Positron imaging is demonstrating improved outcomes for oncology. Reimbursement for certain applications is now approved—with the likelihood for more indications in the near future.

Successful integration of positron imaging into the clinical practice goes well beyond the delivery of a camera. It requires assistance in reimbursement, clinical protocols, radio-pharmaceuticals...and much more. That’s why Siemens offers total solutions for every aspect of PET and coincidence imaging. We make it easy to establish a quality positron imaging service.

Whether you perform a few positron procedures a month—or many each day—Siemens has specific product and service solutions to meet your every need. With the most extensive worldwide support network...and over 20 years of positron experience, we are well prepared to meet your individual challenges.

And when it comes to technology, there’s none better—for dedicated PET or coincidence imaging. See why Siemens ECAT® PET and E.CAM™ coincidence cameras are setting the standard in positron imaging today.
the standard in clinical excellence

logy

Siemens medical Solutions that help
Don’t perform coincidence imaging without Capintec’s 511 keV Accessories.

If your facility is planning to get involved in performing coincidence imaging using F-18 FDG, you must consider the added radiation protection required when dealing with a positron emitting radionuclide. Shielding products used for Tc-99m and other standard Nuclear Medicine nuclides are not designed to fully protect you from the higher energy radiation associated with PET isotopes. Capintec has addressed these new shielding concerns and has already been involved with providing special help and equipment for hospitals and radiopharmacies now involved with 511 keV materials. We have developed an exceptional line of products in response to the need for more appropriate shielding. Please visit our PET/511 Products page on the World Wide Web at www.capintec.com/pet.html, or give us a call to find out what we can do for your Department’s needs. Capintec’s PET/511 Shielding Products... just another example of our excellence in the field of Nuclear Medicine.

Not Just Quality... Capintec Quality
Give your nuclear department “rapid clearance” capability with MYOVIEW. MYOVIEW clears quickly from the blood, liver, and lungs for quality target-to-background ratios and timely imaging (as soon as 15 minutes or up to 4 hours post-injection). The clearance properties of MYOVIEW allow for highly flexible camera scheduling and enhanced patient management. Any way you look at it, you’re cleared for efficiency with MYOVIEW.

MYOVIEW is not indicated for use with pharmacologic stress agents.

In studying patients with known or suspected coronary artery disease, care should be taken to ensure continuous cardiac monitoring and the availability of emergency cardiac treatment.

The image of efficiency.

Increase patient throughput—with rapid hepatic clearing, highly efficient MYOVIEW

References:

MYOVIEW. The image of efficiency.
WARNINGS

The Tc99m CONTRAINDICATIONS

Caution: a Technetium exercise General stannic Sometimes maximum heart rate achieved and peak systolic blood pressure were comparable after Myoview and thallium-201 exercise studies.

Clinical Trials

A total of 252 patients with ischemic heart disease or atypical chest pain who had a reason for exercise stress imaging were studied in two open-label, multi-center, clinical trials of Tc99m tetrofosmin (study a and study b). Of these 252 patients there were 212 (83%) males and 40 (17%) females with a mean age of 60.5 years (range 33.7 to 82.4 years). At peak exercise, maximum heart rate achieved and peak systolic blood pressure were comparable after Myoview and thallium-201 exercise studies.

All patients had exercise and rest planar imaging with Myoview and thallium-201; 191 (76%) patients also had SPECT imaging. The Myoview and thallium-201 images were separated by a mean of 5.1 days (1-14 days before or 2-14 days after Myoview). For Myoview imaging, each patient received 185-296 MBq (5-6 mCi) Tc99m tetrofosmin at peak exercise and 55-888 MBq (15-24 mCi) Tc99m tetrofosmin at rest approximately 4 hours later. For thallium-201 imaging, patients received thallium-201 55-74 MBq (1-5-2 mCi) at peak exercise.

The images were evaluated for the quality of the image (excellent, good or poor) and the diagnosis (with scores of 0 = normal, 1 = ischemia, 2 = infarct, 3 = mixed infarct and ischemia). The primary outcome variable was the percentage of correct diagnoses in comparison to the final clinical diagnosis. Planar images were blindly read; SPECT images were evaluated by the unblinded investigator. A subset of 181/252 (71%) patients had coronary angiography comparisons to the planar images of Myoview or thallium-201.

INDICATIONS AND USAGE

Myoview is indicated for scintigraphic imaging of the myocardium following separate administrations under exercise and resting conditions. It is useful in the delineation of regions of reversible myocardial ischemia in the presence or absence of infarcted myocardium.

CONTRAINdications

None known.

WARNINGS

In studying patients with known or suspected coronary artery disease, care should be taken to ensure continuous cardiac monitoring and the availability of emergency cardiac treatment.

PRECAUTIONS

General

To minimize radiation dose to the bladder, the patient should be encouraged to void when the examination is completed and as often thereafter as possible. Adequate hydration should be encouraged to permit frequent voiding.

The contents of the Myoview vial are intended only for use in the preparation of technetium Tc99m tetrofosmin injection and are NOT to be administered directly to the patient.

As with all injectable drug products, allergic reactions and anaphylaxis may occur.

Sometimes Tc99m labeled myocardial imaging agents may produce planar and SPECT images with different imaging information.

Technetium Tc99m tetrofosmin injection, like other radioactive drugs must be handled with care and appropriate safety measures should be used to minimize radiation exposure to the personnel. Care should also be taken to minimize radiation exposure to the patient consistent with proper patient management.

Radiopharmaceuticals should be used by or under the control of physicians who are qualified by specific training and experience in the safe use and handling of radionuclides, and whose experience and training have been approved by the appropriate governmental agency authorized to license the use of radionuclides.

Drug interactions: Drug interactions were not noted and were not studied in clinical studies in which Myoview was administered to patients receiving concomitant medication. Drugs such as beta blockers, calcium blockers and nitrates may influence myocardial function and Blood flow. The effects of such drugs on imaging results are not known.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY

Studies have not been conducted to evaluate carcinogenic potential or effects on fertility. Tetrofosmin sulphanilic acid was not mutagenic in vitro in the Ames test, mouse lymphoma, or human lymphocyte tests, nor was it clastogenic in vivo in the mouse micronucleus test.

Pregnancy Category C

Animal reproduction studies have not been conducted with Myoview. It is not known whether Myoview can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Therefore, Myoview should not be administered to a pregnant woman unless the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

Technetium Tc99m Pertechnetate can be excreted in human milk. Therefore, formula should be substituted for breast milk until the technetium has cleared from the body of the nursing woman.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS

Adverse events were evaluated in clinical trials of 764 adults (511 men and 253 women) with a mean age of 58.7 years (range 29-94 years). The subjects received a mean dose of 7.67 mCi on the first injection and 22.4 mCi on the second injection of Myoview.

Deaths did not occur during the clinical study period of 2 days. Six cardiac deaths occurred 3 days to 16 months after injection and were thought to be related to the underlying disease or cardiac surgery. After Myoview injection, serious episodes of angina occurred in 3 patients. Overall cardiac adverse events occurred in 5/764 (less than 1%) of patients after Myoview injection.

The following events were noted in less than 1% of patients:

Cardiovascular: angina, hypertension, Torsades de Pointes

Gastrointestinal: vomiting, abdominal discomfort

Hypersensitivity: cutaneous allergy, hypotension, dyspnea

Special Senses: metallic taste, burning of the mouth, smelling something

There was a low incidence (less than 4%) of a transient and clinically insignificant rise in white blood cell counts following administration of the agent.

DOSE AND ADMINISTRATION

For exercise and rest imaging, Myoview is administered in two doses:

• The first dose of 5-8 mCi (185-296 MBq) is given at peak exercise.

• The second dose of 15-24 mCi (555-888 MBq) is given approximately 4 hours later, at rest. Imaging may begin 15 minutes following administration of the agent.

Dose adjustment has not been established in renal or liver impaired, pediatric or geriatric patients.

RADIATION DOSIMETRY

Based on human data, the absorbed radiation doses to an average human adult (70 kg) from intravenous injections of the agent under exercise and resting conditions are listed in Table 1. The values are listed in descending order as rad/mCi and Gy/MBq and assume urinary bladder emptying at 3.5 hours.

Table 1

Estimated Absorbed Radiation Dose (Technetium Tc99m Tetrofosmin Injection)

<table>
<thead>
<tr>
<th>Target organ</th>
<th>Exercise</th>
<th>Rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gall bladder wall</td>
<td>0.123</td>
<td>0.13</td>
</tr>
<tr>
<td>Upper large intestine</td>
<td>0.075</td>
<td>0.113</td>
</tr>
<tr>
<td>Bladder wall</td>
<td>0.058</td>
<td>0.071</td>
</tr>
<tr>
<td>Lower large intestine</td>
<td>0.037</td>
<td>0.082</td>
</tr>
<tr>
<td>Small intestine</td>
<td>0.045</td>
<td>0.125</td>
</tr>
<tr>
<td>Kidney</td>
<td>0.039</td>
<td>0.104</td>
</tr>
<tr>
<td>Salivary glands</td>
<td>0.030</td>
<td>0.043</td>
</tr>
<tr>
<td>Ovaries</td>
<td>0.029</td>
<td>0.035</td>
</tr>
<tr>
<td>Urterus</td>
<td>0.027</td>
<td>0.031</td>
</tr>
<tr>
<td>Bone surface</td>
<td>0.023</td>
<td>0.021</td>
</tr>
<tr>
<td>Pancreas</td>
<td>0.019</td>
<td>0.008</td>
</tr>
<tr>
<td>Stomach</td>
<td>0.017</td>
<td>0.017</td>
</tr>
<tr>
<td>Thyroid</td>
<td>0.016</td>
<td>0.022</td>
</tr>
<tr>
<td>Adrenals</td>
<td>0.016</td>
<td>0.015</td>
</tr>
<tr>
<td>Heart wall</td>
<td>0.015</td>
<td>0.015</td>
</tr>
<tr>
<td>Red marrow</td>
<td>0.015</td>
<td>0.015</td>
</tr>
<tr>
<td>Spleen</td>
<td>0.015</td>
<td>0.015</td>
</tr>
<tr>
<td>Muscle</td>
<td>0.013</td>
<td>0.012</td>
</tr>
<tr>
<td>Testes</td>
<td>0.013</td>
<td>0.011</td>
</tr>
<tr>
<td>Liver</td>
<td>0.012</td>
<td>0.015</td>
</tr>
<tr>
<td>Thymus</td>
<td>0.012</td>
<td>0.009</td>
</tr>
<tr>
<td>Brain</td>
<td>0.010</td>
<td>0.008</td>
</tr>
<tr>
<td>Lungs</td>
<td>0.008</td>
<td>0.008</td>
</tr>
<tr>
<td>Breasts</td>
<td>0.008</td>
<td>0.007</td>
</tr>
</tbody>
</table>

Dose calculations were performed using the standard ICRP method (IRP Pampfett No.1 rev. Society of Nuclear Medicine, 1976). Effective dose equivalents (EDE) were calculated in accordance with ICRP 53 (Ann. ICRP 1988) and gave values of 0.81 x 10^8 mSv/mBq and 1.12 x 10^8 mSv/mBq after exercise and rest, respectively.

Manufactured by Amersham International plc

Amersham, United Kingdom

Patent No. 5,045,302 (r)

Distributed by: Medi-Physics, Inc. Amersham Healthcare

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1-800-633-4123 (Toll Free)

Printed in UK

February 1996

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By measuring perfusion defect size, you can determine extent and severity of CAD.\(^7\) From the same test, you also get an extra measure of information with left ventricular function.\(^8\) If his stress study with Cardiolite\(^*\) is normal, you'll know he has a very low risk of a serious cardiac event during the next year.\(^9\) If his stress study with Cardiolite\(^*\) is abnormal, cath may be the next step,\(^1\) especially if EF is low, or if the defect size is moderate to severe.\(^9\)

That's the kind of clear, reliable, and reproducible information you need to make patient management decisions with confidence. So, when the question is whether to cath or not, order Cardiolite\(^*\). It clears your line of vision.

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There have been infrequent reports of signs and symptoms consistent with seizure and severe hypersensitivity after administration of Tc99m Sestamibi.

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*Please see brief summary of prescribing information on the following page.*
INDICATIONS AND IMAGE: Cardiolite® imaging: In the preparation of Technetium Tcm Sestamibi, a myocardial perfusion agent that is indicated for detecting coronary artery disease by localizing myocardial ischemia (reversible defects) and infarction (non-reversible defects), in patients with angina pectoris, chest pain, cardiomyopathy, and/or with evidence of coronary artery disease at the time of stress or baseline. The use of Technetium Tcm Sestamibi is considered safe and effective in patients who are undergoing cardiac catheterization. Cardiolite® imaging is not indicated for the evaluation of myocardial ischemia or infarction in patients who are undergoing angiography.

CONTRAINDICATIONS: Cardiolite® imaging is not indicated for the evaluation of myocardial ischemia or infarction in patients who are undergoing angiography.

PRECAUTIONS: Cardiolite® imaging is not indicated for the evaluation of myocardial ischemia or infarction in patients who are undergoing angiography.

Radiation Dose: Radioactive technetium-99m (Tcm) Sestamibi can be used for single-photon emission computed tomography (SPECT). The radiation dose for each patient is based on the patient’s body habitus and the specific imaging protocol. It is important to note that the radiation dose can vary depending on the image acquisition parameters and the patient’s body habitus.

Image Acquisition: Breast Imaging: Cardiolite® imaging is used in the evaluation of breast masses. It is important to note that the radiation dose can vary depending on the image acquisition parameters and the patient’s body habitus.

For more information, please refer to the product literature and package insert.
AcuTect—a new, unique, radiolabeled synthetic peptide—is the first to offer you the ability to clearly, safely, and comfortably target acute clots. AcuTect is indicated for scintigraphic imaging of acute venous thrombosis in the lower extremities of patients who have signs and symptoms of acute venous thrombosis. AcuTect binds preferentially to the glycoprotein (GP) IIb/IIIa receptors found on activated platelets. AcuTect appears to detect acute and not chronic venous thrombosis. This is based on in vivo and ex vivo animal data; not confirmed clinically. The result is a new sensitivity that challenges venography—the “gold standard.”

More than just another diagnostic option—AcuTect is designed for a more confident course of treatment in a potentially life-threatening condition.

Clinical follow-up studies of patients with negative AcuTect scans have not been performed to determine if negative image findings mean the absence of acute venous thrombosis. If a patient has clinical signs and symptoms of acute venous thrombosis, a clinical management decision to withhold treatment with anticoagulants should not be based on a negative AcuTect study alone.

After administration of AcuTect, as with the administration of other intravenous drugs, patients with a history of drug reactions, other allergies, or immune system disorders should be observed for several hours.

For customer service, call 1-877-DIATIDE.

The difference is acute.

Diatide, Inc.
ADVERSE REACTIONS

Adverse events were evaluated in clinical studies of 842 adults who received technetium Tc 99m 2.0 mCi labeled to approximately 70-100 μg of bibiscidate. Of these adults, 46% were women and 54% men. The mean age was 57.9 years (17 to 95 years). In all patients, adverse events were monitored for at least 24 hours. In a subset of 186 patients, adverse events were monitored for 24 hours. Deaths did not occur during the clinical study period. Following injection of technetium Tc 99m as a serious episode of hypotension occurred in one patient who had acute hypotension that began within 10 minutes of injection and after 60 minutes, progressed to a systolic pressure of 70 mm Hg. At least one adverse event occurred in 25/842 (3.0%) of patients after technetium Tc 99m injection. Pain was the most commonly reported adverse event (1.7% of patients or healthy volunteers). Table 1 lists adverse events reported in 0.5% or more of patients who received technetium Tc 99m apcitide.

Table 1: Adverse Events Reported in ≥0.5% of Patients Following AcuTect® Injection in Clinical Studies

<table>
<thead>
<tr>
<th>Event</th>
<th>Number of Patients Exposed to AcuTect®</th>
<th>Number of Patients with at Least One Adverse Event</th>
<th>Body as a Whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain (back, leg, chest)</td>
<td>29 (4.3%)</td>
<td>21 (3.3%)</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>11 (1.7%)</td>
<td>5 (0.7%)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular System</td>
<td>13 (2.0%)</td>
<td>5 (0.7%)</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>3 (0.5%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other adverse events which occurred in ≥0.5% of patients following receipt of AcuTect™ included asthenia, agitation, bradycardia, cardiovascular disorder, chills, convulsions, dizziness, fever, hyperesthesia, injection site reaction, liver enzyme elevation, nausea, palpitations, pruritus, sweat, tachycardia, twitch, urticaria, and vomiting.

OVERDOSAGE: Clinical consequences of overdosage with technetium Tc 99m apcitide have not been studied.

DOSAGE AND ADMINISTRATION: To detect acute venomous thrombosis in a lower extremity reconstructed Arterectomy™ should be administered as a peripheral intravenous injection in an upper extremity, at a dose of approximately 100 μg of bibiscidate radiolabeled with 20 mCi of technetium 99m. Technetium Tc 99m apcitide should be drawn into the syringe and administered using sterile technique. If nonradioactive equipment is used, scrupulous care should be taken to prevent residual contamination with traces of cleaning agents. Unused portions of the drug must be discarded appropriately. (See Instructions for Preparation Section of Full Product Information.)

Lower Extremity Imaging

AcuTect™ imaging should be begun between 10 and 60 minutes after injection. Patients should be scanned just before imaging in order to limit the influence of urinary bladder radioactivity since technetium Tc 99m is cleared from the blood by the kidneys. If it is determined that imaging needs to be repeated, additional images may be obtained up to 180 minutes without renal injection. The safety of more than one dose has not been studied.

Positive AcuTect™ uptake in the deep vein structures is defined as asymmetric vascular uptake (with or without superimposed diffuse uptake) in contrast enhanced images, and asymmetry in both anterior and posterior projections. If asymmetry appears only after extreme contrast enhancement, then diffuse asymmetry must also be present for scoring an image as positive.

Superficial increased uptake is not to be interpreted as acute deep venous thrombosis.

RADIATION DOSIMETRY

Based on human data, the absorbed radiation doses to an average adult (70 kg) from an intravenous injection of technetium Tc 99m apcitide are listed in Table 2. The values are listed in descending order as mSv/MBq and mGy/MBq and assume urine bladder emptying at 4.5 hours.

Table 2: Radiation Absorbed Doses for a 70kg Adult

<table>
<thead>
<tr>
<th>Target Organ</th>
<th>mSv/MBq</th>
<th>mGy/MBq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Bladder Wall</td>
<td>0.22</td>
<td>0.060</td>
</tr>
<tr>
<td>Kidneys</td>
<td>0.050</td>
<td>0.014</td>
</tr>
<tr>
<td>Upper Large Intestine Wall</td>
<td>0.029</td>
<td>0.0051</td>
</tr>
<tr>
<td>Lower Large Intestine Wall</td>
<td>0.019</td>
<td>0.0030</td>
</tr>
<tr>
<td>Urethra</td>
<td>0.034</td>
<td>0.0092</td>
</tr>
<tr>
<td>Bladder</td>
<td>0.022</td>
<td>0.0060</td>
</tr>
<tr>
<td>Testes/Ovaries</td>
<td>0.0020/0.023</td>
<td>0.0001/0.0023</td>
</tr>
<tr>
<td>Lungs</td>
<td>0.016</td>
<td>0.0043</td>
</tr>
<tr>
<td>Rectum/Marrow</td>
<td>0.039</td>
<td>0.0095</td>
</tr>
<tr>
<td>Breast</td>
<td>0.050</td>
<td>0.013</td>
</tr>
</tbody>
</table>

Dose calculations were performed using the standard MIRD method (MIRD Pamphlet No. 1 rev. Soc. Nucl. Med. 1978) Effective dose equivalent was calculated in accordance with ICRP 53 (Ann. ICRP 18, 1.4, 1988) and gave a value of 0.0029mSv/MBq (0.0004 rem/mCi).

HOW SUPPLIED

Each kit contains one vial containing a sterile, nonpyrogenic, freeze-dried mixture of bibiscidate, mammalian chloride dextrate and sodium gluconate dextrate, together with a package insert and adverse event reporting cards. Kits are available in packs of 5 vials.

Storage

Store the kit in a refrigerator at 2 to 8°C (36 to 46°F). Store the reconstituted injection solution at 20 to 25°C (68 to 77°F) using appropriate radiation shielding, for up to 6 hours.

The kit should be protected from light.

Rx only

Diatide, Inc.

9 Delta Drive, Londonderry, New Hampshire 03053

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BD(10)1971

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- Consistently produces maximal vasodilation.
- Blood flow increases 3- to 4-fold over baseline.¹

RAPID RETURN
- <10-second half-life.
- Side effects usually resolve quickly and spontaneously.*

STRONG FINISH
- Imaging comparable to exercise.
- Lower cost-per-case than dipyridamole.²
* Despite the short half-life, 10.6% of the side effects occurred not with the infusion of Adenoscan but several hours after infusion. Also, 8.4% of the side effects that began coincident with infusion persisted for up to 24 hours after infusion was completed. In many cases, it is not possible to know whether these late adverse events are the result of Adenoscan infusion.

Please see the brief summary of prescribing information on the following page.
adenosine

BRIEF SUMMARY
For Intravenous Infusion Only

DESCRIPTION
Adenosine is an endogenous nucleoside occurring in all cells of the body. It is chemically 9-amino-9-deoxy-D-ribofuranose-1-O-phosphate. Adenosine is a white crystalline powder. It is soluble in water and practically insoluble in alcohol. Solubility increases by warming and lowering the pH of the solution.

Each Adenoscan vial contains a sterile, non-pyrogenic solution of adenosine 3 mg/mL, and sodium chloride 9 mg/mL, in Water for Injection, q.s. The pH of the solution ranges from 4.5 and 7.5.

INDICATIONS AND USAGE
Intravenous Adenosine is indicated as an adjunct to thallium-201 myocardial perfusion scintigraphy in patients unable to exercise adequately. See WARNINGS.

CONTRAINDICATIONS:
Intravenous Adenosine (adenosine) should not be administered to individuals with:

1. Second- or third-degree AV block, unless a functioning artificial pacemaker;
2. Sinus node disease, such as sick sinus syndrome or symptomatic bradycardia (except in patients with a functioning artificial pacemaker);
3. Known or suspected bronchoconstrictive or bronchospastic lung disease (e.g., asthma);
4. Known hypersensitivity to adenosine.

WARNINGS:

Pulmonary Embolism, Arrhythmias, and Myocardial Infarction

Intravenous adenosine administration has been associated with the development of severe pulmonary emboli. Pulmonary emboli may be fatal.

Adenosine may lead to the development of symptomatic and potentially fatal ventricular arrhythmias in patients with preexisting structural heart disease. Exacerbation of cardiac disease, including cardiac arrest, has been reported. The use of adenosine in patients with severe structural heart disease is contraindicated.

Adenosine may cause significant hypotension and bradycardia, which may be life-threatening. Patients with a history of cardiovascular disease or who are at risk for cardiac arrhythmias may be more susceptible to these effects. The potential for these effects should be considered in any patient with cardiovascular disease.

Drug Interactions

Intravenous adenosine has been shown to have additive effects when given in combination with other agents known to cause hypotension or bradycardia. The use of adenosine in patients receiving these agents should be avoided.

Drug/Laboratory Test Interactions

Intravenous adenosine has been shown to cause a transient increase in plasma creatinine and creatine kinase levels. These changes are typically transient and do not require specific treatment.

ADVERSE REACTIONS

The most frequent reactions were a fall in blood pressure and/or a reduction of cardiac output. These effects usually occurred within the first 30 seconds after the beginning of administration and typically resolved within 2 minutes after the infusion was stopped. The reactions were not serious and did not require specific treatment.

The usual initial dose of adenosine is 140 micrograms/kg infused for 60 seconds, with subsequent increases of 70 micrograms/kg at 2-minute intervals if necessary. The maximum dose is 6 mg, or 420 micrograms/kg.

Dosage and Administration

For intravenous infusion only.

Adenosine should be given as a continuous peripheral intravenous infusion.

The recommended infusion dose for adults is 140 micrograms/kg infused for 60 minutes (total dose of 8.4 mg/kg).

The recommended dose of thallium-201 should be injected at the end of the adenosine infusion (i.e., after the last three minutes of Adenosine). Thallium-201 is a radioactively labeled compound that may be injected directly into the patient's vein.

The injection should be given to the venous access as possible to prevent an inadvertent increase in the dose of Adenosine (the contents of the IV tubing) being administered. There are no data on the safety or efficacy of alternative Adenosine infusions. The safety and efficacy of intravenous infusion other than the intravenous route have not been established.

Note: Peripheral drug products should be inspected visually for particulate matter and discoloration prior to administration.

CAUTION: Federal law prohibits dispensing without prescription.

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Cardiology Topics
Series Editor: Elias H. Botvinick, MD

**Published**

**Topic 1:** Physical and Technical Aspects of Nuclear Cardiology (October 1997)
Contributors: Ernest Garcia, MD, Elias Botvinick, MD, Bruce Hasagawa, PhD and Neil Ratzlaff, MS, CNMT
ISBN 0-932004-52-0
Price: $25 (SNM members); $35 (nonmembers)

**Topic 2:** Pharmacologic Stress (June 1998)
Contributors: Mario S. Verani, MD, Jeffrey Leppo, MD, Elias H. Botvinick, MD, Michael W. Dae, MD and Susan Alexander, MD
ISBN 0-932004-60-1
Price: $45 (SNM members); $60 (nonmembers)

**Topic 3:** Cardiac PET Imaging (September 1998)
Contributors: Richard A. Goldstein, MD, Randall A. Hawkins, MD, PhD, Edward M. Geltman, MD, Carl Hoh, MD, Richard Brunken, MD, Yong Choi, PhD, Maria Sciammarella and Elias H. Botvinick, MD
ISBN 0-932004-54-7
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**Topic 4:** Radionuclide Assessment of Congenital Heart Disease (September 1998)
Contributor: Michael W. Dae, MD

**Published**

**Topic 5:** Myocardial Perfusion Imaging by Single-Photon Radionuclides, part I (February 1998)
ISBN: 0-932004-57-1

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Contributors in remaining Self-Study Cardiology topics include: Drs. Daniel S. Berman, MD, Cedars-Sinai Medical Center, Los Angeles; Elias Botvinick, MD, University of California, San Francisco; Jamshid Maddahi, MD, UCLA, Los Angeles; H. William Strauss, Stanford University Medical Center, Stanford; and Mario S. Verani, Methodist Hospital, Houston.

Note: Topics 3 and 4 appear in one volume.
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Oncology Series Writers: Gerald L. Denardo, MD, Randall Hawkins, MD, PhD, E. Edmund Kim, MD, Alexander J. McEwan, MD, Hani A. Nabi, MD, Patrice K. Rehm, MD, Edward B. Silberstein, MD and Richard Wahl, MD

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The Society of Nuclear Medicine, in partnership with the Medical Imaging Division of DuPont Pharmaceuticals Company, is offering a new one year fellowship available July 1, 1999 in the amount of $30,000.00 to support diagnostic, prognostic or outcomes research focused on the use of Nuclear Medicine or Nuclear Cardiology techniques which will assist clinicians and post-menopausal patients with respect to hormone replacement therapy. Primary research areas of the fellowship are known or suspected coronary artery disease, elevated serum cholesterol, breast cancer and/or osteoporosis.

Funds can be used to support the research and/or salary of the investigator. Grants are limited to research performed in the United States or Canada. Eligible applicants are those who are: (a) currently serving as Residents or Fellows in accredited Nuclear Medicine, Cardiology, Gynecology, Oncology or Radiology training programs, or have just recently completed training; or (b) have completed at least one year of an accredited residency or fellowship training program.

For further information and to obtain application forms, contact the Society of Nuclear Medicine, Attention: Committee on Awards, 1850 Samuel Morse Drive, Reston, VA 22090, Tel: 703/708-9000, ext. 246, Facsimile: 703/708-9777. Downloadable application materials are also available on the Society's homepage (www.snm.org)

Deadline for receipt of applications and all supporting materials is April 15, 1999.
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For more information or to purchase the Bone Module CD-ROM, please contact the SNM PEP Coordinator at (703) 708-9000.

SNM PEP is sponsored by an educational grant from MDS Nordion, Science Advancing Health and DuPont PHARMA, Radiopharmaceuticals.

This activity was planned and produced in accordance with the ACCME Essentials.
Nuclear Medicine Prostate Cancer Imaging

As a clinician, you know nuclear medicine procedures are safe and effective. But you also know that patients are sometimes uneasy about them. Give your patients peace of mind by providing them with concise and thorough information.

This pamphlet describes what patients will experience when they have a nuclear medicine test for prostate cancer. The pamphlet explains how monoclonal antibody imaging is used to detect tumors and to determine the extent or spread of various types of cancers, and prepares patients for the exam. The pamphlet answers questions such as, “What is a nuclear medicine test?” “How should I prepare for the test?” and “What will I experience during the test?”

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REGISTRATION FEES:
Categorical
Saturday, June 5, 1999
Pre-Registration: $115
On-Site: $135
Member
Non-Member: $145
(BOXED LUNCH IS PROVIDED FOR THE SATURDAY CATEGORICAL ONLY, THE COST OF WHICH IS INCLUDED IN THE FEE)

CATEGORICALS
Sunday, June 6, 1999
Pre-Registration: $100
On-Site: $120
Member
Non-Member: $130

INQUIRIES:
Society of Nuclear Medicine
Department: Meeting Services
1850 Samuel Morse Drive
Reston, VA 20190
Phone: (703) 708-9000 x229
Fax: (703) 709-9274
www.snm.org

CONTINUING EDUCATION
Monday, June 7, 1999 through Thursday, June 10, 1999
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Technologist: $205
Non-Member
Physician/Scientist/Pharmacist: $530
Technologist: $395
Companion: $55

EXHIBITS:
Monday, June 7, 1999 through Thursday, June 10, 1999
Exhibit space is $21.50 per square foot.
Contact Jane Day at jday@snm.org for further information.

HOW TO OBTAIN PRE-REGISTRATION AND HOUSING FORMS:
1. The SNM Web Site, www.snm.org
2. Fax-On-Demand*, 888-398-7662 or 703-7531-1514
3. The Journal of Nuclear Medicine, February Issue
4. Journal of Nuclear Medicine Technology, March Issue

* Fax-on-Demand is an automated system that faxes you those portions of the Annual Meeting Precise your request. If you do not know exactly which portion you would like to receive (or what is available), you can request an index of documents when prompted by the system.
WHAT IS THE UA DATA BASE?
The Commission on Health Care Policy and Practice in conjunction with the SNM Technologist Task Force on Utilization Data, has developed a quarterly survey on SNM’s website. Participants enter data quarterly.

The website’s data entry form will collect information from nuclear medicine practitioners to compile a utilization analysis database.

The database contains information on:
• Facility type and location
• Active general medicine and surgical beds
• Outpatient encounters (visits)
• Physician, technologist and clerical FTEs
• Planar, SPECT, PET Hybrid gamma cameras and PET scanners
• Inpatient and outpatient procedures for a selected set of commonly used nuclear medicine CPT-4 codes

WHY SHOULD YOU PARTICIPATE?
Participants receive standard reports on utilization by procedure, place of service, type of patient, etc.

Participants will be able to compare their facility data with others in the region and with the national (global) averages.

Subscribers may query reports on-line or receive printed reports quarterly via mail. This is a free service. As long as you input your data quarterly, you will be able to obtain data and reports.

All information is confidential.
For more information or to participate in this program, contact UA Project Coordinator at (703) 708-9000 x255 or e-mail: wsmith@snm.org.
The 1999 examination will be given Sunday, June 6, 1999 in Los Angeles, CA in conjunction with the 46th Annual Meeting of the Society of Nuclear Medicine.

The examination is written and consists of two parts —

**Part One** (3.5 hours) assesses knowledge of basic aspects of Nuclear Medicine Science.

**Part Two** (2.5 hours) examines in depth the knowledge of a predetermined subspecialty area of the candidate’s choice including:

- Nuclear Medicine Physics and Instrumentation
- Nuclear Pharmaceutical Science and Radiochemistry
- Radiation Protection

Completed Applications must be postmarked by March 12, 1999. The examination fee is $650 ($550 refundable if you do not qualify).

For applications and more information, please contact:

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American Board of Science in Nuclear Medicine
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The Division of Cardiology at the College of Physicians & Surgeons of Columbia University is recruiting a radiochemist for research and development of positron-emitting radiotracers for cardiac PET applications. The successful candidate will receive an appointment at F&S commensurate with academic background and experience. Applicants must have a strong, direct background in both synthetic chemistry as well as labeling with positron emitters. Please send a CV and 3 references to Steven Bergmann, MD, PhD, Columbia University, College of Physicians & Surgeons, PH 10-Stem 405, 630 W. 168th St., New York, NY 10032. Fax: (212) 305-9882. Email: sb40@columbia.edu. We take affirmative action toward equal opportunity.

Research Associate—Yale University
Research in radiochemistry in PET with application to the brain and positron emission tomography. Candidate should have background in: radiochemistry and organic synthesis of chemical precursors and a record of independent research. Prefer PhD in Chemistry. If interested and qualified, please submit a scannable resume referencing Source Code E25NUCMED: Ms. A. Michaels, Department of Human Resources (Source Code E25NUCMED), Yale School of Medicine, P.O. Box 208344, New Haven, CT 06520-8344. Fax (203) 432-9817.

Nuclear Medicine Residency/Fellowship
The UCSD Division of Nuclear Medicine has available a 1 or 2 year position leading to eligibility for the ABNM or ACR special competency examinations. Training includes a broad range of general and special nuclear medicine procedures, including PET. Trainees are expected to participate in the research activities of the Division. Applications will be accepted until March 1, 1999, and the position commences on July 1, 1999. Please forward letter of interest, CV and 3 letters of recommendation as soon as possible to: Frank J. Papaioannou, MD, PhD, UCSD Medical Center, Division of Nuclear Medicine, 200 West Arbor Dr., San Diego, CA 92103-8758.

Nuclear Medicine Technologist
The Department of Veterans Affairs, Medical and Regional Office Center, White River Junction, Vermont is currently recruiting for a full-time Nuclear Medicine Technologist certified or eligible for exam in AART or NMTCB. Salary range $31,897-$41,470. Apply to Human Resources Management Service, VAM & ROC, 215 N. Main St., White River Junction, VT 05069. Phone: (802) 296-5144. EOE.

Nuclear Medicine Residency/Fellowship
The Harvard Medical School, Joint Program in Nuclear Medicine invites applications for one-year fellowship and two-year residency positions beginning July 1, 1999 and 2000. Please direct your inquiries to: Cathy O’Callaghan, Training Program Coordinator, Joint Program in Nuclear Medicine, Children’s Hospital, 300 Longwood Ave., Boston, MA 02115 or by e-mail at: ocallaghan@al.tch.harvard.edu.

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A Publication of the Society of Nuclear Medicine

DIAGNOSTIC PATTERNS IN NUCLEAR MEDICINE

Authors: Edward B. Silberstein, MD
John G. McAfee, MD
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- The Forte imaging system includes today's fastest computer platform: the new Pegasys™ Ultra 60.
- High performance EPIC™-HP detectors provide unsurpassed image quality.
Defining Leadership into the Next Millennium