minimum intensity, and score 5 was any pattern with intense uptake ($SUV_{max} > 12$). These 2 scores showed an excellent predictive value for the probability of csPC, especially score 5, with a positive predictive value of 100% (*1*). On the basis of multiparametric MRI findings, definite extraprostatic extension/invasive behavior played an important role in the identification of csPC, and it was defined as the highest score, 5, of PI-RADS (*3*). Although the soft-tissue contrast and anatomic details of the prostate gland were not identical on PSMA PET/CT images, apparent extraprostatic extension may be observed in some patients. However, this information was not mentioned in the PRIMARY score. It is questionable whether this feature is out of the scope of the PRIMARY score, which relies predominately on intraprostatic patterns. If patients with suspected prostate cancer were to present with apparent extraprostatic extension on the initial PSMA PET/CT evaluation, and the SUV_{max} was higher than 12, then a PRIMARY score of 5 might be judged present. However, is there an appropriate PRIMARY score for apparent extraprostatic extension but an SUV_{max} lower than 12?

Next, in the PRIMARY score, PSMA intensity ($SUV_{max} > 12$) is used for the definition of only score 5. This cutoff was identified by obtaining the best positive predictive value, or a specificity of 100%, for detecting csPC (*1,2*). In addition, in patients with PI-RADS 3 or initially diagnosed with International Society of Urological Pathology grade groups 1 and 2 by biopsy, every patient with a PRIMARY score of 5 had csPC, indicating the added value of PSMA PET/CT in identifying csPC (*4,5*). In fact, as the author demonstrated, the optimum cutoff of score 5 should be continuously assessed in future versions of PRIMARY. Meanwhile, as a quantitative parameter, the obtained SUV_{max} may be influenced by variations in imaging acquisition and reporting, and a standardized protocol should also be required. Furthermore, the optimum cutoff should also be validated across different PSMA-targeted tracers, especially ^{18}F-labeled tracers such as ^{18}F-DCFPyl and ^{18}F-PSMA-1007.

At present, PRIMARY assessment based on PSMA PET/CT findings is used to identify only the presence of csPC. To improve future iteration of this score tool, we suggest that some clinical information, specifically PSA density, be added in PRIMARY reporting; that the ideal positive biopsy rate for each PRIMARY score be explored just as is done in the Thyroid Imaging–Reporting and Data System tool for thyroid nodules; that the potential of the PRIMARY score in risk prediction, the posttreatment setting, and active surveillance be considered; and that artificial intelligence be integrated into the score system for increasing readers' accuracy and improving interobserver agreement.

DISCLOSURE

No potential conflict of interest relevant to this article was reported.

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Linlin Guo
Guohua Shen*
**West China Hospital of Sichuan University*
Chengdu, China
E-mail: shengh1990@hotmail.com

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Erratum

In the article "A Prospective Randomized Multicenter Study on the Impact of [^{18}F]F-Choline PET/CT Versus Conventional Imaging for Staging Intermediate- to High-Risk Prostate Cancer" by Evangelista et al. (*J Nucl Med*. 2024;65:1013–1020), the affiliation for Eugenio Borsatti and Tanja Baresic is "Nuclear Medicine Unit, Department of Radiation Oncology, Centro di Riferimento Oncologico di Aviano (CRO)-IRCCS, Aviano, Italy". We regret the error.