

Johannes Czernin, MD  
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Dear Professor Czernin,

We read with great interest the letter to the editor submitted by Iagaru and Franc in response to our article published in the fall of 2020 entitled, “Disparities in PET imaging for prostate cancer at a tertiary academic medical center” (1-2). They note the key finding of our paper: that in patients with biochemical recurrence of prostate cancer, African American patients had nearly four times lower odds of receiving PET imaging with  $^{68}\text{Ga}$ -PSMA-11, compared to  $^{18}\text{F}$ -Fluciclovine, compared to their non-Hispanic White counterparts. This held true even though we controlled for age, preferred language, neighborhood socioeconomic status, and health insurance, among other demographic factors.

Iagaru and Franc describe a “different experience in equitable access to care through a research trial” at their neighboring institution in Northern California. They point out that, in contrast to our study, a very slightly higher percentage of African American patients (4.8%) had access to PSMA PET ( $^{18}\text{F}$ -DCFPyL) compared to  $^{18}\text{F}$ -Fluciclovine (4.4%) at their institution, and go on to note differences in how their trial was conducted with regard to patient financial liability. However, they do not clearly address the fact that the additional data they report demonstrate similar concerning trends in equitable access to advanced imaging technologies.

The other side of the coin to decreased access for any one demographic group is often relatively increased access for a different group. Similar to our own institution, Iagaru and Franc report an 11.7% absolute increase in the percentage of whites who received PSMA PET imaging: 79.7% compared to 68%. We reported a similar absolute increase of 8.4% at UCSF: 80% compared to 71.6%. While Iagaru and Franc do not report the results of further statistical analysis, their stated data suggest similar preferential access for non-Hispanic whites to a novel advanced imaging technology. The difference appears to be that, while at our institution better access for non-Hispanic whites was disproportionately associated with decreased access for African Americans, at their institution, the burden of reduced access was distributed across a wider spectrum of different racial/ethnic minorities. Indeed, they report a 33% lower rate of utilization of PSMA PET for Asian American patients. At both institutions, access for persons of color to a rapidly emerging gold standard for PET imaging in prostate cancer, was likely reduced.

How can two sets of investigators look at the same data and reach such different conclusions? Part of the answer may be related to the traditional roles of imaging departments, which tend to more often focus on how to provide the highest quality imaging experience for the patients who make it through our doors and less time thinking about who, how, and why patients reach our doorstep. Radiology is often thought of as an intermediary step in health care delivery, unlikely to contribute directly to differential patient outcomes. But it's critical to recognize that many of the most frustratingly persistent health disparities we face may result from the accrual of differential patient experiences across multiple aspects of a health system.

A commitment to health equity means working intentionally and systematically to apply our research toolkits to investigations of health care delivery across all domains. There has never been a moment with a greater mandate to proactively identify and root out biases that reduce patient access to the best possible care. Let's not waste this moment.

Sincerely,

Matthew D. Bucknor, MD  
Thomas A. Hope, MD

### **References**

1. Bucknor MD, Lichtensztajn DY, Lin TK, Borno HT, Gomez SL, Hope TA. Disparities in PET imaging for prostate cancer at a tertiary academic medical center. *J Nucl Med.* 2020.
2. Franc BL, Iagaru A. Letter to the Editor: Disparities in PET imaging for prostate cancer at a tertiary academic medical center. *J Nucl Med.* 2020.