



## Complete Summary

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### GUIDELINE TITLE

Stress/insufficiency fracture, including sacrum, excluding other vertebrae.

### BIBLIOGRAPHIC SOURCE(S)

Manaster BJ, Grossman JW, Dalinka MK, Daffner RH, DeSmet AA, El-Khoury GY, Kneeland JB, Morrison WB, Pavlov H, Rubin DA, Schneider R, Steinbach LS, Weissman BN, Haralson RH III, Expert Panel on Musculoskeletal Imaging. Stress/insufficiency fracture, including sacrum, excluding other vertebrae. [online publication]. Reston (VA): American College of Radiology (ACR); 2005. 7 p. [38 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Manaster BJ, Dalinka MK, Alazraki N, Berquist TH, Daffner RH, DeSmet AA, el-Khoury GY, Goergen TG, Keats TE, Newberg A, Pavlov H, Haralson RH, McCabe JB, Sartoris D. Stress/insufficiency fractures (excluding vertebral). American College of Radiology. ACR Appropriateness Criteria. Radiology 2000 Jun;215(Suppl):265-72.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

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## SCOPE

### DISEASE/CONDITION(S)

Stress/insufficiency fractures including sacrum, excluding other vertebrae

**GUIDELINE CATEGORY**

Diagnosis

**CLINICAL SPECIALTY**

Emergency Medicine  
Family Practice  
Geriatrics  
Nuclear Medicine  
Orthopedic Surgery  
Radiology  
Sports Medicine

**INTENDED USERS**

Health Plans  
Hospitals  
Managed Care Organizations  
Physicians  
Utilization Management

**GUIDELINE OBJECTIVE(S)**

To evaluate the appropriateness of initial radiologic examinations for stress/insufficiency fractures including sacrum, excluding other vertebrae

**TARGET POPULATION**

Patients with stress/insufficiency fractures including sacrum, excluding other vertebrae

**INTERVENTIONS AND PRACTICES CONSIDERED**

1. X-ray
2. Computed tomography (CT)
3. Magnetic resonance imaging (MRI)
4. Nuclear medicine (NUC), bone scan, 3-phase

**MAJOR OUTCOMES CONSIDERED**

Utility of radiologic examinations in differential diagnosis

**METHODOLOGY**

**METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

## **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The guideline developer performed literature searches of peer-reviewed medical journals, and the major applicable articles were identified and collected.

## **NUMBER OF SOURCE DOCUMENTS**

The total number of source documents identified as the result of the literature search is not known.

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Not Given)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not stated

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review with Evidence Tables

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

One or two topic leaders within a panel assume the responsibility of developing an evidence table for each clinical condition, based on analysis of the current literature. These tables serve as a basis for developing a narrative specific to each clinical condition.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus (Delphi)

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Since data available from existing scientific studies are usually insufficient for meta-analysis, broad-based consensus techniques are needed to reach agreement in the formulation of the appropriateness criteria. The American College of Radiology (ACR) Appropriateness Criteria panels use a modified Delphi technique to arrive at consensus. Serial surveys are conducted by distributing questionnaires to consolidate expert opinions within each panel. These questionnaires are distributed to the participants along with the evidence table and narrative as developed by the topic leader(s). Questionnaires are completed by the participants in their own professional setting without influence of the other members. Voting is conducted using a scoring system from 1 to 9, indicating the least to the most appropriate imaging examination or therapeutic procedure. The survey results are collected, tabulated in anonymous fashion, and redistributed after each round. A maximum of three rounds is conducted and opinions are unified to the highest degree possible. Eighty multiple-image plane percent

agreement is considered a consensus. This modified Delphi technique enables individual, unbiased expression, is economical, easy to understand, and relatively simple to conduct.

If consensus cannot be reached by the Delphi technique, the panel is convened and group consensus techniques are utilized. The strengths and weaknesses of each test or procedure are discussed and consensus reached whenever possible. If "No consensus" appears in the rating column, reasons for this decision are added to the comment sections.

### **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

### **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

### **METHOD OF GUIDELINE VALIDATION**

Internal Peer Review

### **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Criteria developed by the Expert Panels are reviewed by the American College of Radiology (ACR) Committee on Appropriateness Criteria.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

#### **ACR Appropriateness Criteria®**

**Clinical Condition: Stress/Insufficiency Fracture, Including Sacrum, Excluding Other Vertebrae**

**Variant 1: Suspect stress/insufficiency fracture. First imaging modality.**

| <b>Radiologic Exam Procedure</b> | <b>Appropriateness Rating</b> | <b>Comments</b>  |
|----------------------------------|-------------------------------|--|
| X-ray                            | 9                             | Radiograph is a required first step before consideration of other imaging. |
| CT                               | 1                             |  |
| MRI                              | 1                             |  |
| NUC, bone scan, 3-               | 1                             |  |

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b> |
|---|-------------------------------|-----------------|
| phase   |                               |                 |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |                 |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 2: Suspect stress fracture in patient with need to know diagnosis, not hip or sacrum. Radiographs normal.**

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| X-ray, repeat in 14 days  | 9                             | Many patients will recover in the interim and not return.   |
| MRI   | 9                             | In this clinical situation, many clinicians would wait until repeat radiograph was negative before going to MR; with an anxious patient or clinician, or repeated negative radiograph, MR is the favored next imaging modality. |
| NUC, bone scan, 3-phase   | 1                             | If the patient or clinician is too anxious to wait for repeat radiographs, could do MR <u>or</u> bone scan (but not both); panel prefers MR since it is usually more specific than bone scan.                                   |
| CT  | 1                             | Not indicated.  |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 3: Suspect stress fracture, not hip or sacrum. Radiographs normal. Bone scan positive and nonspecific.**

| <b>Radiologic Exam Procedure</b> | <b>Appropriateness Rating</b> | <b>Comments</b>                               |
|----------------------------------|-------------------------------|---|
| X-ray, repeat in 10 to 14 days   | 7                             | For confirmation or question of complication. |

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| MRI   | 7                             | Depends on history and if there is an immediate need to know. |
| CT  | 1                             |   |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variant 4: Suspect stress fracture in otherwise normal patient. Radiographs and bone scan or MRI normal.**

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| MRI   | 2                             | Not indicated if radiographs and MRI were normal; but if the studies were radiographs and bone scan that were normal and there is persistent pain, the clinician might re-examine the diagnosis and consider MRI, looking for soft tissue injury. |
| X-ray, repeat in 10 to 14 days  | 1                             | Not necessary. No further imaging is warranted.   |
| CT  | 1                             |   |
| NUC, repeat bone scan, 3-phase  | 1                             |   |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variant 5: Clinical differential fracture versus metastasis in long bone. Radiographs normal, bone scan hot but nonspecific.**

| <b>Radiologic Exam Procedure</b> | <b>Appropriateness Rating</b> | <b>Comments</b> |
|----------------------------------|-------------------------------|-----------------|
| MRI                              | 9                             |                 |

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>  |
|---|-------------------------------|--|
| X-ray, repeat in 10 to 14 days.   | 1                             | Too anxiety producing. An occult metastasis is unlikely to appear on radiographs in this period. |
| CT  | 1                             |  |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |  |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 6: Clinical differential insufficiency fracture versus metastasis in sacrum. Radiographs normal, bone scan hot but nonspecific.**

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| CT  | 8                             | First choice. Definitive for diagnosis of fracture.               |
| MRI   | 6                             | Alternative choice may show other cause for pain or the fracture. |
| X-ray, repeat in 10 to 14 days  | 1                             |   |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 7: Suspect insufficiency fracture in sacrum/pelvis; elderly patient. Radiographs normal. Bone scan hot in linear pattern typical for fracture.**

| <b>Radiologic Exam Procedure</b> | <b>Appropriateness Rating</b> | <b>Comments</b>  |
|----------------------------------|-------------------------------|--|
| CT                               | 2                             | As long as it is unequivocal on bone scan, CT not needed- otherwise, go to axial CT. |
| X-ray, repeat in 10 to 14 days   | 1                             |  |

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b> |
|---|-------------------------------|-----------------|
| MRI   | 1                             |                 |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |                 |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 8: Suspect insufficiency fracture in osteoporotic patient or patient on long-term steroid therapy, not hip. Radiographs normal.**

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| X-ray, repeat in 10 to 14 days  | 9                             | Panel agrees one of the three exams should be done (X-ray; NUC, bone scan, 3-phase; or MRI). The clinical condition and location will dictate which. If the diagnosis is not urgent, repeat radiographs may be all that is necessary. If there is greater urgency, the panel favors MRI over bone scan because bone scans can be falsely negative in this patient population. |
| MRI   | 9                             | Same comment as above.  |
| NUC, bone scan, 3-phase   | 9                             | Same comment as above.  |
| CT  | 1                             |   |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**Variation 9: Suspect insufficiency fracture in osteoporotic patient or patient on long-term steroid therapy; not hip. Radiographs and bone scan (3-phase) normal at 48 hours.**

| <b>Radiologic Exam Procedure</b> | <b>Appropriateness Rating</b> | <b>Comments</b>                   |
|----------------------------------|-------------------------------|-----------------------------------|
| X-ray, repeat in 10 to           | 9                             | If diagnosis is nonurgent, repeat |

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>   |
|---|-------------------------------|---|
| 14 days   |                               | radiographs -- otherwise go to MRI. Bone scan may be falsely negative in this patient population. |
| MRI   | 9                             | Same comment as above.  |
| CT  | 1                             |   |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |   |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

**VARIANT 10: Suspect subacute insufficiency fracture of hip in osteoporotic patient or patient on steroid therapy. Radiographs normal.**

| <b>Radiologic Exam Procedure</b>  | <b>Appropriateness Rating</b> | <b>Comments</b>  |
|---|-------------------------------|--|
| MRI   | 9                             | A limited MRI exam may yield the diagnosis, may need to proceed to full MRI (no IV contrast needed). |
| NUC, bone scan, 3-phase   | 1                             | Indicated if MR cannot be performed.   |
| X-ray, repeat in 10 to 14 days  | 1                             |  |
| CT  | 1                             |  |
| <b><i>Appropriateness Criteria Scale</i></b><br><b>1 2 3 4 5 6 7 8 9</b><br><b>1 = Least appropriate 9 = Most appropriate</b> |                               |  |

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Although many stress/insufficiency fractures are self-limited because they heal with or without diagnosis, there is usually value to making the diagnosis. With continued activity, some stress fractures will progress to completion and require more invasive treatment or prolonged delay in return to activity. Also the differential diagnosis of stress/insufficiency fractures includes entities that would be treated significantly differently than stress fractures (osteoid osteoma or osteomyelitis in the younger patient, metastases in the older patient).

The clinical setting is often highly suggestive of the diagnosis of stress or insufficiency fractures. Such clinical settings include repetitive or new athletic activity for stress fractures, osteoporosis, radiated bone, or resumption of activity post-arthroplasty for insufficiency fractures. Specific athletic activities often result in specific sites of stress fracture. Insufficiency fractures also occur at fairly predictable sites. Thus, radiographic diagnosis using such pattern and site recognition is usually quite specific. Late radiographic findings may be quite typical in appearance as well: linear sclerosis, often perpendicular to the major trabecular lines. However, early radiographic findings are less specific (subtle periosteal reaction; "gray cortex sign") or even nonexistent. Radiographs in stress/insufficiency fractures may be negative initially in 60 to 82% and remain negative in 46 to 60%, depending on different specifications of bone scan gold standards. Additionally, radiographs are more likely to be negative initially in older or osteoporotic patients, insufficiency fractures, and the sooner that the patient is imaged after the symptoms begin. Additionally, radiographs may remain negative depending on the timing of re-imaging, the patient's metabolic bone status, and the type and location of the fracture. Thus, radiographs are specific but significantly insensitive. All references agree that radiographs should be the initial imaging modality; if the findings are conclusive, no further imaging need be performed.

Bone scans have long been accepted as extremely sensitive for detecting stress/insufficiency fractures, especially if single photon emission computed tomography (SPECT) is used. The objection to the studies quoting high accuracy for bone scan is that, in each, a positive bone scan is taken as the gold standard for detecting stress fractures and therefore sensitivity is 100%. However, depending on the staging criteria for bone scan pattern, the abnormalities may in fact be stress reactions rather than actual stress fractures. Nonetheless, it is clear that bone scans show stress fractures days to weeks earlier than radiographs in many instances, and differentiate between osseous and soft tissue injury as well. In some cases, the pattern of fracture is such that the diagnosis is secure, and no further imaging is required (for example, the H sign of sacral insufficiency fractures). However, in most cases bone scans lack specificity (with synovitis, arthritis, degenerative joint disease, stress reactions, and tumor appearing similar) and supplemental imaging may be necessary for conclusive diagnosis or to avoid false positives.

Because of the sensitivity of bone scan, 80% of all fractures show bone scan abnormality 24 hours post injury and 95% at 72 hours. A normal bone scan generally excludes the diagnosis of stress/insufficiency fracture, and the patient may return to normal activity. However, there are exceptions. Elderly or osteoporotic patients may have a delay in bone scan activity that may last several days. Patients using steroids may also have less sensitive bone scan results.

Because of the (often) nonspecificity of bone scan, the length of time necessary for the examination, and the frequency with which supplemental imaging is required, there is a growing body of literature suggesting that cross sectional imaging should supersede bone scan as the imaging of choice for stress fracture when the radiograph is negative. There are specific sites for which CT is particularly well-suited.

However, axial CT alone may have false negatives due to the constraint of the axial plane (in one study, half of stress fractures were adequately demonstrated on CT. Therefore, if CT is used to confirm stress fracture in a long bone, reformatting is necessary.

MRI is extremely sensitive and appears to demonstrate stress abnormalities as early as bone scan and with as much sensitivity. Short tau inversion recovery (STIR) sequences are emerging as the favored initial sequence for MRI screening. With a small field of view (FOV), STIR and/or T1 imaging will usually demonstrate a fracture line, surrounded by edema. In the absence of an actual stress fracture, stress reaction or muscle/tendon injuries are identified in the STIR sequence. Thus, a careful MRI may be as sensitive as a bone scan, but also considerably more specific. One study suggests that MRI exam of an osseous stress injury may contain prognostic as well as diagnostic information, with demonstration of an actual fracture line or cortical signal portending a longer healing time required.

The critical time for MRI becoming positive has not yet been established, although it seems that the edema pattern would be present within hours of the injury.

The choice of cross sectional imaging modality is not always clear cut. Some studies demonstrate that the MRI pattern is nonspecific and even confusing when only edema and not the fracture line is shown. This problem seems particularly severe in differentiating sacral or pelvic insufficiency fractures from metastases. Over reliance on nonspecific low-signal T1 and high-signal T2 MRI patterns leads to misdiagnosis of stress fractures as more aggressive lesions. In these cases, CT may be necessary to add specificity to the diagnosis.

MRI may, however, also demonstrate other reasons for occult pelvic pain, such as soft tissue abnormality or the supra-acetabular stress fractures recently described in some osteoporotic patients. Conversely, it is recommended that MRI for hip fractures also include the sacrum since stress fractures of the sacrum appear to be associated with stress-related hip pain in young adult patients.

MRI of long bones often shows the fracture line itself; in this case, MRI becomes not only sensitive but quite specific (fracture line seen in 11/14 stress fractures, 7/9 hip fractures, and 13/13 true positive hip fractures. The site where this phenomenon has been evaluated most completely is the hip, which may yield false negatives early on both radiographs and bone scan of the osteoporotic patient. A single T1 coronal MRI sequence yielded 100% accuracy in studies of 23 and 20 hips (8 and 13, respectively). Some experts recommend that a single T1 MRI sequence in the plane of interest be performed and initially evaluated when stress fracture is suspected. If a fracture line is clearly seen, the examination may be terminated. If the question persists after the single sequence, other MRI sequences may be used for more complete examination (e.g., STIR or FST2 sequences for even more sensitive evaluation of marrow edema, or nearby soft tissue injury). Intravenous contrast should not be required. In a younger patient population (e.g., military recruits), STIR imaging was found to have a higher accuracy than T1 imaging and may be chosen as the initial MRI sequence.

Another circumstance that deserves specific attention is the longitudinal stress fracture. Longitudinal stress fractures of the tibia have been emphasized in the literature recently. Up to 25% may appear normal on radiographs, but CT or MRI

findings are characteristic. MRI is very sensitive to the bone marrow edema accompanying these longitudinal fractures, and may give a misleadingly aggressive appearance. Ultrasound has not been shown to be useful in diagnosing longitudinal stress fractures.

### **Abbreviations**

- CT, computed tomography
- MRI, magnetic resonance imaging
- NUC, nuclear medicine

### **CLINICAL ALGORITHM(S)**

Algorithms were not developed from criteria guidelines.

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The recommendations are based on analysis of the current literature and expert panel consensus.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Selection of appropriate radiologic imaging procedures to evaluate possible stress/insufficiency fractures

### **POTENTIAL HARMS**

Nuclear medicine (NUC) bone scans may render false negative results in osteoporotic patients or patients on long-term steroid therapy.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

An American College of Radiology (ACR) Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists, and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those exams generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate

imaging procedures or treatments. Imaging techniques classified as investigational by the U.S. Food and Drug Administration (FDA) have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

### IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Manaster BJ, Grossman JW, Dalinka MK, Daffner RH, DeSmet AA, El-Khoury GY, Kneeland JB, Morrison WB, Pavlov H, Rubin DA, Schneider R, Steinbach LS, Weissman BN, Haralson RH III, Expert Panel on Musculoskeletal Imaging. Stress/insufficiency fracture, including sacrum, excluding other vertebrae. [online publication]. Reston (VA): American College of Radiology (ACR); 2005. 7 p. [38 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1995 (revised 2005)

### **GUIDELINE DEVELOPER(S)**

American College of Radiology - Medical Specialty Society

### **SOURCE(S) OF FUNDING**

The American College of Radiology (ACR) provided the funding and the resources for these ACR Appropriateness Criteria®.

### **GUIDELINE COMMITTEE**

Committee on Appropriateness Criteria, Expert Panel on Musculoskeletal Imaging

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Panel Members:* B.J. Manaster, MD, PhD; Jeffery W. Grossman, MD; Murray K. Dalinka, MD; Richard H. Daffner, MD; Arthur A. De Smet, MD; George Y. El-Khoury, MD; John B. Kneeland, MD; William B. Morrison, MD; Helene Pavlov, MD; David A. Rubin, MD; Robert Schneider, MD; Lynne S. Steinbach, MD; Barbara N. Weissman, MD; Robert H. Haralson III, MD

### **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

### **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Manaster BJ, Dalinka MK, Alazraki N, Berquist TH, Daffner RH, DeSmet AA, el-Khoury GY, Goergen TG, Keats TE, Newberg A, Pavlov H, Haralson RH, McCabe JB, Sartoris D. Stress/insufficiency fractures (excluding vertebral). American College of Radiology. ACR Appropriateness Criteria. Radiology 2000 Jun;215(Suppl):265-72.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

### **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [American College of Radiology \(ACR\) Web site](#).

ACR Appropriateness Criteria® *Anytime, Anywhere*™ (PDA application). Available from the [ACR Web site](#).

Print copies: Available from the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191. Telephone: (703) 648-8900.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- ACR Appropriateness Criteria®. Background and development. Reston (VA): American College of Radiology; 2 p. Electronic copies: Available in Portable Document Format (PDF) from the [American College of Radiology \(ACR\) Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This summary was completed by ECRI on May 6, 2001. The information was verified by the guideline developer as of June 29, 2001. This summary was updated by ECRI on March 28, 2006.

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Date Modified: 9/29/2008

