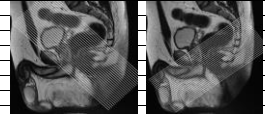


Radiology of Indiana

Protocols	Scan #	FOV (CM)	Slice Thickness (mm)	Spacing (mm)	Special Instructions/Comments
Abdomen					Any abdomen study without an organ specific indication. Otherwise, see organ specific protocol.
Ax Fiesta/ True FISP		-30-40	5	1	
Ax 3D Dual Echo		-30-40	5	2.5	
Ax T2 SSFSE/HASTE		-30-40	5	1	
Cor T2 SSFSE/HASTE		-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS		-30-40	5	1	
Ax DWI (50/1000)		-30-40	8	2	Only send B50 and 1000
ADC		-30-40	8	2	
Ax Pre (Lava or sim)		-30-40	5	2.5	If there is a "mask" phase you don't need to complete pre-contrast LAVA. If not, we need a separate pre-contrast LAVA.
Ax Post Dyn (20 sec, 1 min 3 min)		-30-40	5	2.5	
Cor Post 5 min		-30-40	4	2	
Ax Post 10 min		-30-40	5	2.5	
Ax T1 Lava 20 min (Eovist only)		-30-40	5	2.5	FYI: All Vibes/Lavas should be Fat Sat or "water only" images for all MRI body protocols
Adrenal					
Ax Fiesta/ True FISP		-30-40	5	1	
Ax 3D Dual Echo		-30-40	5	2.5	
Coronal 3D Dual Echo		-30-40	5	2.5	
Ax T2 SSFSE/HASTE		-30-41	5	1	
Cor T2 SSFSE/HASTE		-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS		-30-40	5	1	
Ax DWI (50/1000)		-30-40	8	2	Only send B50 and 1000
ADC		-30-40	8	2	
Ax Lava or similar		-30-40	5	2.5	
Liver					
Ax Fiesta/ True FISP		-30-40	5	1	Please refer to Liver & Abdominal MRI Clinical Guidelines for Gadolinium Based Contrast Agents
Ax 3D Dual Echo		-30-40	5	2.5	For dedicated liver indication, axial coverage can be from lung bases to below liver. Does not need to cover below kidneys
Ax T2 SSFSE/HASTE		-30-41	5	1	
Cor T2 SSFSE/HASTE		-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS		-30-40	5	1	
Ax DWI (50/1000)		-30-40	8	2	Only send B50 and 1000
ADC		-30-40	8	2	
Ax Pre (Lava or sim)		-30-40	5	2.5	
Ax Post Dyn (20 sec, 1 min 3 min)		-30-40	5	2.5	
Cor Post 5 min		-30-40	4	2	
Ax Post 10 min		-30-40	5	2.5	
Ax T1 Lava 20 min (Eovist only)		-30-40	5	2.5	
Pancreas with MRCP					Pancreatic protocol must include MRCP in order
Ax Fiesta/ True FISP		-30-40	3	1	F/U IPMN, pancreatic cyst, chronic pancreatitis, pancreatic mass.
Ax 3D Dual Echo		-30-40	4	2	For dedicated pancreas indication, axial coverage can be from bottom of heart/left hemidiaphragm to below C-loop of duodenum. Plan from coronal localizer. Coronal images must cover pancreas from front to back using axial images for planning. Do not need to cover skin to skin on coronal. Smallest FOV as possible.
Ax T2 SSFSE/HASTE		-30-41	5	1	
Cor T2 SSFSE/HASTE		-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS		-30-40	4	1	
Ax DWI (50/1000)		-30-40	7	1	Only send B50 and 1000
3D MRCP		-30-40	40	0	3 Oblique views. See planning images
Cor 3D MRCP		-30-40	1.4	0.7	Focus on pancreatic duct
3D MIP		-30-40			Single thick slab from 3D images
ADC		-30-40	7	1	
Ax Pre (Lava or sim)		-30-40	3	1	
Ax Post Dynamic (45 sec, 80 sec, 3 min)		-30-40	4	1.5	
Cor Post 5 min		-30-40	4	2	
Ax Post 10 min		-30-40	3	1	
Renal					
Ax Fiesta/ True FISP		-30-40	4	1	For dedicated renal indication (usually renal mass), axials must cover from above adrenal glands to below kidneys. Plan from localizer. Does not need to cover entire abdomen. Coronal images must cover both kidneys from front to back using axial images for planning. Do not need to cover skin to skin.
Ax 3D Dual Echo		-30-40	6	1.5	
Ax T2 SSFSE/HASTE		-30-41	5	1	
Cor T2 SSFSE/HASTE		-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS		-30-40	4	1	
Ax DWI (50/1000)		-30-40	7	1	Only send B50 and 1000
ADC		-30-40	7	1	
Ax Pre (Lava or sim)		-30-40	3	1	
Cor Pre (Lava or sim)		-30-40	3	1	
Ax Post Dyn (20 sec, 60 sec, 90 sec)		-30-40	3	1	
Cor Post 3 min		-30-40	3	1	
Ax Post (acquired after Cor Post 3 min)		-30-40	3	1	
Post process subtraction					Cor post minus pre; Ax post minus pre

Liver with MRCP				
Ax Fiesta/True FISP	-30-40	5	1	Any MRCP study without a pancreas specific indication (otherwise use Pancreas with MRCP protocol). Must cover entire liver axial and coronal. Does not need to include entire kidney on axial unless needed to cover liver. Does not need skin to skin coverage on coronal.
Ax 3D Dual Echo	-30-40	5	2.5	
Ax T2 SSFSE/HASTE	-30-41	5	1	
Cor T2 SSFSE/HASTE	-30-40	4	1	
Ax T2 FS Propeller/T2 Haste FS	-30-40	5	1	
Ax DWI (50/1000)	-30-40	8	2	Only send B50 and 1000
ADC	-30-40	7	1	
2D MRCP	-30-40	40	0	3 Oblique views. See planning images
Cor 3D MRCP	-30-40	1.4	0.7	
3D MIP	-30-40			Single thick slab from 3D images
Ax Pre (Lava or sim)	-30-40	5	2.5	
Ax Post Dyn (20 sec, 1 min 3 min)	-30-40	5	2.5	
Cor Post 5 min	-30-40	4	2	
Ax Post 10 min	-30-40	5	2.5	
Ax T1 Lava 20 min (Eovist only)	-30-40	5	2.5	
Appendicitis (Order as MR Abd and Pelvis)				
Sag SSFSE	42	4	1	
Cor 2D Fiesta	42	4	1	
Cor SSFSE	42	4	1	
Cor SSFSE FS	42	4	1	
Ax Fiesta	40	5	1	
Ax SSFSE	40	5	1	
Ax SSFSE FS	40	5	1	
Ax T1 Lava	40	6	3	
Ax DWI (800 to 1000)	40	8	2	
Enterography - Order as MR Abdomen and Pelvis				
Cor Fiesta Cine	32	8	0	* Coverage for all sequences to include stomach (as much stomach as possible) to perineum (through anus); axial images may need to be split into 2 stacks for appropriate coverage
(Give .5 mg Glucagon)				* Glucagon contraindications: Allergy to glucagon or history of pheochromocytoma, insulinoma, or glucagonoma.
Cor SSFSE	40	3	1	* NPO 4 hours prior to exam
Ax SSFSE	40	4	1	* 2 bottles Breeze/Volumen over 1 - 1.5 hour as tolerated by patient prior to imaging, water if can't tolerate Breeze/Volumen (adult and ped)
Ax SSFSE FS	40	4	1	* Please send images to PACS in appropriate orientation
Cor SSFSE FS	40	3	1	
Ax T1 Lava +C (70 sec delay)	40	5	2.5	
Cor T1 Lava +C	40	5	2.5	
Axial DWI (50,1000)	40	8	2	
Perianal Fistula or Perianal Abscess				
T2 propeller or FRFSE	22	2	0.2	* Axial scan range from bladder base to gluteal skin, coronal scan range from pubic symphysis to coccyx
Ax T2 propeller or FRFSE	22	2	0.2	* Oblique axial and coronal to anal canal based on sagittal image
Ax T2 FS propeller or FRFSE	22	2	0.2	* Need surgeon note.
Cor T2 propeller or FRFSE	22	4	0.1	* Does pt. have seton drain?
Cor T2 FS propeller or FRFSE	22	4	0.1	
Ax T1 SPGR FS sm FOV	24	4	0.5	
Ax T1 SPGR FS +C	42	5	1	
Cor T1 SPGR FS +C	24	4	0.5	
Ax T1 Sm FOV +C	24	4	0.5	
Prostate				
Ax Global Lava	40 freq x 32 phase	2.5	0	Iliac Crest through Pubic Symphysis
T2 Sag propeller or FRFSE	12cm - 20cm	3	0	Entirety of Prostate gland including seminal vesicles
T2 Cor propeller or FRFSE	12cm - 20cm	3	0	Entirety of Prostate gland including seminal vesicles
T2 Ax propeller or FRFSE	12cm - 20cm	3	0	Entirety of Prostate gland including seminal vesicles; Diffusion/ Ax T2 Dynam are all same plane
Ax Focus Diffusion (50/1000)	24	4	1.5	Entirety of Prostate gland including seminal vesicles; Diffusion/ Ax T2 Dynam are all same plane
Ax Perfusion (Dynamic)	24	4	1.5	Entirety of Prostate gland including seminal vesicles; Diffusion/ Ax T2 Dynam are all same plane
Ax Global Lava + Contrast	(not specified)	3	0	Entirety of Prostate gland including seminal vesicles; Diffusion/ Ax T2 Dynam are all same plane
	40 freq x 32 phase	2.5	0	Iliac Crest through Pubic Symphysis; Diffusion/ Ax T2 Dynam are all same plane
				Each type for Diffusion
				Use B value of 1000 to calculate ADC map
				Send B value of 1400 to PACS for diffusion. Do NOT use this B value to calculate ADC
				If your MRI can extrapolate B values of 1400, use to save time. If not acquire 2 separate diffusion sequences
				Please send "water only" LAVA images
				If your MRI can extrapolate B values of 1400, use to save time. If not acquire 2 separate diffusion sequences
				Only provide 10 sequences



PELVIS FEMALE GYN (see subtype)					
					These exams use the same protocol except that double oblique (angulation) imaging is done perpendicular to the tumor location / or body part if tumor is not seen (see illustrations)
					Tumors tend to be a light grey on T2W sequences. Look at history provided if you can't see the tumor and scan relative to the body part (like vagina, cervix, endometrium)
					if cervix cancer then double oblique images are done with attention to cervix but if endometrial cancer then with attention to the endometrium
<p>Figure 2. The double oblique technique. Illustration shows a uterus that is anteriorly rotated in the sagittal plane (anterovent) and laterally tilted to the left in the coronal plane. The double oblique sequence is performed by angling images anteriorly in the sagittal plane (green line) and laterally in the coronal plane (blue line), which creates true oblique images along the true axis of the uterus (orange line). A = anterior, P = posterior.</p>		<p>Schematic representation of specific MRI planes orientation:</p> <ul style="list-style-type: none"> Axial of the cervix Axial of the uterus Coronal of the uterus or cervix Sagittal of the uterus Axial of the vagina 			<p>Stage IB2 cervical adenocarcinoma in a 48-year-old woman with radical hysterectomy (A) T2-weighted axial MR images show a 5 cm well defined exophytic mass (star) mainly involving right posterior exocervix with no disruption of peripheral rim. The maximum diameter of the lesion is measured 5cm (arrowhead) on the T2-weighted sagittal image. At histopathological finding, bilateral parametrial lesion was found. MRI stage T1b (> 4 cm) was underdiagnosed as final pathologic stage T2b.</p>
GYNECOLOGIC CANCER		Scan number		Best done without and WITH IV CONTRAST	
Includes: Endometrial, cervix and vaginal cancer					
Patient Prep:				Fast for at least 4 hours and empty bladder/ rectum about 1 hour before examination (so bladder is part full) .	
Patient Prep:				Use 40 mL of warmed Vaginal ultrasound gel or KY jelly	
Patient Prep:				Air in rectum may interfere with exam. If full of air have patient empty.	
Technical note:				Scan perpendicular to the tumor site (or body part of the study such as cervix, endometrium or vaginal if tumor is not seen) using double oblique imaging	
Technical note:				small FOV images (above)- see diagram. These oblique images are used for scans 5, 6, 7, 8, 9	
Technical note:				The color indicators (yellow and blue scans) which use the same imaging FOV and planes for each color	
Technical note:				use ANTERIOR SAT BAND when possible for imaging below if phase is AP; use phase AP in most situations; if artifacts might need to swap phase direction	
LOC (3 planes)		1			
Large FOV Cor (to body) T2 (> 3000/90 to 102 ms)		2		40 (30 to 50) cm 8 (6 to 10) mm 2 mm	
Small FOV Obl SAG T2 no Fat Sat (>3000/90 to 102 ms)		3		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
Small FOV Obl COR to tumor site T2 no Fat Sat (>3000/90 to 102 ms)		4		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
Small FOV Obl AX to tumor site T2 no Fat Sat (>3000/90 to 102 ms)		5		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
Small FOV AX to tumor site DWI (same as immediately above)		6		22 (18 to 28) cm 3 to 4 mm 0.3 mm	
Create ADC from data above		6 (create ADC map)			
Small FOV Obl AX GE T1 to tumor site (like scan 5) (NO Fat Sat 3D GRE T1*)		7		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
AX (to body) (NO Fat Sat dual echo GRE T1)		8		28 cm (20 to 44) cm 3 (2 to 4) mm	
same as scan above 7 GRE T1 with FATSAT AX (to body)		9		28 cm (20 to 44) cm 3 (2 to 4) mm	
Small FOV Obl SAG (Sag to tumor/ body part) DCE (Fat Sat, 3D GRE T1*)		10		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
make subtractions (all post & pre contrast scans)		10 (make subtractions)		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
OBL AX +C (like scan 5) Fat Sat GRE T1		11		22 (18 to 28) cm 3 to 4 mm 0.3 to 0.4 mm	
optional Large FOV COR delayed post e+ (Fat Sat, 3D GRE T1*)		12		40 (30 to 50) cm 10 mm 1 to 2 mm	
UTERINE FIBROIDS / LEIOMYOMA		Scan #		Done without and WITH IV CONTRAST	
Patient Prep:				Fast for at least 4 hours and empty bladder/ rectum about 1 hour before examination (so bladder is part full) .	
Patient Prep:				NOT needed (vaginal gel or KY jelly)	
Patient Prep:				Air in rectum may interfere with exam. If full of air have patient empty.	
Technical note:				Imaging FOV should include all of uterus and all fibroids / masses (may need to increase or decrease FOV)	
Technical note:				use ANTERIOR SAT BAND when possible for imaging below if phase AP; use phase AP in most situations; if artifacts might need to swap phase direction	
LOC: (3 planes)		1		any	
				Smaller or larger FOV images are fit to patient and all pelvic organs	
Small FOV SAG T2 no Fat Sat (>3000/90 to 120 ms)		2		28 cm (20 to 44) cm 4 to 5 mm 0.4 to 0.5 mm	
Small FOV AX (to endometrium) T2 no Fat Sat (>3000/90 to 120 ms)		3		28 cm (20 to 44) cm 4 to 5 mm 0.4 to 0.5 mm	
Small FOV AX DWI (same FOV and plane as immediately above for scan 3)		4		28 cm (20 to 44) cm 4 to 5 mm 0.4 to 0.5 mm	
Create ADC from data above		4 (create ADC map)			
AX (to endometrium or uterus, same FOV and plane as scan 3,4) (NO Fat Sat 3D GRE T1*)		5		28 cm (20 to 44) cm 4 to 5 mm	
DCE (pre contrast then dynamic post) SAG +C Fat Sat GRE T1		6		28 cm (20 to 44) cm 4 to 5 mm 0.4 to 0.5 mm	
make subtraction		6 (make subtractions)		28 cm (20 to 44) cm 4 to 5 mm 0.4 to 0.5 mm	
AX (to endometrium/ uterus) (with Fat Sat otherwise same as scan 3,4 and 5, 3D GRE T1*)		7		28 cm (20 to 44) cm 4 to 5 mm	

FEMALE UTERINE CONGENITAL ABNORMALITIES		NO IV contrast needed for this type of scan			
Patient Prep:					
Patient Prep:					
Patient Prep:					
Technical note:					
Technical note:					
LOC: (3 planes)					
1 40 cm any					
Large FOV Cor (to body) T2 no Fat Sat (>3000/90 to 102 ms)					
2 40 to 50 cm 8 (6 to 10) mm 2 mm					
Small FOV Obi SAG no Fat Sat T2 (>3000/90 to 102 ms)					
3 20(18 to 24) cm 4 to 5 mm 0.4 to 0.5 mm					
Small FOV Obi COR to Endometrium no Fat Sat T2 (>3000/90 to 102 ms)					
4 20(18 to 24) cm 4 to 5 mm 0.4 to 0.5 mm					
Small FOV Obi AX to Endometrium no Fat Sat T2 (>3000/90 to 102 ms)					
5 20(18 to 24) cm 4 to 5 mm 0.4 to 0.5 mm					
NO FAT SAT - AX to body (NO Fat Sat dual echo GRE T1)					
6 28 cm (20 to 44 cm) 4 to 5 mm 0.4 to 0.5 mm Nex =2					
with FAT SAT AX to body same as scan 7 but with FS (w Fat Sat, GRE (dual echo) T1)					
7 28 cm (20 to 44 cm) 4 to 5 mm 0.4 to 0.5 mm Nex =2					
ADNEXAL MASS or ENDOMETRIOSIS or R/O OVARIAN TORSION (female gynecologic emergencies)					
Best done without and WITH IV CONTRAST					
Patient Prep:					
Patient Prep:					
Patient Prep:					
Technical note:					
Technical note:					
Technical note:					
Technical note:					
LOC: (3 planes)					
1 40 cm any					
Cor (to body) T2 (>3000/90 to 102 ms)					
2 40 to 50 cm 8 (6 to 10) mm 2 mm					
SAG (to body) Small FOV no Fat Sat T2 (>3000/90 to 102 ms)					
3 28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm					
COR (to body) Small FOV no Fat Sat T2 (>3000/90 to 102 ms)					
4 28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm					
AX (to body) Small FOV no Fat Sat (>3000/90 to 102 ms)					
5 28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm					
AX DWI (same as immediately above)					
6 28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm b= 50, 1000					
Create ADC from data above					
AX (to body) (NO Fat Sat dual echo GRE T1)					
7 28 cm (20 to 44 cm) 3 (2 to 4) mm					
same as scan above 7 GRE T1 with FAT SAT AX (to body)					
8 28 cm (20 to 44 cm) 3 (2 to 4) mm					
SAG (to body) pre then post contrast DCE +C Fat Sat GRE T1					
9 28 cm (20 to 44 cm) 3 (2 to 4) mm make subtractions					
make subtractions of ALL post contrast - pre contrast					
9 (make subtractions)					
Sag images are pelvic bone to pelvic bone					
same as scan 8 but post contrast AX (to body) +C (Fat Sat, 3D GRE T1)					
10 28 cm (20 to 44 cm) 3 (2 to 4) mm go to bathroom for urethra diverticulum					
Bladder Mass					
Patient Prep:					
Patient Prep:					
Patient Prep:					
Technical note:					
Technical note:					
LOC: T2W SFSE or Haste COR					
40 cm any					
Large FOV Axial (to body) T2 (4000/90 ms)*					
34 (30 to 40 cm) 6 mm 1 mm					
Large FOV Cor (to body) T2 (4000/90)*					
40 to 50 cm 8 mm 2 mm					
FOV to view bone to bone in pelvis (view both ovaries and Uterus)					
SAG T2 (4000/90 ms)					
28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm **from inside of one hip to the other (small FOV); ETL = 17 (13 to 21); NEX = 2 Matrix at least 256 x 256					
COR T2 (4000/90 ms)					
28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm					
AX T2 (4000/90 ms)					
28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm					
AX DWI (same as immediately above)					
28 cm (20 to 44 cm) 3 to 4 mm 0.3 to 0.4 mm Diffusion b= 50, 1000					
Create ADC from data above					
28 cm (20 to 44 cm)					
AX DCE (NO Fat Sat 3D GRE T1)*					
28 cm (20 to 44 cm) 3 (2 to 4) mm					
AX DCE (Fat Sat, 3D GRE T1)*					
28 cm (20 to 44 cm) 3 (2 to 4) mm make subtractions					
SAG +C Fat Sat GRE T1					
28 cm (20 to 44 cm) 8 mm Nex = 2					
COR +C delayed (Fat Sat, 3D GRE T1)*					
40 cm (30 to 50 cm) 8 mm 2 mm					
From mid kidneys through upper thigh (include all pelvis and lower Abd)					
Use Ax, Cor and Sag imaging to the body (not cervix or endometrium)					
Penis (Fracture)					
Cor STIR Global					
30 5 1					
Tape penis to abdomen if needed					
Ax T1 Lava Global					
30 4 2					
Sag T2 Propeller					
24 3 0.4					
Sag T1					
24 3 0.4					
Cor T2 Propeller					
22 3 0.1					
Cor T1					
22 3 0.1					
Ax T2 Propeller					
17 3 0.2					
Ax T1					
17 3 0.2					
Penis (Peyronie's Disease)					
Cor STIR Global					
40 5 1					
Tape penis to abdomen if needed					
Ax T1 Lava Global					
40 4 2					
Sag T2 FS Propeller					
24 3 0.4					
Sag T1 FS					
24 3 0.4					
Cor T2 Propeller					
22 3 0.1					
Cor T2 FS Propeller					
22 3 0.1					
Cor T1 FS					
22 3 0.1					
Rev 7-11-19					
Ax T2 Propeller					
17 3 0.2					
Ax T2 FS Propeller					
17 3 0.2					
Ax T1 FS					
17 3 0.2					
Ax T1 FS +C					
17 3 0.2					
Cor T1 FS +C					
22 3 0.1					
Sag T1 FS +C					
24 3 0.4					

Rectal Cancer (1.5 T)					Prep: Nothing to eat or drink 12 hours prior, no caffeine morning of exam, 1 bisacodyl suppository (Dulcolax) 10 hours prior to study, void just before exam
Technical note:					Rectal US gel or KY jelly is used when tolerated
Technical note:					Low rectal ca: 20 cc of rectal gel Mid-High rectal ca: then use 60cc rectal gel
Ax Diff Global (50/800)	~30	5	1		
Sag T2 FRFSE	24	4	0	320x224	Do axials PERPENDICULAR to mass. VERY IMPORTANT** See images
Cor T2 FRFSE	24	3	0	320x224	
Ax OBL T2 FRFSE	24	3	0	320x224	(See Images Below)
					The second image shows how sometimes multiple axial planes must be used to get it perpendicular.
					* Rectal gel to be used in all cases, including patients post recent or remote diverting surgery, expect if patient can't tolerate due to pain.
					** No laxative is needed for diverted patients
Rectal Cancer (3.0 T)					Prep: Nothing to eat or drink 12 hours prior, no caffeine morning of exam, 1 bisacodyl suppository (Dulcolax) 10 hours prior to study, void just before exam
Technical note:					Rectal US gel or KY jelly is used when tolerated
Technical note:					Low rectal ca: 20 cc of rectal gel Mid-High rectal ca: then use 60cc rectal gel
Ax T2 FRFSE Global	~30	5	0	320x320	
Ax Diff Global (50/800)	~30	5	1		
Sag T2 FRFSE	24	4	1	416x384	
Cor T2 FRFSE	24	3	1	320x320	These are overlapped images, 3mm then move 1 mm
Ax OBL T2 FRFSE	24	3	1	416x384	Perpendicular to tumor
					The second image shows how sometimes multiple axial planes must be used to get it perpendicular.
					* Rectal gel to be used in all cases, including patients post recent or remote diverting surgery, expect if patient can't tolerate due to pain.
					** No laxative is needed for diverted patients
Urethra Diverticuli					
Ax T2 FS Global	28	4	1		Include entire urethra from bladder neck to external meatus.
Axial T2	12-16	3	0.3		No vaginal gel.
Sag T2	12-16	3	0.3		
Cor T2	12-16	3	0.3		
Ax T1 Laven	12-16	3	1		
Ax T1 Laven -C (Dynamic)	12-16	3	1		Nex =1 at 0 (pre contrast) then 25, 60, 100, 140, 180 seconds (and make subtraction of each of these from non contrasted exam)
Ax T1 Laven + C Global	34-40	3	6		
Ax T1 Laven +C (after voiding)	12-16	3	1		Images acquired after voiding through urethra (to answer the question does the abnormality fill with contrast after voiding to confirm a urethra diverticulum)
MRV Pelvis (May-Thurner's Syndrome)	40		na		
CEMRA (Mask + 4 phases 20 sec apart , 3D Lab recons)	40	4	2		
MRA Aorta					
Ax 3D Dual Echo	40	4	2		
Ax T2 FS Propeller	40	6	1		
CEMRA (Mask + Dyn 2cc/sec 32 Locs)	40	3	1.5		
MRA Renal					
Ax 3D Dual Echo	40	4	2		
Ax T2 FS Propeller	40	6	1		
Ax 3D Enhance wo (60 locs/slab)	38	2	1		
Mediastinal Mass					
Coronal T2 Haste	20-30	4	1		
Axial T2 Haste	20-30	4	1		Please confirm with radiologist regarding scan range to ensure lesion is imaged appropriately, as this is an uncommon exam. Typically, thoracic inlet through base of heart.
Axial STIR	20-30	4	1		
Axial IN/OUT phase	20-30	3	1		
Axial TRUFISP	20-30	4	1		
Axial DWI (B50, B1000)	20-30	5	1		
Axial T1 VIBE pre	20-30	3	1		
Axial T1 VIBE post (20-30s, 60-70s, 3 min)	20-30	3	1		
Coronal T1 VIBE post (5 min)	20-30	3	1		

