

## DICOM Structured Reporting Overview

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RSNA Industry Forum on Structured Reporting

## Results DICOM Structured Reporting

- The scope of DICOM SR is the standardization of structured data and clinical observations in the imaging environment.
- SR objects record observations made for an imaging-based diagnostic or interventional procedure, particularly those that describe or reference images, waveforms, or specific regions of interest.

Most important in the stages before report creation

## Why do you need to know about DICOM SR?

- DICOM SR is the standard to exchange structured data produced in the course of image acquisition or post-processing, where:
  - Leveraging the DICOM infrastructure is easy and desirable
  - Results should be managed with other study evidence
- Replaces legacy kludges
  - Manually transcribed worksheets, screen scrapes from analysis apps, one-off integrations
- Examples
  - Sonographer measurements
  - Computer-aided detection results
  - QC notes about images
  - Radiation dose reports
  - Image exchange manifests

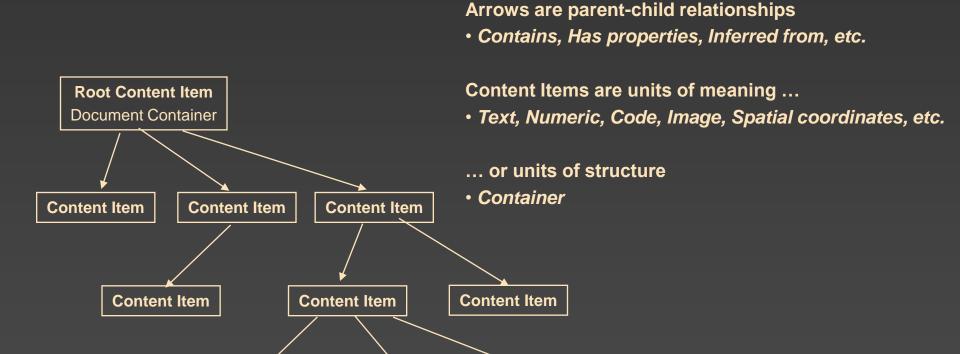
# DICOM SR is not "Structured Data Entry"

- Hierarchical pull-down menus for results capture or report creation is often denoted "structured reporting"
- DICOM does not standardize applications or data entry techniques
- Structured data entry is a valuable means of creating SR content in certain circumstances
  - Standard SR templates and value sets can support the implementation of structured data entry forms

### **Key Aspects of DICOM SR**

- SR documents are encoded using DICOM standard data elements and leverage DICOM network services (storage, query/retrieve)
- SR uses DICOM Patient/Study/Series information model (header), plus hierarchical tree of "Content Items"
- Extensive use of coded nomenclature
  - Allows use of vocabulary/codes from non-DICOM sources (especially LOINC and SNOMED, possibly RadLex)
- Templates define content constraints for specific types of documents / reports

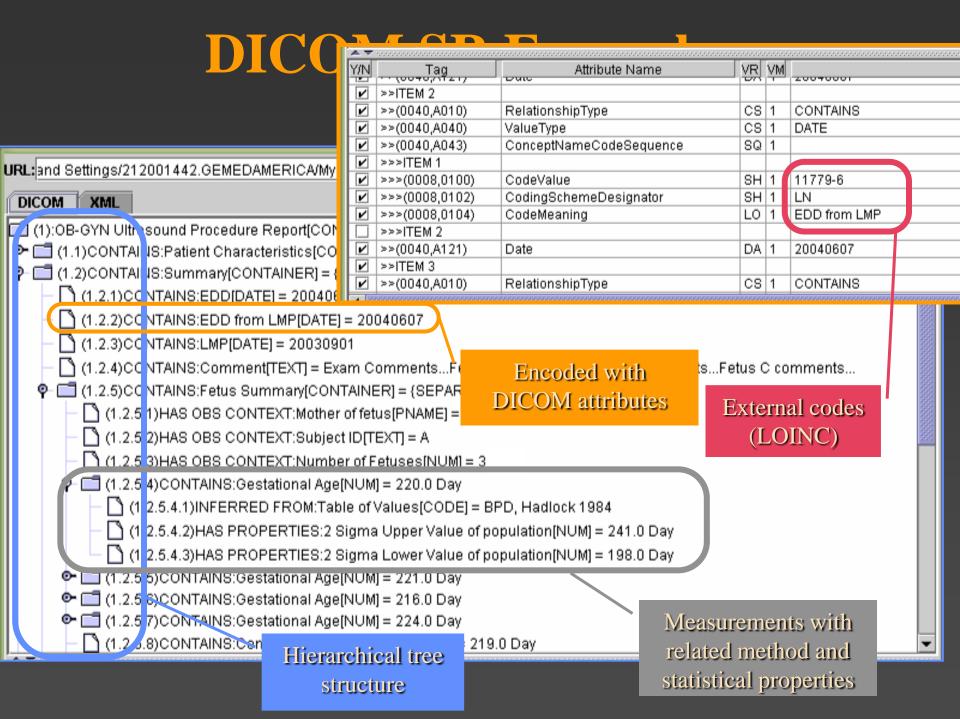
#### **SR** Content Item Tree



**Content Item** 

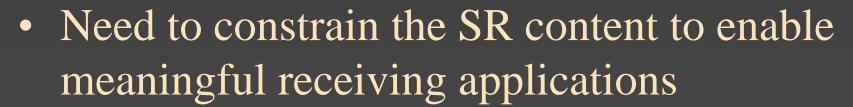
**Content Item** 

**Content Item** 



### The Problem of SR Flexibility

- A document creator can put in anything in any structure
- A document reader must handle every possible document



- Structure
- Content



#### **SR** Templates

- Like IODs, but for SR content
  - Define attributes (concepts), required/optional, and allowed values
  - Specify hierarchical structure of sections and subsections (containers)
- Specified for a variety of uses, often in conjunction with specialty societies
  - OB/GYN, vascular, echo, and IVUS ultrasound
  - X-ray, CT, and MR angiography
  - Mammo, chest, and colon computer-aided detection
  - Radiation dose

### DICOM SR Object Classes

- General use Enhanced and Comprehensive Text, coded content, numeric measurements, spatial and temporal ROI references (any template)
- CAD Automated analysis results (SOP Class per CAD template)
- Key Object Selection (KO) Flags one or more images
  - Purpose ("for referring physician", "for surgery", ...) and textual note
  - Used for key image notes and image manifests (in IHE profiles)
- Procedure Log For extended duration procedures (e.g., cath)
- Radiation Dose Report Projection X-ray; CT

#### Summary

- DICOM SR is the standard for exchange of structured data / clinical observations in the imaging environment
- DICOM SR leverages existing imaging infrastructure and toolkits
- DICOM SR is constrained by templates and SOP Classes to improve interoperability for specific use cases

#### For more information

- DICOM Standard ftp://medical.nema.org/medical/dicom/2008
  - Part 3: SR SOP Classes (Section A.35), SR Modules (Section C.17)
  - Part 16: Templates (Annex A)
- David Clunie's introduction to DICOM SR <u>http://www.pixelmed.com/srbook.html</u>
- IHE use cases for DICOM SR
  - Radiology Technical Framework Vol 1: Key Image Note (Section 8), Evidence Documents (Section 14)
  - Cardiology Technical Framework Vol 1: Evidence Documents (Section 7)