Radiation Dose to Patients and Clinicians During Fluoroscopically-Guided Biopsy of Peripheral Pulmonary Lesions

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BACKGROUND: Fluoroscopic guidance may be utilized in some bronchoscopic procedures, including ultrasound-guided bronchoscopy for investigation of peripheral pulmonary lesions. Some authors have suggested this procedure may be performed without fluoroscopy, to minimize risks due to radiation exposure. However, the radiation dose has never been quantified, so the risk remains unknown. OBJECTIVE: To determine the patient and clinician radiation exposure from fluoroscopy during bronchoscopy. METHODS: We recorded exposure parameters during 45 consecutive ultrasound bronchoscopies with fluoroscopic guidance with a mobile C-arm fluoroscopy system. We calculated the patient effective radiation dose with Monte Carlo computer simulations. Passive personal film dosimeters were placed on 4 sites on both the proceduralist and the primary nursing assistant. RESULTS: The mean fluoroscopy screening time was 96 ± 55 s. Patients received a median effective radiation dose of 0.49 ± 0.37 milli-Sieverts (mSv) (range 0.16–1.3 mSv). Only the film dosimeters worn outside the clinicians’ protective aprons recorded measurable radiation doses. Based on typical attenuation properties of the protective garments across the diagnostic x-ray energy range, we estimate that the effective radiation dose per procedure to the proceduralist was 0.4 micro-Sieverts (µSv) and to the assistant was 0.2 µSv. CONCLUSIONS: Patients are exposed to relatively small amounts of radiation from fluoroscopy during bronchoscopy. Clinically indicated fluoroscopic guidance during bronchoscopy should not be precluded on the basis of radiation safety concerns. Adequate shielding of clinicians results in negligible radiation doses during ultrasound bronchoscopy. (Australian and New Zealand Clinical Trials Registry ACTRN12607000514404) Key words: bronchoscopy; transbronchial lung biopsy; ultrasound; radiology toxicity; lung cancer; fluoroscopy. [Respir Care 2010;55(11):1469–1474. © 2010 Daedalus Enterprises]

Introduction

Due to changes in the epidemiology of lung cancer, a majority of lung cancers are now located in the lung periphery and therefore are not visible at routine bronchoscopy. The diagnostic yield of transbronchial lung biopsy without guidance in the investigation of peripheral pulmonary lesions is less than 20%. Diagnostic yield may be improved with fluoroscopic guidance to more accurately target the area of interest. Recently, endobronchial ultrasound used in the investigation of peripheral pulmonary lesions has allowed accurate localization of such lesions, resulting in diagnostic accuracy of up to 85%.

Initial reports describing the technique utilized fluoroscopic guidance in addition to ultrasound guidance, though a more recent study suggested that the diagnostic yield of ultrasound bronchoscopy may be unaffected by removal of fluoroscopic guidance. However, that report also noted a reduced yield in the right-lower lobe and attributed it to inadvertent relocation of the guide sheath during the procedure. There is potential for movement of the bronchoscope probe after deployment in any lobe, due to deep respiration or vigorous coughing. Even movement to a bronchiole adjacent to a mass may compromise diagnostic yield.
As radial-probe ultrasound bronchoscopy is not a real-time procedure, we feel that once the lesion has been localized with endobronchial ultrasound, optimal performance of the biopsy is achieved with fluoroscopic guidance, as it allows confirmation that the guide sheath remains in its original position and that the biopsy forceps are passed the correct distance into the lung periphery. This ensures a high diagnostic yield and reduces the likelihood of advancing the biopsy forceps too far, which may result in pneumothorax. The benefit of using ionizing radiation in medical imaging should always outweigh the risks of the radiation exposure. The radiation exposure from fluoroscopic guidance during bronchoscopy has never been quantified.

In order to quantify the radiation exposure and, therefore, the risk associated with fluoroscopic guidance during ultrasound bronchoscopy, we measured the radiation exposure to the patient, bronchoscopist, and bronchoscopy assistant in consecutive ultrasound bronchoscopies with fluoroscopic guidance.

**Methods**

Our institutional ethics committee approved the study. We studied 45 ultrasound/fluoroscopy bronchoscopies conducted for the investigation of peripheral pulmonary lesions, from July 1, 2007, to January 31, 2008. All patients with pulmonary lesions not endobronchially visible were investigated with both radial-probe endobronchial ultrasound and fluoroscopic guidance. The procedures were performed as previously described, by one physician (DPS).

**Measurement of Patient Dose**

Fluoroscopic guidance was performed with a C-arm mobile fluoroscopy system (GE/OEC 9600, General Electric Healthcare, New York, New York). In all the bronchoscopies the mobile image intensifier was positioned with the x-ray tube underneath the patient, which is a standard procedure to minimize radiation to the clinicians. To estimate the effective radiation received by the patient, we recorded the geometry, anatomical area screened, x-ray beam dimensions, peak kilovoltage (kVp), milli-Amperes (mA), and fluoroscopy screening time from the fluoroscopy x-ray equipment at the completion of the procedure. Machine parameters such as fluoroscopic radiation dose rate and kVp were measured with a radiation analyzer (9095 analyzer and 90X5-6 ion chamber, Radcal, Monrovia, California). The equipment’s half-value layer was also estimated from these measurements. Using those measured parameters and the Monte Carlo software developed by Tapiovaara, the effective dose received by each patient was estimated.

**Measurement of Clinician Dose**

Radiation to the clinicians was measured with passive personal film dosimeters (National Radiation Laboratory, Christchurch, New Zealand), which can record photon energies of 15–180 kilo-electronvolts (keV) and have a minimum reportable dose (threshold) of 50 micro-Sieverts (μSv). Four film dosimeters were placed identically on the bronchoscopist and the assistant in the following positions: one overlying the thyroid shield; one over the sternum outside the protective apron; one over the sternum beneath the protective apron; and one posteriorly at waist level, outside the protective apron. The film dosimeters (including control) were assessed at 3-month intervals.

**Ultrasound Bronchoscopy Procedure**

All procedures were performed with the patient under conscious sedation, as previously described, with the patient in the supine position on a radio-transparent trolley. Fluoroscopic guidance was with a C-arm mobile fluoroscopy system, with a tube potential of 60–80 kVp, depending on the size of the patient. The fluoroscopy screening parameters (kVp, mA, and area screened) were optimized at the beginning of each bronchoscopy, and not altered during the procedure. Fluoroscopic screening was predominantly used to check that the guide sheath had not moved after the lesion had been localized with endobronchial ultrasound, and to visualize the forceps while specimens were obtained. Transbronchial lung biopsies and cytology brushings were performed in all cases.

The bronchoscopist was positioned at the head of the trolley and remained in that position throughout the procedure. The assistant usually stood next to the bronchoscopist, but moved away for brief periods to retrieve equipment or handle collected specimens, although this rarely occurred during fluoroscopy. All the clinicians in the procedure room wore lightweight “non-lead” composite aprons that cover both front and back. The apron’s lead equivalence is 0.35 mm across the diagnostic x-ray energy range.

**Results**

Data were recorded during 45 consecutive bronchoscopies for suspected lung cancer. The mean lesion size was 3.1 ± 1.1 cm. The mean fluoroscopic exposure time was 96 ± 55 s.

The bronchoscopy was diagnostic in 36 patients (80%). Table 1 lists the diagnoses. Two patients demonstrated resolution of radiologic abnormality on subsequent imaging, confirming the benign nature of the pulmonary lesion. Of the remaining 4 patients, two had non-small-cell lung cancer demonstrated on subsequent procedures, and two are undergoing radiologic surveillance of pulmonary le-
sions. One patient experienced transient hypoxia following the procedure, which resolved with supportive care only. He was discharged home the same day. No other complications occurred.

### Radiation Exposure to Patients

Sufficient data were recorded to allow calculation of effective radiation dose for 37 of the patients. The mean effective dose was 0.49 ± 0.37 milli-Sieverts (mSv) (range 0.02–1.3 mSv). There were substantial differences in the patients’ calculated effective doses, as seen in Table 2, which shows quartile values for screening time and effective dose.

Table 3 shows radiation exposures from common sources of ionizing radiation, for comparison to our findings.13-19

### Radiation Exposure to Clinicians

We assessed clinician radiation exposure during two 3-month intervals, with 21 and 24 procedures performed in the first and second periods, respectively. Table 4 shows the radiation doses recorded by the film dosimeters. The only film-dosimeter position that recorded a radiation dose above these dosimeter’s minimum threshold was the sternum position outside the protective apron.

### Discussion

To our knowledge, this is the first study to describe radiation exposure to patients and clinicians during fluoroscopy-guided bronchoscopy. Our study demonstrates that patients are not exposed to substantial radiation during fluoroscopy-guided bronchoscopy. The mean and median effective doses, which were < 0.5 mSv, are equivalent to approximately 10 chest radiographs,13 and compare favorably to CT-guided lung biopsy, where the effective patient dose is 6 mSv,17 and CT-fluoroscopy for transbronchial lung biopsy, with a mean thoracic-organ dose of 380 mSv.20 It is much lower than the 5 mSv from low-dose chest CT, and substantially less than that in other fluoroscopy-guided medical procedures such as endoscopic retrograde cholangiopancreatography (6 mSv),21,22 vertebroplasty (10 mSv),22 and coronary angioplasty (11–17 mSv).18

The variation in patient effective dose appears to be due to differences in patient size and in the complexity of the individual procedures. Wide variation in effective dose has been noted for both routine chest radiograph13 and fluoroscopy-guided interventional cardiac procedures,23 mainly due to differences in patient size. However, the additional variable of screening time, which is linearly related to effective dose, is most responsible for the wider variation in effective dose among our patients. Such variation has been noted in previous studies of fluoroscopy-guided procedures such as endoscopic retrograde cholangiopancreatography21 and fluoroscopy-guided orthopedic procedures.24

Importantly, as well as minimizing patient radiation exposure, our results are consistent with previous reports that confirm ultrasound bronchoscopy to be a very safe procedure.7,8 This is in contrast to percutaneous lung biopsy, which has a diagnostic yield comparable to that of ultrasound bronchoscopy25,26 but is associated with a pneumothorax rate from 25%25,26 to over 40%.27

Deterministic adverse effects of radiation exposure from fluoroscopy, such as radiation-induced dermatitis or burns,28 have been reported but are of much less concern in bronchoscopic procedures that use mobile image inten-
Table 4. Effective Radiation Doses to Clinicians From Fluoroscopy During Bronchoscopy

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<td>Sternum, outside apron</td>
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Additional information for Table 4:

- Our recorded effective doses to clinicians compare favorably to other fluoroscopy-guided medical procedures. CT-guided biopsy results in a proceduralist effective dose of up to 28 µSv per procedure. Effective doses of up to 38 µSv per procedure have been reported for diagnostic cardiac catheterization, and up to 166 µSv per procedure for percutaneous coronary intervention. Interventional cardiologists receive a maximum annual dose of 2.8 mSv, despite optimal shielding. To achieve a similar (albeit safe) annual dose would require the performance of over 5,000 fluoroscopy-guided bronchoscopies, which is well beyond even the most prolific bronchoscopist.

- Atomic bomb survivors do not provide useful comparison of risk in subjects exposed to much lower radiation doses over prolonged periods. Recovery from radiation-induced injury is much more effective following low-dose exposure and with a low dose rate. Cohorts exposed to occupational radiation are therefore more representative of the risks to bronchoscopists using fluoroscopy.

- Airline cabin crews have radiation exposure above the background radiation level, due to ionizing cosmic radiation. Examination of 19,184 commercial airline pilots with mean annual doses of 2–5 mSv in excess of the background radiation level, and cumulative lifetime doses not exceeding 80 mSv, found no increase in all-cause or all-cancer mortality. Nuclear industry workers have no increased incidence of malignancy, even following cumulative exposures of ≤ 200 mSv. McGeoghegan et al recently reported on a cohort of 64,937 nuclear industry workers; subjects exposed to < 10 mSv had no adverse health effects at all.

- Fluoroscopic procedures are by far the largest source of occupational exposure in medicine, but reports of deterministic injuries from such exposure are rare. Vano et al reported a case series of ophthalmologically confirmed lens injuries in interventional radiologists who received estimated lens doses of 450–900 mSv per year, over several years, which is vastly in excess of the magnitude of radiation to which interventional bronchoscopists are exposed. The probability of stochastic risks is dependent on radiation dose. Lifetime risk of fatal cancer for bronchoscopists, based on the work of Goodenough, is of the magnitude of 1×10^{-7} per procedure. The literature, there-
fore, clearly supports the assertion that fluoroscopic bronchoscopy should not be associated with any adverse outcomes.

**Limitations**

Effective patient and clinician doses differ considerably, according to fluoroscopy screening time, which is determined by the number of diagnostic specimens taken and the proficiency of the bronchoscopist.99 Our results will not be identical to those for other bronchoscopists utilizing fluoroscopy, because the fluoroscopy parameters (most notably, screening time) will differ between proceduralists and institutions. In addition, the measurement of such low doses is subject to substantial uncertainty. However, the magnitude of radiation exposure is very likely to be reproducible, so, given the very small amount of radiation, we feel our findings of safe radiation exposure levels is generalizable to all bronchoscopists.

The use of ultrasound guidance, in addition to increasing the diagnostic accuracy of bronchoscopic biopsy, is likely to reduce radiation exposure by decreasing the time required to confidently locate the lesion. This is valuable in minimizing radiation exposure, and additional measures can further reduce patient dose, such as maximizing the distance between the x-ray tube and the patient, minimizing the distance between the patient and the image intensifier, coning the x-ray beam to the region of interest, minimizing the use of electronic magnification, lowering fluoroscopy frame rates, and more judicious use of screening.99 The International Commission on Radiological Protection notes that the principal aim with regard to medical radiation exposure is to do more good than harm to the patient.51 In the setting of almost certainly very low patient radiation exposure, we feel there is no rationale to preclude patients from undergoing a single bronchoscopy with fluoroscopy on the basis of safety concerns.

**Conclusions**

Adequate shielding of the proceduralist’s front, back, and thyroid with protective garments with a minimum lead equivalence of 0.35 mm across the diagnostic energy range results in negligible radiation to the bronchoscopist from mobile C-arm fluoroscopic guidance.

The effective radiation doses we measured are much smaller than those previously associated with no adverse health outcomes. Concern regarding radiation exposure should not preclude the use of fluoroscopic guidance in the performance of diagnostic bronchoscopy if it is clinically indicated.

**REFERENCES**


