

REPLY: We thank Drs. Wong and Khong for their attention to our article (1). Although their comments about ^{18}F -FDG PET in lymphoma may be valid, our article was not about ^{18}F -FDG PET but rather about observations from biodistribution imaging before ^{90}Y -ibritumomab administration. The figures included ^{18}F -FDG PET scans only to illustrate the extent of disease before and after treatment. Furthermore:

1. Our paper did not raise issues about functional imaging in oncology but about the significance of the results of imaging with the therapeutic agent or its analog.
2. Tumor transformation, changes in antigen expression, and changes in grade are all possible. The point was that the degree of visualization with the therapeutic agent or its analog could not be used (by itself) to predict response or, conversely, that lack of visualization is not (as has been claimed) a contraindication to treatment with that agent.
3. The discourse about PET is interesting but does not invalidate the point, which is, in general, that low tumor burdens make imaging findings less likely to be positive but make cure more likely.

4. Perhaps we could have mentioned that macroscopic imaging is a poor predictor of microscopic dosimetry.

The views expressed in the letter may be valid for an article regarding ^{18}F -FDG PET evaluation of response to therapy in non-Hodgkin lymphoma.

REFERENCE

1. Iagaru A, Gambhir SS, Goris ML. ^{90}Y -ibritumomab therapy in refractory non-Hodgkin's lymphoma: observations from ^{111}In -ibritumomab pretreatment imaging. *J Nucl Med.* 2008;49:1809–1812.

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