A) Policy Statement

Cardiac Nuclear Medicine procedures will not be performed on patients, who are pregnant, potentially could be pregnant, or who are breast feeding a child unless it is absolutely essential for a diagnosis. Both the patient and the ordering physician must give approval for the procedure to be performed.

B) Purpose of Policy

To identify and address issues relating to the administration of radioactive material to a pregnant, potentially pregnant or breast feeding patient.

C) Procedure

1. Signs are posted within the camera and stress rooms that state: "If you are pregnant or breast feeding, please notify the technologist or nurse.

2. The technologist or nurse must ask all female patients if they are or may be pregnant and if they are breast feeding and infant or child.

3. Pregnancy:
   a. If the patient is neither post-menopausal nor surgically sterile and their last menstrual period began within the past 10 days, the technologist or nurse must consult the Authorized User before administering the radiopharmaceutical dose. The procedure should be postponed until pregnancy status can be verified.

4. If the patient is breast feeding:
   a. Notify the Authorized User and the Radiation Safety Officer before the radiopharmaceutical is administered.
   b. The referring physician may be contacted and questioned whether a Nuclear Medicine procedure is still indicated.
   c. The patient must agree to discontinue breast feeding for a period of 24 hours as prescribed by the Radiation Safety Officer:
      i. Myocardial Perfusion Imaging using Tetrofosmin or Sestamibi, 40 mCi.
         1. NRC NUREG-1492
      ii. Myocardial Function Imaging using Tc99m RBC's, 30 mCi.
         1. NRC Reg-8.39
   d. Written instructions regarding the length of time to discontinue breast feeding must be signed by the patient before administering the radiopharmaceutical and documented in the patients chart.
   e. The patient will be given a copy of the completed "Instructions for Breast Feeding Patients" form.
5. It is the policy of the Heart Station not to perform a radioactive diagnostic procedure on any patient that is pregnant. If all the guidelines are followed, this should not occur.

6. In the event that an exposure does occur, the Radiation Safety Office will provide the most accurate data available to the parent concerning fetal dosing.
# RECOMMENDED BREAST FEEDING INTERRUPTION TIMES

<table>
<thead>
<tr>
<th>Radiopharmaceutical</th>
<th>Procedure</th>
<th>Dose</th>
<th>Recommended Breast Feeding Interruption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tc99m Labeled RBC's</td>
<td>MUGA</td>
<td>20-30 mCi</td>
<td>9 hours</td>
</tr>
<tr>
<td>Tc99m Tetrofosmin/Mibi</td>
<td>Myocardial Perfusion</td>
<td>40 mCi</td>
<td>3 hours</td>
</tr>
<tr>
<td>TI201</td>
<td>Myocardial Perfusion</td>
<td>5 mCi</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

All others consult radiopharmacy and manufacturers dose sheet

Your physician has referred you to the UTMC Heart Station for the following procedure:

During this procedure, you will be given a small amount of radioactive material:

You have also indicated that you are currently breast feeding an infant. Please follow the instructions indicated below relating to breast feeding after the administration of the radioactive material.

**Interrupt breast feeding for a period of**

Small quantities of the radioactive material you will be given will be present in your breast milk following the procedure. Although failure to interrupt your breast feeding will not produce any noticeable adverse effects in your infant, it is prudent to avoid the unnecessary radiation exposure to your infant during the interruption time recommended above. You may continue breast feeding your infant after the recommended interruption time.

Patient Signature: __________________________ Date: _______________________

Witness Signature: __________________________ Date: _______________________
Pregnancy and/or Breast Feeding Verification

Patient Name:___________________________________________________________

Birth Date:____________________________________________________________

1. Are you (check the appropriate line):
   _____ Post-menopausal
   _____ Pre-menopausal, surgically sterile (e.g. hysterectomy, tubal ligation, etc.)
   _____ Pre-menopausal, not surgically sterile.
      If so, are you or do you think you may be pregnant?
         Yes___ No___ Date of your last menstrual period:____________________

2. Are you currently breast feeding: Yes___ No___

3. Have you ever had a mastectomy? Yes___ No___
   Right___
   Left___
   Implant___
   Prosthesis___

Patient Signature:_________________________________________ Date:________________