

Thymic Concentration of Radiolabeled Octreotide

TO THE EDITOR: A radioactive agent that would help distinguish between anterior mediastinal neoplasia and normal or hyperplastic thymic tissue would be of considerable value in pediatric patients. I was, therefore, interested in the recent report in which Lastoria et al. (1) documented ^{111}In -labeled octreotide concentration by malignant thymic tumors (mainly thymomas) but not by the hyperplastic thymuses of the adult patients included in their study. These findings corroborated earlier reports of lack of thymic uptake of this agent in humans (2,3) but are inconsistent with the autoradiographic demonstration of high densities of somatostatin receptors in the medulla of the normal thymus in both adults and children (2).

I reviewed the images of 11 children, ages 5 mo to 11 y, who underwent octreotide scintigraphy to evaluate abdominal or pelvic neuroblastoma (4). None of the patients had mediastinal masses but 9 patients had abundant thymic tissue demonstrated on chest CT scans obtained within 1–13 d of nuclear imaging.

Three of the patients (ages 4, 5 and 16 mo) had thymic activity visible on planar images obtained 2–4 h and 24 h after administration of [^{111}In -diethylenetriamine pentaacetic acid-D-Phe¹]-octreotide (Octreoscan; Mallinckrodt, Inc., St. Louis, MO). This activity was generally more conspicuous on the delayed scans. No histologic examination of mediastinal tissue was warranted in these 3 patients because anterior mediastinal involvement due to neuroblastoma is exceedingly rare and, in each case, the CT appearance of the chest was normal with an anterior mediastinal configuration typical of thymus.

It is difficult to explain the difference between our results and those reported by the previous investigators. Tracer dose and technical considerations relating to small infants may play a role. Because thymic activity was detected in 3 of our youngest patients, it is also possible that thymic somatostatin receptor expression or binding affinity is greater in this age group. Regardless, our findings suggest that uptake of radiolabeled octreotide is not a specific indicator of mediastinal disease in infants and that these scintigrams should be interpreted with caution because of potential false-positive results in this patient population.

Our work was supported in part by the National Cancer Institute, Cancer Center Support (CORE) grant P30CA21765, and by the American Lebanese Syrian Associated Charities.

REFERENCES

1. Lastoria S, Vergara E, Palmieri G, et al. In vivo detection of malignant thymic masses by indium-111-DTPA-D-Phe¹-octreotide scintigraphy. *J Nucl Med.* 1998;39:634–639.
2. Reubi JC, Waser B, Horisberger U, et al. In vitro autoradiographic and in vivo scintigraphic localization of somatostatin receptors in human lymphatic tissue. *Blood.* 1993;82:2143–2151.
3. Rettenbacher L, Galvan G. Differentiation between residual cancer and thymic hyperplasia in malignant non-Hodgkin's lymphoma with somatostatin receptor scintigraphy. *Clin Nucl Med.* 1994;19:64–65.
4. Fletcher BD, Kauffman WM, Santana VM, Bowman LC, Furman WL. Preliminary evaluation of octreotide scintigraphy in children with neuroblastoma [abstract]. *Radiology.* 1996;201(P):243.

Barry D. Fletcher

St. Jude Children's Research Hospital
Memphis, Tennessee

Conventional Treatments for Non-Hodgkin's Lymphoma: The Need for New Therapies

TO THE EDITOR: We read with interest the article by Moskowitz (1). We were concerned, however, that Table 12 entitled "Studies of Radiolabeled and Immunotoxin-Conjugated Monoclonal Antibodies" confuses the results of our current experimental radioimmunotherapy for non-Hodgkin's lymphoma, IDEC-Y2B8,

with earlier data on our murine ^{90}Y -labeled anti-idiotypic monoclonal antibodies (2). Thus, the row in Table 12 labeled "White et al. (82)" is incorrect.

IDEC-Y2B8 is a highly specific murine anti-CD-20 monoclonal antibody covalently linked to MXDTPA which securely chelates ^{90}Y . As such, IDEC-Y2B8 combines the advantages of the target nonmodulating, nonshedding antigen CD-20 with the advantages of the high-energy pure β -emitting ^{90}Y . Table 12 should be corrected to read as follows:

Reference	Indication	Treatment	No. of patients	Response rate (%)	Complete response (%)	Partial response (%)	Duration of response
Wiseman et al. (3,4)	Relapsed/refract: low/int mantle	IDEC-Y2B8 (anti-CD20)	51	67	25	41	10.5+ mo (8.1–13.5+ mo)
	Low grade		34	82	27	56	N/A
Grillo-López et al. (5)	Relapsed/refract B-cell NHL	IDEC-Y2B8 (anti-CD20)	17	64	28	36	7.4+ mo (5.9–14.8 mo)
White et al. (2)	B-cell NHL	^{90}Y anti-Id	9	33	22	11	4 mo (1.5–12 mo)