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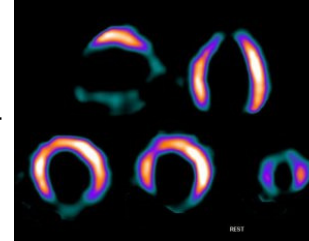
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SPECT MPI for Ischemic Left Ventricular Dysfunction

According to a non-randomized observational cohort published in the January/February issue of the Journal of Nuclear Cardiology, there is potential diagnostic utility for SPECT myocardial perfusion imaging (MPI) for ischemic left ventricular (LV) dysfunction in new-onset heart failure (HF).

Prem Soman, MD, PhD, from the University of Pittsburgh Medical Center, and colleagues undertook the IMAGING in HF study as a prospective, multinational trial, designed to explore the role of SPECT MPI as an initial investigative strategy in patients hospitalized with new-onset HF.

The researchers examined 201 patients (approximately 65.3 years old, 43 percent women) hospitalized with their first episode of HF at 14 sites in the United States and the United Kingdom. They performed rest/stress gated SPECT Tc-99m sestamibi (Cardiolite, Lantheus Medical Imaging) MPI during or within two weeks of the index hospitalization, in addition to standard care.



The investigators found that SPECT MPI revealed a broad range of ejection fractions with preserved systolic function in 36 percent of patients.

Also, the authors noted that 41 percent of patients had normal perfusion. In the remaining patients, Soman and colleagues found that perfusion abnormalities were predominantly due to prior heart attack, with extensive ischemia seen only in 6 percent. Among patients who underwent coronary angiography, SPECT performance characteristics revealed excellent negative predictive value (96 percent) for extensive coronary artery disease (CAD). In multivariable analyses, the extent of perfusion abnormality and advancing age predicted the presence of extensive CAD.

As a result, Somen and colleagues concluded that while “this pilot study provides encouraging preliminary data regarding the utility of MPI for the diagnosis of ischemic LV dysfunction in patients with new-onset HF, further confirmation of these results is required before clinical implementation can be recommended.”

—HealthImaging.com

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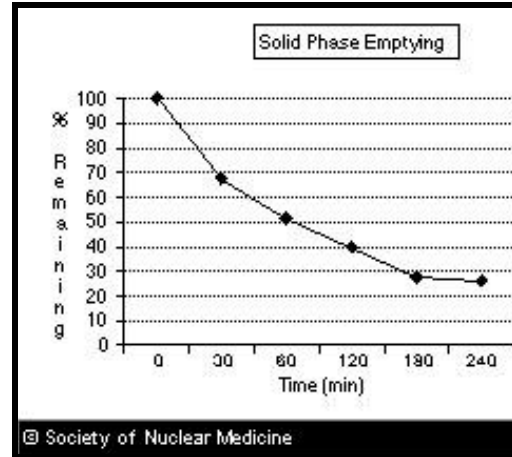
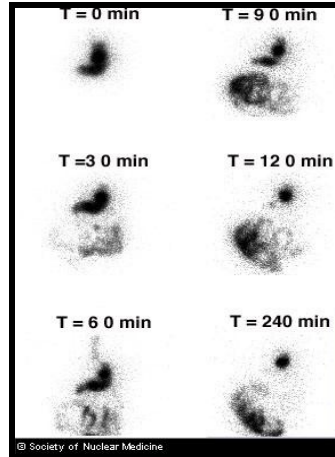
Gastric Emptying Q & A

A 52 year old obese male had gastric surgery two years ago and is referred for a gastric emptying study because of persistent post prandial abdominal pain, nausea and vomiting. Gastric emptying images (anterior view only) following oral ingestion of a Tc-99m scrambled egg meal are shown as well as the gastric emptying curve. The normal values (upper limits of normal) for this meal are 50% at two hours and 10% at four hours.

Based on these images what was most likely the operation performed?

- A. Gastrojejunostomy
- B. Gastric wrap for gastroesophageal reflux
- C. Gastric banding
- D. Partial gastrectomy

The normal small bowel anatomy and normal appearance of the fundus and antrum exclude answers A, B, and D. The scan shows very



localized retention in the mid portion of the stomach just proximal to a prominent mid gastric band (at 90 min). While a prominent mid gastric band is a common normal variant it is not normal to see persistent retention (at 120 and 240 min) in the fundus proximal to a physiologic gastric band. This patient had a silicone gastric band placed as treatment for obesity.

What other complication of gastric banding is demonstrated?

- A. Esophageal dilatation
- B. Gastroesophageal reflux
- C. Hiatal hernia
- D. Gastric erosions

There is marked gastroesophageal reflux seen at 60 minutes. Complications following gastric banding include esophageal dysmotility and dilatation. There is no esophageal retention in the early images to suggest an esophageal problem but esophageal dysmotility would best be diagnosed with either esophageal manometry or esophageal transit scintigraphy. Esophageal dilatation could be evaluated with a barium contrast study if a pre-banding study had been performed. Endoscopy would be required to document gastric erosions.

Alpharadin™ Starts Phase III

A lpharadin (radium-223 chloride) is a unique targeted therapeutic in hormone-refractory prostate cancer (HRPC) that has metastasized to the skeleton.

Alpharadin™ has completed a planned comprehensive phase II clinical program

evaluating it as a new treatment for bone metastases in patients with HRPC. The program provides strong evidence that Alpharadin™ can prolong patient survival times, improve quality of life, and has a placebo-like safety profile.




These exciting clinical results combined with Alpharadin's

unique bone-targeting properties highlight the potential of this new cancer therapeutic to be a first-choice treatment for those bone metastases which occur frequently in major cancers including hormone-refractory prostate cancer, breast, lung, kidney, and thyroid cancers. The unmet medical need is high: bone me-

tastases are a serious consequence of most common advanced cancers, causing intractable and debilitating pain as well as further reducing life expectancy. In addition the results suggest that Alpharadin has an ideal profile for use in combination with other cancer therapies.

The Alpharadin™ phase II program comprised three trials and involved 286 individuals. The data were compelling and consistent: in all three phase II trials completed, the primary efficacy endpoints were met while providing unequivocal evidence of the benign, safety profile of Alpharadin.

In addition to prostate cancer, Alpharadin™ may also have potential in treat-

Product Pipeline	Indication	Development Phase			
		Research	Preclinical	Clinical Development	Registration
				Phase I Phase II Phase III	
Alpharadin™	Skeletal metastases from prostate cancer				
Alpharadin™	Pain palliation — Skeletal metastases from prostate cancer				
Alpharadin™	Skeletal metastases from breast cancer				

ing bone metastases originating from other types of cancer, such as breast, lung, kidney and thyroid.

An estimated 1.5 million patients worldwide suffer from skeletal metastases and there are approximately 300,000 new cases per year.

Phase III trial started

The manufacturer, Algeta, has recently commenced the ALSYMPCA (ALpharadin in SYMptomatic Prostate CAncer) study. This study is a phase III double-blind, placebo controlled trial.

SNM Coding Q & A

Diagnosis Code Matched to Procedure
Created: January 14, 2009

Question :

Is there a list of proper diagnosis for nuclear medicine procedures? For example, if a lung scan is ordered and the diagnosis is listed as CHF; would this diagnosis be appropriate or should the diagnosis be Chest Pain or Shortness of Breath? In other words is there a list that tells what diagnosis should go with a procedure.

Answer:

The answer is both yes and

no. The covered diagnosis codes for individual procedures are dependent on the individual payer and the state. Some of these policies are publicly available on web sites or in payers newsletters (yes), while others are private (no). The SNM recommends that you contact each of your top payers including your Medicare Contractor to get a list of local coverage policies for the procedures that you perform.

Captopril Renogram

Created: January 14, 2009

Question

When A baseline renogram is done on day 1 and the Renogram with Captopril is done

on day 2 what is the appropriate CPT code(s) to use for accurate billing.

Answer

The CPT code for the procedure you are describing is 78709 Kidney Imaging Morphology; with Vascular Flow and Function, Multiple Studies, with and without Pharmacological Intervention. Note the "with and without pharmacological intervention" portion of the code as it is the one code that accurately describes two or more studies including with and without the additional (non-radioactive) drug.

—SNM Website

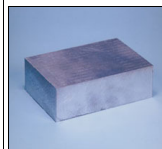
FOR SALE

Slightly used, heavily discounted



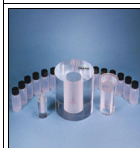
**Used Dose Calibrator
Capintec CRC-10R.....\$1,575.00**

works well...



Lead Bricks.....\$60.00 each

*Rectangular Lead Brick; 8" l x 4" w x
2" h (20 x 10 x 5 cm), 27 lb (12.5 kg)/
each*



**Thyroid Uptake Neck Phantom....
\$295.00**

*(Complete with Bottle Carrier, Capsule
Holder and 12 Polyethylene bottles)*

Technologist Job Line

If you are interested in the following position please feel free to contact the department directly, or give us a call at the pharmacy.

Diagnostic Health Services is seeking a technologist to cover 1 day per week (Tuesdays) in Indiana. Call Bill Gooch at (800) 322-6341.

Technologist looking for full-time or part-time position .

Karen Foncannon

Contact info:

Karen.foncannon@hotmail.com

731-661-9287

Wk: 731-541-7866

Current Practices in Renal Imaging

**Thursday, March 5, 2009
Refreshments at 6:00 p.m.
Presentation at 6:30 p.m.**

**Radiopharmacy, Inc.
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Please RSVP by Monday, March 2, 2009
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