varying aspects of disease (in this case, organ vs. nodal involvement). Future studies investigating these agents must work to align clinical questions with clinically relevant endpoints.

I will end this summary with a disease setting seen every day in the nuclear medicine clinic: breast cancer bone metastases, where the question of bone scanning vs. ^{18}F-FDG PET is a growing focus. Nasr and colleagues from Cairo University Hospital (Egypt), Prince Sultan Military Medical City (Riyadh, Saudi Arabia), and Assuit University Hospital (Egypt) reported on the "Difference between ^{18}F-FDG PET/CT and ^{99m}Tc-methyl diphosphonate (^{99m}Tc-MDP) bone scintigraphy in estimation of metastatic osseous burden in breast cancer patients: A comparative study in view of CA15-3 and alkaline phosphatase" [609]. In 37 patients with breast cancer metastasized to bone, they showed (not surprisingly) that a semiquantitative metastatic osseous score based on ^{18}F-FDG PET was more closely correlated with changes in tumor and bone markers than a bone scan score. Comparative examples in Figure 8 show ^{18}F-FDG uptake throughout the bones. Although uptake is evident in the ^{99m}Tc-MDP bone scan, it does not have the same extent or detail as the PET/CT. After successful treatment in this study, PET scores decreased but the bone scan scores remained the same. Figure 8 also shows a classic example of an FDG-avid lytic lesion that became non-FDG-avid and sclerotic after treatment. The bone scan remains the go-to test in many clinics and clinical trials assessing response in metastatic breast cancer, but here we see an example of old bread-and-butter imaging concepts that we may not be optimizing to their fullest potential.

Conclusion

This is an exciting time in general nuclear medicine, with new and potentially transforming technologies and methods. We have seen here only a few examples of the outstanding work presented at this meeting. Going forward, we must be engaged and work closely with our clinical colleagues to demonstrate benefits in workflow and/or outcomes. I am optimistic that if we do this as a community, we can continue to advance general nuclear medicine.

COVID-19 and Ventilation/Perfusion (V/Q) Lung Studies

On August 28 SNMMI released updates to a previous statement responding to concerns regarding ventilation/perfusion (V/Q) lung scans and, specifically, the inherent risk of spread of COVID-19 to patients and staff from the ventilation portion of this study. At the time of the release of the original statement on March 19, many institutions opted not to perform ventilation studies. In the interim, the COVID-19 pandemic has evolved in different ways depending on institutions, locations, and populations, with questions about the timing and safety of resuming performance of the ventilation portion of V/Q studies.

The transmissibility of COVID-19 associated with medical ventilation systems has not yet been fully elucidated. In some situations, it may remain appropriate not to perform ventilation studies, for example, in institutions or practices in areas of high or increasing COVID-19 prevalence or where access to COVID-19 testing is inadequate.

The goal of the updated statement was to recognize that, in some regions and clinical situations, a ventilation study may be deemed to be clinically necessary to help diagnose lung disease, including vascular and airway disease. In these settings, performance of ventilation studies may be considered, with local and institutional COVID-19 policies and procedures for aerosol-generating and nonaerosolizing procedures serving as the primary source of guidance. The following considerations, which typically are included in facility policies and procedures, should be reviewed prior to performing ventilation studies:

1. In general, patients should have documentation of a negative COVID-19 polymerase chain reaction test; however, in some cases, local policies or regulations may be different.
2. Technologists should wear appropriate personal protective equipment (PPE) when performing ventilation studies, consistent with local policies for the performance of aerosol-generating and nonaerosolizing procedures.
3. Airflow in the room in which ventilation studies are performed should be evaluated, which may help determine the required time for room turnover after such studies.
4. The availability and administration feasibility of ventilation agents—including FDA-approved agents such as ^{99m}Tc-DTPA, ^{133}Xe gas, and other agents (e.g., ^{99m}Tc-labeled fine carbon particles or ^{99m}Tc-sulfur colloid)—should be considered for performance of ventilation studies.
5. It is recommended that local infection control groups be engaged for guidance and to help evaluate facilities, equipment, and staff PPE use for performing ventilation studies.
6. The approach to performing a ventilation scan in relation to the perfusion scan (i.e., ventilation then perfusion vs. perfusion then ventilation) should be considered on a case-by-case basis, depending on the clinical indication and in consultation with the referring physician.

SNMMI will continue to monitor the COVID-19 pandemic and provide updated information whenever possible.

SNMMI