of the tumor was known by morphologic imaging. In some cases, regional physiologic uptake in the myocardium was observed, but as reported, the vicinity of the tumors showed a mean myocardial uptake of as low as 2.1 ± 0.6 standardized uptake value (SUV) (*1*). Peritumoral myocardial dysfunction might be discussed as an explanation of this finding, but in the absence of further evidence this assumption was not discussed in the article.

Nevertheless, we support the concept of a prolonged fasting period.

Sarcoidosis is certainly a condition that may mimic malignant disease. Patient inclusion criteria were primarily based on morphologic imaging. The probability of sarcoidosis was low according to imaging and clinical information. The differential diagnosis was therefore no major problem in this series of patients. In that context it has to be emphasized that sufficient results in functional imaging can be obtained only with state-of-the-art morphologic imaging techniques in the background.

Tumor biopsy was performed before ^{18}F-FDG PET/CT in 3 of 24 patients: almost 2 mo before PET/CT in one of these patients and within 1 wk in the other two. In all patients, the tumors had a malignant histology, and the smallest tumor had a maximum diameter of 5.6 cm. There is no evidence that inclusion of these 3 patients systematically affect the results of the study.

We completely agree with Drs. Cheng and Alavi that the proposed cutoff of 3.5 SUV cannot be applied to an unselected population to screen for myocardial malignancy. Maximum SUV depends on many factors such as scanner resolution, lesion size, scan delay after injection, and the use of motion correction. The cutoff is valid only in the technical and clinical setting described in detail in the article. We thank Drs. Cheng and Alavi for emphasizing this important issue.

REFERENCE

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Erratum

The authors of "Impact of Dynamic ^{18}F-FDG PET on the Early Prediction of Therapy Outcome in Patients with High-Rish Soft-Tissue Sarcomas After Neoadjuvant Chemotherapy: A Feasibility Study" (Dimitrakopoulou-Strauss et al. *J Nucl Med.* 2010;51:551–558) regret that Table 2 contained some errors. The corrected table appears below.

TABLE 2
Results of Linear Discriminant Analysis with Equal Prior Probabilities Based on ^{18}F-FDG Parameters of First PET Study (1) or Second PET Study (2) or Combination of Both Studies

Parameter	PPV	NPV	Sensitivity	Specificity	Accuracy
1: SUV	9/15 (60.00%)	7/10 (70.00%)	9/12 (75.00%)	7/13 (54.00%)	16/25 (64.00%)
1: SUV, VB, k1, k3, FD	9/11 (81.81%)	11/14 (78.57%)	9/12 (75.00%)	11/13 (84.62%)	20/25 (80.00%)
2: SUV	10/16 (62.5%)	6/8 (75.00%)	10/12 (83.33%)	6/12 (50.00%)	16/24 (66.70%)
2: SUV, influx	8/10 (80.00%)	10/14 (71.43%)	8/12 (67.00%)	10/12 (83.30%)	18/24 (75.00%)
2: FD, k4	9/11 (81.81%)	10/13 (76.92%)	9/12 (75.00%)	10/12 (83.30%)	19/24 (79.20%)
1 + 2: SUV	9/14 (64.30%)	7/10 (70.00%)	9/12 (75.00%)	7/12 (58.33%)	16/24 (66.70%)
1 + 2: SUV, influx	11/14 (78.60%)	9/10 (90.00%)	11/12 (91.67%)	9/12 (75.00%)	20/24 (83.33%)
% change SUVmax	8/14 (57.14%)	6/10 (60.00%)	8/12 (66.67%)	6/12 (50.00%)	14/24 (58.33%)

Groups were defined according to histologic classification of 10% variable tumor tissue.
PPV = positive predictive value; NPV = negative predictive value.