

# ACR PRACTICE PARAMETER FOR THE PERFORMANCE OF CONTRAST ENEMA EXAMINATION IN ADULTS

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**

The fluoroscopic/radiographic examination of the colon by single-contrast or double-contrast technique is a proven and useful procedure for the detection of intrinsic or extrinsic colonic pathology. It could be the primary imaging study or used as an adjunct to endoscopic or cross-sectional imaging evaluation. The purpose of this examination is to establish the presence or absence of disease and its nature by luminal distension with or without mucosal coating.

## **II. INDICATIONS AND CONTRAINDICATIONS**

A. The indications for a fluoroscopic contrast enema examination include, but are not limited to [1-4]:

1. Diverticular disease
2. Inflammatory bowel disease
3. Colon cancer screening, including the completion of screening in incomplete colonoscopy [5-7] only if other methods such as repeat colonoscopy or performance of CT colonography are not available or if the patient's clinical condition precludes these examinations.
4. Distal intestinal obstruction syndrome or meconium ileus equivalent in cystic fibrosis patients [8,9]
5. Evaluation of questionable findings on other imaging examinations such as computed tomography (CT) or magnetic resonance imaging (MR)
6. Colonic volvulus
7. Assessing the integrity of rectal or colonic anastomosis or ileal pouch before take down of diverting colostomy or ileostomy
8. Assessment of possible colonic fistulae
9. Diseases involving the colon with familial inheritance pattern
10. Preoperative evaluation of the colon for surgical planning and postoperative follow-up
11. Evaluation of suspected colonic intrinsic or extrinsic strictures or large bowel obstruction, if equivocal results on CT or type/length of stricture are needed for surgical planning
12. Therapeutic enema in cases in which nurse or patient administered enemas have been ineffective as well as in patients with cystic fibrosis
13. Evaluation for potential colonic perforation or leak
14. Evaluation of remaining colonic anatomy in a postoperative patient

B. Pertinent symptoms for the fluoroscopic contrast enema examination include, but are not limited to:

1. Abdominal pain
2. Diarrhea
3. Constipation
4. Other changes in bowel habits
5. Abdominal distension
6. Gastrointestinal bleeding, acute or chronic leading to anemia (only if colonoscopy, CT colonography, and/or CT/angiographic techniques are not available or cannot be performed)
7. Weight loss

C. The possible contraindications for a fluoroscopic contrast enema examination include, but are not limited to:

1. Unexplained pneumoperitoneum or pneumoretroperitoneum (not contraindicated if water soluble contrast is used)
2. Acute colitis, including toxic megacolon
3. Combative or uncooperative patient
4. In the setting of recent endoscopic intervention, there should be a 7-day interval between the fluoroscopic double contrast enema examination and the performance of large forceps biopsy

through a rigid colonoscope or proctoscope, snare polypectomy, hot biopsy, or biopsy of any size or type in infectious or active inflammatory bowel disease.

5. Acute presentation of known malignant colon obstruction except if a single contrast enema is used for guiding or planning intervention (eg, before stent placement if not a surgical candidate)

For the pregnant or potentially pregnant patient, see the [ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Patients with Ionizing Radiation](#) [10].

### **III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL**

For qualifications of physicians, registered radiologist assistants, radiologic technologist, and other ancillary personnel see the [ACR–AAPM Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures](#) [11].

### **IV. SPECIFICATIONS OF THE EXAMINATION**

The written or electronic request for a fluoroscopic contrast enema examination should provide sufficient information to demonstrate the medical necessity of the examination and allow for its proper performance and interpretation.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). Additional information regarding the specific reason for the examination or a provisional diagnosis would be helpful and may at times be needed to allow for the proper performance and interpretation of the examination.

The request for the examination must be originated by a physician or other appropriately licensed health care provider. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient's clinical problem or question and consistent with the state scope of practice requirements. (ACR Resolution 35, adopted in 2006 – revised in 2016, Resolution 12-b)

### **IV. SPECIFICATIONS OF THE EXAMINATION**

#### **A. Colon Preparation**

The preparation should consist of an effective combination of dietary restriction, hydration, osmotic laxatives, contact laxatives, and cleansing enemas. These preparations are intended to rid the colon of fecal material and excess fluid as much as possible, particularly for the double contrast screening enema evaluation. In appropriate clinical situations, preparation may be limited and, in the setting of suspected bowel obstruction or colonic volvulus, should be omitted [12-14]. There is also no routine need for colonic preparation in the case of existing ileal or colonic diversion.

### **IV. SPECIFICATIONS OF THE EXAMINATION**

**B.**  
**Examination Preliminaries**

1. An appropriate medical history should be available, including results of laboratory tests and imaging, endoscopic, and surgical procedures as applicable.
2. The enema tip should be inserted by a physician or a trained assistant (eg, technologist, radiologist assistant, nurse, or physician assistant). Rectal perforations are rare but often would require surgical intervention if barium was used with a reported improvement in outcome in these cases due to the early intervention [15,16]. A retention cuff may be used, which should be inflated carefully in accordance with the manufacturer's guidelines and under fluoroscopic guidance and after the instillation of a small amount of contrast for better visualization of the balloon whenever possible. A retention cuff should be avoided for recent low rectal anastomoses (in rare instances it may be inflated under extreme care and under strict fluoroscopic guidance to avoid anastomotic dehiscence), following pelvic radiation therapy and in very distal rectal strictures. In patients with an ileo-anal anastomosis, a small caliber catheter should be used rather than an enema tip, and the tube should be secured to the patient's skin surface with adhesive rather than inflating a balloon.
3. Medications (eg, glucagon) may be administered to facilitate the examination in the case of suspected muscle spasm.

**IV.**  
**SPECIFICATIONS OF THE EXAMINATION**

**C.**  
**Examination Technique**

The following fluoroscopic contrast examination procedures should be tailored by the physician to the individual patient, as warranted by clinical circumstances and the condition of the patient, to produce a diagnostic-quality examination [1,12,13].

1. Single-contrast examination
  - a. A sufficient volume of an appropriate low-density (ie, 15%–25% weight/volume) barium suspension or water-soluble iodinated contrast should be administered to provide luminal opacification. .

In early postsurgical patients, if perforation or leak is suspected or if preparation is contraindicated or not possible for other reasons, water-soluble contrast should be used. Examination of residual or constructed colonic segments (eg, rectal remnant following the Hartmann procedure or an ileal pouch) is most commonly performed with water-soluble contrast. Water-soluble contrast contains 300–370 mg of iodine/mL, equivalent to 60%–76% density. It may be diluted with water to 20%–30%, depending on the indication. Water-soluble contrast is also recommended in patients with suspected colonic obstruction or volvulus.

- b. Water-soluble contrast should also be used if the patient is at high risk for formation of barium concretions that can lead to obstruction (eg, intestinal diversion or motility disorders) [17].
- c. For barium studies, a kilovoltage of 100 kVp or greater should be used (depending on patient size) during image acquisition. A lower kilovoltage of 70–80 kVp optimizes iodine contrast visualization on water-soluble contrast studies.
- d. Palpation (manual or mechanical compression) in conjunction with patient rotation should be applied as appropriate to all accessible segments of the colon during fluoroscopy.
- e. Spot large-format images should demonstrate all fluoroscopically identified suspicious findings as well as those segments of the colon in profile that may not routinely be demonstrated on overhead projections
- f. Images should include frontal and oblique views of the entire filled colon, an angled-beam view of

the sigmoid colon, and a lateral view of the rectum. Whenever possible, the lateral rectal view should include an image obtained after the enema tip has been removed

- g. Postevacuation images are usually obtained in the evaluation for leak
- h. The quality assurance indicators specific to the single-contrast enema examination are:
  - i. Compression views may be helpful
  - ii. Each accessible segment of the colon is seen during fluoroscopy
  - iii. Each segment of the entire colon should be seen without overlap, if possible
  - iv. Imaging technique should optimize visualization of all segments of the colon
  - v. Complete visualization of the entire colon should be ensured through the demonstration of ileocecal valve, terminal ileum, appendix or ileocolic anastomosis (if the right side of the colon has been resected)
- i. In the setting of distal intestinal obstruction syndrome/meconium ileus equivalent in patients with cystic fibrosis, a water-soluble contrast enema examination can demonstrate the level of the obstruction and possibly be therapeutic by promoting evacuation of inspissated bowel contents. The water-soluble contrast material enema procedure has become an accepted supplement to other nonsurgical therapeutic measures, and multiple enemas with water-soluble contrast agents over several days may be required to mobilize the tenacious stool plugs [8,9]. Repeat enemas in this setting may be performed without fluoroscopic guidance.

## 2. Double-contrast barium examination

- a. Commercially prepared high-density (80% weight/volume or greater) barium suspension is used.
- b. Kilovoltage of 90 kVp or greater, depending on the patient's size, is used.
- c. Barium suspension followed by air is introduced under fluoroscopic control to achieve adequate coating and distention of the entire colon.
- d. The entire colon should be examined fluoroscopically during the course of the examination.
- e. Images should be taken to attempt to demonstrate all segments of the colon in double contrast. Suggested views include the following:
  - i. Spot images of the rectum, sigmoid colon, flexures, and cecum in double contrast
  - ii. Large-format images, including prone and supine views of the entire colon, an angled-beam view of the sigmoid colon, and a lateral view of the rectum, either cross-table lateral or vertical beam, preferably with the enema tip removed
  - iii. Both lateral decubitus views of the entire colon using a horizontal beam (a wedge filter is recommended)
  - iv. Erect or semierect flexure views, and postevacuation views, when possible, may be helpful
- f. The quality assurance indicators specific to the double-contrast barium enema examination are as follows:
  - i. Adequate barium coating of the entire colon has been achieved
  - ii. The colon is well distended with air
  - iii. Each segment of the colon is seen in double contrast on at least 2 images taken in different positions, whenever possible
  - iv. Complete visualization of the entire colon is ensured through demonstration of the ileocecal valve, terminal ileum, or appendix

## 3. Colostomy or colonic mucous fistula fluoroscopic contrast enema

- a. These procedures are indicated when disease is suspected involving a colostomy or colonic mucous fistula or to delineate anatomy in preparation for colostomy revision/takedown. A single contrast enema technique should always be used. The ostomy should be examined by the radiologist or a trained assistant. An appropriate device should be inserted into the ostomy. Examples of appropriate devices include, but are not limited to:
  - i. Foley catheter
  - ii. Red rubber catheter
  - iii. Cone colostomy tip

If a Foley catheter is used, the balloon should be inflated on the outside of the stoma and held

firmly against the stoma by the patient's gloved hand. Alternatively, the Foley balloon may be inflated under care inside the stoma and under strict fluoroscopic guidance to avoid injury.

- b. Low-density barium or water-soluble contrast should be instilled into the ostomy through the device under fluoroscopic observation. The examination should attempt to answer the clinical question and should be recorded on spot radiographic images.

#### **IV. SPECIFICATIONS OF THE EXAMINATION**

##### **D. Quality Assurance**

1. The following quality assurance indicators should be applied as appropriate to all fluoroscopic contrast enema examinations:
  - a. Colon preparation should be adequate for the clinical indication.
  - b. When examinations are completed, patients should be held in the fluoroscopic area until the physician has reviewed the images.
  - c. An attempt should be made to resolve questionable radiologic findings before the patient leaves. Repeat fluoroscopy of the patient should be performed as necessary.
2. The following step is suggested for a quality assurance and continuing quality improvement program:
  - a. Correlation of radiologic, endoscopic, and pathologic findings
  - b.

#### **V. DOCUMENTATION**

Reporting should be in accordance with the [ACR Practice Parameter for Communication of Diagnostic Imaging Findings](#)

#### **VI. EQUIPMENT SPECIFICATIONS**

Equipment performance monitoring should be in accordance with the [ACR–AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic Equipment](#) and the [ACR–AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Fluoroscopic Equipment](#) [19,20].

Examinations should be performed with fluoroscopic image intensification and radiographic equipment that meets all applicable federal and state radiation standards.

Equipment should provide diagnostic fluoroscopic image quality and recording (image, video, or digital) capability. Equipment should be capable of producing kilovoltage >100 kVp. Equipment necessary to compress and isolate regions of the colon should be readily available.

#### **VII. RADIATION SAFETY IN IMAGING**

Radiologists, medical physicists, non-physician radiology providers, radiologic technologists, and all supervising physicians have a responsibility for safety in the workplace by keeping radiation exposure to staff, and to society as a whole, "as low as reasonably achievable" (ALARA) and to assure that radiation doses to individual patients are appropriate, taking into account the possible risk from radiation exposure and the diagnostic image quality necessary to achieve the clinical objective. All personnel who work with ionizing radiation must understand the key principles of occupational and public radiation protection (justification, optimization of protection, application of dose constraints and limits) and the principles of proper management of radiation dose to patients (justification, optimization including the use of dose reference levels). [https://www-pub.iaea.org/MTCD/Publications/PDF/PUB1775\\_web.pdf](https://www-pub.iaea.org/MTCD/Publications/PDF/PUB1775_web.pdf)

Nationally developed guidelines, such as the [ACR's Appropriateness Criteria®](#), should be used to help choose the most appropriate imaging procedures to prevent unnecessary radiation exposure.

Facilities should have and adhere to policies and procedures that require ionizing radiation examination protocols (radiography, fluoroscopy, interventional radiology, CT) to vary according to diagnostic requirements and patient body habitus to optimize the relationship between appropriate radiation dose and adequate image quality. Automated dose reduction technologies available on imaging equipment should be used, except when inappropriate for a specific exam. If such technology is not available, appropriate manual techniques should be used.

Additional information regarding patient radiation safety in imaging is available from the following websites – Image Gently® for children ([www.imagegently.org](http://www.imagegently.org)) and Image Wisely® for adults ([www.imagewisely.org](http://www.imagewisely.org)). These advocacy and awareness campaigns provide free educational materials for all stakeholders involved in imaging (patients, technologists, referring providers, medical physicists, and radiologists).

Radiation exposures or other dose indices should be periodically measured by a Qualified Medical Physicist in accordance with the applicable ACR Technical Standards. Monitoring or regular review of dose indices from patient imaging should be performed by comparing the facility's dose information with national benchmarks, such as the ACR Dose Index Registry and relevant publications relying on its data, applicable ACR Practice Parameters, NCRP Report No. 172, Reference Levels and Achievable Doses in Medical and Dental Imaging: Recommendations for the United States or the Conference of Radiation Control Program Director's National Evaluation of X-ray Trends; 2006, 2009, amended 2013, revised 2023 (Res. 2d).

## **VIII.**

### **QUALITY CONTROL AND IMPROVEMENT, SAFETY, INFECTION CONTROL, AND PATIENT EDUCATION**

Policies and procedures related to quality, patient education, infection control, and safety should be developed and implemented in accordance with the ACR Policy on Quality Control and Improvement, Safety, Infection Control, and Patient Education appearing under the heading *Position Statement on QC & Improvement, Safety, Infection Control, and Patient Education* on the ACR website (<https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Quality-Control-and-Improvement>).

## **ACKNOWLEDGEMENTS**

This practice parameter was revised according to the process described under the heading *The Process for Developing ACR Practice Guidelines and Technical Standards* on the ACR website (<https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards>) by the Committee on Practice Parameters – Body Imaging (Abdominal) of the ACR Commission on Body Imaging and Committee on Practice Parameters – General, Small, Emergency and/or Rural Practice of the ACR Commission on General, Small, Emergency and/or Rural Practice.

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

## ACR

Mahmoud M. Al-Hawary, MD, Chair

Mark Early Baker, MD, FACR

David J. DiSantis, MD, FACR

Chenchan Huang, MD

Farnoosh Sokhandon, MD

## Committee on Practice Parameters – General, Small, Emergency and/or Rural Practices (GSER)

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

Candice Johnstone, MD, Chair

Nathan J. Rohling, DO

Justin P. Dodge, MD

Samir S. Shah, MD

Brian D. Gale, MD, MBA

Derrick Siebert, MD

Rachel Gerson, MD,

Michael Straza, MD, Ph.D

Mallikarjunarao Kasam, PhD

## Committee on Body Imaging - Abdominal

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



### Committee on Body Imaging - Abdominal

Benjamin M Yeh, MD, Chair

Erick Remer, MD, FACR

Olga R. Brook, MD

Kumar Sandrasegaran, MD

Alessandro Furlan, MD

Mary A. Turner, MD, FACR

David Kim, MD, FACR

Ellen L. Wolf, MD, FACR

Diego Martin, MD, PhD

Adam S. Young, MD, MBA

Alec Megibow, MD, MPH, FACR

Ashish Wasnik, MD

Achille Mileto, MD

Paula Yeghiayan, MD

Robert S. Pyatt, Jr., MD, FACR, Chair, Commission on General, Small, Emergency and/or Rural Practice

Andrew B. Rosenkrantz, MD, Chair, Commission on Body Imaging

David B. Larson, MD, MBA, Chair, Commission on Quality and Safety

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

### Comments Reconciliation Committee

Elizabeth Hawk, MD, MS, Ph.D-CSC Chair

David A. Larson, MD

Nolan J. Kamentsu, MD, FACR-CSC Co-Chair

Paul A. Larson, MD, FACR

Mahmoud M. Al-Hawary, MD

Kambiz Motamedi, MD

Mark Early Baker, MD, FACR

Terry L. Levin, MD, FACR

Laura Carucci, MD

Mary S. Newell, MD, FACR

Timothy A. Crummy, MD, MHA, FACR

Andrew B Rosenkrantz, MD

## Comments Reconciliation Committee

David J. DiSantis, MD, FACR

Farnoosh Sokhandon, MD

Chenchan Huang, MD

Roland Wong, ScM

Amy L. Kotsenas, MD, FACR

Benjamin Yeh, MD

## REFERENCES

1. Rubesin SE, Levine MS, Laufer I, Herlinger H. Double-contrast barium enema examination technique. *Radiology* 2000;215:642-50.
2. Levine MS, Yee J. History, evolution, and current status of radiologic imaging tests for colorectal cancer screening. *Radiology* 2014;273:S160-80.
3. Levine MS Laufer I. Barium Studies of the Colon. *Textbook of Gastrointestinal Radiology*. 4th ed. Philadelphia: Elsevier; 2015:879-89.
4. Bass R, McNamara MM, Little MD, Pietryga JA, Sanyal R, Zarzour JG. Contrast Enema Examination: Technique and Essential Findings: RadioGraphics Fundamentals | Online Presentation. *Radiographics : a review publication of the Radiological Society of North America, Inc* 2018;38:90-91.
5. Chong A, Shah JN, Levine MS, et al. Diagnostic yield of barium enema examination after incomplete colonoscopy. *Radiology* 2002;223:620-4.
6. Halligan S, Wooldrage K, Dadswell E, et al. Computed tomographic colonography versus barium enema for diagnosis of colorectal cancer or large polyps in symptomatic patients (SIGGAR): a multicentre randomised trial. *Lancet (London, England)* 2013;381:1185-93.
7. Parsa N, Vemulapalli KC, Rex DK. Performance of radiographic imaging after incomplete colonoscopy for nonmalignant causes in clinical practice. *Gastrointestinal endoscopy* 2020;91:1371-77.
8. Agrons GA, Corse WR, Markowitz RI, Suarez ES, Perry DR. Gastrointestinal manifestations of cystic fibrosis: radiologic-pathologic correlation. *Radiographics : a review publication of the Radiological Society of North America, Inc* 1996;16:871-93.
9. Robertson MB, Choe KA, Joseph PM. Review of the abdominal manifestations of cystic fibrosis in the adult patient. *Radiographics : a review publication of the Radiological Society of North America, Inc* 2006;26:679-90.
10. American College of Radiology. ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Patients with Ionizing Radiation. February 11. Available at: Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Pregnant-Pts.pdf>. Accessed 2022.
11. American College of Radiology. ACR–AAPM Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/MgmtFluoroProc.pdf>. Accessed February 11, 2022.
12. Frank ED, Long BW, Smith B. *Merrill's Atlas of Radiographic Positioning and Procedures*. 11th ed. St. Louis, MO: Mosby; 2007.
13. Houston JD. *Fundamentals of Fluoroscopy*. Philadelphia, Pa: WB Saunders; 2001.
14. Federle MP, Jaffe TA, Davis PL, Al-Hawary MM, Levine MS. Contrast media for fluoroscopic examinations of the GI and GU tracts: current challenges and recommendations. *Abdom Radiol (NY)* 2017;42:90-100.
15. de Feiter PW, Soeters PB, Dejong CH. Rectal perforations after barium enema: a review. *Diseases of the colon and rectum* 2006;49:261-71.
16. Ghahremani GG, Gore RM. Intraperitoneal Barium From Gastrointestinal Perforations: Reassessment of the Prognosis and Long-Term Effects. *AJR. American journal of roentgenology* 2021;217:117-23.
17. Kurer MA, Davey C, Chintapatla S. Intestinal obstruction from inspissated barium (Barolith): a systematic

Revised 2023 (Resolution 13) in 1950 to 2006. Colorectal disease : the official journal of the Association of Coloproctology of Great Britain and Ireland 2008;10:431-9.

18. American College of Radiology. ACR Practice Parameter for Communication of Diagnostic Imaging Findings. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf>. Accessed February 11, 2022.
19. American College of Radiology. ACR-AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Fluoroscopic Equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Fluoro-Equip.pdf>. Accessed February 11, 2022.
20. American College of Radiology. ACR-AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic Equipment. Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/RadEquip.pdf>. Accessed February 11, 2022.

\*Practice parameters and technical standards are published annually with an effective date of October 1 in the year in which amended, revised, or approved by the ACR Council. For practice parameters and technical standards published before 1999, the effective date was January 1 following the year in which the practice parameter or technical standard was amended, revised, or approved by the ACR Council.

#### Development Chronology for this Practice Parameter 1991 (Resolution 7)

Amended 1995 (Resolution 24, 53)

Revised 1999 (Resolution 31)

Revised 2002 (Resolution 32)

Amended 2006 (Resolution 17, 34, 35, 36) Amended 2007 (Resolution 12m)

Revised 2008 (Resolution 37)

Amended 2009 (Resolution 11)

Revised 2013 (Resolution 25)

Amended 2014 (Resolution 39)

Revised 2018 (Resolution 2)

Revised 2023 (Resolution 13)