Diagnosis of Pulmonary Artery Embolism: Comparison of Single-Source CT and 3rd Generation Dual-Source CT using a Dual-Energy Protocol Regarding Image Quality and Radiation Dose


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Key words
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ZUSAMMENFASSUNG


Ergebnisse CTDVol und DLP waren in der DECT Gruppe jeweils signifikant niedriger als in der SSCT Gruppe (p < 0,001 [CTDVol]; p < 0,001 [DLP]) und der DSCT Gruppe (p = 0,003 [CTDVol]; p = 0,003 [DLP]). Die effektive Dosis war mit 2,79 ± 0,95 mSv in der DECT Gruppe signifikant geringer als in der SSCT Gruppe (4,60 ± 1,68 mSv, p < 0,001) und der DSCT Gruppe (4,24 ± 2,69 mSv, p = 0,003). SNR und CNR waren in der DSCT Gruppe signifikant höher (p < 0,001). Die subjektive Bildqualität der drei Protokolle war vergleichbar und wurde in 75 % der Fälle (135/180) als gut bzw. sehr gut bewertet mit einer Interobserver-Variabilität von 80 %.


Kernaussagen:
- Die Verwendung von 90/Sn150 kV Dual-Energy CT-Protokollen in der pulmonalen CTA erlaubt eine signifikante Dosisreduction bei erhaltener exzellenter Bildqualität und potentieller zusätzlicher Information im Sinne von Perfusions-Karten.
- Die subjektive Bildqualität aller drei untersuchten CT-Protokolle (64-Zeilen SSCT, Single-Energy DSCT, 90/Sn150 kV DECT) war vergleichbar und wurde in 75 % der Fälle als gut bzw. sehr gut bewertet.
Introduction

Pulmonary embolism (PE) is a frequent and potentially life-threatening condition [1]. Early initiation of treatment significantly reduces morbidity and mortality [2, 3]. Therefore, timely and accurate diagnosis is of utmost importance. Due to its high sensitivity and specificity, multi-detector row computed tomography pulmonary angiography (CTPA) has become the imaging modality in many hospitals and radiological institutions.

The introduction of dual-source CT (DSCT) scanner systems and the associated rediscovery of dual-energy CT (DECT) contribute additional functional information [9]. The use of two different tube energies (kV) allows for visualization of absorption characteristics of different materials, especially of those with high atomic numbers, such as iodine and calcium [10]. The dedicated advantages and possibilities of dual-energy imaging in patients with suspected pulmonary embolism have been discussed extensively in literature [11–15].

Some data regarding the dose and image quality of CTPA of first and second generation DSCT scanners is available [16, 17]. However, the potential of the latest (third) generation scanners to further decrease radiation dose while maintaining image quality has scarcely been assessed so far [18]. Concerning first and second generation DSCT scanners, DECT was reported to carry a signal-to-noise-ratio (SNR) and contrast-to-noise-ratio (CNR) were calculated. Two readers assessed subjective image quality according to a five-point scale.

Results

Mean CTDIvol and DLP were significantly lower in the dual-energy group compared to the SSCT group (p < 0.001 [CTDIvol]; p < 0.001 [DLP]) and the DSCT group (p = 0.003 [CTDIvol]; p = 0.003 [DLP]), respectively. The effective dose in the DECT group was 2.79 ± 0.95 mSv and significantly smaller than in the SSCT group (4.60 ± 1.68 mSv, p < 0.001) and the DSCT group (4.24 ± 2.69 mSv, p = 0.003). The SNR and CNR were significantly higher in the DSCT group (p < 0.001).

Subjective image quality did not differ significantly among the three protocols and was rated good to excellent in 135/180 cases with an inter-observer agreement of 80%.

Conclusion

Dual-energy pulmonary CTA protocols of 3rd generation dual-source scanners allow for significant reduction of radiation dose while providing excellent image quality and potential additional information by means of perfusion maps.

Key Points:
- Dual-energy CT with 90/Sn150 kV configuration allows for significant dose reduction in pulmonary CTA.
- Subjective image quality was similar among the three evaluated CT-protocols (64-slice SSCT, single-energy DSCT, 90/Sn150 kV DECT) and was rated good to excellent in 75% of cases.
- Dual-energy CT provides potential additional information by means of iodine distribution maps.

Materials and Methods

Patients

The local ethics committee waived the need for individual informed consent for this study. From October 2015 through December 2015, 60 patients referred to CTPA for suspected PE were scanned on a conventional single-source 64-slice CT system (SOMATOM Definition AS 64, Siemens Healthcare, Forchheim, Germany) in a standard clinical routine setting (group 1). From January 2016 through February 2016, a total of 60 consecutive patients were examined on a third generation DSCT (SOMATOM Force, Siemens Healthcare, Forchheim, Germany) with a single-energy protocol (group 2). Since March 2016, all patients referred to CTPA have been consecutively examined with the same third generation DSCT (SOMATOM Force, Siemens) using a dedicated dual-energy pulmonary CTA protocol. The data of the first 60 patients acquired with this dual-energy protocol were included in this study (group 3). The age, gender distribution and body habitus (anteroposterior and lateral chest diameter) of the patients in the three cohorts are displayed in Table 1. Inpatients as well as
patients from our emergency room were recruited 24/7. Except for pregnancy and known severe allergic reactions to iodine-based contrast agents, no exclusion criteria were applied.

**CT protocols**

Patient studies were performed on a conventional 64-slice CT system and on a third generation DSCT system, the latter comprising a selective photon shield tin filter (+Sn). This latest generation CT system differs from previous DSCT generations by offering a greater FOV (35.3 cm instead of 33.0 cm [SOMATOM Definition Flash, Siemens] and 28.0 cm [SOMATOM Definition, Siemens], respectively), enabling high-pitch spiral and DE acquisition in larger patients, too. The use of higher tube energies (90 kV/Sn150 kV instead of 100 kV/Sn140 kV [SOMATOM Definition Flash] and 80 kV/140 kV [SOMATOM Definition, Siemens], respectively) results in superior spectral differentiation.

Automatic topogram and real-time-based anatomical tube current modulation (CARE Dose 4 D, Siemens) was applied per default in all patients. In addition, automated tube potential control (CARE kV, Siemens) was applied in group 1 and group 2. Due to the preassigned kV ratio between the two tubes, this was not applicable in the dual-energy cohort (group 3). All CT images were acquired in caudocranial orientation between the lung apices and costophrenic recesses within a single inspiratory breath hold. The caudocranial scan length (mm) was recorded.

Transverse images were reconstructed at a slice thickness of 1 mm with a position increment of 1 mm using a medium soft ker-

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**Table 1** Demographic data of patients referred to CTPA for suspected pulmonary embolism.

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
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<tbody>
<tr>
<td>SSCT</td>
<td>DSCT</td>
<td>DECT</td>
</tr>
<tr>
<td>Age (±SD) [years]</td>
<td>65.1 (± 15.8)</td>
<td>61.3 (± 20.7)</td>
</tr>
<tr>
<td>Male (n)/female (n)</td>
<td>29 / 31</td>
<td>35 / 25</td>
</tr>
<tr>
<td>Lateral chest diameter (±SD) [cm]</td>
<td>34.7 (± 4.3)</td>
<td>35.9 (± 4.4)</td>
</tr>
<tr>
<td>AP chest diameter (±SD) [cm]</td>
<td>26.3 (± 3.8)</td>
<td>26.6 (± 4.2)</td>
</tr>
<tr>
<td>Pulmonary embolism (n)</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

CTPA = computed tomography pulmonary angiography; AP = anteroposterior; SSCT = conventional single-source computed tomography; DSCT = dual-source computed tomography; DECT = dual-energy computed tomography; SD = standard deviation; n.s. = not significant.

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**Table 2** Applied single- and dual-source/energy CT protocols. The high voltage spectrum in dual-energy scans is additionally hardened by a tin filter (Sn).

<table>
<thead>
<tr>
<th>Group 1</th>
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<th>Group 3</th>
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<td>CTPA = computed tomography pulmonary angiography; AP = anteroposterior; SSCT = conventional single-source computed tomography; DSCT = dual-source computed tomography; DECT = dual-energy computed tomography; SD = standard deviation; n.s. = not significant.</td>
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</table>
nel (B30f). By default, three image sets were reconstructed for the dual-energy examinations: One series each for the low (90 kV) and the high (Sn150 kV), and one mixed series merging information of both data sets to create an image impression comparable to a 120 kV examination. For that purpose, 60 % of the 90 kV data and 40 % of the hardened Sn150 kV spectrum data were blended (so-called M_06 series). Blending ratios followed the vendor’s recommendations.

An automated injector (CT motion™, Ulrich medical, Ulm, Germany) was used to administer an iodinated contrast medium (45 mL in group 1; 40 mL in group 2; 40 mL in group 3) with 350 mgI/mL (Imeron® 350, Bracco, Konstanz, Germany) with a flow of 3.5 mL/s followed by a 40 mL NaCl chaser bolus. In the case of advanced obesity, up to 90 mL of contrast medium was administered. Automated bolus tracking (CARE Bolus, Siemens) was used with a trigger attenuation of 120 HU within the pulmonary trunk and a 5 second delay preceding diagnostic image acquisition.

CT protocol settings of each patient cohort were chosen according to the manufacturer’s recommendations (Table 2):

1. For conventional 64-slice SSCT, the parameters were: 120 reference (ref.) kV tube voltage, 130 ref. mAs, 2×32×0.6 mm collimation with z-flying focal spot, 0.33 seconds gantry rotation time, and 300 mm/s table speed at a pitch factor of 1.4.
2. For single-energy DSCT, the following parameters were used: 100 ref. kV tube voltage, 120 ref. mAs, 2×96×0.6 mm collimation with z-flying focal spot, 0.25 seconds gantry rotation time, and 400 mm/s table speed at a pitch factor of 1.55.
3. For DECT acquisition, the parameters were: 90 kV tube voltage (A tube) / 150 kV tube voltage (B tube), 60 ref. mAs (A tube) / 46 ref. mAs (B tube), 2×96×0.6 mm collimation with z-flying focal spot, 0.25 seconds gantry rotation time, and 200 mm/s table speed at a pitch factor of 0.55. The dual-energy FOV was limited to 35.3 cm because of the smaller x-y axis coverage of the B detector.

Radiation dose
For estimation of the applied radiation dose, the volume computed tomography dose index (CTDIdvol [mGy]) and the dose length product (DLP [mGy·cm]) were manually recorded from the patient protocol, which is automatically stored in the PACS (Merlin, Phönik-PACS, Freiburg, Germany). As recommended by Schenzle et al., we used a conversion factor of 0.018 mSv/mGycm for estimation of the effective radiation dose [19].

Image quality analysis
The subjective image quality was rated independently by two blinded radiologists (B.P. and A.K., with 8 and 3 years of experience in cardiovascular radiology, respectively) according to a five-point scale (1 = excellent image quality extending to the very peripheral branches, no artifacts, excellent diagnostic confidence; 2 = good image quality, minor artifacts and/or little subjective image noise, feasible evaluation of PE to subsegmental level, good diagnostic confidence; 3 = moderate image quality, feasible evaluation of PE to segmental level, still of diagnostic quality; 4 = poor image quality, severe artifacts and/or high subjective image noise, limited diagnostic confidence; 5 = non-diagnostic image quality) in a randomized fashion.

For the assessment of objective image quality, the mean pulmonary artery CT attenuation (in Hounsfield units [HU]) and image noise (standard deviation of HU) were measured within regions of interest (ROI) at three different locations (pulmonary trunk, right lower lobe pulmonary artery, left upper lobe pulmonary artery) by one observer (B.P.). ROIs were drawn as large as anatomically possible. In the case of the presence of an embolus, the corresponding contralateral vessel was used for density measurements. In addition, the background noise (BN) was determined as the standard deviation of air measured anteriorly to the sternum on the level of the pulmonary trunk. Based on these measurements, the signal-to-noise ratio (SNR) and contrast-to-noise-ratio (CNR) were calculated as follows:

SNR = [intrapulmonary artery attenuation (HU) / image noise (SD of HU)]
CNR = (intrapulmonary artery attenuation (HU) – density of 70 HU) / image noise (SD of HU)

According to previous studies, we assumed a maximum value of 70 HU for a fresh blood clot [21–23]. In group 3 all measurements and ratings were performed in the blended virtual 120 kV series.

Statistical analysis
The interobserver agreement between subjective image quality ratings was calculated with Cohen’s weighted kappa statistics. The significance of differences between the groups was tested with the Mann-Whitney U-test for independent samples. Binary data was analyzed with the chi-square test. Differences in age and chest diameters between the groups were tested with the one-way ANOVA. All statistical analyses were performed using statistical software (IBM SPSS Statistics for Windows, Version 23.0, Armonk, NY, USA); p-values < 0.05 were considered significant.

Results
The age, gender distribution and body habitus (anteroposterior and lateral chest diameter) of the patients in the three different cohorts did not differ significantly (Table 1). A total of 36 acute pulmonary embolisms (20% of the patients) were diagnosed (13 in group 1; 12 in group 2; 11 in group 3) (Table 1).

Radiation dose
The scan length, effective tube current, and effective tube potential (median and range) for each of the three CT protocols are shown in Table 3. The mean CTDIvol and DLP were significantly lower in the dual-energy group compared to both the SSCT group (p < 0.001 [CTDI]; p < 0.001 [DLP]) and the single-energy DSCT group (p = 0.003 [CTDI]; p = 0.003 [DLP]). When comparing group 1 and 2, significantly lower radiation dose levels were found in the DSCT group (p = 0.013 [CTDI]; p = 0.032 [DLP]). In detail, CTDIvol was 7.63 ± 2.72 mGy for group 1, 6.78 ± 4.37 mGy for group 2, and 4.32 ± 1.43 mGy for group 3 (Fig. 1). The DLP was 255.7 ± 93.2 mGycm for group 1, 235.6 ± 149.4 mGycm for group 2,
and 155.2 ± 52.6 mGycm for group 3 (▶ Fig. 2). The mean effective radiation dose of 2.79 ± 0.95 mSv found in the dual-energy group was significantly lower compared to the two other groups, i.e. the single-energy DSCT group (mean effective radiation dose 4.24 ± 2.69 mSv; p = 0.003) as well as the conventional SSCT group (mean effective radiation dose 4.60 ± 1.68 mSv; p < 0.001) (▶ Fig. 3).

Subjective image quality

The overall interobserver agreement rate was 80.0% (linear-weighted kappa 0.64; 95% CI 0.54 – 0.74). Summarizing scores 1 – 2 as “fully diagnostic” and scores 3 – 4 as “partially diagnostic”, the interobserver agreement rate was improved to 95.0% (linear-weighted kappa 0.82; 95% CI 0.69 – 0.94). One pulmonary CTA
Details of the subjective assessment of image quality by both observers are summarized in Table 4. For group 1 the image quality was rated 1.70 ± 0.91 [1] and 1.72 ± 0.92 [2]; k = 0.81 with p < 0.001; 95% CI 0.61 – 1.9; for group 2 the image quality was rated 1.53 ± 0.72 [1] and 1.50 ± 0.75 [2]; k = 0.90 with p < 0.001; 95% CI 0.71 – 1.1; for group 3 the image quality was rated 1.47 ± 0.70 [1] and 1.48 ± 0.77 [2]; k = 0.77 with p < 0.001; 95% CI 0.52 – 1.0.

The mean subjective image quality was rated similar between group 1 and 2 (p = 0.264) as well as between group 2 and group 3 (p = 0.423). The mean subjective image quality tended to be lower in group 1 compared to group 3, although this was not significant (p = 0.076).

**Objective image quality**

The attenuation within the pulmonary trunk was significantly higher in group 2 (376 ± 144 HU) compared to group 1 (309 ± 124 HU) (p = 0.006) and group 3 (303 ± 72 HU) (p = 0.004). The corresponding SNR for the pulmonary trunk was also significantly higher in group 2 (29.69 ± 9.25) compared to group 1 (20.79 ± 6.19) (p < 0.001) and group 3 (20.16 ± 4.77) (p < 0.001). The CNR for the pulmonary trunk was also significantly higher in group 2 compared to the two other groups (p < 0.001 for both groups). All three image parameters (attenuation level, SNR and CNR) showed no statistic differences between group 1 and group 3. Regarding the right lower lobe and left upper lobe segmental arteries, observations were equal to the results from pulmonary trunk measurements. The BN was significantly lower (p < 0.001) in group 1 compared to group 3. Differences between group 1 and group 2 had to be repeated due to severely reduced image quality (score value 5).

### Table 4 Computed tomography pulmonary angiography: SSCT, DSCT, DECT. Subjective image quality.

<table>
<thead>
<tr>
<th>Score</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SSCT</td>
<td>DSCT</td>
<td>DECT</td>
</tr>
<tr>
<td>1</td>
<td>31 (51.7%)</td>
<td>35 (58.3%)</td>
<td>39 (65.0%)</td>
</tr>
<tr>
<td>2</td>
<td>20 (33.3%)</td>
<td>19 (31.7%)</td>
<td>14 (23.3%)</td>
</tr>
<tr>
<td>3</td>
<td>6 (10.0%)</td>
<td>5 (8.3%)</td>
<td>7 (11.7%)</td>
</tr>
<tr>
<td>4</td>
<td>2 (3.3%)</td>
<td>1 (1.7%)</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>1 (1.7%)</td>
<td>0</td>
<td>0</td>
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</table>

Observer 1

<table>
<thead>
<tr>
<th>Score</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31 (51.7%)</td>
<td>37 (61.7%)</td>
<td>40 (66.6%)</td>
</tr>
<tr>
<td>2</td>
<td>19 (31.6%)</td>
<td>18 (30%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>3</td>
<td>7 (11.7%)</td>
<td>3 (5%)</td>
<td>7 (11.7%)</td>
</tr>
<tr>
<td>4</td>
<td>2 (3.3%)</td>
<td>2 (3.3%)</td>
<td>1 (1.7%)</td>
</tr>
<tr>
<td>5</td>
<td>1 (1.7%)</td>
<td>0</td>
<td>0</td>
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</table>

Observer 2

1 = excellent image quality; 2 = good image quality; 3 = moderate image quality; 4 = poor image quality; 5 = non-diagnostic image quality. SSCT = conventional single-source computed tomography; DSCT = dual-source computed tomography; DECT = dual-energy computed tomography.
and 2 and group 2 and 3 were not significant (p = 0.270 and p = 0.410). The data is summarized in Table 5.

**Discussion**

Patients undergoing DECT are exposed to a significantly lower effective radiation dose than patients examined with the other CTPA protocols. Third generation DSCT provides comparable subjective diagnostic image quality using single-energy and dual-energy scan mode in this study. In contrast, the SNR and CNR as indicators of objective image quality were significantly higher in the single-energy DSCT group compared to the other groups.

Today, CT is considered the reference standard for the diagnosis of pulmonary embolism [24 – 27]. During the last decade, CT angiography scanning time has decreased. Nowadays, substantial improvements in the spatial and temporal resolution of CTPA allow analysis of the pulmonary arteries down to the subsegmental level within less than 1 second. Recent research focuses on gaining additional functional information from CT scans. Thereby, DECT holds the potential to provide simultaneous information on the presence of endoluminal thrombus and lung perfusion impairment by generating iodine distribution maps of the lung parenchyma (Fig. 4) [11, 12, 14, 20, 28, 29]. The most recent technical advancements in DECT include a new powerful X-ray tube (Vetron tube, Siemens) in third generation scanners which allows for dual-energy examinations utilizing a new 90/Sn150 kV scan
In dual-energy CTPA in single-energy mode is feasible with this scanner generation, achieving dose reduction compared to standard CTPA at 120 kV. However, a 100/Sn140 kV configuration is not capable of achieving dose reduction compared to standard CTPA at 120 kV. Concerning third generation DSCT scanners, there is currently only one study by Sabel et al. demonstrating that high-pitch CTPA in single-energy mode is feasible with this scanner generation, even though no distinct decrease in radiation dose was observed compared to standard pitch cohorts [18]. Independent of the vendor, scanner generation, and protocol used, several basic strategies have been proposed for effectively decreasing radiation exposure in chest examinations, for example limiting the scan volume from the aortic arch to the right diaphragm [31, 32].

The effective radiation dose of current conventional SSCT protocols for CTPA is estimated at 3.58 to 5.81 mSv when using a conversion factor of 0.018 mSv/mGy cm [17, 19]. Zordo et al. estimated a mean radiation dose of 4.2 mSv in their dual-energy group when using 2nd generation DSCT [17]. This is the first study investigating the radiation dose of dual-energy CTPA with third generation DSCT. Our findings show that 3rd generation DECT with the 90/Sn150 kV dual-energy configuration allows for a significant reduction of patient dose in the clinical routine. When using the same conversion factor of 0.018 mSv/mGy cm, an estimated mean effective radiation dose of 2.79 mSv was found in our dual-energy DSCT group [19]. Compared to our single-energy DSCT group (mean effective radiation dose 4.24 mSv) and to conventional SSCT at 120 kV (mean effective radiation dose 4.60 mSv), this indicates a potential reduction of effective radiation dose ranging between 34.2 % and 39.4 %, respectively. However, when interpreting our results, one must be aware that different tube potentials were applied in our protocols and that radiation dose varies with the square of the tube potential [33].

Nearly equal subjective image quality was found in the single-energy DSCT and the DECT group of this study, which was rated good to excellent by both readers. The mean subjective image quality tended to be rated lower in the conventional SSCT group by both readers, while continuing to provide good to excellent image quality in most patients. However, the above mentioned lower image quality in group I did not reach statistical significance (p = 0.076). The overall interobserver agreement of 80.0 % emphasizes the results of previous CTPA investigations [17].

SNR and CNR were significantly higher in the DSCT group compared to the two other groups. On the one hand, the reduction of tube potential in the DSCT group increases the photoelectric effect and consequently the attenuation of iodinated contrast medium. On the other hand, image noise increases with lowered tube potential. However, the increase in the attenuation of contrast medium was found to outweigh the increase in the image noise when using 100 kV. Furthermore, the new Stellar detector (Siemens Healthcare, Forchheim, Germany) installed in the Force CT produces less electronic noise than the standard detector installed in the 64-slice scanner. However, we observed an increase in the electronic noise when using 100 kV. Furthermore, the new Stellar detector (Siemens Healthcare, Forchheim, Germany) installed in the Force CT produces less electronic noise than the standard detector installed in the 64-slice scanner. However, we observed an increase in the electronic noise when using 100 kV. Furthermore, the new Stellar detector (Siemens Healthcare, Forchheim, Germany) installed in the Force CT produces less electronic noise than the standard detector installed in the 64-slice scanner. However, we observed an increase in the electronic noise when using 100 kV.
in background noise in the DECT group, when compared to single-energy DSCT. This effect of DECT was reported earlier by Kerl et al. and Johnson et al. and is due to cross-scatter radiation [10, 34].

To achieve a similar image impression with the 90/Sn150 kV dual-energy configuration, the 90 kV data in group 3 needed to be blended with the hardened Sn150 kV data at a ratio of 60/40. Lowering the tube potential to 90 kV (instead of typically 100 kV in second generation DECT) will move the X-ray spectrum more toward the k-edge of iodine and thus increase CT numbers and vascular opacification. On the other hand, a tube potential of 90 kV will influence image noise negatively when compared to a standard tube potential of 100 kV or 120 kV. As one can change the composition of the acquired 90/Sn150 kV dataset, it is possible to use DECT to increase the vascular attenuation of the contrast medium by adding more of the 90 kV data to the blended images. While Bauer et al. reported a significantly higher SNR in their single-energy 64-MDCT group compared to second generation DECT in 100/Sn140 kV configuration, we found a similar SNR and CNR in our conventional SSCT and DECT groups. Additionally, the higher spectral separation achieved with the 90/150Sn kV configuration used in our study accounts for better material quantification, potentially strengthening the impact and trustworthiness of iodine perfusion maps.

We have to acknowledge several study limitations. Due to installation of the third generation DECT scanner, the study is not designed in a randomized fashion. The data of group 1 was retrospectively investigated on the previous SSCT scanner, whereas the investigations in group 2 and 3 were of prospective nature and performed on the third generation DECT scanner. Nevertheless, since there were no exclusion criteria except pregnancy and severe allergic reactions to contrast medium by adding more of the 90 kV data to the blended images. While Bauer et al. reported a significantly higher SNR in their single-energy 64-MDCT group compared to second generation DECT in 100/Sn140 kV configuration, we found a similar SNR and CNR in our conventional SSCT and DECT groups. Additionally, the higher spectral separation achieved with the 90/150Sn kV configuration used in our study accounts for better material quantification, potentially strengthening the impact and trustworthiness of iodine perfusion maps.

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**Conclusion**

Third generation DECT in 90/Sn150 kV configuration allows for a significant decrease in radiation exposure compared to other protocols in the clinical routine, while maintaining excellent image quality and enabling additional contemporaneous lung perfusion assessment. Pulmonary perfusion data by means of iodine maps acquired with DECT has become feasible with a decreased radiation dose when using the latest generation dual-source CT scanners.

**CLINICAL RELEVANCE OF THE STUDY**

- Timely and accurate diagnosis of pulmonary embolism is of utmost importance
- Due to its high sensitivity and specificity, computed tomography pulmonary angiography is the image modality of choice when pulmonary embolism is suspected
- New dual-source CT scanners enable the use of dual-energy CT protocols which allow for a significant dose reduction compared to other protocols in the clinical routine

**Conflict of Interest**

The authors declare that they have no conflict of interest.

**References**


