Niederhuber to Head NCI

President Bush announced on August 18 his intention to formally appoint John E. Niederhuber, MD, as the 13th director of the National Cancer Institute (NCI). Niederhuber has been a professor, cancer center director, National Cancer Advisory Board chair, external advisor to the NCI, grant reviewer, and laboratory investigator supported by NCI and the National Institutes of Health (NIH). Since June he has served as NCI's acting director. "Dr. Niederhuber is a nationally renowned surgeon and researcher and has dedicated his entire academic career to the treatment and study of cancer, thus making him an excellent choice to be the next director of NCI," said National Institutes of Health (NIH) director Elias A. Zerhouni, MD. NCI is the only NIH institute or center with a leader directly appointed by the U.S. president.

In addition to his management of NCI, Niederhuber remains involved in research through a laboratory on the NIH campus. Under his leadership, the Laboratory of Tumor and Stem Cell Biology (part of the Cell and Cancer Biology Branch of the NCI Center for Cancer Research) is studying adult tissue stem cells as the cell of origin for cancer. Niederhuber also holds an appointment on the NIH Clinical Center medical staff.

Before joining NCI in a full-time capacity, Niederhuber was a professor of surgery and oncology at the University of Wisconsin School of Medicine in Madison. He also served as director of the University of Wisconsin Comprehensive Cancer Center, one of 61 NCI-designated cancer centers. Earlier in his career, he chaired the Department of Surgery at Stanford University in Palo Alto, CA, and has held professorships at the Johns Hopkins University School of Medicine (Baltimore, MD) and at the University of Michigan in Ann Arbor.

National Cancer Institute

Nuclear Medicine Week, October 1–7

Each year, the SNM and SNMTS join forces with the nuclear medicine and molecular imaging community to gain recognition and support for the field. Celebrated during the first week of October, Nuclear Medicine Week encourages community members to take pride in their profession—recognizing their colleagues for their hard work and promoting nuclear medicine to the entire medical community as well as to the public. The theme of this year's celebration, to be held October 1–7, is "Tomorrow's Technology: Today's Images."

Nuclear Medicine Week allows physicians, technologists, scientists, and others involved in nuclear medicine and molecular imaging to take a proactive role in the advancement of the field. Each practice and institution takes its own approach to marking the annual event, but popular activities include distribution of informational pamphlets on nuclear medicine to hospital staff, referring physicians, patients, and local schools; holding staff appreciation events; creating public or school programs where information about nuclear medicine procedures and advances are discussed; opening facilities for tours by hospital staff and educators; and contacting local media outlets to encourage coverage of the benefits of nuclear medicine.

The SNM makes support materials available each year to help in Nuclear Medicine Week activities. In addition to informational pamphlets and posters, this year's supplementary materials include Nuclear Medicine Week–labeled lunch coolers, USB memory sticks, sports bottles, pens, and patches.

Society of Nuclear Medicine

Topic of Security Detector Triggers Resurfaces

Concern about patients triggering radiation-sensitive security alarms after undergoing nuclear medicine procedures came again to the attention of the public this summer with a border security incident and a widely publicized British report and recommendations. An 83-year-old Canadian man who had undergone nuclear cardiac imaging on the previous day set off radiation detectors at the U.S.–Canadian border. The *Vancouver Sun* reported on Aug. 16 that border guards stopped Stanley Smith on August 11 when he attempted to enter the United States at the Peace Arch. Alarms were set off during a routine security screening. Smith was surrounded by heavily armed security guards, who took his passport and medical documents and questioned him for more than a half hour. Smith said, "It was a nightmare, believe me. All I heard was buzz, buzz, buzz, and I thought, 'What in the hell is that for?' I had no idea I was radioactive. I got the injection in the hospital, but I didn't know what it was. There must be a lot of people who get these injections, and don't know. Today's security is so tough. And those security people, they have no sense of humor whatsoever."

Only days earlier, the *British Medical Journal* (2006;333:293–294) published an article reinforcing previous advice about informing patients that they might trigger alarms. Their research was sparked by reports of a patient who activated an airport radiation detector more than 6 weeks after receiving ^{131}I therapy. After a literature search, the authors identified 4 additional cases that highlight the length of time necessary before a patient can be assured of passing through security checkpoints without incident. They noted that their own nuclear medicine department had amended the advice given to patients after radioiodine treatment to indicate that airport alarms may be triggered up to 12 weeks after therapy. "Airports

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worldwide are deploying more sensitive radiation detection systems and hence one would expect more such cases unless we take responsibility of forewarning our patients," they wrote.

The *Washington Post* recently reported that in the last 6 years U.S. customs officers have responded to 318,000 radiation detection alarms, but that none of these alarms have resulted in the identification of illegal materials. SNM provides information for clinicians on this issue online at www.snm.org/security.

Vancouver Sun
British Medical Journal

Neagley to Edit *JNMT*

Frances L. Neagley of San Francisco, CA, has been named editor in chief of the SNM Technologist Section's *Journal of Nuclear Medicine Technology*. The peer-reviewed quarterly journal, published by SNM since 1972, focuses on technology, quality assurance, radiation safety, and clinical applications of nuclear medicine. Neagley recently retired as a senior nuclear medicine technologist from the Davies campus of the California Pacific Medical Center in San Francisco. She succeeds Beth A. Harkness, a physicist in the radiology department of the Henry Ford Health System in Detroit, MI. Harkness will leave the editor in chief post on December 31, after 2 terms (6 years) of service.

"I believe Fran Neagley will make an excellent editor in chief," noted SNMTS President D. Scott Holbrook, speaking for the Technologist Section's 8,000 members. "Fran brings nearly 35 years of clinical experience, along with a passion for excellence, to the top editorial position. I'm confident Fran—like her predecessor Beth Harkness—will add new and exciting dimensions to the journal."

"*The Journal of Nuclear Medicine Technology* is the primary SNMTS member benefit," said Neagley, who began transitioning into the editor position on July 1. "While keeping the high scientific content of *JNMT*, I intend to increase its relevancy to all technologists—beginning with some state-of-the-art articles." Neagley, who will assume full editorial responsibility for the journal on January 1, also wants to increase the number of continuing education articles. She is currently identifying associate and consulting editors and wants "to increase input, variety, and topicality" in the journal.

Neagley served as nuclear medicine supervisor with the Davies Medical Center, 1980–1998; as chief technologist with the San Diego Nuclear Medical Group, 1975–1980; and as staff technologist with Stanford University Hospital in Palo Alto, CA, 1970–1973. She holds a bachelor's degree in biology and is certified by the Nuclear Medicine Technology Certification Board and the American Registry of Radiologic Technologists.

Society of Nuclear Medicine

FDA Seeks UDI Comments

The U.S. Food and Drug Administration (FDA) announced on August 9 that it is seeking information on how the use of a unique identifier system could improve the delivery and monitoring of medical care. The complete notice appeared in the August 11 *Federal Register* (www.fda.gov/OHRMS/DOCKETS/98fr/06-6870.htm). A public meeting is planned in the fall, and comments received before November 9 will be used to help the agency determine what next steps to take in developing a unique device identifier (UDI) system.

"Much like the bar code rule for drugs and biological products, unique identifiers for medical devices could have many potential benefits for improving the quality of care for patients," said Daniel Schultz, MD, director of the FDA Center for Devices and Radiological Health. "A UDI system could have broad applications in reducing medical errors, facilitating device recalls, improving medical device adverse event reporting, and encouraging cost effectiveness by improving delivery and supply chain efficiency." As the number and complexity of medical devices grow, the FDA is looking at new technologies that may help to identify and manage risk. According to a press release announcing the opening of the comment period, the FDA believes that a UDI system could provide information that would be associated with a specific device throughout its lifetime. For example, a UDI could identify which devices are compatible, such as implanted devices that can be used safely with MR imaging systems.

FDA representatives have already met with groups of stakeholders and found that most supported the development of a UDI system as a way to improve patient safety. Another potential benefit cited was better management of the purchase, distribution, and use of medical devices. The FDA also commissioned 2 reports from outside experts on automatic and unique identification of medical devices. The reports identified several potential benefits, including identifying incompatibility with devices or potential allergic reactions. In addition, FDA has been working with the Agency for Healthcare Research and Quality and with other federal partners to better understand issues associated with the development, implementation, and use of a UDI system.

"It is essential that we monitor the performance of medical products after they are approved and make sure that we quickly discover any potential problems that might arise," said Andrew C. von Eschenbach, MD, Acting Commissioner, FDA. "To improve our postmarket data collection at FDA, we are using a total product lifecycle approach to how we look at medical devices and focusing more attention on the kinds of systems and processes we need to have in place to monitor products after they are approved."

During the comment period, FDA wants to learn about the feasibility, utility, benefits, and costs associated with developing and implementing a UDI system for medical devices. In addition, the agency wants to hear about various automatic identification technologies, such as bar code and radiofrequency, that could be used with a UDI system. A list of questions

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^{188}Re-Labeled Pretargeting

Liu et al. from the University of Massachusetts Medical School (Worcester) and the University of Oklahoma Health Sciences Center (Oklahoma City) reported in the August 15 issue of *Clinical Cancer Research* (2006;12:4958–4964) on a study of ^{188}Re-radiolabeled pretargeting for more effective drug delivery in radiotherapy. This article is a follow-up to original work in which the authors proposed the Watson–Crick pairing of phosphorodiamidate morpholino oligomers (MORF) as a recognition system in tumor pretargeting and initial studies using MORF pretargeting with ^{99m}Tc as the radiolabel. In the current study, mice injected with ^{188}Re-labeled MORF showed rapid tumor localization of tracer and rapid clearance from normal tissues. Tumor growth in the study group ceased 1 day after injection, whereas tumors continued to grow at a constant rate among the 3 different control groups. Average net tumor weights were also significantly lower in the treatment than the control groups at day 5, when the mice were killed and results analyzed. The authors concluded that "MORF pretargeting has now been shown to be a promising approach for tumor radiotherapy as well as diagnosis."

Clinical Cancer Research

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offer demonstrations, and answer questions. This provides a new opportunity to present this excellent work at the SNM Annual Meeting. I hope that many members of the nuclear medicine community will consider participating in this novel effort.

(2) We will also designate a classroom in which educational and informational programs on information science and technology will be offered throughout the meeting. These programs may be specific to our field or of more general interest. For example, a representative of the Integrating the Healthcare Enterprise initiative may discuss the development of guidelines for the more effective display of nuclear medicine image data within a PACS environment. Another individual might present different approaches to comparing a patient's ^{18}F-FDG PET brain scan with a normalized database. Because we will be in Washington, DC, it might be useful to invite a representative from the National Library of Medicine to show us how to perform more directed and efficient PubMed literature searches.

Both of these components of the InfoSNM program will be located in the same meeting area, with a partition that can be pulled to separate them if necessary. This area will be well marked and should be easy to find. I am very excited about this new program. Although it may begin slowly, I hope it will continue to grow in the years to come. If you have questions, please feel free to contact me at frederic.fahey@childrens.harvard.edu (617-355-2809), other members of the InfoSNM Committee (Jim Halama, Marie Kijewski, and Jerry Wallis), or Lynn Barnes, director of education at the SNM (lbarnes@snm.org). I look forward to seeing all of you in the InfoSNM area next June in Washington, DC!

Frederic H. Fahey DSc
Chair, SNM Scientific Program Committee

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is included in the *Federal Register* notice.

To submit electronic comments, visit www.fda.gov/dockets/ecomments. Written comments may be sent to: Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD, 20852. Comments must be received by November 9 and include the docket number 2006N-0292.

U.S. Food and Drug Administration

PET in Court

The nuclear medicine community watched with interest in August as PET imaging was used as part of the defense strategy in an appeal on behalf of a convicted murderer in Georgetown County, SC. Lawyers for Stephen Stanko, an inmate on death row at Lieber Correctional Institution in Ridgeville, filed an appeal on August 21 indicating that PET imaging showed brain damage. The basis of the appeal, which will go to the South Carolina Supreme Court, is that Stanko's execution would be unconstitutional because he has brain damage and could not control his actions. The filing came at the same time that state prosecutors announced their intention to seek a second death penalty for Stanko in another killing. The defendant's lawyer told the press that the initial introduction of PET in the defendant's first trial "was a precedent-setting case.... We're opening our eyes to why people do these things. He [Stanko] has a brain defect from birth. He has 50%–80% loss of function in the frontal lobe and that translates into lack of character." The appeal may take up to 1 year.

Prosecutors and most medical observers were skeptical of the attorney's remarks and of the relevance of PET results in this case. However, the case—and the public interest generated—are reminders that as nuclear medicine procedures continue to explore verifiable measures of brain function in addiction, schizophrenia, and a range of dementias, nuclear medicine experts will be more frequently called upon to interpret the results of imaging in the legal setting.

Myrtle Beach Online