



# SCANNER

THE OFFICIAL NEWSLETTER OF THE ACNP  
March/April 2005

## President's Message



Many of you are probably aware that the budget proposed for FY 2006 by the Department of Energy (DOE) eliminates funding for nuclear medicine research.

The DOE has managed the Medical Applications and Measurement Science Program (MAMSP) for many years. Much of it has funded research in nuclear medicine. This research has led to the development of the  $^{99}\text{Mo}/^{99\text{m}}\text{Tc}$  generator,  $^{201}\text{Tl}$  chloride as a myocardial perfusion agent, and PET imaging, to name a few of the highlights.

The current practice of nuclear medicine would not be possible if not for the outstanding success of these developments by this DOE program. In my opinion, this has been one of the most successful programs in all of government.

In FY 2005, the MAMSP was funded for approximately \$37 million, \$24 million for nuclear medicine research, and \$13–\$14 million for retina research. In FY 2006, the DOE is proposing a budget that would completely eliminate the nuclear medicine funding (but keep the retina research).

The SNM and ACNP are deeply disappointed in this proposal and have spoken out against it. On March 11, I attended a meeting of the Nuclear Science Advisory Committee of the DOE with Dr. Mathew Thakur, president of SNM, and Mike Welch, professor of radiology and chemistry at Washington University (St. Louis, MO) to present our point that the funding of nuclear medicine research should be continued in the Department of Energy. I believe that we all performed creditably and that the committee heard our message.

This will be an uphill battle, but we have at least some chance of keeping some of this funding in the DOE budget, if not all of it. I would encourage everyone to write their Senators and Representatives asking them to continue this funding in the DOE budget. Support from the nuclear medicine community will help promote our viewpoint: that these cuts will be detrimental to future progress in molecular/nuclear medicine and that patients should not be denied advances in innovative care in imaging and therapy. Please refer to the SNM and ACNP Web sites for further information on this issue.

*Bennett S. Greenspan, MD, FACNP, FACR  
President, ACNP*

## Congratulations to the New Officers of ACNP's Board of Regents

On January 16, 2005, the board unanimously approved the following members to serve on the ACNP Board of Regents:

Michael Middleton, MD, Vice President  
Letty Lutzker, MD  
Lale Kostakoglu, MD  
Jay Harolds, MD  
Renee Moadel, MD  
Hazem Chehabi, MD

## ACNP Residency Organization

At the 31st ACNP Annual Meeting, the nuclear medicine residents from the Hospital of the University of Pennsylvania presented the highest number of abstracts for the second consecutive year. In fact, during last year's and this year's award ceremonies, three out of five of ACNP's travel grants and best essay awards were presented to UPenn residents.

**Nuclear medicine residents attending the 31st Annual Meeting of the ACNP: (From left) Wichana Chamroonrat, MD; Gysel Acikgoz, MD; Dr. and Mrs. Muammer Urhan, Sankaran Shrikanthan, MD; Gonca Bural, MD; Ayse Mavi, MD. Dr. Acikgoz is from Thomas Jefferson University Hospital (Philadelphia). The others are from the University of Pennsylvania (Philadelphia).**



The success of each nuclear medicine resident in the residency program heavily depends on the resident's effort as well as the direct supervision and enthusiasm of the residency program director. ACNP would like to extend special thanks to Abass Alavi, MD, for his continuous, tireless effort in encouraging the residents to participate and present their updated research at the national meetings.

Congratulations to all abstract presenters who attended the ACNP's 31st Annual Meeting. Our best wishes to all nuclear medicine residents-in-training, and we hope to see you at future national meetings.

*Simin Dadparvar, MD, FACNP*

## Deadline Has Passed for Submission of Manuscripts for Publication

April 1 was the deadline for submission of manuscripts from the ACNP's 31st Annual Meeting. We encouraged all of the participants in the meeting to submit their presentations to the *Journal of Nuclear Medicine*. The manuscripts are undergoing a rapid review by the ACNP's Scientific Committee. Once the manuscripts are reviewed and found acceptable, they will be submitted as a group to the *JNM* editor for scientific review. Accepted manuscripts published in *JNM* will be acknowledged as having been presented at the 2005 ACNP Annual Meeting.

## ACNP/SNM Joint Public Affairs Department Update

### DOE Budget Cuts

The president's proposed \$23 million cut to the Department of Energy's (DOE) Medical Applications and Measurement Science Program has left the nuclear medicine community shocked and appalled. Professionals in the field realize that the eighty-plus nuclear medicine research projects supported by these funds may be severely set back or lost entirely. Future discovery in the nuclear medicine/molecular imaging field could potentially be at stake.

The ACNP, together with the SNM, has adopted an aggressive strategy in the government relations battle against the proposed budget cuts. Thus far ACNP and SNM have:

- Issued an action alert asking the nuclear medicine community to submit brief letters to their respective legislators asking for the reinstatement of nuclear medicine programs to the DOE budget. In the first month alone, the nuclear medicine community sent 2,645 e-mails and faxes to Capitol Hill.
- Submitted official letters of protest to the chairs and ranking members of the Senate and House Appropriations Committees and the Senate and House Energy & Water Development Subcommittees—the Congressional bodies charged with reviewing the president's budget and recommending specific changes.
- Convened (via conference call) with nuclear medicine industry leaders, government relations gurus, and even DOE grantees to strategize and take action in their respective communities. ACNP/SNM staff and consultants offered each of these groups unique political action plans and talking points for Hill visits.
- ACNP President Dr. Bennett Greenspan spoke at the DOE Nuclear Science Advisory Committee (NSAC) meeting with Dr. Mathew Thakur and Dr. Michael Welch to bring further attention to the issue. The NSAC members were very appreciative of the problem facing nuclear medicine programs and were clearly impressed by the unity of the nuclear medicine community in fighting back.
- Monitored and submitted testimony for relevant appropriations-related Congressional bodies.
- Met with members of Congress, DOE Office of Science administrators, and Office of Management and Budget workers.
- Published news articles in ACNP and SNM publications and worked with journalists from outside publications, such as *Newsday* and *The Scientist*, to produce news articles containing quotes from ACNP/SNM members and staff.

In the near future, the ACNP and SNM will:

- Speak at the spring 2005 meeting of BERAC—the advisory committee in charge of the Biomedical and Environmental Research division of the DOE Office of Science—on April 20–21 in Washington, DC.
- Investigate the possibility of utilizing popular publications and “letters to the editor” in city newspapers to publicize ACNP and SNM’s message.
- Look into bringing DOE grantees with legislators in the relevant Congressional committees to Washington, DC, for Capitol Hill visits.

As the Congressional committee hearings kick in following the spring recess, we will work to keep the ACNP posted of any developments on the Hill regarding the president’s proposed budget for fiscal year 2006. In the meantime, ACNP leaders and staff will continue to fight the good fight.

### **DOE Budget Cuts Will Affect the Future of Nuclear Medicine—Contact Legislators Now**

Responding to the SNM Call to Action posted Feb. 11, members of the nuclear medicine community have sent thousands of messages to Capitol Hill opposing the cuts to molecular/nuclear medicine programs in the Department of Energy (DOE) Medical Applications and Measurement Science Program—but more still needs to be done.

As SNM announced last month, President Bush’s proposed budget reduces funding for these programs from approximately \$37 million in FY ’05 to \$13.6 million in FY ’06. Most of the remaining \$13.6 million in FY ’06 will go to research in fields unrelated to nuclear medicine. The SNM strongly opposes these proposed budget cuts and is coordinating an immediate response urging Congress to reinstate molecular/nuclear medicine funding to the DOE.

Since SNM posted the Call to Action, nuclear medicine professionals have sent 2,170 e-mails and 148 printed letters to Capitol Hill lawmakers, for a total of 2,318 messages (as of March 7). Join your colleagues in contacting your senators and representatives; let them know the benefits of continued funding for molecular/nuclear medicine programs. SNM makes this quick and easy for you through its online legislative action center at [www.snm.org](http://www.snm.org).

### **Congressional Hearing on Imaging**

On March 17 the House Ways and Means Subcommittee on Health held a hearing on imaging during which the tremendous growth in imaging in the United States was noted. The reason for this growth is largely due to these services being offered in the physician’s office. Some groups are concerned over the quality of health care that beneficiaries receive, and there is agreement that the creation of quality standards would be a prudent course of action to address this concern. The House Ways and Means Subcommittee is interested in seeing the medical societies work to create these standards.

### **CMS**

The ACNP and the SNM have brought together a PET/CT coalition. The goal of this group is to educate CMS on the benefits of PET/CT and advocate for its coverage. A meeting took place with CMS on March 8 in Baltimore, MD, where the goal of educating CMS was largely accomplished. ACNP, SNM, and the PET/CT coalition will continue to work with CMS on solving PET/CT coverage issues.

## MedPAC

The ACNP/SNM Joint Public Affairs department continues to monitor the MedPAC and their handling of the drug overhead cost issue. Their research shows that some type of payment adjustment is warranted due to the costs associated with the handling of radiopharmaceuticals. They put forth three recommendations:

1. CMS should establish separate budget-neutral payments to cover the costs hospitals incur for handling drugs and radiopharmaceuticals paid based on acquisition costs under the Outpatient Prospective Payment System.
2. The secretary should define a set of handling-fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs.
3. The secretary should instruct hospitals to submit charges for those APCs and should base payment rates for the handling-fee APCs on submitted charges reduced to costs.

## On the Technologists' Side—CARE Bill

Representative Charles Pickering, Jr. (R-MS 3rd), reintroduced the Consumer Assurance of Radiologic Excellence (CARE) bill, now HR 1426, in the House of Representatives on March 17. The CARE bill currently has twenty original cosponsors and will be referred to the Committee on Energy and Commerce.

## Staff News

The ACNP/SNM office is happy to announce the hiring of two new staff members, David Brake and Monica Homonnay. Mr. Brake is SNM's Associate Director of Public Affairs—Health Care Policy. He will focus primarily on coding and reimbursement/CMS issues. As public affairs assistant, Ms. Homonnay will provide administrative support for all departmental operations.

## Coding Update: PET Providers Should Hold Claims Beginning April 4, 2005

The coding change planned for PET procedures will not take place exactly as scheduled (see earlier, related story immediately below). Although many of the G codes will be discontinued in Medicare systems on schedule, the planned implementation and coding instructions for PET CPT codes will be delayed, resulting in a time period during which providers are advised to *hold* claims until instructions can be issued.

The SNM and other professional societies were contacted by a Medicare & Medicaid Services (CMS) official requesting our assistance in communicating this important coding and payment information to both hospital and nonhospital PET providers. The CMS official stated, "G codes (for PET procedures) should not be used after April 4; those claims will not be paid. In the interim, providers should hold claims and wait for communication from their Carriers or Fiscal Intermediaries.... CMS plans to notify contractors of this issue."

SNM received this information as a result of the good working relationship developed between SNM and CMS officials. Denise Merlino, SNM coding advisor, stated, "We continue to work closely with CMS officials and are confident that they are aware of how important it is that our members get timely and accurate coding information." CMS is holding emergency meetings to reach a resolution promptly and provide coding clarification to minimize the time required for providers to hold PET claims.

Several claims processing publications released over the past few months by CMS indicated CMS would activate and adopt CPT codes for PET procedures and discontinue many of the previously used G series HCPCS codes. For physician providers and critical access hospitals, this coding change was to be implemented April 4, retroactive to Jan. 1 or 30th respectively. At present CMS has provided no

instructions to hospitals paid under OPPIs, nor have they released their coding and coverage guidance regarding the use of PET and PET/CT codes or the instructions for the implementation of the PET data registry.

Essentially, these instructions would have activated three cardiac, two brain, and six (new this year) tumor PET CPT codes for Medicare and other patients covered by CMS programs. Due to several constraints not identified by CMS, the CMS official stated, “CMS currently is unable to issue our instructions to carriers regarding the registry or the new PET CPT coding.” The SNM strongly recommends that PET providers contact their carrier or fiscal intermediaries regarding coding for PET procedures in April.

### **CMS Activates CPT Codes, Discontinues G Codes for PET Procedures—Change Will Affect All Providers of PET Services**

A publication released recently by the Centers for Medicare & Medicaid Services (CMS) activates the adoption of CPT codes for positron emission tomography (PET) procedures, essentially discontinuing previously used G series HCPCS codes. This coding change will be implemented April 4 and be retroactive to Jan. 30. Essentially, this action will activate three cardiac, two brains, and six (new this year) tumor PET CPT codes for Medicare and other patients covered by CMS programs.

SNM President Mathew L. Thakur, PhD, hailed this action as “the first in a series of steps toward a more uniform coding system for all PET procedures.” He said, “SNM has long believed that the continued use of G series Healthcare Common Procedure Coding System (HCPCS) codes is administratively burdensome, creating complicated charge description masters and often requiring different codes for different payers for the same study.” SNM has strongly advocated the use of CPT codes and submitted recommendations in a series of letters to CMS representatives—some as recently as last month.

“Current Procedural Terminology (CPT) codes describe the PET procedures based on the resources used,” agreed SNM President-Elect Peter S. Conti, MD, PhD. He explained that G codes primarily represent the indications for the uses of PET in patients for oncologic, cardiac, and neurologic diseases; CPT codes represent the procedures themselves and are not tied to a specific indication. Conti, who chairs SNM’s PET Center of Excellence, also noted, “While this action directly impacts physicians and physician offices, the policy decision affects all providers of PET services.”

The Feb. 11 CMS action, published as Change Request 3726, is the first of several anticipated clarifying policy statements on eliminating G codes and moving to CPT codes. The memo includes the relative value units for physician services (-26) previously assigned to the CPT PET codes by CMS, but it does not address other reimbursement issues, such as the payment for technical services; SNM will obtain further clarification regarding the coding change and will keep members notified. Members who work on behalf of the society on issues like this include Gary L. Dillehay, MD, chair of SNM’s Coding and Reimbursement Committee; Kenneth A. McKusick, MD, chair of the Nuclear Medicine PTC Task Force; and Denise Merlino, CNMT, the society’s coding adviser.

The 53-page CMS change request, posted at [http://www.cms.hhs.gov/manuals/pm\\_trans/R475CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R475CP.pdf),

lists the code changes. In its “First Update to the 2005 Medicare Physician Fee Schedule Database,” CMS indicates that payment files issued to carriers based on a Nov. 15, 2004, Medicare Physician Fee Schedule Final Rule have been amended. CMS is expected to post a related Medlearn Matters provider education article online (<http://www.cms.hhs.gov/medlearn/matters>) that will provide additional information on this coding issue.

## Update—CMS Announces Transition to PET CPT Codes

The Centers for Medicare and Medicaid Services (CMS) has issued Transmittal 475—CR 3726 [http://www.cms.hhs.gov/Manuals/pm\\_trans/R475CP.pdf](http://www.cms.hhs.gov/Manuals/pm_trans/R475CP.pdf), the first in a series of instructions and guidance documents that will begin the transition from billing PET procedures using a complex set of HCPCS G codes to 11 PET CPT codes. This communication—dated Feb. 11, 2005—is the “1st Update of the 2005 Medicare Physician Fee Schedule Database.” These instructions to CMS contractors highlight the activation of the CPT codes and designate the G codes with a status indicator “I—not payable by Medicare.” The 11 CPT codes will cover PET for all brain, cardiac, and oncologic indications. CMS did not change the designation for the two noncovered G codes and added one new G code. Carriers will set the payment allowables. For hospital providers paid under OPSS, the CPT codes will be assigned to specific APCs. The update on OPSS should be released soon.

Providers should wait for their carrier to announce the updates from this transmittal within the next few weeks. Carrier updates will describe the implementation process including claims filing instructions and effective dates. The implementation date for this transition is April 4, 2005. Please watch for instructions from your carrier.

CMS issues regular electronic updates through a series of listservs. If you wish to receive these transmittals directly from CMS, please click on this link to the CMS listserv and subscribe to the information links that would benefit your practice: <http://www.cms.hhs.gov/medlearn/listserv.asp>.

The next several months will be filled with news on payment and billing instructions related to the transition to CPT codes in addition to information and updates on the PET registry. Stay tuned!

### **CPT Code Procedure Description**

78459	Heart muscle imaging (PET)
78491	Heart PET, perfusion single (rest or stress)
78492	Heart PET, perfusion multiple (rest &/or stress)
78608	Brain imaging (PET), metabolic evaluation
78609	Brain imaging (PET), perfusion evaluation
78811	Tumor imaging (PET), limited
78812	Tumor image (PET), skull-thigh
78813	Tumor image (PET), full body
78814	Tumor image PET/CT, limited
78815	Tumor image PET/CT, skull-thigh
78816	Tumor image PET/CT, full body

### **Summary:**

- Transmittal 475 announced CMS will transition to CPT code billing for PET scans.
- There are 11 CPT codes that will be used to bill for all cardiac, brain, and oncologic PET scans.
- There are a few G codes that will be used to bill noncovered indications/services.
- Providers should watch for their carrier announcements, which will clarify claims filing instructions and implementation dates for the inactivation of the G codes and the implementation of the CPT codes.
- The CPT codes will be carrier priced.
- The OPSS information should be available soon.
- All CMS updates will be posted as soon as they are available.

## NIH Grant for ACNP Fellow

Congratulations to Hossein Jadvar, MD, PhD, assistant professor of radiology and biomedical engineering at the Keck School of Medicine, University of Southern California. Dr. Jadvar's R01 grant application for "FDG PET-CT evaluation of metastatic prostate cancer," National Institutes of Health—National Cancer Institute was given a 1.2% priority rating in its recent scientific review.

Dr. Jadvar is an active member of ACNP Board of Regents who recently was honored as a Fellow at the 31st Annual Meeting.

## Diagnostic Horizons in PET: Evaluation of Prostate Cancer

Prostate cancer is the cancer most frequently affecting men in the United States. As life expectancy increases, so will the incidence of this disease, creating what will become an epidemic male health problem. The common histology is adenocarcinoma. Digital rectal examination is considered the standard of reference for detection of prostate cancer. About 50% of all palpable nodules are carcinomas. Neither prostatic acid phosphatase (PAP) nor prostate specific antigen (PSA) are useful for screening prostate cancer, although elevated serum levels of these substances are usually suggestive of locally advanced or metastatic disease. The commonly used Gleason Score, which ranges from a minimum of 2 to a maximum of 10, is based on both the tumor's glandular differentiation and its growth pattern and has been shown to be associated with the clinical stage of disease (1).

Development of an accurate noninvasive imaging technique to detect recurrent and residual prostate cancer is critical to the effective management of the growing numbers of patients. Current imaging tests—including ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), and In-111 capromab pendetide (Prostascint)—are not sufficiently accurate to detect local recurrence or metastatic disease. Although bone scans can be useful in detecting osseous metastases, the false positive rate is high. Bone scans also cannot detect soft tissue or lymph nodal involvement.

Positron emission tomography (PET) with [F-18]fluorodeoxyglucose (FDG) has become an important diagnostic imaging tool for identification of a diverse group of common and rare malignancies (2–4). Clinical utility of FDG PET has included initial staging of cancer, detection of metastases, evaluation for therapy response, and differentiation of post-therapy changes from residual or recurrent tumor. PET differs from the other anatomic imaging modalities such as ultrasonography, CT, and MRI in that PET allows high resolution imaging of biochemistry and physiology in health and disease. The ability of FDG PET to detect cancer is based upon elevated glucose metabolism in the malignant tissue in comparison to the normal tissue as a result of increased expression of cellular membrane glucose transporters (mainly GLUT-1) and enhanced hexokinase (HK-II) enzymatic activity in tumors.

Despite the utility of FDG PET in cancer imaging, several tumor types (e.g., carcinoid, bronchioloalveolar carcinoma) may not sufficiently accumulate FDG. Early studies of FDG PET in prostate cancer have shown that FDG accumulation in the primary prostate cancer is generally low and may overlap with the uptake in benign prostatic hyperplasia (BPH) and uptake in the normal gland. FDG PET may be useful, however, in the evaluation of patients with advanced disease, for detection of active osseous and soft tissue metastases, and in the evaluation of hormonal treatment response (5-17).

There has also been a growing interest in the utility of other PET radiotracers for imaging of prostate cancer. Previous studies have shown that C-11 acetate may be clinically useful in a number of cancers

including nasopharyngeal carcinoma, renal cell carcinoma, glial and meningeal brain tumors, and prostate cancer (18). Acetate participates in cytoplasmic lipid synthesis (believed to be increased in tumors). Shreve et al. showed, in an in-vitro study, that cellular retention of radiolabeled acetate in prostate cancer cell lines is primarily due to incorporation of the radiocarbon into phosphatidylcholine and neutral lipids of the cells (19). The lack of accumulation of acetate in urine is also advantageous to imaging prostate cancer in particular, because the prostate bed remains unobstructed by the adjacent high levels of radioactivity in the urinary bladder, commonly a problem with FDG. Seltzer et al. performed C-11 acetate PET in 10 men with primary prostate cancer, in 5 patients with local recurrence, and in 7 normal volunteers (20). Pelvis images were obtained 20 minutes after intravenous administration of 515 MBq C-11-acetate. There was a considerable overlap between the uptake level in primary cancer and normal prostate gland. But in general the uptake was greater in tumor than in normal tissue. C-11 acetate was useful in detection of tumor recurrence in patients who had been treated previously with prostatectomy or radiation therapy.

Preliminary results from previous studies have also shown that choline PET may be very useful in imaging prostate cancer (21, 22). The biological basis for radiolabeled choline uptake in tumors is the malignancy-induced up-regulation of choline kinase, which leads to the incorporation and trapping of choline in the form of phosphatidylcholine (lecithin) in the tumor cell membrane in proportion to the rate of tumor duplication. In a recent study, C-11 choline PET was evaluated for detecting local, regional, and metastatic disease in 13 patients with prostate cancer (23). All patients were treated with androgen deprivation therapy. Three patients were, however, refractory to treatment. PET scans were performed before and after treatment, 5 and 20 minutes after intravenous administration of 370 MBq C-11 choline. The tracer uptake was noted to decrease in both the primary tumor and in the metastases after hormonal therapy, even in 3 patients who were reported to be refractory to the treatment. In the latter group of patients, lesion choline uptake, however, increased after relapse as measured by the increase in the serum PSA level.

Although both acetate and choline appear to be more or less equally useful in imaging prostate cancer in individual patients (24) and are more advantageous than FDG in some clinical circumstances, such as in detection of locally recurrent disease (25), large clinical studies in well-defined clinical situations will be needed to determine their exact diagnostic role in the imaging evaluation of patients with prostate cancer. The potential clinical role of other newer radiotracers such as  $16\beta$ - $^{18}\text{F}$ -fluoro- $5\alpha$ -dihydrotestosterone (FDHT, a radiotracer developed for PET imaging of androgen receptor expression) will also need to be explored (26). The role of PET in clinical management decision making and effect on patient outcome are other important areas for future investigations.

*Hossein Jadvar, MD, PhD, FACNP*

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## ACNP 2005 Abstract Award Winners

The ACNP would like to congratulate the winners of the ACNP travel grants and best essay awards, which were awarded to individuals who presented abstracts at the 2005 ACNP Annual Meeting. The awards were presented by Simin Dadparvar, MD, chair of the Scientific Committee. Pictured below with Dr. Dadparvar (left) are Shyam Mohan Srinivas, MD, PhD; Ayse Mavi, MD; Günsel Acikgoz, MD; Sankaran Shrikanthan, MD; and Thomas F. Heston, MD.



## ACNP's Lifetime Achievement Award



ACNP honored Terence Beven, MD, FACNP, with the Lifetime Achievement Award for his outstanding and ongoing contributions throughout many years. Dr. Beven has been actively involved in advancement of the organization at various levels over the past three decades. He is now serving as chairman of ACNP/SNM Government Relations.

Terence Beven

## Congratulations to New ACNP Fellows

ACNP honored new Fellows at the 31<sup>st</sup> Annual Meeting in San Diego, CA. Shown here with (from left) current and past ACNP presidents Ben Greenspan, MD, and Gary Dillehay, MD, are Fellows Jay Harolds, MD; Hossein Jadvar, MD, PhD (2005); and Richard B. Noto, MD (2004).



## ACNP's President's Award

Warren Moore, MD, outgoing president of ACNP, awarded Simin Dadparvar, MD, FACNP, the 2005 President's Award for her contributions to ACNP at the 31st Annual Meeting. Dr. Dadparvar has been an active member of the ACNP for more than a decade and is the chair of the "Residents As Future Leaders" committee.

## Volunteer News Scouts Needed for ACNP Web Site

We strongly encourage you to share any news material you may run across regarding the practice of nuclear medicine at the local, state, or federal level to be posted on ACNP's Web site. Please give us the source of your information with a link to the source. Please send your e-mails to [sdadparvar@aol.com](mailto:sdadparvar@aol.com).

## Share Your News and Information

We would appreciate it if you would share any information regarding your institution or practice management in "Scanner." If you have received a grant from NIH, DOE, U.S. Army, etc.... or if you have successfully passed a milestone such as NRC inspection, the Nuclear Medicine Residency Review, or practice accreditation ... please let us know. We will publish your experience and help you share your wealth of knowledge with ACNP members. Please e-mail your information to the editor: [sdadparvar@aol.com](mailto:sdadparvar@aol.com).

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