RIH – PROSEPCTIVE GATED AORTA
GE LIGHTSPEED VCT PROTOCOL

Indications: ascending aorta aneurysm/dissection or aortic valve disease

Position/Landmark	Feet first-Supine Sternal Notch
Topogram Direction	Craniocaudal
Respiratory Phase	Inspiration
Scan Type	Cine
KV / mA / Rotation time (sec) **Pitch / Speed (mm/rotation)** **Noise Index / ASiR / Dose Reduction**	120kv / 600 mA / 0.35 sec 40.00mm - / 30 / 20%
Detector width x Rows = Beam Collimation	0.625mm x 64 = 40mm
Average Tube Output	ctdi – 14.5mGy dlp – 301 mGy.cm
Cine Set Slice Thickness/ Spacing Algorithm Recon Destination	recon / body part / thickness/ spacing / algorithm / recon destination 1 **small fov gated aorta** 0.6mm x 0.6mm standard pacs
Scan Start / End Locations **DFOV**	just superior to aortic arch 2cm inferior to heart 25cm
IV Contrast Volume / Type / Rate	60mL Iohexol (Omnipaque 350) / 5.5mL per second 50mL Iohexol (Omnipaque 350) / 4mL per second 40mL saline / 4mL per second
Scan Delay	Smart Prep at **ascending thoracic aorta** at level of carina
2D/3D Technique Used	2.5mm x 2.5mm, mip mode, **full chest fov coronal and sagittal reformats** 2.5mm x 2.5mm, average mode, **full chest fov axial reformats**

Comments: This protocol scans a small fov prospective gated aorta. Then full chest retro-recons and reformats are created afterwards.

The dynamic padding time should stay at 10ms for this protocol. Adjusting the padding with the patient's heart rate is not needed.

- The cardiac monitor leads should be below the clavicles and just below the curvature of the left ribs.

Please create a 2.5mm, full chest field of view, lung algorithm in retro-recon and send it to pacs.

Images required in PACS	Scouts, .6mm x .6mm small fov axial gated aorta cta, 2.5mm x 2.5mm full chest axial gated chest cta, 2.5mm x 2.5mm coronal aorta mip, 2.5mm x 2.5mm sagittal aorta mip, 2.5mm x 2.5mm axial full chest fov lung window Dose Report