PET/CT Curriculum Debuts

The Society of Nuclear Medicine Technologist Section (SNMTS) and the American Society of Radiologic Technologists (ASRT) announced in early April the development of a new PET/CT training curriculum aimed at combining and improving skills currently practiced separately in most institutions by nuclear medicine and radiology technologists. “Both the ASRT and SNMTS recognized early on how important it is to bring together the stakeholders of PET/CT to outline an infrastructure and a plan that could be adapted for evolving multimodal applications,” said SNMTS President Lyn M. Mehlberg, BS, CNMT. “This curriculum is the product of a multiorganizational effort to define the educational needs of imaging technologists and radiation therapists and establish a pathway for ensuring that competent, qualified technologists are available to operate this unique equipment. Collaboration is key to the advancement of these emerging imaging technologies.”

The new curriculum was developed by a consortium of SNM and ASRT volunteer experts and addresses in detail the question of which skills technologists trained in radiology, nuclear medicine, or radiation therapy should add to their current capabilities in order to become competent in both PET and CT. More than 400 hybrid PET/CT units have been sold to hospital and outpatient units, with this number expected to continue to

A Focus on PET at SNM 2004

A record is likely to be quietly broken at this year’s SNM Annual Meeting in Philadelphia, PA (June 19–23): PET, only 2 decades ago considered a novelty unlikely to achieve routine clinical use, will account for more than half of all scientific presentations. Henry N. Wagner, Jr., MD, who has been studying the scientific abstracts accepted for oral and poster presentations in preparation for his 27th annual Highlights Lecture, told the PCOE Newsletter: “In 1991, I wrote an editorial called, optimistically, ‘Clinical PET: Its Time Has Come.’ As I review the submitted abstracts of work to be presented at this year’s meeting, I can, without hesitation, say that ‘Truly, PET’s time has come.’ It is not only a major focus of nuclear medicine today but has led to the establishment of the new imaging institute at NIH and the concept of ‘molecular imaging’ in all fields, especially onology, neurosciences, and cardiology. An increasing number of presentations at SNM 2004 will offer quantitative ‘proof of value’ of specific indications for PET and PET/CT, producing a substantial body of useful knowledge that attendees can take back with them to their practice settings.”

The SNM PET Center of Excellence (PCOE) and the Correlative Imaging Council will offer a special enhancement to this focus on PET with a full-day-plus categorical seminar and breakout sessions on “PET/CT: State of the Art—Controversies, Correlative Imaging, and Clinical Applications.” The June 19 morning session will include presentations by Lalithe Ramanna, MD, Alan Maurer, MD, James Fletcher, MD, Abbas Alavi, MD, and Richard L. Wahl, MD, and will cover both the challenges and successes that have greeted the rapid entry of hybrid imaging into clinical use.

In the afternoon, attendees may choose between 2 breakout sessions. The first, “Emerging Role of PET and PET/CT for Optimum Patient Care,” will feature an expert panel who will review cutting-edge but clinically relevant PET and PET/CT applications for optimum management of oncology patients. These applications include lung carcinoma, head and neck tumors, and clinical correlative cases pertaining to a variety of oncology patients. In addition, the course will provide a perspective on dedicated PET vs. PET/CT and operational issues with hybrid imaging, protocols, and interpretation. The course will also offer a refresher on basic cross-sectional anatomy for the nonradiologist.

The second breakout session, “Clinical PET/CT Imaging,” is designed for the practicing clinician who wants to increase his or her knowledge of clinical PET/CT. The course begins on June 19 and continues on the afternoon of June 20. Technical aspects of patient preparation and imaging protocols specific to PET/CT will be covered, with emphasis on the appropriate use of PET/CT for diagnosis, staging, restaging, and assessing response to therapy. Participants with a basic knowledge of PET will benefit most from this course.

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**View from the Chair**

Shaping New Perspectives

The PET Center of Excellence (PCOE) is approaching the end of its first year, with an encouraging track record of firsts. As the nexus of interest for a broad range of physicians, technologists, and physicists, the goal is to focus on PET through the center of excellence model that has been widely successful in both academia and business. We’ve provided a central resource for educational aspects of PET and PET/CT through the PET Learning Center, with popular weekend seminars and, this year, the addition of equally popular 1-day seminars focusing on neurology, cardiology, radiopharmaceuticals, and radiation safety. We’ve brought our collective expertise and energy to bear in working with industry and SNM councils on lobbying for new clinical trials, the development of new radiopharmaceuticals, and extended approvals of PET in Alzheimer’s disease and other indications. Finally, we’ve exceeded our expectations with an initial membership of more than 1,400. Clearly the time is right for the PCOE, and you’ve responded enthusiastically with your support and interest.

One of our challenges is to use this momentum to continue to build on the range and quality of resources and activities coordinated through the PCOE. Communication will be a key factor in rising to this challenge, and this first issue of our redesigned newsletter opens a number of new communication avenues with members. Editors Paul Christian, BS, CNMT, David Lilien, MD, and Gabriel Soudry, MD, bring their professional expertise to include the rapidly developing technology of fusion imaging.”

The editors and I realize that few of you have the time or opportunity to read extensive e-publications. For this reason, the PCOE newsletter will soon serve as a portal to our newly expanded, members-only PCOE Web site—pointing you to a host of new features that you can access through www.snm.org/PET. In the coming months, we’ll be adding special features and functionalities to the site that make it reflect the best qualities of a center of excellence. You’ll be only a mouse-click away from educational resources, full-search literature capabilities, expert advice, the latest regulatory and reimbursement news, standards and guidelines, and a closed channel where you can exchange experiences and observations with PCOE colleagues from across the United States and beyond.

Communication, of course, only works as a 2-way exchange. Let us know which features you’d like to see in the newsletter, what functionalities could be added to the Web site, and what information you could use in improving the quality of your PET imaging environment. Ultimately, we’re all working toward the same thing: improving patient care through the expanding applications of this extraordinary technology. The channels of communication that the PCOE has opened hold great promise. Help us keep them open. Don’t hesitate to contact me or any of the editors with your ideas and input. We are, quite literally, shaping this new imaging field together through our efforts at the PCOE.

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**NMTCB Announces PET Specialty Exam**

The Nuclear Medicine Technology Certification Board (NMTCB) announced on March 31 that its first PET Specialty Examination will be held on Saturday, September 18. The exam will be administered nationally by LaserGrade Computer Testing, Inc. Eligibility to sit for the 2004 exam includes:

- Active membership in the NMTCB, American Registry of Radiologic Technologists (ARRT) (N), or Canadian Association of Medical Radiation Technologists (CAMRT) and
- 700 hours of documented clinical experience on a dedicated PET scanner.

Detailed exam information, including content outline, LaserGrade testing locations, and instructions for obtaining an application booklet can be found on the NMTCB Web site at www.nmtcb.org (select “Specialty Exams” from the pull-down menu, then select “PET Exam”).

Beginning in 2005, an augmented version of the PET Specialty Exam will be offered. Eligibility for the exam will be expanded to include those technologists who meet the following qualifications:

- Active membership in the ARRT (R) or (T), and
- 700 hours of documented clinical experience on a dedicated PET scanner under the direct supervision of a certified NMTCB, ARRT(N), or CAMRT technologist and a nuclear medicine physician or radiologist, and
- Satisfactory completion of a minimum of 15 contact hours of course work in each of the following areas: radiopharmacy, nuclear medicine instrumentation, and radiation safety. Only coursework in an accredited college or university, accredited nuclear medicine program, or approved continuing education credits recognized by NMTCB will be accepted.

The augmented exam will be based on an updated content outline that includes information on topics that are pertinent to the practice of PET but are not part of entry-level exams for radiology or radiation therapy.

The NMTCB noted that through this new examination and the collaborative efforts that went into its preparation, “imaging technologists and therapists will have an opportunity to expand their professional expertise to include the rapidly developing technology of fusion imaging.”
PET Suite Shielding, Things to Consider

David A. Tripp, PhD, Peter A. Jenkins MS, CHP, and Paul E. Christian, BS, Huntsman Cancer Institute, University of Utah, Salt Lake City

Currently, no formal publications from professional organizations, such as the National Council on Radiation Protection and Measurements, the American Association of Physicists in Medicine, or others, are available to offer direction on shielding calculations for PET imaging suites. However, several published papers may be helpful (1,2).

Each institution must ensure that the dose from activities in the imaging suite does not expose individuals to levels above the regulatory limits. The 10 CFR 20 limits for annual exposure are 5 rem for occupationally exposed and 100 mrem for nonoccupationally exposed individuals. These limits equate to exposure rates of 2.5 and 0.05 mR/h, respectively. With the quantity of activity and gamma-ray energies associated with PET imaging, these doses can be reached rapidly without proper shielding.

Traditional shielding calculations are carried out using a battery of conservative assumptions. When using similar assumptions with PET, the resulting shielding requirements can be quite large and expensive. If attention is paid to each assumption, however, a conservative shield can be designed without overshielding. Here are some items to consider in your shielding calculations:

1. Because positron emitters have relatively short half-lives compared with those tracers traditionally used in nuclear medicine studies, you can consider that the activity used in the calculation reflects some sort of average rate. For example, if you use $^{18}$F, with a half-life of 110 min, and the patient is held for 1 hour before scanning, then 68% of the activity remains at the time of scanning and the average activity is about 83% over that hour.

2. The daily patient workload should be considered, as well as the number of uptake rooms available. For example, if patients are held for 1 hour before scanning, injected patients in different uptake rooms will have different activities at any given time.

3. Design your shielding for activities higher than those currently being used. As protocols for PET imaging are refined, injected activities are slowing being increased. For example, research has found that uptake in tumors vs. the general body can be effectively increased if the patient is held for a longer period of time before imaging. Thus larger activities are injected to ensure that sufficient activity is left at scanning.

4. Scanning and uptake rooms require different amounts of shielding. Remember that (a) the scanning room is bigger and that distance plays a large role in reducing exposure rate, (b) that the activity is significantly less as a result of patient waiting time, (c) and that the patient voids as much as 30% of the remaining activity before the scan.

5. Hot labs use lead bricks to store radionuclides, and shielding is easy to construct. However, don’t forget the floor and ceiling above the storage area.

6. Remember that the patient does not represent a point source but that the activity is distributed within the body and that there is internal attenuation of the gamma rays. For example, although the exposure rate for $^{18}$F may be close to 12 mR/h at 1 meter for a point source, the exposure rate is probably closer to 6 or 7 mR/hr at 1 meter from an injected patient. If you do not take this difference into consideration, the shielding you design will be much heavier than needed. Actual patient exposure rate measurements with known activities or phantom measurements will be helpful.

7. Consider occupancy factors. That is, an adjacent office area may have an occupancy factor of 1.0 compared with 1/8 for a corridor or 1/20 for a bathroom. Thus, in some areas the exposure rates can be somewhat higher than in others but still meet the requirements for maximum permissible exposure rates.

8. Don’t forget personnel above and below the PET area. Concrete floors are usually less than 4 inches thick. Moreover, concrete in new construction is of low density to lessen floor loads. Gamma rays of 511 keV will obviously penetrate much more easily than at diagnostic x-ray energies. You may need to see that additional lead is attached in the ceilings or floors of adjacent floors.

9. The mass attenuation coefficients for lead and concrete used in your shielding calculations for 500 keV photons can be found on the National Institute of Standards and Technology Web site (http://physics.nist.gov/Divisions/Div846/Gp2/gp2.html). Remember the attenuation coefficient for low-density concrete will be about 20% lower than that for concrete of regular density.

10. Don’t forget build-up factors. Because we are essentially dealing with broad-beam conditions, the build-ups on fac-

11. You may have to consider gamma rays of other energies.
in your calculation. Be sure to consult the gamma decay scheme of the nuclide being used.
12. If you have a PET/CT unit, the x-ray scatter from the CT scan should be factored in as well. Also, don’t forget the control room window.
13. Software, such as MicroShield (4), is available to assist in calculations. Otherwise, you can simply use the usual equations relating to attenuation of photons, half-life, etc., and calculate the shielding requirements, factoring in estimates of average activities, build-up, etc.
14. And, finally, be sure to test the shielding during the first week of operation or use a source of known activity (preferably in a phantom) to make preliminary exposure rate measurements to assure that levels are within permissible limits.

References

A Focus on PET at SNM 2004 (Continued from page 1)
“This categorical course is just one of a number of opportunities at the meeting for the SNM and the PET Center of Excellence to build on the existing educational resources we’ve built up through the PET Learning Center,” said Peter Conti, MD, PCOE chair. “Throughout the meeting, at venues large and small, attendees will see and hear presentations from past and present Learning Center faculty members who understand that the interest in PET right now is multifaceted. People want to know more about basic science, apparatus, day-to-day operations, new applications, and innovations that promise to lead to faster diagnoses and optimal treatment assessment. The need for this comprehensive, in-depth focus is one of the reasons we started the PCOE, as a way of channeling the tremendous energy that is propelling PET to the forefront of modern medicine. We think you’ll see the results of this effort throughout the meeting in Philadelphia.” He cited the SNM Technologist Section Categorical Course on “PET/CT Applications in Oncology,” also on June 19, as an example.

So many sessions planned for the SNM 2004 meeting focus entirely or in part on PET that it would, in fact, be physically impossible for one person to attend them all. With the online publication of the Annual Meeting abstracts in May, the PCOE Web site will feature a special highlighted version for members, pointing to sessions of PET and PET/CT interest. To access the PET-highlighted program, visit the PCOE Web site through www.snm.org/PET. For more information on the SNM Annual Meeting, see www.snm.org.

PET/CT Curriculum Debuts (Continued from page 1)
grow throughout the current decade. Fewer than 5,000 technologists are certified in both radiology and nuclear medicine, however, and fewer than 200 technologists are certified in both nuclear medicine and CT. The need for cross training is expected to grow rapidly as more and more fusion scanners are deployed. This need is also being addressed by cross-certification examinations in PET and CT (see story, p. 2).

The new curriculum contains a “gap analysis” specifying what each interested group needs to become proficient in both PET and CT. Radiology and radiation therapy technologists need additional training in radiation protection, radionuclides and radiopharmaceuticals, instrumentation and quality control, and diagnostic procedures. The curriculum specifies additional training for nuclear medicine technologists in patient care, patient assessment, radiation protection, computers, CT computers, image quality in CT, CT process, spiral CT, physics/instrumentation, applied terminology, cross-sectional anatomy (multi-plane) with pathologic correlation, procedure protocol, and procedures. “By identifying the gaps in the curriculum, we hoped to indicate a base foundation, no matter what the technologist’s previous education, so that he or she could see a clear path toward more advanced education,” said Kevin Powers, Director of Education at the ASRT.

The curriculum is now available on the SNM Web site at www.snm.org. During early May, CD-ROMs with the PET/CT curriculum content will be mailed to educational institutions with radiography, nuclear medicine, and/or radiation therapy programs. State regulators have been provided copies of the PET/CT curriculum to assist in their efforts at licensing this technology. Copies of the PET/CT curriculum on CD-ROM will also be available at the SNM 2004 Annual Meeting in Philadelphia in June.
PET Case: B-Cell Lymphoma

This 67-year-old woman presented with left arm pain and swelling. On physical examination, she was found to have palpable adenopathy in the left supraclavicular and axillary regions. An ultrasound-guided biopsy showed large B-cell lymphoma. A staging CT scan of the chest (Figs. 1,2), abdomen, and pelvis was reported as showing marked left axillary adenopathy (arrowheads) with a question of a soft tissue mass associated with an anterior abdominal surgical scar.

A PET scan (Fig. 3) showed large conglomerate areas of uptake extending through the base of the neck on the left, the left supraclavicular region, the left axilla, and the left arm (arrows). Only physiologic bowel activity and renal excretion of tracer were present in the abdomen and pelvis.

How Did PET Imaging help?

PET was helpful in showing the full extent of disease, including left arm involvement that was not previously noted because the arms are routinely raised and out of the field of view on CT scans. PET also showed that there was no abdominal involvement. After successful completion of chemotherapy, the patient was referred to radiotherapy, where, based on the PET findings, the treatment field was extended to include the area of involvement in the left arm.

A number of studies have shown that PET is the most accurate staging modality for lymphoma, significantly better than CT and bone marrow biopsy, and that the use of PET leads in many cases to changes in therapy and improved outcomes. (See, for example, Eur J Nucl Med Mol Imaging. 2003;30(suppl 1):S82–S88; Q J Nucl Med. 2003;47:14–21; J Nucl Med. 2003;44:224–239; Acta Oncol. 2002;41:430–436; Ann Nucl Med. 2002;16:337–345; Cancer. 2001;91:889–899.)

About Views You Can Use

This case was provided by Gabriel Soudry, MD, director of nuclear medicine at Franklin Square Hospital in Baltimore, MD. He regularly features examples of the benefits of PET on his outreach Web site at http://petcases.com. “Many of us in imaging are accustomed to seeing teaching cases that are unusual or rare,” he told the PCOE Newsletter. “But I select our PET cases precisely because they are commonplace. We want to have a battery of examples of the kinds of cases that our referring physician community commonly encounter in their daily practice so that they can see how PET can benefit their patients. We want them to think of PET as a routine, useful adjunct to the work-up of their patients.” In addition to the Web site, Soudry also mails printed versions of his example cases to the referring physicians both within Franklin Square and in the surrounding community.

Working with Soudry and other PET specialists, the PCOE Web site (www.snm.org/PET) will feature regular “Views You Can Use,” single-sheet PDFs that include specific cases, images, and references to supporting documentation. As a PCOE member, you can add your own contact information to these sheets and distribute them electronically or by printed hardcopy to referring physicians for educational purposes.
PET in the Literature

About PET: March and April, 2004


Spotlight on PET in The Journal of Nuclear Medicine:

18F-FDG PET is showing extraordinary promise in its ability to assess and characterize disease activity in patients with rheumatoid arthritis (RA). One upcoming study to be published in the June issue of The Journal of Nuclear Medicine highlights research efforts on PET and RA. Beckers et al. from the University Hospital of Liège (Belgium) will report on a study using 18F-FDG PET to assess synovitis in individual joints and in global analyses of RA disease activity and to compare PET parameters with corresponding clinical, biologic, and sonographic (US) rheumatoid parameters. The study included the assessment of 356 joints in 21 patients with active RA. Areas assessed included the knees in all subjects and at least one wrist, as well as metacarpophalangeal and proximal interphalangeal joints in 13 patients, or ankles and the first metatarsophalangeal joints in the remaining 8 patients. PET analysis consisted of a visual identification of 18F-FDG uptake in the synovium and measurements of standardized uptake values (SUVs). Independent assessors performed the clinical and US examinations. PET identified uptake in 63% of joints, whereas 75%, 79%, and 56% were positive for swelling, tenderness, and US analysis, respectively. Both the rate of PET-positive joints and the cumulative SUV increased with the number of positive parameters present (swelling, tenderness, US positivity) and with the synovial thickness. The mean SUVs were significantly higher in joints where a powerful Doppler signal was found. In a global PET analysis, the number of PET-positive joints and the cumulative SUV were significantly correlated with the swollen and tender joint counts, patient and physician global assessments, erythrocyte sedimentation rate and C-reactive protein serum levels, disease activity scores and simplified disease activity index, number of US-positive joints, and cumulative synovial thickness. The authors concluded that although additional cross-sectional and longitudinal studies are needed before 18F-FDG PET analysis of RA joints can be considered as an established method for diagnosis and therapeutic follow-up in rheumatology practice, this is a unique imaging technique that can assess the metabolic activity of synovitis and measure disease activity in RA.
At the PET Learning Center

The SNM PET Learning Center held its first 1-day session on neurologic applications on April 17 in Rosslyn, VA. Physicians from across the country heard practical advice from noted experts on both approved and pending indications for the use of PET in a range of applications. “We’re seeing a great deal of interest in our new single-topic, 1-day seminars,” said Brenda Johnson, SNM Director of Education. “Attendees report that the experience provides them with the opportunity to focus in-depth on specific aspects of PET and, at the same time, discuss broader issues with colleagues from diverse practice settings.”

The PET Learning Center has recently upgraded its Web site to better serve interested attendees. On the main page, each program is listed chronologically with event title, date(s), location, and credit type(s) offered. A click on a specific program leads to detailed informational pages and downloads, including registration details and housing and travel resources. A complete PET Learning Center brochure and list of official sponsors are also available as downloads from the site, which can be accessed by clicking on the PET Learning Center logo on the SNM home page at www.snm.org.

Upcoming PET Learning Center Dates

**Physician Training**
- May 22–23: Knoxville, TN
- July 17–18: Reston, VA
- July 24–25: Knoxville, TN
- August 7–8: Reston, VA
- August 21–22: Reston, VA
- September 11–12: Reston, VA
- September 18–19: Reston, VA
- October 2–3: Reston, VA
- November 6–7: Palo Alto, CA
- November 20–21: Reston, VA
- December 4–5: Knoxville, TN
- December 11–12: Reston, VA

**Technologist Training**
- July 9–11: Palo Alto, CA
- October 15–17: Reston, VA
- November 12–14: Reston, VA
- September 18–19: Reston, VA
- October 2–3: Reston, VA
- November 6–7: Palo Alto, CA
- November 20–21: Reston, VA
- December 4–5: Knoxville, TN
- December 11–12: Reston, VA

PET in the Literature (Continued from page 6)

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- Halpern BS, et al. Impact of Patient Weight and Emission Scan Duration on Image Quality and Lesion Detectability using PET/CT
- Hattori N, et al. Acute Changes in Regional Cerebral FDG Kinetics in Patients with Traumatic Brain Injury
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- Heeren PAM, et al. Detection of Distant Metastases in Esophageal Cancer with $^{18}$F-FDG PET
- Surti S and Karp JS. Imaging Characteristics of Philips Allegro: a 3D GSO Whole-Body PET Camera
Powering Up the PCOE Web Site

We’re introducing a members-only PCOE Web site, designed with you in mind. We’re looking at ways to add materials you need and constantly update the site with a wealth of information to keep you informed about issues affecting the PET community. In addition to links to JNM articles related to PET, recent clinical and basic science references, a listing of PET centers in the United States, the Center’s current leadership, an archive of PET Center newsletters, a directory of PET Center of Excellence members, and links to other PET-related organizations, we’re planning to add features available nowhere else. Visit the site often, and let us know which features you like and what you’d like to see added. You can access the site through the main PCOE Web page at www.snm.org/PET. Log in to the PCOE Members site by using your SNM password.

Have a PET-Related Question?

One sure-to-be-popular part of the PCOE Web site will be a new question-and-answer tool. This service will be reserved for members of the PCOE, who can submit questions ranging from reimbursement issues to clinical practice and beyond. Look for this feature to be added to the PET Center of Excellence Web site in May 2004. You may also e-mail your questions to pet@snm.org to have them answered by experts in the field.

Call for PCOE Volunteers

The PCOE is breaking new ground in imaging by bringing together a unique—and rapidly growing—membership interested in all aspects of PET. Several committees have been established to work on projects that will be beneficial to our members. We encourage you to look at their activities and volunteer where your skills can benefit your fellow members.

The PET Committee on Credentialing was established to explore issues related to credentialing and certifying physicians to perform PET procedures. The subcommittee participated in the November 2003 meeting of the PET/CT Working Group, a group of individuals from the SNM and the American College of Radiology (ACR), to develop qualifications for radiologists to read PET/CT and to outline a PET curriculum. The committee will continue to collaborate with the ACR and other organizations to develop minimum education requirements for an exam that will allow radiologists to read PET/CT.

The PET Committee on Education oversees all aspects of education offered by the PCOE, including the PET Learning Center. The PET Learning Center began 2 years ago and, over the past year, has developed new programs in specialized areas in PET imaging, including cardiac PET, neuroimaging, physics and instrumentation, and radiopharmaceuticals. The committee is exploring the possibility of expanding the accessibility of sessions by offering more frequent sessions at an increased number of locations.

The Corporate Advisory Committee is designed to create a collaborative environment for practicing physicians and industry and provide a mechanism for the PCOE to receive feedback from industry. The CAC includes members from industry with a vested interest in the practice of PET and further development of PET applications. Members of the CAC will have the opportunity to pool resources for projects dealing with PET.

The PET Guide for Referring Physicians Committee is tasked with developing and maintaining a guide that will explain various issues and practical uses for PET for the referring physician community.

The Nominating Committee is charged with identifying and recruiting potential leaders from within the PCOE. Led by the out-going PCOE chair, the nominating committee is composed of 3 members who are appointed by the chair and approved by the PCOE Board of Directors. Each year the committee must identify individuals to run for 3 Board positions.

If you are interested in volunteering, take a moment to go to the PCOE Web site and fill in the volunteer form. Your interest is appreciated, and your participation is essential in ensuring the long-term success of the PCOE efforts.