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REPLY: My coauthors and I read with interest the letter from Dr. Papantoniou et al. Much of the letter reports on the use of ^{99m}Tc-(V)DMSA for imaging of breast lesions. We did not use this tracer in our study and have only little experience with it. The authors agree with us that a faint and diffuse sestamibi uptake must not be considered as nonspecific or probably benign. The idea of a scoring system for scintimammography is interesting and must be validated. In our study, invasive—not only in situ—lobular carcinoma was associated with a faintly diffuse and heterogeneous uptake of sestamibi. Therefore, we think that the proposed class 3 should not refer only to a preinvasive component. Differentiating in situ from invasive components within a heterogeneous area of tracer uptake is probably not possible because of the limited spatial resolution of SPECT. After initial validation, such a scoring system could be tested in a prospective, preferably multicentric, clinical setting. A robust scoring system would certainly increase the strength of scintimammography as a second-line breast imaging technique.

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Use of ^{99m}Tc-Sestamibi Scintigraphy in Multiple Myeloma

TO THE EDITOR: We read with great interest the excellent review on imaging of malignant bone involvement by Einat Even-Sapir published in the August issue of *The Journal of Nuclear Medicine* (1). We would like to comment on the use of ^{99m}Tc-sestamibi in multiple myeloma. In recent years, different groups have reported a high accuracy for this tracer in the detection of active disease (2–7). In particular, ^{99m}Tc-sestamibi scintigraphy has shown a positive predictive value of 100% and a negative predictive value of 83% in the diagnosis of active multiple myeloma and a positive predictive value of 84% and a negative predictive value of 100% in identifying advanced stages (i.e., II or III) of disease (2). Positive ^{99m}Tc-sestamibi

whole-body results were found in 30% of patients with no evidence of multiple myeloma on a radiologic full skeletal survey, and in the majority (76%), the scintigraphic findings agreed with the subsequent clinical follow-up (3). Moreover, there are consistent published data on the use of ^{99m}Tc-sestamibi in follow-up of patients with multiple myeloma (4–6). In particular, all patients with a negative ^{99m}Tc-sestamibi result at follow-up were actually in disease remission (either complete or partial), whereas 86% of those with a positive ^{99m}Tc-sestamibi result had disease progression (4). Even-Sapir expressed his concern about using ^{99m}Tc-sestamibi in follow-up studies because of the development of multidrug resistance, which may block tracer accumulation (1). In our experience, the multidrug-resistant phenotype is characterized by a faster washout of ^{99m}Tc-sestamibi rather than a lower early tracer uptake (8,9), and washout rates of ^{99m}Tc-sestamibi were indeed predictive of response to chemotherapy in these patients (10). Therefore, when images are acquired 10 min after tracer injection, the diagnostic accuracy of ^{99m}Tc-sestamibi scanning is not significantly affected by P-glycoprotein over-expression, and patients with multiple myeloma can confidently be monitored with ^{99m}Tc-sestamibi scanning after treatment.

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