

ORIGINAL RESEARCH ARTICLE

Lowering head computed tomography radiation dose for craniosynostosis: An institutional change and review of literature

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ABSTRACT

Definitive diagnosis of Craniosynostosis (CS) with computed tomography (CT) is readily available, however, exposure to ionizing radiation is often a hard stop for parents and practitioners. Lowering head CT radiation exposure helps mitigate risks and improves diagnostic utilization. The purpose of the study is to quantify radiation exposure from head CT in patients with CS using a ‘new’ (ultra-low dose) protocol; compare prior standard CT protocol; summarize published reports on cumulative radiation doses from pediatric head CT scans utilizing other low-dose protocols. A retrospective study was conducted on patients undergoing surgical correction of CS, aged less than 2 years, between August 2014 and February 2022. Cumulative effective dose (CED) in mSv was calculated, descriptive statistics were performed, and mean \pm SD was reported. A literature search was conducted describing cumulative radiation exposure from head CT in pediatric patients and analyzed for ionizing radiation measurements. Forty-four patients met inclusion criteria: 17 females and 27 males. Patients who obtained head CT using the ‘New’ protocol resulted in lower CED exposure of $0.32 \text{ mSv} \pm 0.07$ compared to the prior standard protocol at $5.25 \text{ mSv} \pm 2.79$ ($p < 0.0001$). Five studies specifically investigated the reduction of ionizing radiation from CT scans in patients with CS via the utilization of low-dose CT protocols. These studies displayed overall CED values ranging from 0.015 mSv to 0.77 mSv . Our new CT protocol resulted in 94% reduction of ionizing radiation. Ultra-low dose CT protocols provide similar diagnostic data without loss of bone differentiation in CS and can be easily incorporated into the workflow of a children’s hospital.

Keywords: children; computed tomography optimization; craniosynostosis; head; radiation dose; skull

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1. Introduction

Computed tomography (CT) scans are among the most common diagnostic imaging techniques used in pediatric medicine secondary to their ease of use, speed of results and widespread availability at most children’s hospitals. In pediatrics the head is the most frequently imaged body part, with craniosynostosis (CS) being a common condition requiring the use of pediatric head CT^[1]. Craniosynostosis, the pathologically premature fusion of one or more cranial sutures during infancy, occurs approximately one in every 2000 live births^[2–4]. Increasing rates of positional plagiocephaly have made definitive diagnosis with low radiation dose CT more desirable. In the majority of cases, head CT for diagnosis confirmation, surgical planning, and occasionally for post-operative follow-up is standard practice^[5–7].

Bone differentiation, speed of image acquisition and lack of sedation requirement are significant advantages of CT over other imaging modalities (i.e., x-ray, magnetic resonance imaging and ultrasound)^[8]. Radiation exposure over a lifetime raises concerns from

both parents and physicians for radiation induced malignancies, such as reported by Pearce et al.^[9], Boice^[10], Mathews et al.^[11], and Montoya et al.^[12]. Many children’s hospitals utilize lower average dose of CT radiation for children, however they have not dramatically lowered doses for infants with CS. By altering the diagnostic yield to only concentrate on the skull, but not the brain, we have lowered ionizing radiation doses to a fraction of our prior standard pediatric CT imaging. We propose that quality head CT scans in CS patients can be achieved while simultaneously using the lowest level of ionizing radiation possible.

2. Methods

A retrospective study was conducted on patients undergoing surgical correction of CS, aged less than 2 years, between August 2014 and February 2022. Demographic information included the patient’s date of birth, sex, craniosynostosis etiology, date of CT scan(s), the CT scanner type, CTDIvol in mGy, and DLP in mGy-cm. For each patient cumulative effective dose (CED) in millisieverts (mSv) was calculated using previously published methods^[13]. The “Old” CT protocol utilized 4 mm thinly collimated unenhanced spiral CT images from a SOMATOM Definition Flash scanner (Siemens Medical Solutions USA, Inc, Pennsylvania, USA). The “New” protocol altered image acquisition with 1 mm slice thickness from a SOMATOM Drive CMPCT scanner. Two-tailed Student’s *t*-tests were performed to analyze the differences between the ‘Old’ and ‘New’ protocols, with a significance level of $p \leq 0.05$.

A systematic literature review using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines was conducted to analyze low-dose CT imaging protocols utilized in pediatric head CT scans. The search included published articles in the National Library of Medicine (PubMed) database, with no restriction on publication year. Search terms included: ([“low-dose head CT”] and [“craniosynostosis” or “synostosis” or “cranial suture”]) and [“pediatric” or “child”]). Two reviewers independently screened titles and abstracts for identification of articles for inclusion.

3. Results

Forty-four patients met inclusion criteria for our institutional study: 17 females and 27 male patients below the age of two years (**Table 1**). Of the 44 patients included, 20 (45.5%) had sagittal, 8 (18.2%) metopic, 4 (9.1%) coronal, 1 (2.3%) squamous, 1 (2.3%) lambdoid, and 10 (22.7%) multisuture synostosis (**Table 1**). Syndromic CS was noted in 4 (9.1%) of the included patients. Additionally, 24/44 (54.5%) of the patients were exposed to CT scans utilizing the ‘Old’ protocol and 20/44 (45.5%) were exposed to CT scans utilizing the ‘New’ protocol (**Table 2**). No patients required repeat imaging secondary to non-diagnostic scans.

Table 1. Patient demographics.

Gender	N (%)
Female	17 (38.6)
Male	27 (61.4)
Type of CS	N (%)
Sagittal	20 (45.5)
Metopic	8 (18.2)
Coronal	4 (9.1)
Lambdoidal	1 (2.3)
Squamosal	1 (2.3)
Multisutural	10 (22.7)

Patients who obtained CT scans using the ‘New’ protocol had a lower overall CTDIvol (2.03 mGy \pm 0.31) compared to patients who had head CT using the ‘Old’ protocol (21.78 mGy \pm 6.54, $p < 0.0001$) (**Table 2**).

There was also statistically significant difference in the overall DLP between patients that were exposed to CT scans using the ‘Old’ and ‘New’ protocol, 517.28 mGy-cm \pm 263.91 versus 34.20 mGy-cm \pm 7.51 respectively ($p < 0.0001$). After determining each patient’s CED, we determined that patients exposed to CT scans using the ‘New’ protocol had a significantly lower overall CED (0.32 mSv \pm 0.07) compared to patients exposed to CT scans using the ‘Old’ protocol (5.25 mSv \pm 2.79, $p < 0.0001$).

Table 2. Radiation dose in “Old” and “New” protocols for head CT in pediatrics.

Protocol	CTDIvol (mGy) (mean \pm SD)	DLP (mGy-cm) (mean \pm SD)	CED (mSv) (mean \pm SD)
Old (n = 24)	21.78 \pm 6.54	517.28 \pm 263.91	5.25 \pm 2.79
New (n = 20)	2.03 \pm 0.31	34.20 \pm 7.51	0.32 \pm 0.07
<i>p</i>	<0.0001	<0.0001	<0.0001

Literature published using modern CT methods since the advent of rapid multi-detector image acquisition, revealed seventeen studies that investigated cumulative ionizing radiation doses from head CT scans in pediatric patients (**Figure 1**)^[1,12,14–27]. These studies included numerous pediatric patients ranging in age from newborn to 17 years old, with the seventeen studies reporting calculated effective doses ranging from 0.015 mSv to 8.91 mSv^[1,12,14–27].

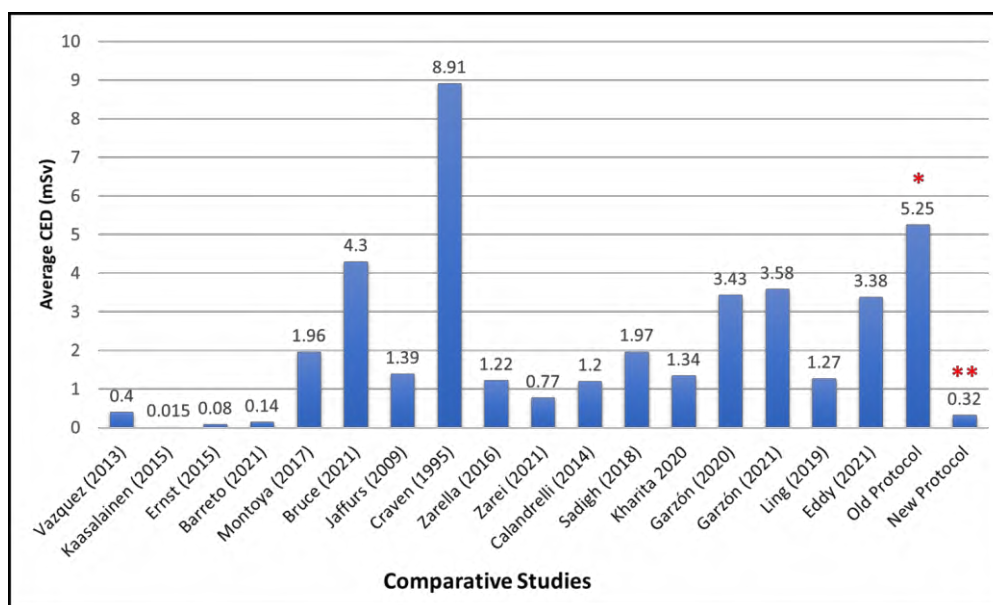


Figure 1. Mean CED (mSv) from comparative pediatric head CT studies alongside ‘Old’ (*) and ‘New’ (**) protocols.

Of the seventeen studies included, five were found to specifically investigate ionizing radiation exposure from CT scans in pediatric patients with CS, with these studies also emphasizing the utilization of low-dose CT protocols that yielded effective doses of less than 1 mSv^[17–20,26]. One study utilized anthropomorphic phantoms and was able to achieve the lowest effective dose of 0.015 mSv^[20]. These studies included a total of 344 patients with ages ranging from newborn to 5 years old (**Table 3**).

These five studies had DLP, CTDIvol, and CED values ranging from 4.65–85.9 mGy-cm, 0.22–5.4 mGy, 0.015–0.77 mSv, and mean values of 32.9 mGy-cm, 1.99 mGy, 0.281 mSv, respectively (**Table 5**)^[17–20,26]. Compared to the DLP, CTDIvol, and CED values from our ‘New’ protocol, our values were slightly higher than the mean values from the five studies, with differences of 3.8% for DLP, 1.97% for CTDIvol, and 12.2% for CED, respectively. Radiation dose reduction corresponds with alteration in CT acquisition parameters. A majority of the studies were performed with a fixed tube current of 10 mA and a tube voltage of 80 kVp, which is commonly the lowest setting available on most CT scanners (**Table 4**).

Table 3. Low-dose CT studies for pediatric CS included in present study.

Source	Year of publication	Journal	Country	Study type	No. of patients	Age (years)
Vazquez JL et al. ^[19]	2013	European Radiology	Spain	Prospective Comparative	80	0–5
Kaasalainen T et al. ^[20]	2015	Pediatric Radiology	Finland	Prospective Comparative	2 ^a	0–5
Ernst CW et al. ^[18]	2015	European Radiology	Belgium	Retrospective Comparative	48	0–3
Barreto IL et al. ^[17]	2021	Pediatric Radiology	U.S.A.	Prospective Comparative	157	0.5–3
Zarei F et al. ^[26]	2021	Iranian Journal of Medical Physics	Iran	Prospective Comparative	57	0–3

^aAnthropomorphic phantoms of pediatric newborn and 5-year-old were utilized.

Table 4. Low-dose CT acquisition parameters for pediatric CS studies.

Source	Detector rows	Detector configuration (mm)	Rotation time (sec)	Tube voltage (kVp)	Tube current (mA)	Pitch factor
Vazquez JL et al. ^[19]	64	40 × 0.625	0.4	80	50-150 ^a	0.984
Kaasalainen T et al. ^[20]	64	64 × 0.625	0.4	80	10	0.9
Ernst CW et al. ^[18]	64	32 × 0.525	0.8	80	10	0.53
Barreto IL et al. ^[17]	80	40 × 0.5	0.5	100	10	0.625
Zarei F et al. ^[26]	8	8 × 1.25	0.8	80	70	1.35

^aTube current modulation used to adjust mA in order to achieve acceptable image quality.

Table 5. Corresponding mean CED, CTDIvol, and DLP for low-dose CT imaging of pediatric CS studies.

Source	CED (mSv)	CTDIvol (mGy)	DLP (mGy-cm)
Vazquez JL et al. ^[19]	0.4	2.3	40
Kaasalainen T et al. ^[20]	0.015	0.22	4.65
Ernst CW et al. ^[18]	0.08	0.94	15.04
Barreto IL et al. ^[17]	0.14	1.1	19.1
Zarei F et al. ^[26]	0.77	5.4	85.9

4. Discussion

Since its development in the early 1970s, computed tomography scanner design advancements and computational processing have reduced the time needed for image acquisition and have resulted in images with progressively better resolution^[28,29]. The very first CT scan took nearly two days of processing at an off-site mainframe computer^[30]. The first-generation of practically sized CT scanners, which utilized a “translate/rotate method” of imaging reduced single-image processing time to only 4.5 min however carried a median effective radiation dose of 2.67 mSv-greater than the average background radiation exposure per person each year^[28,31,32]. Subsequent generations achieved faster processing times with better image quality, but most importantly lowered ionizing radiation exposures.

Eventually, multi-slice or “multi-detector” CT scanners utilized the indefinitely revolving tube concept from previous generations while adding multiple detectors for much faster image acquisition^[31]. When combined with increased tube rotation velocity, the addition of multiple detectors allowed for the creation of detailed images with greater overall coverage in mere fractions of a second. In 2004, with the introduction of the 64-detector scanner, detailed axial images were obtained in approximately 1/3 of a second^[28]. These “modern” CT scanners not only allowed for faster scanning times but the creation of detailed cross-sectional

images with much better resolution, especially of highly dense structures such as bone^[33,34]. Additionally, the amount of ionizing radiation was significantly lower compared to their predecessors. Median effective radiation dose of only 0.93 mSv has been reported from the newest 320-detector scanners, which represents a nearly 66% reduction compared to the doses from first-generation scanners^[32].

Most of our knowledge regarding radiation effects on humans came from nuclear disasters such as atomic bombs used during World War II in Japan and the Chernobyl Reactor explosion in Ukraine. A typical adult can expect to receive an approximate dose of 3.10 mSv of radiation over their lifetime from sources such as the Sun and certain soil types^[35]. It has long been known that the harmful effects of ionizing radiation are enhanced in children both in low doses accumulated over time and large doses accumulated in single exposures^[35]. However the medicinal use of ionizing radiation is quite substantial as 12% of the total human radiation exposure comes from nuclear medicine alone^[36]. Radiation preferentially targets dividing cells, which typically is quite minimal in the brain. However, compared with the fully developed brain of adults, infants' developing and differentiating brain cells suffer far greater from effects of ionizing radiation^[37]. In 2001, Brenner and colleagues estimated the risks of radiation-induced fatal cancer from pediatric CT examinations^[38]. According to their findings, a cumulative absorbed organ dose of 60 mGy (1 mGy = 1 mSv) in pediatric patients tripled the risk of brain cancer^[38]. This risk is further compounded by the fact that the number of diagnostic radiologic examinations have increased almost 10-fold from 1950 to 2006^[39].

Due to this increase in frequency of radiologic studies, exposure to ionizing radiation from medical imaging has significantly increased in the general population, with per-capita annual effective dose from medical procedures rising nearly six-fold from 0.5 mSv in 1980 to 3.0 mSv in 2006 in the United States alone^[39,40]. CT is recognized as the largest contributor to this increase. One recent European cohort study demonstrated an increase in the number of head or neck CT scans in patients less than 22 years old led to increased cumulative brain doses of radiation and increased reported cases of gliomas and other types of brain cancer^[41]. Despite the reported risks, much is still unknown about the lower thresholds of radiation exposure damage. Two things, however, are certain: high radiation exposure (>3000 mSv), particularly in a short amount of time, is widely known to cause harm and possible death, and the susceptibility of children with rapid cell turnover is even greater, and effects may not show themselves for 10–30 years after exposure^[38,40].

Best practice continues to minimize radiation exposure whenever possible. Our recently developed ultra-low dose protocol achieved dose reduction by lowering head CT CED by roughly 94% compared to our previously utilized dose protocol (**Figure 1**). In order to reach the threshold, set by Brenner et al of 60 mSv to the head, a child would need to undergo more than 188 CT scans using the 'New' ultra-low dose protocol. Low-dose CT imaging for pediatric craniosynostosis can be achieved through adjustments to various acquisition parameters, such as tube voltage (kVp), tube current (mA), pitch ratio, and tube rotation time (s) or altering the field of exposure through collimation and protective shielding (**Tables 4 and 5**)^[17–20,26]. These parameters can be adjusted to reduce the radiation dose while still producing high-quality images of the bony calvarium, which is the main focus of imaging in craniosynostosis.

One of the challenges of low-dose CT imaging is an increase in image noise. Advanced image reconstruction techniques, such as model-based iterative reconstruction (MBIR), can be used to improve image quality and resolution while still reducing the patient dose^[18]. MBIR uses forward and backward projections to obtain projection data and images, respectively, and takes into account the optics of the scanner (e.g., focal spot and detector size) to reduce image noise^[42,43]. These techniques can be used to reconstruct low-dose CT images in order to maintain image quality while still reducing the patient dose. It is important to carefully balance all of these factors in order to minimize the patient dose while still producing images that are sufficient for diagnosis and treatment planning.

Our current study is limited by small sample size, and the retrospective nature of the analysis and review.

Although the population was homogenous in their diagnosis of CS, the age difference between a 3-month-old and 2-year-old alters the effective radiation dose as total body surface area is a key variable in the equation. Combining our efforts of lowering effective dose with those of other pediatric institutions, we can see that a new standard of care is emerging.

5. Conclusion

Our study, along with the multiple other institutions providing ultra-low dose head CT for CS patients, demonstrate evidence for diagnostic equipoise while lowering radiation exposure in these children. The utilization of this optimized protocol resulted in a 94% reduction in CED compared to our previous standard protocol. These findings align with similar efforts from other institutions, suggesting the potential for a new standard of care that prioritizes radiation reduction in CT imaging for CS. Children, especially infants, present with much higher susceptibility to the hazardous effects of ionizing radiation. Our study highlights the importance of implementing dose-reducing protocols, such as adjusting acquisition parameters and utilizing advanced image reconstruction techniques in order to minimize radiation risks in pediatric patients. While our study contributes to the growing body of evidence supporting low-dose CT protocols in CS, further research is needed to explore the long-term outcomes and benefits of these protocols. The use of an ultra-low dose CT protocol offers a promising approach to mitigate radiation exposure in pediatric patients with CS. The adoption of such protocols represents an opportunity for broader implementation and should be further investigated to optimize diagnostic imaging while prioritizing patient safety.

Author contributions

Conceptualization, LB and RE; methodology, LB, SL and RE; validation, LB, SL and RE; formal analysis, LB, SL and RE; data curation, LB, SL and CT; writing—original draft preparation, LB, SL and CT; writing—review and editing, LE, SL and RE; supervision, RE.

Conflict of interest

The authors declare no conflict of interest.

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