

# ACR–AAPM TECHNICAL STANDARD FOR THE PERFORMANCE OF LOW-DOSE-RATE BRACHYTHERAPY PHYSICS

The American College of Radiology, with more than 40,000 members, is the principal organization of radiologists, radiation oncologists, and clinical medical physicists in the United States. The College is a nonprofit professional society whose primary purposes are to advance the science of radiology, improve radiologic services to the patient, study the socioeconomic aspects of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and persons practicing in allied professional fields.

The American College of Radiology will periodically define new practice parameters and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice parameters and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

Each practice parameter and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review and approval. The practice parameters and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice parameter and technical standard by those entities not providing these services is not authorized.

## PREAMBLE

This document is an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. Practice Parameters and Technical Standards are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care<sup>1</sup>. For these reasons and those set forth below, the American College of Radiology and our collaborating medical specialty societies caution against the use of these documents in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner considering all the circumstances presented. Thus, an approach that differs from the guidance in this document, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in this document when, in the reasonable judgment of the practitioner, such course of action is indicated by variables such as the condition of the patient, limitations of available resources, or advances in knowledge or technology after publication of this document. However, a practitioner who employs an approach substantially different from the guidance in this document may consider documenting in the patient record information sufficient to explain the approach taken.

The practice of medicine involves the science, and the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to the guidance in this document will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The purpose of this document is to assist practitioners in achieving this objective.

---

<sup>1</sup> *Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing*, 831 N.W.2d 826 (Iowa 2013) Iowa Supreme Court refuses to find that the "ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures (Revised 2008)" sets a national standard for who may perform fluoroscopic procedures in light of the standard's stated purpose that ACR standards are educational tools and not intended to establish a legal standard of care. See also, *Stanley v. McCarver*, 63 P.3d 1076 (Ariz. App. 2003) where in a concurring opinion the Court stated that "published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable in a given situation" even though ACR standards themselves do not establish the standard of care.

## I. INTRODUCTION

This standard was revised collaboratively by the American College of Radiology (ACR) and the American Association of Physicists in Medicine (AAPM).

Brachytherapy is a method of treatment in which a radionuclide is used to deliver radiation by interstitial, intracavitary, intraluminal, or surface application. There exist a number of processes and sealed radioactive sources to perform low-dose-rate (LDR) brachytherapy. This document is explicitly not intended to address the use of remote afterloading devices commonly referred to as high-dose-rate (HDR) or pulsed-dose-rate (PDR) systems.

The practice of brachytherapy physics occurs under a variety of settings. The judgment of a Qualified Medical Physicist, in conjunction with a radiation oncologist (authorized user (AU)), should be used to apply these standards to individual practices. Also, radiation safety requirements must be in compliance with appropriate federal and state regulations.

## II. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

### A. Qualified Medical Physicist

A Qualified Medical Physicist is an individual who is competent to practice independently in one or more of the subfields in medical physics. The American College of Radiology (ACR) considers certification, continuing education, and experience in the appropriate subfield(s) to demonstrate that an individual is competent to practice one or more of the subfields in medical physics, and to be a Qualified Medical Physicist. The ACR strongly recommends that the individual be certified in the appropriate subfield(s) by the American Board of Radiology (ABR), the Canadian College of Physicists in Medicine, the American Board of Science in Nuclear Medicine (ABSNM), or the American Board of Medical Physics (ABMP).

A Qualified Medical Physicist should meet the [ACR Practice Parameter for Continuing Medical Education \(CME\)](#) [1].

The appropriate subfield of medical physics for this standard is Therapeutic Medical Physics (including medical physics certification categories of Radiological Physics, Therapeutic Radiological Physics, and Radiation Oncology Physics). (ACR Resolution 17, adopted in 1996 – revised in 2008, 2012, 2022, Resolution 41f) In addition, the Qualified Medical Physicist must meet all qualifications imposed by the state and/or local radiation control agency to practice radiation oncology physics and/or to provide oversight of the establishment and conduct of the physics quality management program.

Where required, the Qualified Medical Physicist must have a license to practice therapeutic medical physics. Similarly, depending on the bylaws of the relevant hospital/institution, the credentials and delineated privileges for the Qualified Medical Physicist should be confirmed through the medical staff membership process in the appropriate category because clinical brachytherapy physics involves direct contact with patients and access to their hospital records. Regulatory agencies may define requirements for an Authorized Medical Physicist for practice covered in this technical standard. It is assumed in this technical standard that the Qualified Medical Physicist meets all requirements of an Authorized Medical Physicist within the relevant jurisdiction(s) of their practice.

### B. Medical Dosimetrist

Certification by the Medical Dosimetrist Certification Board is recommended. The Medical Dosimetrist activities should be performed under the supervision of the Qualified Medical Physicist.

### C. Radiation Therapist

The Radiation Therapist must fulfill applicable state licensing requirements and should have American Registry of Radiologic Technologists (ARRT) certification in radiation therapy.

## III. RESOURCES

### A. Personnel Requirements

Active brachytherapy programs require physics and support personnel beyond that required for external beam therapy because of the uniqueness and relative complexity of each case. As a special procedure, LDR brachytherapy requires a significant time commitment by the Qualified Medical Physicist to develop and maintain high standards for quality procedures, as well as to provide documentation to comply with regulatory agencies. Consequently, these commitments should be included when budgeting personnel requirements.

## **B. Equipment Needs**

Each facility must have access to instrumentation to independently verify the source strength provided by the manufacturer. This should be done with a well ionization chamber and electrometer or other suitable instrument with a source strength measurement directly traceable to the National Institute of Standards and Technology (NIST) [2]. The AAPM has provided guidelines to verify the source calibration [3,4]. Calibrated survey instruments that are appropriate in energy response and range for the sources used must be available for use at all times [2]. A backup survey meter with current calibration should be readily available in case of primary instrument failure or unavailability.

The facility must have instrumentation to perform periodic sealed-source leak testing or arrange to have this service provided.

Appropriate local shielding, storage facilities, transportation containers, manipulation devices, and storage containers for emergency use must also be available.

A computerized treatment planning system for volumetric image reconstruction or processing (computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), etc), applicator reconstruction, and isodose computation should be available to calculate point doses, generate isodose distributions, and compute dose-volume statistics.

Proper maintenance, calibration, quality control, and update of the equipment must be carried out under the supervision of the Qualified Medical Physicist.

## **IV. QUALITY ASSURANCE PROGRAM**

### **A. Introduction**

The Quality Management Program refers to administrative policies, quality assurance (QA), quality control (QC) measures, and consideration of quality improvement (QI) objectives that ensure a consistent and safe fulfillment of the treatment prescription. The Qualified Medical Physicist is responsible for a QA program that maintains the records regarding appropriate description, calibration, and the current source strength in order to ensure the accurate delivery of the prescribed dose to the specified volume [5]. The complexity of brachytherapy procedures necessitates that comprehensive quality management include treatment-related devices (planning and imaging systems, applicators, radioactive sources, and delivery systems) and the clinical process [6,7]. The AAPM Task Group 100 report provides suggestions for increasing the effectiveness of quality and safety programs based on formal risk analysis methodology [8]. The Qualified Medical Physicist should work closely with the radiation oncologist and other members of the brachytherapy team to build consensus and to document the clinical workflow and resources for specific anatomical site and treatment modality combinations.

Quality control for brachytherapy sources includes maintaining an ongoing review for adherence to regulatory and licensing requirements. Accordingly, the Qualified Medical Physicist must develop, implement, supervise, and review the policies and procedures that encompass sealed sources and their use and maintain proper written documentation [4]. When these activities relate to radiation safety, they should be carried out in conjunction with the institutional radiation safety officer (RSO).

The Qualified Medical Physicist should institute a documented peer-review mechanism for the review of the brachytherapy physics program by a Qualified Medical Physicist with experience relevant to the scope of the program being reviewed. The review should be performed annually. When reviews are performed on a less frequent schedule, the time between reviews should not exceed 3 years or the next state or Nuclear Regulatory Commission (NRC) inspection [9].

## **IV. QUALITY ASSURANCE PROGRAM**

### **B. Sealed Sources**

Because the radiological characteristics of encapsulated sources depend on their physical and chemical form, as well as on the source encapsulation, and the radioactivity distribution within the source, the Qualified Medical Physicist must take these factors into account to properly determine the dose distribution around the source.

Sealed sources with long half-lives (>6 months) must be labeled to distinguish sources that have the same radionuclide and capsule design but different source strengths.

#### **1. Measurement of source strength**

Brachytherapy sources used in radiation oncology must have measurements of their source strength with traceability to national standards. The 1995 AAPM TG 43 report [10], its updated version published in 2004 [11], and supplements [12] should be consulted for dosimetry protocols of specific LDR sources employed for brachytherapy procedures.

The Qualified Medical Physicist must establish acceptable limits of accuracy for source strength measurements as well as a course of action if the source strength does not fall within these limits.

All sources containing radionuclides with a half-life greater than 6 months should have their source strength measured upon receipt. Autoradiographs must be performed on these sources prior to initial use to verify the uniformity of radioactivity spatial distribution for each source.

For sources containing radionuclides with a half-life of less than 6 months, a random sample of sources from each manufacturer's lot number should have their source strength measured upon receipt. The quantities of sources to be assayed are described in the AAPM Report 98 [3].

Source strength should be specified in terms of air kerma strength, not apparent activity, for all clinical aspects of the procedure, such as source ordering, source strength assays, and treatment planning [3]. The current source strengths of new sources must be entered into the treatment-planning system. An additional qualified individual should perform a check of the entered values.

#### **2. Instrumentation**

For direct measurement of source strengths, a well ionization chamber with known axial response and an electrometer, as applicable, are recommended. The constancy of the well ionization chamber and electrometer must be verified upon receipt, after repair, before and after mailing for calibration, and prior to each use. For source calibrations, the well ionization chamber and electrometer must be calibrated at least every 2 years [4].

An uncalibrated well ionization chamber may be used in conjunction with a source whose strength has been determined by an Accredited Dosimetry Calibration Laboratory (ADCL) or NIST by the replacement method to provide relative response for verifying source strength, describing batch variation, and confirming source identity according to strength. The sensitivity, linearity (if appropriate), and reproducibility of the instrument must be documented at least annually [3,13].

#### **3. Brachytherapy applicators and templates**

The Qualified Medical Physicist must determine the source location, the coincidence of dummy and active sources, and the location of shields for intracavitary applicators prior to initial use. Such applicators should be radiographically inspected annually and physically inspected prior to each use. For appropriate interstitial applicators, the coincidence of dummy and active sources must be verified prior to initial use.

Prior to first use, and periodically thereafter, needle-guiding templates should be checked for alignment and scaling between physical needle positions and the superimposed electronic grid generated by the ultrasound and treatment planning system [14].

#### 4. Radiation safety

Radiation safety practices must be consistent with the institution's radioactive material license, license amendments, and existing regulations [2]. Nevertheless, the Qualified Medical Physicist in conjunction with the RSO should be responsible for developing, overseeing, and documenting radiation safety procedures, including, but not limited to, the following:

- a. Written procedures for ordering, receiving, returning, and/or disposing of radioactive materials and for performing patient and room surveys following source removal
- b. Procedures for the safe handling, preparing, cleaning, sterilizing, and sorting of sources
- c. Policies for personnel monitoring of radiation exposure
- d. An inventory control program sufficient to identify the locations of all sealed sources at any time
- e. Emergency procedures for leaking sources and loss of or dislodging of sources
- f. Leak tests of inventoried long half-lived sources
- g. Ensuring the security of all radioactive sealed sources, including procedures for the interdepartmental transport and retrieval of sources prior to and subsequent to implantation
- h. Documentation and reporting of medical events in accordance with state or federal regulations
- i. Determining and evaluating unsafe and risky procedures
- j. Patients should be provided with written release instructions for radiation protection including, but not limited to, potential limitations on patient contact with minors and pregnant women. These instructions must be consistent with guidance of the [ACR–ABS Practice Parameter for the Performance of Low-Dose-Rate Brachytherapy](#) [15].

#### IV. QUALITY ASSURANCE PROGRAM

##### C. Treatment Planning Dosimetry

Brachytherapy treatment planning should include, at a minimum, the determination of the appropriate isodose distribution. A consistent means of specifying and documenting administered activity must be in place. Treatment-planning specifications should include, at a minimum, a description of technique and applicator, radionuclide, source strength(s), anatomical description of target volume, dose-to-target volume, dose to reference points, and the dose distribution. In the planning process, image-based volumetric computerized treatment-planning algorithms that provide a means to conform the dose distribution to the target and minimize the dose to organs at risk (OARs) should be used. The time-dose pattern, anatomical description of the target volume, dose to the target volume, and volumetric dose statistics should be determined if 3-D patient imaging information is used. Prior and/or planned external beam and brachytherapy doses that overlap with the current LDR plan should be considered during the LDR planning to target volumes, and OARs should also be documented with every treatment plan.

##### 1. Imaging

- a. Image-guided applicator/source localization: Image-guided procedures are the standard of care. Imaging modalities such as fluoroscopy, MRI, CT, and ultrasound are used to achieve high-quality delivery of brachytherapy [16-21]. The Qualified Medical Physicist must ensure the spatial resolution, fidelity, applicator compatibility, and appropriate use of each imaging modality. Also, the Qualified Medical Physicist must ensure that proper acceptance testing and commissioning as well as a documented QA program is in place for each imaging modality prior to its clinical use [14,22-24].
- b. Localization images: The position of all intracavitary, intraluminal, and interstitial implants must be verified before treatment, as applicable, with appropriate medical imaging modalities. It is preferred that images be acquired with the patient in the treatment position. The responsible radiation oncologist should be present with the Qualified Medical Physicist or dosimetry personnel during applicator localization. Prior to treatment initiation, the localization images should be approved by the responsible radiation oncologists.

##### 2. Computerized planning system

Computerized planning systems must undergo rigorous acceptance tests and commissioning to ensure that the dose-calculation algorithm properly converts the source strength and dosimetry parameters into the appropriate absorbed dose distribution, including dose-volume statistics, if available, and to ensure that hardware and software were installed properly [2,10-12,25]. Correction for decay of source strength must be made regularly to reflect change in source strength. The handling of image data and their use in dose calculations must also be verified for accuracy in comparison (where appropriate) with well-established methods of dose calculation (eg, nomograms or lookup tables). Model-based treatment planning system algorithms and the use of material heterogeneity corrections have increased the accuracy and complexity of brachytherapy dose calculations [25-27]. These new approaches need to be implemented with great care because current prescription and outcome data are based on the TG-43 formalism [12]. All users must receive proper training. An in-service program should be given for new users and, when appropriate, provided to all users following software releases. A written treatment-planning system QA program must be implemented and documented to ensure the accuracy of dose-calculation algorithms, software changes, hardware changes, and source data files [28,29]. All training should be documented.

### 3. Treatment plan and review

For each brachytherapy procedure, a treatment plan and dosimetry report pertinent to the plan should be reviewed and completed by the Qualified Medical Physicist. The report should include, but is not limited to, the following items:

- a. Patient name, ID, and treatment site
- b. Prescribed dose
- c. Description of the source, the implant technique, and the source distribution pattern used
- d. Total source strength, dose rate, and implant duration
- e. Isodose distributions in appropriate planes
- f. Dose-volume indices used to evaluate coverage of the target and the quality of the treatment plan along with dose constraints of tissue/OARs.

The treatment plan should be independently reviewed by the AU and a Qualified Medical Physicist or a designate not directly involved with generating the treatment plan [30]. This review may include, but is not limited to, ensuring that the:

- a. Planned dose conforms to the prescription
- b. Applicator type, implant geometry and applicator reconstruction, and source position(s) are reasonable
- c. Radionuclide, source configuration and strength, source calculation model, date of implant, and implant duration are correct
- d. Volumetric dose coverage of the target and dose constraints of tissue/OARs are satisfactory

### 4. Independent dose calculation

To validate the treatment plan, an additional dose calculation using an independent method from the treatment-planning system should be used. This validation should be consistent with the prescription, source position(s), and source strength. Consistency with prior practice, when applicable, should be checked using the target volume and total source strength to generate regression fits to dosimetric indices. This plan validation step should be completed prior to treatment initiation. There may be instances in which treatment plan validation may not fit with the implant workflow and may need to be delayed (ie, prostate seed implants, intraoperative implants, etc) until source placement is complete.

## IV. QUALITY ASSURANCE PROGRAM

### D. Clinical Medical Physics Management

#### 1. Source loading and placement

The Qualified Medical Physicist or Medical Dosimetrist must be available for consultation during applicator

placement and loading. The prescribed loading of applicators must be independently confirmed and documented.

## 2. Source removal and radiation safety review

For a temporary implant, the Qualified Medical Physicist or Medical Dosimetrist must be available for consultation during source and applicator removal. The Qualified Medical Physicist, in conjunction with the RSO, should be responsible for developing, overseeing, and documenting the process/procedure for radiation safety review at the time of source removal.

## IV. QUALITY ASSURANCE PROGRAM

### E. New Procedures

In conjunction with the medical director and/or the appropriate AU, the Qualified Medical Physicist must define basic standards of practice and develop a prudent course of action to determine the quality and safety of any new procedures prior to clinical initiation. New devices and applicators must be evaluated with respect to integrity, suitability for use with the radioactive sources, and effects on dose distributions. This evaluation must be prepared as a written report and distributed in accordance with institutional policy.

## V. DOCUMENTATION

The Qualified Medical Physicist is responsible for maintaining complete and accurate records required by regulatory agencies and accrediting bodies. Records documenting the results and frequency of QA checks, QC measures, corrective actions.

## ACKNOWLEDGEMENTS

This technical standard was revised according to the process described under the heading *The Process for Developing ACR Practice Parameters and Technical Standards* on the ACR website (<https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards>) by the Committee on Practice Parameters and Technical Standards – Medical Physics of the ACR Commission on Medical Physics in collaboration with the AAPM.

Collaborative Committee – members represent their societies in the initial and final revision of this practice parameter

### ACR

Tariq A. Mian, PhD, FACP, FAAPM, Chair

Per H. Halvorsen, MS, FACP, FAAPM

Jason J. Savarese, MS

Kristina Woodhouse, MD

### AAPM

Wayne M. Butler, PhD

Mark J. Rivard, PhD, FAAPM

Andrew J. Veres, MS

## Committee on Practice Parameters and Technical Standards – Medical Physics

(ACR Committee responsible for sponsoring the draft through the process)

Maxwell R. Amurao, PhD, MBA, Chair

Ralph P. Lieto, MS, FACR

Mary Ann Keenan, DMP, Vice Chair

Lijun Ma, PhD, FAAPM

Priscilla F. Butler, MS, FACR

Tariq A. Mian, PhD, FACR

Heidi A. Edmonson, PhD

Anshuman Panda, PhD

Samuel A. Einstein, PhD

Douglas E. Pfeiffer, MS, FACR

Per H. Halvorsen, MS, FACR

Premavathy Rassiah, PhD

Loretta M. Johnson, PhD

Thomas G. Ruckdeschel, MS

Mahadevappa Mahesh, MS, PhD, FACR, Chair, Commission on Medical Physics

Jacqueline Anne Bello, MD, FACR, Chair, Commission on Quality and Safety

Mary S. Newell, MD, FACR, Chair, Committee on Practice Parameters and Technical Standards

## Comments Reconciliation Committee

Lauren Golding, MD, Chair

Paul A. Larson, MD, FACR

Ralph P. Lieto, MS, FACR, Co-Chair

Mahadevappa Mahesh, MS, PhD, FACR

Maxwell R. Amurao, PhD, MBA

Tariq A. Mian, PhD, FACR, FAAPM

Jacqueline Anne Bello, MD, FACR

John Moeller, MS

Wayne M. Butler, PhD

Vrinda Narayana, PhD

Gil'ad N. Cohen, MS

Mary S. Newell, MD, FACR



## Comments Reconciliation Committee

Wesley Culberson, PhD

Zoubir Ouhib, MS

Christopher L. Deufel, PhD

Jose Perez-Calatayud, PhD

Larry DeWerd, PhD

Mark J. Rivard, PhD

Richard Duszak Jr., MD, FACR

Jason J. Savarese, MS

Per H. Halvorsen, MS, FACR

Andrew J. Veres, MS

Mary Ann Keenan, DMP

Kristina L. Woodhouse, MD

Rao Khan, PhD

Lori Young, PhD

Amy L. Kotsenas, MD, FACR

## REFERENCES

1. American College of Radiology. ACR practice parameter for continuing medical education (CME). Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CME.pdf?la=en>. Accessed February 5, 2019.
2. United States Nuclear Regulatory Commission. Medical use of by-products material: Title 10; CFR Part 35. Available at: <http://www.nrc.gov/reading-rm/doc-collections/cfr/part035/full-text.html>. Accessed April 26, 2014.
3. Butler WM, Bice WS, Jr., DeWerd LA, et al. Third-party brachytherapy source calibrations and physicist responsibilities: report of the AAPM Low Energy Brachytherapy Source Calibration Working Group. *Med Phys* 2008;35:3860-5.
4. American Association of Physicists in Medicine. Code of practice for brachytherapy physics: Report of the AAPM Radiation Therapy Committee Task Group No. 56. Available at: [https://www.aapm.org/pubs/reports/RPT\\_59.pdf](https://www.aapm.org/pubs/reports/RPT_59.pdf). Accessed April 26, 2014.
5. Butler WM, Merrick GS. Clinical practice and quality assurance challenges in modern brachytherapy sources and dosimetry. *Int J Radiat Oncol Biol Phys* 2008;71:S142-6.
6. Williamson JF, Dunscombe PB, Sharpe MB, Thomadsen BR, Purdy JA, Deye JA. Quality assurance needs for modern image-based radiotherapy: recommendations from 2007 interorganizational symposium on "quality assurance of radiation therapy: challenges of advanced technology". *Int J Radiat Oncol Biol Phys* 2008;71:S2-12.
7. Thomadsen B. Radiation Protection Responsibility in Brachytherapy. *Health Phys* 2019;116:189-204.
8. Huq MS, Fraass BA, Dunscombe PB, et al. The report of Task Group 100 of the AAPM: Application of risk analysis methods to radiation therapy quality management. *Med Phys* 2016;43:4209.
9. Halvorsen PH, Das IJ, Fraser M, et al. AAPM Task Group 103 report on peer review in clinical radiation oncology physics. *J Appl Clin Med Phys* 2005;6:50-64.
10. Nath R, Anderson LL, Luxton G, Weaver KA, Williamson JF, Meigooni AS. Dosimetry of interstitial brachytherapy sources: recommendations of the AAPM Radiation Therapy Committee Task Group No. 43. American Association of Physicists in Medicine. *Med Phys* 1995;22:209-34.

11. Rivard MJ, Coursey BM, DeWerd LA, et al. Update of AAPM Task Group No. 43 Report: A revised AAPM protocol for brachytherapy dose calculations. *Med Phys* 2004;31:633-74.
12. Rivard MJ, Ballester F, Butler WM, et al. Supplement 2 for the 2004 update of the AAPM Task Group No. 43 Report: Joint recommendations by the AAPM and GEC-ESTRO. *Med Phys* 2017;44:e297-e338.
13. Williamson JF. Current brachytherapy quality assurance guidance: does it meet the challenges of emerging image-guided technologies? *Int J Radiat Oncol Biol Phys* 2008;71:S18-22.
14. American Association of Physicists in Medicine. AAPM Task Group 128: quality assurance tests for prostate brachytherapy ultrasound systems. Available at: [http://www.aapm.org/pubs/reports/RPT\\_128.pdf](http://www.aapm.org/pubs/reports/RPT_128.pdf). Accessed April 26, 2014.
15. American College of Radiology. ACR–ABS practice parameter for the performance of low-dose-rate brachytherapy. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/LDR-BrachyRO.pdf?la=en>. Accessed December 17, 2019.
16. Humphrey P, Cornes P, Al-Booz H. Vaginal vault brachytherapy in endometrial cancer: verifying target coverage with image-guided applicator placement. *Br J Radiol* 2013;86:20120428.
17. Kim Y, Muruganandham M, Modrick JM, Bayouth JE. Evaluation of artifacts and distortions of titanium applicators on 3.0-Tesla MRI: feasibility of titanium applicators in MRI-guided brachytherapy for gynecological cancer. *Int J Radiat Oncol Biol Phys* 2011;80:947-55.
18. Mahantshetty U, Khanna N, Swamidas J, et al. Trans-abdominal ultrasound (US) and magnetic resonance imaging (MRI) correlation for conformal intracavitary brachytherapy in carcinoma of the uterine cervix. *Radiother Oncol* 2012;102:130-4.
19. Perez-Calatayud J, Kuipers F, Ballester F, et al. Exclusive MRI-based tandem and colpostats reconstruction in gynaecological brachytherapy treatment planning. *Radiother Oncol* 2009;91:181-6.
20. Sandhu GK, Dunscombe PB, Khan RF. A pre-clinical phantom comparison of tissue harmonic and brightness mode imaging for application in ultrasound guided prostate brachytherapy. *Phys Med* 2011;27:153-62.
21. International Commission on Radiation Units and Measurements. Prescribing, recording, and reporting brachytherapy for cancer of the cervix. 2016; ICRU 13 Report 89.
22. American College of Radiology. ACR–AAPM technical standard for diagnostic medical physics performance monitoring of real time ultrasound equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/US-Equip.pdf?la=en>. Accessed February 5, 2019.
23. American College of Radiology. ACR–AAPM technical standard for diagnostic medical physics performance monitoring of computed tomography (CT) equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CT-Equip.pdf?la=en>. Accessed February 5, 2019.
24. American College of Radiology. ACR–AAPM technical standard for diagnostic medical physics performance monitoring of magnetic resonance imaging (MRI) equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/MR-Equip.pdf?la=en>. Accessed February 5, 2019.
25. Beaulieu L, Carlsson Tedgren A, Carrier JF, et al. Report of the Task Group 186 on model-based dose calculation methods in brachytherapy beyond the TG-43 formalism: current status and recommendations for clinical implementation. *Med Phys* 2012;39:6208-36.
26. Afsharpour H, Landry G, Reniers B, Pignol JP, Beaulieu L, Verhaegen F. Tissue modeling schemes in low energy breast brachytherapy. *Phys Med Biol* 2011;56:7045-60.
27. Mikell JK, Klopp AH, Gonzalez GM, et al. Impact of heterogeneity-based dose calculation using a deterministic grid-based Boltzmann equation solver for intracavitary brachytherapy. *Int J Radiat Oncol Biol Phys* 2012;83:e417-22.
28. Fraass B, Doppke K, Hunt M, et al. American Association of Physicists in Medicine Radiation Therapy Committee Task Group 53: quality assurance for clinical radiotherapy treatment planning. *Med Phys* 1998;25:1773-829.
29. AAPM Medical Physics Practice Guideline 5.a.: Commissioning and QA of Treatment Planning Dose Calculations - Megavoltage Photon and Electron Beams. *J Appl Clin Med Phys* 2016;17:457.
30. Lee LJ, Das IJ, Higgins SA, et al. American Brachytherapy Society consensus guidelines for locally advanced carcinoma of the cervix. Part III: low-dose-rate and pulsed-dose-rate brachytherapy. *Brachytherapy* 2012;11:53-7.

\*As of May 2015, all practice parameters and technical standards that are collaborative with only the American Association of Physics in Medicine are approved by the ACR Council Steering Committee and the ACR Board of

~~Revised 2020 (CSC/BOC)~~ go through the ACR Council (ACR Resolution 54, 2015). The effective date is the first day of the month following a 60-day period that begins on the date the document was approved.

Development Chronology for this Technical Standard

1995 (Resolution 25)

Revised 2000 (Resolution 21)

Revised 2005 (Resolution 17)

Amended 2006 (Resolution 16g)

Revised 2010 (Resolution 5)

Revised 2015 (Resolution 51)

Revised 2020 (CSC/BOC)

Amended 2022 (Resolution 41f)

Amended 2023 (Resolution 2c)