schafer, MD — Partners Healthcare
- Mark Schafer II, PhD — Sonic Tech, Inc.
- Cedric Schmitt, PhD — Rheolution, Inc. (Montréal, Canada)
- Vijay Shamdasani, PhD — Philips
- James Shin, MD — Stony Brook University Medical Center
- Claude Sirlin, MD — University of California, San Diego (UCSD)
- Gale Sisney, MD — University of Wisconsin
- Bob Spaulding — ATS Laboratories, Inc.
- Daniel C. Sullivan, MD — Duke University
- Joon Sunwoo, MD, MBA — Samsung Electronics Co., Ltd. (South Korea)
- Mihra S. Taljanovic, MD, PhD — University of Arizona
- Kai E. Thomenius, PhD — Consultant
- Ronald Tosh, PhD — National Institute of Standards and Technology (NIST)
- Gregg Trahey, PhD — Duke University
- Yao Sheng Tung, PhD — Verasonics
- Theresa Tuthill, PhD — Pfizer
- Matthew Urban, PhD — Mayo Clinic College of Medicine
- Tomy Varghese, PhD — University of Wisconsin, Dept of Medical Physics
- Sudhakar Venkatesh, MD — Mayo Clinic
- Michael Wang, PhD, MAsc — GE Healthcare (Ultrasound)
- Masaki Watanabe, PhD — Canon Medical Systems
- Keith A. Wear, PhD — U.S. Food and Drug Administration (FDA)
- Thaddeus (Thad) Wilson, PhD, MS* — The University of Tennessee Health Science Center
- Russ Witte, PhD — University of Arizona
- Hua Xie, PhD — Philips
- Tadashi Yamaguchi, PhD — Chiba University, Graduate School of Engineering Dept. of Medical Engineering
- Shuji Yamamoto, PhD — National Cancer Center (Japan)
- Zhi Yang — Binzhou Medical University Hospital
- Terry S. Yoo, PhD — Center for Drug Evaluation and Research (CDER)
- Kwon Ha Yoon, MD, PhD — Wonkwang University School of Medicine (South Korea)
- James A. Zagzebski, PhD — University of Wisconsin, School of Medicine & Public Health
- Heng Zhao, MS, PhD — GE Healthcare (Ultrasound)
- Haoyan Zhou, MS — Case Western University

Many of the published papers, proceedings articles and abstracts produced in this effort are referenced in http://qibawiki.rsna.org/index.php/QIBA_in_the_Literature_Citations

under the link “QIBA Literature References”. Major contributors to the primary manuscript reporting much of the SWS US Biomarker Committee’s work were, Mark L. Palmeri and, in alphabetical order, Richard Barr, Paul Carson, Mathieu Couade, Jun Chen, Shigao Chen, Manish Dhyani, Richard Ehman, Brian Garra, Albert Gee, Gilles Guenette, Zaegyoo Hah, [Timothy J. Hall](#), Ted Lynch, Michael Macdonald, Ravi Managuli, Veronique Miette, Kathryn R. Nightingale, Nancy Obuchowski, Ned C. Rouze, Anthony

Commented [WKA58]: Tim Hall is not in alphabetical order.

E. Samir, Vijay Shamdasani, Matthew Urban, Keith Wear, Hua Xie, ~~Timothy J. Hall~~. Not in order, they are from:

Duke University, Durham, NC, USA, CIRS, Norfolk, VA, USA, Mayo Clinic, Rochester, MN, USA, Philips Research, Cambridge, MA, USA, Food and Drug Administration, Silver Spring, MD, USA, Siemens Ultrasound, Issaquah, WA, USA, University of Michigan, Ann Arbor, MI, USA, The Surgical Hospital at Southwoods, Boardman, OH, USA, Philips Ultrasound, Bothell, WA, USA, General Electric, Milwaukee, WI, USA, Toshiba Medical Research Institute, Redmond, WA, USA, Massachusetts General Hospital, Boston, MA, USA, Samsung Medison, Seoul, South Korea, Zonare Medical Systems, Mountain View, CA, USA, The Cleveland Clinic, Cleveland, OH, USA, University of Wisconsin, Madison, WI, USA SuperSonic Imagine, Aix-En-Provence, France Echosens, Paris, France Hitachi Healthcare, Seattle, WA, USA

Appendix B: Background Information

Appendix C: Conventions and Definitions

Appendix D: Model-specific Instructions and Parameters

D.1 Canon

Manufacturer Name:

- Canon Medical Systems Corporation (formerly Toshiba Medical Systems Corporation)

Equipment Models:

- Aplio i-series (i600/i700/i800/i900)
- Aplio a-series (a450/a550/a)
- Aplio Platinum Series (300/400/500)
- Xario 200 Platinum Series

Software Versions:

- Aplio i700/800/900 V1.1 or later
- Aplio i600 V2.0 or later
- Aplio a450/a550/a V1.0 or later
- Aplio 400/500 V6.0 or later
- Aplio 300 V6.7 or later
- Xario 200 V6.0 or later

Transducer(s):

Transducer	Aplio i700/i800/i900	Aplio i600	Aplio a450/a550/a	Aplio 300/400/500	Xario 200
PVI-475BX	X				
PVI-475BT	X	X			

PVI-574BX	X				
PVT-375BT	X	X	X	X	
PVT-375SC	X	X	X	X	
PVT-475BT			X	X	
PVT-574BT	X	X	X		
PVU-375BT					X

Acquisition Procedures:

[See specifications in Profile Section 3.6, 3.8, & 3.10]

- Patient fasted minimum 4- 6 hours (including alcohol)
- Patient lying supine or slight left lateral decubitus position with the right arm behind the head.
- Normal gentle breathing or mid-expiration breath hold, as needed.
- Intercostal acoustic window with minimal rib shadowing and keeping the liver capsule parallel to the transducer surface; optimizing visualization of liver tissue.
- Select an area of the right lobe of the liver parenchyma free of the following structures:
 - Portal Trunk; Vessels; Visible Fibrous Bands
- Shear wave acquisition ROI:
 - ROI size: approximately 3 cm in lateral direction and 3 cm in axial direction.
 - Position acquisition ROI at least 1 cm below the liver surface.
- Shear wave measurement ROI:
 - A circular measurement ROI with a diameter of 1 cm is recommended.
 - Place measurement ROI in region of the shear wave speed /elasticity display that is homogenous and without defect.
 - The Propagation map displays can be used for additional guidance on the placement of the measurement ROI (see below). The measurement ROI should be placed in a region where smooth, parallel contour lines are observed in the Propagation display.
- Repeat at least 5 measurements from the same window in the right lobe of the liver.

Outlier Identification specifications and instructions for use:

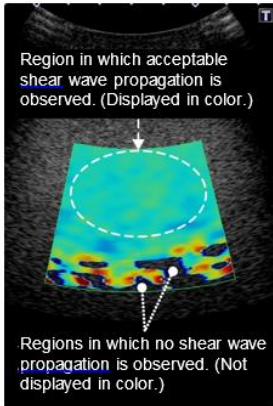
The following shear wave display maps are available:

Map Type	Display	Description
Speed	Shear wave speed display (m/s) ^{*1}	The stiffness distribution for the scanned plane can be observed.
Elasticity	Elasticity display (kPa) ^{*1}	
Propagation	Propagation display ^{*2}	The shear wave arrival time is presented as contour lines. (The wavefront of the shear wave is displayed at regular time intervals.)
Dispersion	Frequency dispersion display ^{*1}	The change in shear wave speed between frequencies is represented (dispersion slope) in color.
Variance	Variance display ^{*1}	Minor distortions in shear wave arrival times are represented in color.

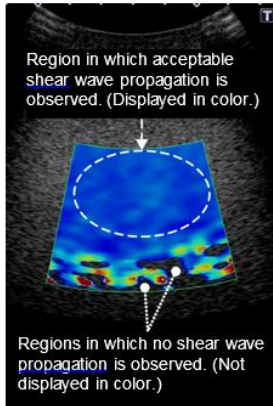
*1: Regions in which no shear wave propagation is observed or acceptable shear wave propagation is not observed are not displayed in color.

*2: Distorted contour lines are displayed for regions where no shear wave propagation is observed or where acceptable shear wave propagation is not observed.

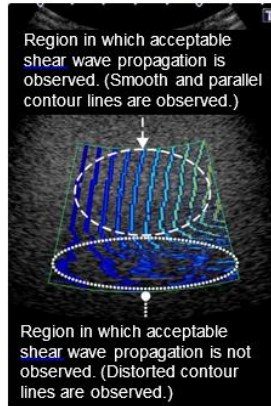
The region in which the desired shear wave propagation is observed can be confirmed by using the propagation display together with the shear wave speed display or elasticity display.



Shear wave speed display



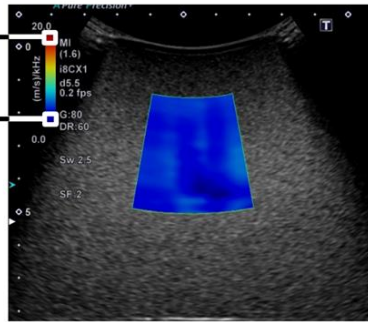
Elasticity display



Propagation display (Contour)

Colors near the top of the color bar indicate greater change in shear wave speed with changes in frequency.

Colors near the bottom of the color bar indicate less change in shear wave speed with changes in frequency.



Dispersion display

The mean, median, standard deviation, and IQR from multiple shear wave measurements can be displayed on a worksheet report page (up to 14 measurements). Individual measurements (i.e., outliers) can be excluded from the calculation of these statistical values as selected by the user.

D.2 ESAOTE

Manufacturer Name:

Esaote S.p.A

Equipment Model

- MyLab Nine
- MyLab X8
- MyLab Eight
- MyLab Twice

Software Versions:

- MyLab 9 F070101 or later
- MyLab X8 version F080101 or later
- MyLab Twice release 10 or later
- MyLab Eight release 11 or later

Transducer(s) to be used

- C 1-8 with MyLab 9, MyLab X8 and MyLab 8
- L 4-15 with MyLab 9, MyLab X8
- L 3-11 with MyLab 9, MyLab X8
- CA541 with MyLab Twice

Acquisition Procedure:

1. Instructions

a. Scanning Instructions

- Recommended fasting of 4 -6 hours
- Right intercostal access has to be used, with the patient in the dorsal decubitus position, examining the right lobe of the liver (VI/VII segments) .by using the Convex array
- Put the right arm of the patient behind his/her head in order to maximize the intercostal space.
- The coupling between probe and liver has to be complete (the whole echo image has to be properly visible) - a correct amount of gel has to be used. Dark areas of the echo image have to be avoided.
- A correct pressure has to be applied, in order to be stable and to be properly coupled with the skin over the liver - the pressure shouldn't be not excessive in order to not compress the liver.
- No respiration during the acquisition, the patient should be asked to stop breathing just for few seconds in neutral respiratory phase.

b. ROI Positioning

- The ROI has to be positioned in an area free of vessels, bile ducts or nodules. It is recommended to check also the adjacent planes, not only the one of the ROI.
- The ROI should be positioned about 1 cm below the Glisson capsule to avoid reverberation artefacts. The optimized depths are between 3 cm and 5 cm.

c. ROI Size

- Point Shear Wave ~ 1.0cm x 1.0 cm
- 2D Shear Wave ~ 2 x 2.5 cm

d. Number of measurements

- Point Shear Wave 10 measurements or more
- 2D Shear Wave 5 measurements or more

2. Pitfalls

- Low echogenicity and thick abdominal wall could make weak shear waves
- Modification of the acquisition liver window
- ROI axis not perpendicular to the liver capsule
- Reverberations could generate artefacts
- Some liver diseases may affect the stiffness assessment with SWE technique

Outlier Identification specifications and instruction for use:

Outliers are excluded based on a statistical signal analysis

The users have the possibility to discard some unreliable measurements and proceed to a new acquisition.

In pSWE stiffness assessment, a quality index is indicated side the measurement with a capital letter H for High, M for Medium and L for Low giving some indication to the user about the reliability of the measurement.

In 2D SWE stiffness assessment, a reliability color map is available, indicating to the user, the areas where the measurement values are more stable and affordable.

Ultrasound System	No fibrosis (F0 – F1)	Moderate fibrosis (F 2- F3)	Severe Fibrosis (> F4)
MyLab 9 / X8			
MyLab Twice / Eight			

D.3 General Electric

Manufacturer Name: GE Healthcare

Equipment Model: LOGIQ E9, E10, E10s, S8, P7, P9

Software Version and Transducer(s) to be used:

System	Minimum software revision	Transducer(s)
E9	R5	C1-6-D
E10/E10s	R1	C1-6-D
S8	R3	C1-6-D

P7/P9	R3	C1-5-RS, 4C-RS
-------	----	----------------

1475 **Acquisition Procedures:**

1. Instructions

- 1480
- Fasting 4 – 6 hours
 - Utilize supine position (obtain slight left lateral decub as needed)
 - Elevate right arm above head
 - Scan intercostally with enough pressure to maintain stable contact
 - Take measurements in right lobe of the liver with few vessels
 - Avoid rib shadows
 - Avoid vessels in the Shear Wave Elastography ROI
 - Obtain measurements on breath hold during the quiet breathing, not inspiration
- 1485

2. ROI positioning

- 1490
- Place top of Shear Wave Elastography ROI 1 – 2 cm below liver capsule with middle of the Shear Wave Elastography ROI between 4 – 5 cm for best results
 - Place ROI near center of image (laterally) if possible
- 1495

3. ROI size

- Minimum measurement caliper size should be 1 cm in diameter (default is 1.25cm)

4. Number of Measurements

- 10 measurements recommended

5. Pitfalls

- 1500
- Large skin-to-capsule distance
 - Poor B-mode image quality (low echogenicity, poor speckle definition)
 - Motion (patient or transducer)
 - Inadequate probe contact, coupling gel, or probe pressure
- 1505
- 1510

Outlier Identification specifications and instructions for use:

1515 A Quality image can be shown side-by-side with the shear wave elastography image to find the best location on the image to take the measurement. Locations with high quality are more likely to have accurate shear wave measurements.

1520 When the shear wave quality within the circular measurement caliper is lower than recommended, its color will change to red to indicate low confidence in the measurement accuracy. It is recommended not to measure at such a location.

1525 Motion artifact can cause vertical stripes in the shear wave elastography image. Do not measure if there is motion artifact.

Per WFUMB guidelines, exams where IQR/Median ratio is >30% when using Young's Modulus (kPa), and >15% when using shear wave speed (m/s) should be considered not reliable.

1530
GE Healthcare
LOGIQ E9 Shear Wave Elastography

Liver Fibrosis Staging

Liver Fibrosis Staging	Metavir Score	kPa	m/s
Normal – Mild	F1	5.48 kPa – 8.29 kPa	1.35 m/s – 1.66 m/s
Mild – Moderate	F2	8.29 kPa – 9.40 kPa	1.66 m/s – 1.77 m/s
Moderate – Severe	F3	9.40 kPa – 11.9 kPa	1.77 m/s – 1.99 m/s
Cirrhosis	F4	> 11.9 kPa	> 1.99 m/s

A GE study has demonstrated that LOGIQ® E9 Shear Wave Elastography is a robust technique and capable of evaluating stiffness changes in the liver associated with fibrosis. Although a limited number of subjects were evaluated at the hospital in this study, liver stiffness measurements were shown to be useful for discriminating different stages of fibrosis. It is important to note that a small number of subjects with intermediate stages of fibrosis were evaluated in this study, and that a mix of disease etiologies were present. Therefore, the values shown may not be directly applicable to other patient populations. Data was acquired using LOGIQ E9 RS.1.0 equivalent software and the C1-6-D probe. For detailed information, please see the LOGIQ E9 Shear Wave Elastography white paper.



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D.4 Hitachi

Manufacturer Name:

1535 Hitachi, Ltd.

Equipment Model:

- ARIETTA 850
- ARIETTA 70
- 1540 - HI VISION Ascendus

Software Version:

- ARIETTA 850 Ver.1 or later

- ARIETTA 70 Ver.3 or later
- 1545 - HI VISION Ascendus Step 4 or later

Transducer(s) to be used:

- C252 and C251 with ARIETTA 850
- C251 with ARIETTA 70
- 1550 - C715 with HI VISION Ascendus

Acquisition Procedures:

1. Instructions

a. ROI positioning

1555 Same as QIBA profile. See below.

- Position the ROI at least 2cm deep to the liver capsule and less than 6.5 cm from the transducer face.
- Position the ROI away from discrete structures such as liver margin, nodules, portal triads or hepatic veins for acquisition of SWS estimates.
- 1560 • Position the ROI near the center of the image in the lateral direction and away from the right or left image margins.

b. Measurement ROI size

Fixed ROI size with 10mm width and 15mm depth.

c. Number of measurements

1565 10 measurements

2. Pitfalls

Under the following conditions, the generation and/or detection of shear wave will be insufficient.

- Low echogenicity
- Thick abdominal wall
- 1570 - Liver capsule non parallel to the abdominal wall or not perpendicular to beams
- Place the ROI on rib shadows and/or near the liver capsule
- Large body motion by respiration

Outlier Identification specifications and instructions for use:

- 1575 - Hitachi has a reliability index (VsN). Outliers are excluded using specific Vs range and/or shear wave signal quality. If VsN equals 0%, all data are outliers and error message is displayed.
- IQR/Median is displayed. Users can exclude individual measurements and the statistical values (i.e. IQR/Median) are automatically updated. (only for ARIETTA 850)

1580 **D.5 Philips**

Manufacturer Name: Philips

Equipment Model: EPIQ

1585 **Software Version: Evolution 3.0**

Transducer(s) to be used: C5-1 Curvilinear Transducer

Acquisition Procedures: Please refer to Philips “Quick Guide EPIQ Series ElastQ Imaging” for complete instruction

1. Instructions

a. ROI positioning

i. Ensure good transducer contact

ii. Before starting shear wave elastography, always scan the region of interest in 2D mode to assess tissue consistency

- Do not position the shear wave imaging region of interest (ROI) box over fetal tissue, tissue with gas pockets (lung, stomach, bowels), a bone tissue boundary, gallstones, metal, or the borders of the image.

- Avoid rib shadow in the image, when possible.

- Position the ElastQ Imaging ROI box in the center of the image.

- Do not place the ElastQ Imaging ROI box on or near a rib shadow or liver capsule.

- Place the top of the ROI box 1.0 to 1.5 cm below the liver capsule, to avoid reverberation artifacts

- Do not place the circle caliper on a rib shadow, blood vessels

- Position the circle caliper in the area of the ROI box that displays the majority of the uniform color

- ROI size

iii. ElastQ Imaging ROI: maximum size ~5cm (height) x 7 cm (width)

iv. Making stiffness measurement and calculations

1. Default circle caliper size: diameter 1cm

2. User has the option to calculate the average stiffness in the entire ElastQ Imaging ROI

3. User has the option to make single point measurements in the ROI

4. Stiffness measurement is also available for areas defined by the user in the form of ellipse and continuous trace

b. Number of measurements

- Take a minimum of 8 to 10 liver stiffness measurements

2. Pitfalls

Outlier Identification specifications and instructions for use:

To ensure high quality stiffness measurement, a concurrent real-time confidence map that combines multiple image quality metrics is also available along with the stiffness image. Outliers in stiffness measurement are automatically detected and excluded from subsequent quantification and statistical analysis. In addition, users are provided with the ratio of stiffness interquartile range (IQR) to median as a measure of variability for further measurement quality control.

D.6 Samsung

Manufacturer Name:

1630 Samsung Medison Co., Ltd.

Equipment Model:

- RS80A
- RS85

1635

Software Version:

- RS80A v2.0 or later
- RS85 v1.0 or later

1640 **Transducer(s) to be used:**

- RS80A
 - CA1-7A
 - LA2-9A

1645

- CA1-7A
- LA2-9A

Acquisition Procedures:

1650

- Patient position
 - Supine / oblique left decubitus position is recommended
 - The right arm would better be elevated to make the intercostal spaces wider
 - Scan while patients' holding a normal breath (If not possible, ask the patient to breath as shallowly as possible)

1655

- Prolonged breath holding should be avoided
- Patients should not move during the measurements

1660

- Liver segment
 - Right hepatic lobe (between 5 and 8 segments from the right intercostal space) is recommended.
 - Avoid the left hepatic lobe because the measurement is affected by cardiac movements.
 - Segment 4 of the liver is sensitive to the motion artifact. There are more chances of the failure of measurement.

1665 **ROI positioning**

- Position the ROI Box neat the homogeneous region
- Position the ROI Box at the suspected lesion without obscuring vessels.
- The ROI must be positioned at least 1.5 cm below the liver capsule.
- To obtain a stable measurements, position the ROI on the same locations and repeat the measurements
- The depth of ROI is recommended 6cm or less (if the depth is more than 6cm, the result may not be reliable). The bottommost depth should be less than 7cm.
- ROI is recommended to be positioned near the center line.

1670

1675 **ROI size**
Point shear wave: 1.0cm X 1.0cm
S shear wave: 2.5cm X 3.0cm

1680 **Number of measurements:**
10 times or more

Scanning instruction

- After checking the probe and the application, start a scan.
- When you get the desired image, tap the **S-Shearwave Imaging** on the touch screen.
- 1685 - Use the track ball to move to a desired ROI measurement position.
- Press the **Freeze** button on the control panel, and then the **Elasticity Measure** button on the touch screen.
- Use the trackball to move to a desired ROI measurement position within the Elasticity Image ROI.
- 1690 - Pressing the **Set** button will display elasticity statistics within the Measure ROI, and save the value.
- A maximum of four Sites can be specified, and a maximum of ten Measure ROIs can be specified per Site

1695 **2. Pitfalls**

(1) Weak shear waves
Avoid the ROI in the region where B mode image is too dark. This can induce insufficient tissue displacement by the push pulse to measure shear wave speed. Severe attenuation in tissue/muscle layer, shadowing by the ribs, defocusing of push pulses, loose probe contact can be the reasons.

(2) Reverberation
Obese patients typically have a thick fat/muscle layer and produce reverberations deep in the liver. The reverberations distort scanning pulses to produce erroneous shear wave speed readings. To reduce reverberation artifact, depth of ROI should be at least twice the thickness of the muscle/fat layer, and the probe angle should be chosen to minimize reverberation between strong parallel reflectors. Measurements deemed contaminated by reverberation will display RMI (Reliability Measurement Index) value of 0.0.

(4) Reflections
Abrupt changes at the tissue/ tumor boundary produces reflections that may alter the observed propagation of shear waves. Typically this alteration may produce higher stiffness at the periphery of stiff tumors.

1715 **Outlier Identification specifications and instructions for use:**

- Reliable Measurement Index (RMI) shows how reliable the measurement is and it is more reliable if the value gets closer to the maximum value of 1. (If RMI is 0.4 or higher, it is considered as very reliable.)
- It is recommended that this process is repeated more than 10 times.
- Auto profiling automatically removes outliers with RMI less than 0.4 or too far away from the calculated median value. The process automatically repeats itself until the number of remaining measurements is bigger than 5 and IQR/MED is less than 0.3.
- Following table is the chart provided by Samsung for liver fibrosis staging.

Liver Grading	Normal – Mild	Mild	Moderate – Severe	Severe
METAVIR Scoring	F0 - F1	F1 - F2	F3 - F4	F4
Kpa	2 - 5.4kpa	5.4 - 7.4kpa	7.4 - 11.6kpa	11.6 – 21.4kpa
m/s	0.81 - 1.34 m/s	1.34 - 1.57 m/s	1.57 - 1.97 m/s	1.97 – 2.7 m/s

D.7 Siemens

Manufacturer Name:

Siemens Medical Solutions, USA, Inc.

Equipment Model:

ACUSON Sequoia
ACUSON S2000, S3000

Software Version:

ACUSON Sequoia: VA10A or later
ACUSON Redwood
ACUSON Juniper VA10A or later
ACUSON S2000, S3000: VC20A or later

Transducer(s) to be used:

ACUSON Sequoia: 5C1, DAX, 4V1, 10L4
ACUSON S2000, S3000: 6C1HD, 4C1, 4V1

Acquisition Procedures:

Follow cross-vendor recommendations in Profile

Best Practice Techniques

- Patient has fasted for a minimum of 4-6 hours

- Position patient supine or slight (30°) left lateral decubitus position with right arm raised above head
- Scan with the transducer parallel to ribs and in an intercostal space in the right lobe of the liver (segments 5 or 8)
- Optimize B-mode image so liver parenchyma is bright and large vessels, bile ducts and rib shadows are avoided

1755 Activate Virtual Touch from the Abdomen exam preset

- ACUSON Sequoia
 - Press **VT** button on control panel
 - Select **pSWE** for point Shear Wave Elastography or **SWE** for 2D Shear Wave Elastography
- ACUSON S2000 and S3000 systems
 - Press **E** button on control panel
 - Select **VTQ** (Virtual Touch Quantification) on the touch screen

1760 Position the Region of Interest (ROI)

- Position the ROI between 3–6 cm deep and at least 1–2 cm below liver capsule
- To position the ROI, roll the trackball
- In SWE, if desired, press **Set** key and roll trackball to resize the ROI

1770 Perform Acquisition

- Perform acquisition during suspended respiration, neither deep inspiration nor expiration; patient may resume normal breathing after audible “beep” is heard
- To begin acquisition, press **Update** on the control panel; an audible tone indicates when the acquisition ends

1775 Store Measurement Result

- ACUSON Sequoia pSWE
 - The **Liver Site 1** label is automatically selected; change the measurement label if desired on the touch screen
 - Press **Image** to store an image, or Press right or left **Set** key to store the measurement without storing an image
- ACUSON Sequoia SWE
 - Press **Caliper** to enter measurement workflow
 - Select desired measurement label on the touch screen
 - Roll the trackball to position measurement caliper
 - If needed, rotate **ROI Diameter** control to resize measurement caliper
 - Press **Image** to store an image, or Press right or left **Set** key to store the measurement without storing an image
- ACUSON S2000 and S3000 systems
 - Select desired measurement label on the touch screen
 - Press **Image** to store an image, or Press right or left **Set** key to store the measurement without storing an image

1795 Study Conclusion

- Acquire and store 10 total valid measurements at the same imaging location
- Select Report on left side of touch screen
- Ensure IQR/Median is less than 0.3

1800 **Outlier Identification specifications and instructions for use:**

The ACUSON Sequoia pSWE and ACUSON S2000/S3000 VTQ measurements display X.XX m/s when the threshold for measurement quality was not reached. Users should discard those measurements and repeat the acquisition until the system displays a numerical value.

1805 The ACUSON Sequoia SWE image provides a Quality map to confirm that shear wave generation was adequate and identify regions of the shear wave image where shear wave velocity or elasticity estimations may be incorrect due to poor shear wave signal quality. To view the quality map, rotate the **Shear Wave** control from **Velocity** to **Quality**. The measurement caliper should be placed in regions of
1810 the highest visible quality and near the center of the acquisition ROI.

Ensure overall IQR/Median ratio for acquired measurements is less than 0.3 as provided in the patient report.

1815 **D.8 Supersonic Imagine**

Manufacturer Name:
SuperSonic Imagine

1820 **Equipment Model:**
Aixplorer®

Software Version:
Most recent version released: V11.1.1

1825 **Transducer(s) to be used:**
SC6-1 from version V3.0 to V11.1
XC6-1 from version V9.3.1 to V11.1

- 1830 1. Number of values averaged for each pixel in the color image:
The number of values averaged for each pixel depends on imaging parameters.
Operator-adjustable parameters are:
- Map persistence: the operator can change the number of frames averaged from 1 to 3
 - Map smoothing: this spatial filtering uses sizeable 2D areas to calculate and display one pixel value on the color image. The size of this 2D area ranges from 3x3 to 19x19, the default size being 11x11 values.
- 1835

2. Average Variance per pixel:

Acquisition Procedures:

6. Instructions – Pre-requisites

Optimal acoustic window should be found, assessed on grayscale imaging, prior to engaging SWE™ Mode by appropriate patient’s positioning and proper probe holding.

a. Patient’s positioning:

- i. Patient is placed in supine position to favor acquisitions and measurements on the right liver lobe
- ii. Right arm in maximum abduction
- iii. Change to left lateral decubitus only when necessary

b. Probe holding

- i. Acquisitions and measurements should be preferably performed on the right liver lobe via intercostal access
- ii. Probe should be placed parallel to the intercostal space to avoid shadowing from the ribs
- iii. Probe should be held orthogonal to the liver capsule to maximize ultrasound transmission, shear wave generation and shear wave propagation recording
- iv. When scanning intercostally, extra pressure should be applied on the probe to:
 1. Enlarge intercostal space
 2. Decrease subcutaneous fat thickness
 3. Ensure optimal contact between the probe and patient’s thoracic wall

Image stabilization must be achieved before freezing the image

- Motion from the operator and the probe must be avoided
- Appropriate patient’s normal breath hold for 3-4 seconds must be achieved

7. Instructions – SWE Acquisition

a. ROI positioning

i. The colored SWE Box should be positioned:

1. At a minimum depth of 2 cm from the liver capsule,
2. Ideally enabling measurements between 3 to 7 cm in depth,
3. Over morphologically homogeneous, vessel-free, liver parenchyma

ii. The Q-Box™ ROI should be placed:

1. In the central area of the SWE Box; borders of the SWE Box should be avoided.
2. Over an area of relative homogeneous elasticity, avoiding recognizable artifacts
3. From V10.0, use the stability index to reject any location for which the SI would be < 90%

b. ROI size [See specifications in Profile Section 3.10.2]

The SWE default settings have been optimized for the assessment of liver fibrosis. Default settings should be used first, and adjusted only when necessary.

- i. The default size of the SWE Box is 2 cm in height and 3 cm in width.
- ii. The default size of the Q-Box ROI may be enlarged to encompass the largest quantification area possible, while ensuring no vessels, no parenchyma heterogeneity and no artifact are included.

c. Number of measurements

- i. Because of the large amount of SWS measurements included in 1 Q-Box ROI, a total number of 3 valid measurements* performed on 3 independent valid acquisitions are recommended.
- ii. The average value of 3 valid measurements* can be considered as the estimation of SWS for a given patient.

* Invalid measurements obtained with XC6-1 probe from V10.0 must be defined as measurements obtained with a Stability Index < 90%. Invalid measurements obtained with SC6-1, regardless of software version, or XC6-1 probe before V10.0 software release must be defined as measurements obtained from unstable SWE map evaluated as non-reliable acquisitions.

8. Pitfalls

- a. Usual limitations of conventional ultrasound apply to SWE™ mode
 - i. Narrow intercostal spaces,
 - ii. Thick layer of fat,
 - iii. Highly attenuating medium, low echogenicity
- b. Several clinical ~~factor~~**Actors** influence liver stiffness measurements, and should be considered when assessing liver SWS:
 - i. Respiration, deep breath
 - ii. Central venous pressure
 - iii. Intrahepatic cholestasis
 - iv. Hepatic necro-inflammatory activity
 - v. Peliosis hepatitis
 - vi. Hepatic vein thrombosis
 - vii. Congestive hepatopathy

Outlier Identification specifications and instructions for use:

Acquisitions that are performed in sub-optimal acoustic conditions should be discarded and may present high risk for generating unreliable SWS measurements and outliers. Such sub-optimal conditions are:

- Lack of acoustic coupling and reduced acoustic transmission,
- Unstabilized grayscale and/or SWS image, particularly due to lack of breath control,
- Large highly attenuating or hypoechoic areas, especially from ribs shadowing.

Acquisitions that are unstable as illustrated by SWS maps being highly unstable over time, or with varying color patterns, should be considered as unreliable acquisitions and should be discarded. Such unreliable acquisitions may present high risk for generating unreliable SWS measurements and outliers.

Unreliable measurements and outliers should be expected in areas close to major hepatic vessels, focal liver nodules, and any visible structure on grayscale ultrasound that looks different from liver parenchyma.

Ultrasound System	No Fibrosis or Minimal Fibrosis (METAVIR F0-F1)	Moderate Fibrosis (METAVIR F2 and F3)	Severe Fibrosis/Cirrhosis (METAVIR F3 – F4)
System A			

1930

Appendix E: Primary Checklists for Profile Execution and Conformance

See the Microsoft Excel file in this folder for the checklists. A link is given below:

[Appendix E - clean version for public.xlsx](#)

1935

Appendix F: Secondary Checklists for Profile Execution and Conformance

Appendix G: Patient information sheet and Data collection

1940

Standardized case report form for Elastography studies

Subject ID: _____

1945

A. Patient Demographics

- | | | |
|--------------------------|-------|----|
| 1. Gender | M | F |
| 2. Age (years) | _____ | |
| 3. Patient Fasting Hours | Yes | No |
| 4. Height (inches) | _____ | |
| 5. Weight (pounds) | _____ | |

1950

B. Clinical Data

- | | | |
|--------------------------------------|-----|----|
| 1. Confounders: | | |
| a. Right Heart Failure | Yes | No |
| b. Steatosis (on US) | Yes | No |
| c. Elevated markers for inflammation | Yes | No |
| 2. Reason for Exam | | |

1955

Elevated LFT's?

<input type="checkbox"/> F/U Known Hx of Liver Disease	<input type="checkbox"/> Diagnostic for Fibrosis
<input type="checkbox"/> HCV	<input type="checkbox"/> ?NASH
<input type="checkbox"/> HBV	<input type="checkbox"/> ?AIH
<input type="checkbox"/> HIV + HCV	<input type="checkbox"/> ?Drug Toxicity _____
<input type="checkbox"/> AIH _____	
<input type="checkbox"/> Alcoholic Liver Disease	
<input type="checkbox"/> Healthy volunteer	
<input type="checkbox"/> Other _____	

C. Serum Biomarkers (If evaluated)

- i. Platelets (x10⁹/L) _____
- ii. AST (IU/L) _____
- iii. ALT (IU/L) _____
- iv. Alkaline phosphatase _____
- v. Total Bilirubin (µ mol/L) _____

Automated Calculations from above values:

- 1. AST/ALT ratio
- 2. APRI
- 3. Fib-4

Optional

FibroSURE _____

FibroScan _____

MR Elastography _____

D. SWS Examination

Depth of liver capsule from skin _____

Measurement No.	Depth of measurement from capsule (cm)	SWS (m/sec)	Comments
1			

2			
3			
4			
5			
6			
7			
8			
9			
10			

IQR/Median Value: _____

References

References (Steatosis has no effect):

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1. [Yoneda M, Mawatari H, Fujita K, Endo H, Nozaki Y, Yonemitsu K, et al. Noninvasive assessment of liver fibrosis by measurement of stiffness in patients with nonalcoholic fatty liver disease \(NAFLD\). *Dig Liver Dis* \[Internet\]. 2008 May; 40\(5\):371–8. Available from:<http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=18083083&retmode=ref&cmd=prlinks>](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=18083083&retmode=ref&cmd=prlinks)
2. [Friedrich-Rust M, Wunder K, Kriener S, Sotoudeh F, Richter S, Bojunga J, et al. Liver fibrosis in viral hepatitis: noninvasive assessment with acoustic radiation force impulse imaging versus transient elastography. *Radiology*. 2009 Aug;252\(2\):595–604.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
3. [Lupsor M, Badea R, Stefanescu H, Sparchez Z, Branda H, Serban A, et al. Performance of a new elastographic method \(ARFI technology\) compared to unidimensional transient elastography in the noninvasive assessment of chronic hepatitis C. Preliminary results. *J Gastrointest Liver Dis*. 2009 Sep;18\(3\):303–10.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
4. [Fierbinteanu-Braticevici C, Andronesu D, Usvat R, Cretoiu D, Baicus C, Marinoschi G. Acoustic radiation force imaging sonoelastography for noninvasive staging of liver fibrosis. *World J Gastroenterol* \[Internet\]. 2009 ed. 2009 Nov 28;15\(44\):5525–32. Available from:<http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks>](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
5. [Bota S, Sporea I, Sirli R, Popescu A, Danila M, Sendroiu M. Factors that influence the correlation of acoustic radiation force impulse \(ARFI\), elastography with liver fibrosis. *Medical ultrasonography*. 2011 Jun;13\(2\):135–40.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
6. [Rifai K, Cornberg J, Mederacke I, Bahr MJ, Wedemeyer H, Malinski P, et al. Clinical feasibility of liver elastography by acoustic radiation force impulse imaging \(ARFI\). *Dig Liver Dis* \[Internet\]. 2011 Jun;43\(6\):491–7. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S1590865811000752>](http://linkinghub.elsevier.com/retrieve/pii/S1590865811000752)
7. [Palmeri ML, Wang MH, Rouze NC, Abdelmalek MF, Guy CD, Moser B, et al. Noninvasive evaluation of hepatic fibrosis using acoustic radiation force-based shear stiffness in patients with nonalcoholic fatty liver disease. *J Hepatol*. 2011 Sep;55\(3\):666–72.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
8. [Motosugi U, Ichikawa T, Niitsuma Y, Araki T. Acoustic radiation force impulse elastography of the liver: can fat deposition in the liver affect the measurement of liver stiffness? *Japanese journal of radiology*. 2011 Sep 29;29\(9\):639–43.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
9. [Ebinuma H, Saito H, Komuta M, Ojiro K, Wakabayashi K, Usui S, et al. Evaluation of liver fibrosis by transient elastography using acoustic radiation force impulse: comparison with Fibroscan\(\(R\)\). *J Gastroenterol*. 2011 Oct;46\(10\):1238–48.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
10. [Rizzo L, Calvaruso V, Cacopardo B, Alessi N, Attanasio M, Petta S, et al. Comparison of transient elastography and acoustic radiation force impulse for non-invasive staging of liver fibrosis in patients with chronic hepatitis C. *Am J Gastroenterol*. 2011 Dec;106\(12\):2112–20.](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)
11. [Chen S-H, Li Y-F, Lai H-C, Kao J-T, Peng C-Y, Chuang P-H, et al. Effects of patient factors on noninvasive liver stiffness measurement using acoustic radiation force impulse elastography in patients with chronic hepatitis C. *BMC Gastroenterology* \[Internet\]. 2012;12\(105\):105. Available](http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=19938190&retmode=ref&cmd=prlinks)

from: <http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=22877310&retmode=ref&cmd=prlinks>

12. Guzmán-Aroca F, Frutos-Bernal MD, Bas A, Luján-Mompeán JA, Reus M, Berná-Serna J de D, et al. Detection of non-alcoholic steatohepatitis in patients with morbid obesity before bariatric surgery: preliminary evaluation with acoustic radiation force impulse imaging. *Eur Radiol.* 2012 Nov;22(11):2525–32.
13. Ferraioli G, Tinelli C, Dal Bello B, Zicchetti M, Filice G, Filice C, et al. Accuracy of real-time shear wave elastography for assessing liver fibrosis in chronic hepatitis C: a pilot study. *Hepatology.* 2012 Dec;56(6):2125–33.
14. Bota S, Sporea I, Sirli R, Popescu A, Jurchis A. Factors which influence the accuracy of acoustic radiation force impulse (ARFI) elastography for the diagnosis of liver fibrosis in patients with chronic hepatitis C. *Ultrasound Med Biol.* 2013 Mar;39(3):407–12.
15. Friedrich-Rust M, Buggisch P, de Knegt RJ, Dries V, Shi Y, Matschenz K, et al. Acoustic radiation force impulse imaging for non-invasive assessment of liver fibrosis in chronic hepatitis B. *J Viral Hepat.* 2013 Apr;20(4):240–7.
16. Poynard T, Munteanu M, Luckina E, Perazzo H, Ngo Y, Royer L, et al. Liver fibrosis evaluation using real-time shear wave elastography: applicability and diagnostic performance using methods without a gold standard. *J Hepatol.* 2013 May;58(5):928–35.
17. Tomita H, Hoshino K, Fuchimoto Y, Ebinuma H, Ohkuma K, Tanami Y, et al. Acoustic radiation force impulse imaging for assessing graft fibrosis after pediatric living donor liver transplantation: A pilot study. *Liver transplantation: official publication of the American Association for the Study of Liver Diseases and the International Liver Transplantation Society.* 2013 Sep 21;19(11):1202–13.

References (Inflammation affects SWS):

1. Friedrich-Rust M, Wunder K, Kriener S, Sotoudeh F, Richter S, Bojunga J, et al. Liver fibrosis in viral hepatitis: noninvasive assessment with acoustic radiation force impulse imaging versus transient elastography. *Radiology.* 2009 Aug;252(2):595–604.
2. Lupsor M, Badea R, Stefanescu H, Sparchez Z, Branda H, Serban A, et al. Performance of a new elastographic method (ARFI technology) compared to unidimensional transient elastography in the noninvasive assessment of chronic hepatitis C. Preliminary results. *J Gastrointest Liver Dis.* 2009 Sep;18(3):303–10.
3. Takahashi H, Ono N, Eguchi Y, Eguchi T, Kitajima Y, Kawaguchi Y, et al. Evaluation of acoustic radiation force impulse elastography for fibrosis staging of chronic liver disease: a pilot study. *Liver Int.* Blackwell Publishing Ltd; 2010 Apr;30(4):538–45.
4. Rifai K, Cornberg J, Mederacke I, Bahr MJ, Wedemeyer H, Malinski P, et al. Clinical feasibility of liver elastography by acoustic radiation force impulse imaging (ARFI). *Dig Liver Dis.* 2011 Jun;43(6):491–7.
5. Ebinuma H, Saito H, Komuta M, Ojiro K, Wakabayashi K, Usui S, et al. Evaluation of liver fibrosis by transient elastography using acoustic radiation force impulse: comparison with FibroScan®. *J Gastroenterol.* 2011 Oct;46(10):1238–48.
6. Chen S-H, Li Y-F, Lai H-C, Kao J-T, Peng C-Y, Chuang P-H, et al. Effects of patient factors on noninvasive liver stiffness measurement using acoustic radiation force impulse elastography in patients with chronic hepatitis C. *BMC Gastroenterology.* BioMed Central Ltd; 2012;12(1):105.

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7. [Yoon KT, Lim SM, Park JY, Kim DY, Ahn SH, Han K-H, et al. Liver stiffness measurement using acoustic radiation force impulse \(ARFI\) elastography and effect of necroinflammation. Dig Dis Sci. Springer US; 2012 Jun;57\(6\):1682–91.](#)
8. [Guzmán-Aroca F, Frutos-Bernal MD, Bas A, Luján-Mompeán JA, Reus M, Berná- Serna J de D, et al. Detection of non-alcoholic steatohepatitis in patients with morbid obesity before bariatric surgery: preliminary evaluation with acoustic radiation force impulse imaging. Eur Radiol. Springer-Verlag; 2012 Nov;22\(11\):2525–32.](#)
9. [Sporea I, Bota S, Peck-Radosavljevic M, Sirlu R, Tanaka H, Iijima H, et al. Acoustic Radiation Force Impulse elastography for fibrosis evaluation in patients with chronic hepatitis C: an international multicenter study. Eur J Radiol. 2012 Dec;81\(12\):4112–8.](#)
10. [Potthoff A, Attia D, Pischke S, Kirschner J, Mederacke I, Wedemeyer H, et al. Influence of different frequencies and insertion depths on the diagnostic accuracy of liver elastography by acoustic radiation force impulse imaging \(ARFI\). Eur J Radiol. 2013 Aug;82\(8\):1207–12.](#)
11. [Bota S, Sporea I, Peck-Radosavljevic M, Sirlu R, Tanaka H, Iijima H, et al. The influence of aminotransferase levels on liver stiffness assessed by Acoustic Radiation Force Impulse Elastography: a retrospective multicentre study. Dig Liver Dis. 2013 Sep;45\(9\):762–8.](#)
12. [Fierbinteanu-Braticevici C, Sporea I, Panaitescu E, Tribus L. Value of acoustic radiation force impulse imaging elastography for non-invasive evaluation of patients with nonalcoholic fatty liver disease. Ultrasound Med Biol. 2013 Nov;39\(11\):1942–50.](#)
13. [Takaki S, Kawakami Y, Miyaki D, Nakahara T, Naeshiro N, Murakami E, et al. Non- invasive liver fibrosis score calculated by combination of virtual touch tissue quantification and serum liver functional tests in chronic hepatitis C patients. Hepatol Res. 2014 Mar;44\(3\):280–7.](#)
14. [\[Reference - IEC 61391-2: Ultrasonics – Pulse-echo scanners – Part 2: Measurement of maximum depth of penetration and local dynamic range. 2010, Int Electrotechnical Comm: Geneva.\]](#)

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