<table>
<thead>
<tr>
<th>Commenter</th>
<th>Section</th>
<th>Issue</th>
<th>Resolution</th>
<th>Owner</th>
<th>Status</th>
<th>Post-resolution</th>
<th>Reviewed</th>
<th>Post-review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fernando Calamante</td>
<td>3.10</td>
<td>626</td>
<td>M</td>
<td>None</td>
<td>Done</td>
<td>Chad</td>
<td>Done</td>
<td>resolved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>Erickson</td>
<td>TBD</td>
<td>Bricker</td>
<td>resolution completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>Erickson</td>
<td>TBD</td>
<td>Bricker</td>
<td>resolution completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>L</td>
<td>Erickson</td>
<td>TBD</td>
<td>Bricker</td>
<td>resolution completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>L</td>
<td>Erickson</td>
<td>TBD</td>
<td>Bricker</td>
<td>resolution completed</td>
<td></td>
</tr>
</tbody>
</table>

**Commenter:** Use PDF, make a copy... to copy this template into a new file for your comments and edit the name (upper left) to rename it.

See http://gbawiki.rna.org/index.php/Public Comment: Process for more guidance on how to comment, and resolution process.

[Reto](mailto:cotton.f@sydney.edu.au)  0 OK  No action requested

**Proposition:**

I believe this section needs a more clear description of how that point data is defined. It would be helpful to add a figure to show this more clearly, if figures are allowed.

If the definition is not very clear, it will lead to variability and subjectivity on how users interpret how the point should be selected.

**Committee Discussion:**

Identify point of maximum drop, calculate baseline (from ~1 min of collection) mean and standard deviation. Work backwards from point of max drop to within std. deviation, step back a few (~3) timepoints.

Difficult to capture algorithmically. Can be s/w-specific. Present above as an_example, of how to approach? Ona: Perhaps limit duration to be 2 minutes maximum for AUC-TN estimates

**Resolution:**

Resolved by adding section 4.5 to provide details for post-bolus calculation

**Post-resolution:**

Edit: Made to 4.5 and not 4.3, otherwise resolved

Update 4.3 to 4.5 in spreadsheet/O/D

**Proposition:**

I couldn't find where the AUC calculation is described. I would expect this should be included in section 3.10 (which describes the Image Data Reconstruction). In particular, I couldn't find if the AUC is meant to be computed numerically (and if so by which approach?), by fitting, etc, what happens to the recirculation, etc? All these factors will play a role in the value measured, and thus would need to be clarified (or at least discussed what the various approaches are, and what the implications of choosing one vs the other are).

Otherwise, again, if this is left ' vague', the risk is that this will be a source of variability and subjective choice.

**Committee Discussion:**

Identify point of maximum drop, calculate baseline (from ~1 min of collection) mean and standard deviation. Work backwards from point of max drop to within std. deviation, step back a few (~3) timepoints.

Difficult to capture algorithmically. Can be s/w-specific. Present above as an_example, of how to approach?

**Resolution:**

Resolved by adding detailed explanation to 4.6

**Post-resolution:**

Done Chad

**Proposition:**

In 3.10 the AIF is not taken into consideration in this QIBA? I kept on looking through the document to see where the AIF was discussed, and then I realized it is not used or discussed. I have no issue with the decision of not using the AIF information, but it seems odd not to mention it up front.

**Committee Discussion:**

I would therefore suggest it would be better to refer to “Analysis” (or something like that) rather than "Reconstruction", which in MRI has a very specific meaning.

Section 3.10 contains a bit of analysis, majority of this section should be incorporated/merged into 3.13, specification table adjusted accordingly (which may mean its elimination).

**Resolution:**

Rejected. The organization of profiles typically has 3.10 focusing on how to make the maps. Section 3.13 focuses on how to measure regions of interest in the tumors which are the focus of the Aims.

**Post-resolution:**

Done Chad resolved

**Proposition:**

Should there be a separate explicit statement to indicate that the effect of 3D is not taken into consideration in this QIBA? I kept on looking through the document to see where the 3D was discussed, and then I realized it is never used or discussed. I have no issue with the decision of not using the 3D information, but it seems odd not to mention it up front.

**Committee Discussion:**

Again avoiding proscribing s/w approach in an effort to allow for different s/w packages, pending confirming performance with DRD.

Might be useful to have some explanatory text in the Profile addressing this.

**Resolution:**

Resolved by adding to discussion of 3.10 that AIF is used by some software, but beyond the scope of the profile due to lack of reproducibility data

**Post-resolution:**

Done Chad resolved
| Kyrr Emblem | Kyrr.Eeg.Emblem @rr-research.no | In our clinical trials, we observe quite some variation when using multiple expert readers (radiologists) to outline the lesion volumes (both for enhancing and non-enhancing). The profile recognizes the potential advantage of automatic routines, as well as the limiting factor of not all centers having access to such specialized to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one software. Have you considered suggesting one dedicated radiologist as a 'local centralized review' to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one expert reader on study, but in our experience, using one dedicated reader as final approval seems to be of big help vis-à-vis outline reproducibility. | not best practices document. perhaps can mention something about "ideal" world, but not practical. we already mention inter and intra reader reproducibility. - Smith paper. that you need to account for that in your estimation of wCV | Mark Shiroishi | Resolved by adding to discussion of Section 3.13 | Done | Chad Quaries | resolved |
| Kyrr Emblem | Kyrr.Eeg.Emblem @rr-research.no | the profile discusses the vs-EPI spatial distortion issue on page 42. Owing to a long-time collaboration with fellow Norwegian Anders Dale, we've had the multi-phase DSC setup going for quite some years. Having this data, impact of the artifact can be quite dramatic, especially when co-registered to non-EPI anatomical scans. This is just as much a focus for EPI-based diffusion MRI and I know vendors like GE have already started implemented automatic correction algorithms in some of their sequences (multi shell, etc). The literature on the impact of this for DSC is limited, but may be of relevance to mention that adding a simple non-bolus opposite-phase encoding scheme (~acquisition time in seconds) may provide imaging studies with the necessary tools to compensate for this artifact post-scan? | This is a very specific technique - need special sequences so likely not generalizable in the clinics | Ona | Resolved by adding to discussion of 3.6 about alternate sequences and adding reference to review article Reference 25. | Done | Chad Quaries | I couldn’t find best about alternate sequence | Corrected section from 3.10 to 3.6 in spreadsheet / Ona |
| Kyrr Emblem | Kyrr.Eeg.Emblem @rr-research.no | 3.13 757-760 M Inter- and intra-observer variations versus centralized review | In our clinical trials, we observe quite some variation when using multiple expert readers (radiologists) to outline the lesion volumes (both for enhancing and non-enhancing). The profile recognizes the potential advantage of automatic routines, as well as the limiting factor of not all centers having access to such specialized software. Have you considered suggesting one dedicated radiologist as a 'local centralized review' to oversee the manual outlines? I absolutely agree and recognize it may not always be feasible having just one expert reader on study, but in our experience, using one dedicated reader as final approval seems to be of big help vis-à-vis outline reproducibility. | see 12 | Resolved by adding to discussion of Section 3.13 | Done | Chad Quaries | resolved |
| Kyrr Emblem | Kyrr.Eeg.Emblem @rr-research.no | 3.11 711-715 M The need for EPI spatial distortion correction | We've had an opposite phase DSC setup going for quite some years. Having this data, impact of the artifact can be quite dramatic, especially when co-registered to non-EPI anatomical scans. This is just as much a focus for EPI-based diffusion MRI and I know vendors like GE have already started implemented automatic correction algorithms in some of their sequences (multi shell, etc). The literature on the impact of this for DSC is limited, but may be of relevance to mention that adding a simple non-bolus opposite-phase encoding scheme (~acquisition time in seconds) may provide imaging studies with the necessary tools to compensate for this artifact post-scan? | see 13 | Resolved by adding to discussion of 3.10 | Done | Chad Quaries | resolved |
| Todd Jensen | todd@jenseninformatics.com | 1 123-125 H AUC-TN seems to be equivalent to what is typically referred to as normalized rCBV (nrCBV) in vendor products and journal articles. I understand the desire to differentiate that the biomarker called rCBV may not actually be a 1:1 measure of CBV, but it has become very common-place and will be difficult to explain what AUC-TN is to clinicians not interested in reading the QIBA profiles. | Replace AUC-TN with nrCBV and include black box type warning. Or at least make clear in this section that AUC-TN why that term is being used versus nrCBV. | Ona/Bra d | Resolved by updating Executive Summary to explain why we use the term AUC-TN instead of rCBV | Done | Chad Quaries | resolved |
| Todd Jensen | todd@jenseninformatics.com | Title S M As a number of biomarkers can be derived from DSC-MRI, but only one is discussed in this profile. | Include biomarker in profile title or as a subtitle. | keep title as is | Reject since there will be future profiles to cover other biomarkers | Done | Chad Quaries | resolved |
Resolved by adding to Executive Summary

Add something like "see Section 2.2 for more information about how these CI were derived."
agree to edit
Resolved by updating K2 calculation description and references to Section 4.6
ona
Resolved by adding to Executive Summary

Done Chad
Quaries resolved

Done Chad
Quaries resolved

Done Chad
Quaries resolved

Done Chad
Quaries resolved

Done Chad
Quaries resolved

Resolved with edits to executive summary
ona
Resolved with edits to executive summary
ona
Resolved with edits to executive summary
ona
Resolved by clarifying that the parameters in Appendix F are for DSC phantom studies in the appendix
ona
Resolved with edits to Section3.9
ona
Resolved

Done Yuxiang Zhou
OK

Done Yuxiang Zhou
OK

Done Yuxiang Zhou
OK

None

None

None

None

None

None
Having multiple actors can lead to confusion on who is responsible for carrying out checklist items. Leave as is unless there is a strong rationale.

Done: Yuliang Zhou
Suggest to assign to Technologist because they use it everyday and for others.
Resolved: Changed to technologist/OW

Brian Taylor | bataylor2@vcu.edu NA Not provided H Acceptance and QA testing of the power injector should be the responsibility of a biomedical engineer (preferably) or technologist and not the medical physicist.
Assign the power injector actor (acceptance testing and QA) to biomedical engineer or technologist see comment 2B ona see response to 2B.
Done: Yuliang Zhou
Same as above
Resolved: Changed to technologist/OW

Brian Taylor | bataylor2@vcu.edu NA Not provided M Lines 563 - 571 pertain to MR safety. Many implants are MR conditional at 1.5T; cylindrical bore only. At some point can QIBA provide guidance at 1.5T for (1) patients with 1.5T MR-conditional implants and (2) facilities with no 3T systems.
Not provided we focus on 3T. ona Resolved by adding 3T specifications to 9.2
Done: Yuliang Zhou
OK

Brian Taylor | bataylor2@vcu.edu Page 48 Not provided M For the Philips acquisition, why is the flip angle °60 (or 30)°? 60 only may be more appropriate and is consistent with the other vendors.
Not provided accept changes ona Accepted and changed as proposed
Done: Yuliang Zhou
OK

Brian Taylor | bataylor2@vcu.edu NA Not provided L For multiple lesions, care must be done if there are lesions in both hemispheres in selecting an ROI in normal appearing white matter. In addition, multiple lesions involving the same side of cerebral and cerebellar hemispheres can affect perfusion in the contra-lateral hemisphere if used for a reference (crossed cerebellar diaschisis).
Not provided make comment in the profile discussion. Brad Resolved by adding discussion of 2.2 and 3.13
Done: Yuliang Zhou
OK

Lisa Cimino | lcimino@acr.org 3.9.1 615 M cover as much of the brain as possible cover the entire tumor (have had multiple sites cover full brain and double the acquisition, causing them to double the temporal resolution. So possibly mention not to go over the affected ideas?) priority is the keep TR at 1.5 ms and focus on covering the tumor ona Resolved by editing 3.9 specifications
Done: Yuliang Zhou
OK

Jim Gimpel | jgimpel@acr.org 3.2.2 424 L What is meant by “Site Image Header” (see second row of table) as opposed to “Image Header” (in rows 3 and 4)?
Elaborate or fix typo typo ona Accepted and changed as proposed
Done: Yuliang Zhou
OK

Jim Gimpel | jgimpel@acr.org 3.2.2 426 L There is a mention regarding feasibility at 1.5T or why the profile is limited to 3T. Literature cited (Bell), states that, “when normalized...CBV does not differ across field strengths”.
Remove reference to preload or elaborate on instructions for preload injections.
agree Brad Resolved by editing Section 3.8 and described 2 methods, either by RT doing manual injection or via power injector and specifying appropriate delay (minimum time 5 min) (one to prepopulate table)
Done: Yuliang Zhou
OK

Jim Gimpel | jgimpel@acr.org 3.7.1 579 L There is a mention regarding feasibility at 1.5T or why the profile is limited to 3T. Literature cited (Bell), states that, “when normalized...CBV does not differ across field strengths”.
There is no mention regarding feasibility at 1.5T or why the profile is limited to 3T. Literature cited (Bell), states that, “when normalized...CBV does not differ across field strengths”.
Change wording as described.
agree ona Accepted and changed as proposed
Done: Yuliang Zhou
OK

Jim Gimpel | jgimpel@acr.org 3.9.1 615 M There is no mention regarding feasibility at 1.5T or why the profile is limited to 3T. Literature cited (Bell), states that, “when normalized...CBV does not differ across field strengths”.
Reconsider use of term | Recommend a brief statement in the discussion on the rationale for limiting focus to 3T.
no data on 1.5T is why we focused on 3T. Paper cited is based on simulations.
ona Resolved by editing Section 2.2 explaining why we focus on 3T in claims
Done: Yuliang Zhou
OK

Kevin O'Donnell | kodonnell@mri.medicalex.ca N/A 12 N/A N/A Remove template notation. It’s a profile row. That being said, per the “Example text” entry, all the grey text throughout your profile should have been edited and color changed to black/Automatic.
agree ona Accepted and changed as proposed
Done: Mike Boss

Kevin O'Donnell | kodonnell@mri.medicalex.ca N/A 97 N/A N/A If you don’t have anything you are seeking feedback from reviewers on, you can remove Open Issues section.
agree ona Accepted and changed as proposed
Done: Mike Boss

Kevin O'Donnell | kodonnell@mri.medicalex.ca N/A 105 N/A N/A Must have row in the closed Issues table can be removed.
-Consolidate Actors row – since we can see what you did and there is no rationale here, can remove the row
-Every specification row – seems like a todo that’s done. Can remove
-Just saw this row – seems like it’s done. Can remove Table 1 row – seems like it’s done. Can remove.
agree ona Accepted and changed as proposed
Done: Mike Boss

Kevin O'Donnell | kodonnell@mri.medicalex.ca N/A 112 N/A N/A “Initial draft” -> “public comment”
agree ona Accepted and changed as proposed
Done: Mike Boss
| Kevin O'Donnell | kodonnell@mru.medical.canon | 126 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 127 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 140 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 148 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 221 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 362 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 391 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 424 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 424 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 424 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 424 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 424 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 446 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | 462 | N/A | N/A |
| Kevin O'Donnell | kodonnell@mru.medical.canon | Missed | N/A | N/A |

- **Issue**: If the sentence is a useful summary to readers, it should match your actor list from Table 1.
- **Resolution**: The sentence should match actor list in Table 1
- **Status**: Accepted and changed as proposed

- **Issue**: If the sentence is a useful summary to readers, it should match your activity list from Table 1.
- **Resolution**: The sentence should match activity list in Table 1
- **Status**: Accepted and changed as proposed

- **Issue**: What is the disclaimer claiming? And does this belong in the executive summary?
- **Resolution**: N/A remove disclaimer
- **Status**: Resolved by removing sentence from Executive Summary

- **Issue**: This section is intended to be a paragraph or two stating what you think AUC-TN is used for clinically so readers can confirm we're on the same page.
- **Resolution**: Consider if it could be shortened.
- **Status**: Resolved by editing Section 2

- **Issue**: All these bullets should be requirements: in the requirement tables down in the profile. Once there, they don't need to be repeated here. Skipped Section 2.1 and 2.2.
- **Resolution**: Not sure whether we need to remove these sections
- **Status**: Accepted and changed as proposed

- **Issue**: Can tidy up some of the cell merges for the leftmost column (e.g. merge 3 Acquisition Device cells)
- **Resolution**: Agree
- **Status**: Accepted and changed as proposed

- **Issue**: Has staff lacking the certifications or qualifications listed here been found to be a common source of variability in AUC-TN measurements? If not, might consider dropping this section.
- **Resolution**: If it has, focus the requirements on the specific actors and qualifications that were found to affect variability. Suggesting drop section
- **Status**: Rejected. Some sites may have technologists serving the role of physicists or vice versa. This section clarifies that the actor roles may not be filled with someone with the job title. For example, a technologist may be fulfilling the role of the Physicist Actor for setting up protocols if qualified without having the MR Physicist job title at a site.

- **Issue**: Remove bullets. Just use sentences.
- **Resolution**: Agree
- **Status**: Accepted and changed as proposed

- **Issue**: When copying into checklist tables, try not to put two requirements in the same cell.
- **Resolution**: Make two rows.
- **Status**: Accepted and changed as proposed

- **Issue**: “SiteImage Header” -> "Image Header”?
- **Resolution**: Fixed
- **Status**: Accepted and changed as proposed

- **Issue**: Contrast Media – avoid the slippery slope of embedding an incomplete MR safety/best-practices guide inside the profile.
- **Resolution**: Recommend removing this since it doesn’t affect the claim. Remove safety language. Change to focus on field effect size, paramagnetic agent.
- **Status**: Accepted and changed as proposed

- **Issue**: “shall be confirmed that performance is linear” -> “shall demonstrate linear performance” – and should likely reference an assessment procedure unless you let everyone choose their own method.
- **Resolution**: Point to 4.6 assessment procedure
- **Status**: Accepted and changed as proposed

- **Issue**: “shall record volume of regions of interests uses.” -> “shall record the volume of each region of interest.”
- **Resolution**: Agree
- **Status**: Accepted and changed as proposed

- **Issue**: Do you want to include a requirement that the MR be 3T?
- **Resolution**: N/A yes
- **Status**: Accepted and changed as proposed

- **Issue**: Given that you have a periodic QA activity, it seems like you can perhaps drop the Pre-Delivery and Installation sections as redundant.
- **Resolution**: Copy from DWI profile
- **Status**: Resolved by modifying 3.3 and 3.4 to be consistent with DWI profile

- **Issue**: Just a reminder that all the stuff in discussion is helpful background or clarification, but there are not actual requirements here. All the requirements are in the specification requirement tables.
- **Resolution**: Agree
- **Status**: Accepted and changed as proposed

- **Issue**: Make text black, remove bullets, put one requirement per row.
- **Resolution**: Ok
- **Status**: Accepted and changed as proposed

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

- **Issue**: Done Mike Boss

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