Appropriateness criteria of FDG PET/CT in oncology

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Abstract

18F-Fluorine-2-fluoro-2-deoxy-D-glucose (18F-FDG) positron emission tomography/computerized tomography (PET/CT) is a well-established functional imaging method widely used in oncology. In this article, we have incorporated the various indications for 18F-FDG PET/CT in oncology based on available evidence and current guidelines. Growing body of evidence for use of 18F-FDG PET/CT in select tumors is also discussed. This article attempts to give the reader an overview of the appropriateness of using 18F-FDG PET/CT in various malignancies.

Key words: Cancer; 18F-Fluorine-2-fluoro-2-deoxy-D-glucose; guidelines for PET/CT; oncology; positron emission tomography/computerized tomography; positron emission tomography

Introduction

Positron emission tomography/computerized tomography (PET/CT) is a technological advancement having a significant impact in oncology. 18F-Fluorine-2-fluoro-2-deoxy-D-glucose (18F-FDG) is an expensive, short-lived radiopharmaceutical used for PET/CT scanning and is synthesized in a cyclotron by a complex process. The net result is an expensive modality. However, with rising concerns of expenditure and radiation exposure, it becomes necessary to critically evaluate the utility of this modality. Health technology assessment boards of several countries have evaluated available evidence to decide on the appropriateness and cost-effectiveness of 18F-FDG PET/CT in cancer. In 2010, the International Atomic Energy Agency (IAEA) pooled expert evidence in a manual named “Appropriate use of PET/CT for the management of cancer patients.”[1] The National Comprehensive Cancer Network (NCCN), which represents a group of cancer institutions in the USA, produced a summary based on NCCN practice guidelines in March 2013.[2]

This article attempts to familiarize the reader with current appropriateness criteria for using 18F-FDG PET/CT in various malignancies based on evidence. The NCCN guidelines are based on availability of reimbursement for FDG PET/CT for various indications. The IAEA appropriateness criteria are recommendations based on the evidence published prior to 2009. This article amalgamates the recommendations of both guideline bodies. Attempt has been made to add evidence generated from 2010 till date and its possible impact on the appropriateness criteria.

Generally, to consider an investigation “appropriate,” there must be a clear evidence of better diagnostic performance with higher sensitivity, specificity, and accuracy compared to conventional imaging or existing standard of care. The information obtained from the investigation should change the clinical practice and impact patient outcome. The change could be in the form of adopting better therapeutic strategies or elimination of ineffective, morbid, and expensive practices. “Potentially appropriate” refers to evidence of clear radiological superiority compared to current imaging, but with inadequate evidence about impact on treatment and outcome. “Possibly appropriate” refers to a situation where there is inadequate evidence for use despite a large number of well-planned studies, but a strong rationale exists...
due to clinical benefit from PET shown by case reports or inadequately performed studies. “Inappropriate” refers to a situation where performance of PET is inferior to that of conventional imaging.[1]

The various utilities of PET/CT in oncology can be categorized and defined as follows:[1]

**Diagnosis**
- To characterize a lesion to suggest whether it is benign or malignant
- For the detection of a possible primary when the patient presents with metastases
- To identify an appropriate site from which a biopsy would yield adequate representative tissue for diagnosis
- Detection of malignancy when tumor markers are abnormal

**Staging**
After the histological diagnosis, to assess the extent of disease before the start of treatment

**Response Evaluation**
Assessment of response to treatment during or after therapy

**Restaging**
Assessment of the extent of the disease after treatment or after confirmed recurrence

**Suspected Recurrence**
Assessment of disease following clinical or biochemical suspicion of recurrence

**Follow-up or Surveillance**
Assessment of disease in the absence of critical evidence of recurrence

**Radiotherapy Planning (RT)**
When the study is used for contouring and planning the radiation fields.

The evidence discussed is based on the superior performance of FDG PET or FDG PET/CT compared to contrast-enhanced CT (CECT), which in most situations represents the conventional choice of imaging. CECT may be merged with FDG PET as FDG PET/CECT, as being practiced in many centers, which has shown improved radiological performance compared to FDG PET or FDG PET/CT in a few tumors.

The appropriate timing of the PET/CT study for maximum accuracy is important. To avoid false-positive results, the best time to perform a PET/CT study is 8-12 weeks after completion of chemotherapy and radiotherapy. Postoperative inflammatory changes are seen till about 12 weeks or, at times, longer. The effect of colony stimulating factor (administered to stimulate production of blood cells after chemotherapy) is seen as intense metabolic activity in the marrow of the bones. This effect is less pronounced after 3 weeks. Ideal timing for performing a postoperative PET/CT study is also after 12 weeks.

**Role of FDG PET/CT in Various Cancers**

**Lymphoma**
There is an overwhelming body of evidence regarding the use of PET/CT in staging, restaging, and post-therapy evaluation in Hodgkin’s lymphoma (HL) and non-Hodgkin’s lymphoma (NHL), except in a few low-grade lymphomas like small lymphocytic lymphoma (SLL)/chronic lymphocytic leukemia (CLL), marginal zone lymphoma (MZL), mucosa-associated lymphoid tissue (MALT), cutaneous T-cell lymphoma (CTCL), mycosis fungoides, and Sezary syndrome.[1-3]

FDG PET leads to upstaging of disease in about 30% of cases at initial staging[4] [Figure 1]. The sensitivity and specificity of PET/CT is higher as compared to CECT for detection of nodal as well as extranodal disease.[5-6] The International Harmonization Project recommends the use of a baseline FDG PET in HL and aggressive NHL.[7] There is no added advantage of adding CECT in staging or combining it with PET/CT.[8] This only increases the cost and radiation burden. It is also helpful in management of residual masses that are seen
after completion of therapy by correctly predicting the presence or absence of viable disease [Figure 2]. CECT is the imaging modality of choice in staging all low-grade lymphomas, except in MALT where FDG PET/CT may have a potential role.

Bone marrow biopsy is an integral part of the work-up of lymphoma. FDG PET/CT has shown increased sensitivity in detection of marrow involvement, especially when the disease is focal in nature. Interim PET or early treatment response after two cycles of chemotherapy helps in prognostication and may modify treatment in some lymphomas [Figure 1], if there is no response or there is progression of the disease seen on PET/CT.

Bone and soft tissue tumors

Both NCCN and IAEA recommend the use of PET in staging, restaging, and in surveillance with options of using either PET or bone scan. A recent meta-analysis has shown that FDG PET is a valuable tool for staging and detecting recurrences in patients with Ewing’s sarcoma (ES). The pooled sensitivity and specificity of FDG PET/CT in detection of ES is 95%. It is more sensitive in detection of recurrent bone lesions, as compared with other imaging modalities. It is also superior to bone scintigraphy and magnetic resonance imaging (MRI) in detection of bone metastases and may lead to change in management. Earlier studies have reported low sensitivity of PET as compared to CT for detection of pulmonary metastases. But now, with the availability of PET with diagnostic quality CT, lung nodules can be diagnosed using the CT component of PET/CT with similar accuracy, making it a one-stop-shop staging modality. A prospective multicenter trial has shown the usefulness of PET in detection of primary tumor and metastases with higher sensitivity and specificity as compared to conventional imaging modalities in ES, osteosarcoma, and rhabdomyosarcoma.

There is growing evidence to suggest the role of FDG PET/CT in predicting the response to neoadjuvant chemotherapy (NACT) prior to surgery in osteosarcoma with a pooled sensitivity and specificity of 73% and 86%, respectively. FDG PET/CT has shown promise in demonstrating sarcomatous change in osteochondromas by identifying the hypermetabolic sarcomatous focus. It has also demonstrated clinical impact and outcome in chondrosarcomas.

Breast cancer

FDG PET/CT is useful in providing more accurate metastatic (M) stage and metabolic information in locally advanced breast cancer and inflammatory breast cancer. It has limited/no role in initial detection of the primary and axillary nodes. It also predicts outcome after NACT.

Gastrointestinal and hepatobiliary cancers

Though the NCCN and IAEA do not recommend the use of PET/CT in hepatocellular cancer (HCC), the role of functional imaging with PET/CT and PET/MR is gradually evolving. Triple-phase CECT and MRI are the gold standard for diagnosis and staging of HCC. The uptake of FDG in HCC is dependent on the size and differentiation with well-differentiated tumors showing low FDG avidity and more undifferentiated tumors showing high FDG uptake. It is useful in the detection of multifocal lesions and extra-hepatic disease with detection rates of 83-89.6%. Preoperative PET helps in predicting tumor differentiation and post-surgical outcome. Higher standardized uptake values (SUVs) are associated with poor differentiation and worse prognosis. PET is used in pre-transplant evaluation in HCC, with high recurrence rates seen in patients with positive PET.

The work-up of cholangiocarcinoma is mainly by CECT and MRI with cholangio-pancreatography. Few studies have evaluated the role of PET/CT in diagnosis and staging of cholangiocarcinoma. PET has high sensitivity for the detection of intrahepatic cholangiocarcinoma, whereas the sensitivity is very low for extrahepatic cholangiocarcinoma (91-95% vs 60%). Reported sensitivities for detection of distant metastases are in the range of 65-100%, with very low sensitivity for detection of lymph nodal metastases. PET/CT is useful in detection of recurrences where anatomical...
imaging has limited use due to post-surgical distortion and fibrosis, with sensitivity and specificity of 94% and 100%, respectively, for PET/CT and 82% and 43%, respectively, for CT.[35]

There is scarcity of literature on the role of PET/CT in evaluation of gall bladder cancer, primarily because most of these are detected incidentally. FDG PET/CT seems to have a potential role in staging, as these cancers are intensely FDG avid. PET/CT has an overall diagnostic accuracy of 95.9% for the primary disease and 85.7% and 95.9% for the detection of lymph nodes and metastatic disease, respectively.[36] In our own experience, PET/CT scores over multi-detector CT (MDCT) in detection of occult metastatic disease.[37]

Pancreatic cancer
The primary imaging modality in staging pancreatic carcinoma is MDCT or MRI with/without MRCP (Magnetic Resonance cholangiopancreatography). FDG PET/CT may have a role in triaging patients for curative versus palliative treatment depending on the absence or presence of metastasis in locally advanced disease.[38] A recent meta-analysis has shown pooled sensitivity of 90% and specificity of 76% for FDG PET/CT. It has no additional benefit over the current conventional imaging modalities in diagnosing primary pancreatic cancer.[39] Current evidence regarding the role of FDG PET/CT in the evaluation of intraductal papillary mucinous neoplasms (IPMN) is limited.

Gastric cancer
CT is the modality of choice in defining resectability of gastric cancer due to exquisite anatomic detail, whereas FDG PET/CT has a role in predicting the biological behavior and in prognostication based on the metabolic activity.[40‑42] PET/CT has low sensitivity for detection of the primary gastric tumor[43,44] because of normal physiological uptake of FDG in the stomach and due to certain histologies like signet cell and mucinous adenocarcinomas which are low FDG avid.[45] For nodal (N) staging, PET/CT has similar diagnostic performance as compared to CECT, with a sensitivity of 50% for detection of N2, N3 disease and a specificity of about 90%.[44,46,47] CECT has higher sensitivity than PET/CT (77% vs 35%) and lower specificity than PET/CT (92% vs 99%) for the detection of peritoneal metastases.[48] PET/CT has moderate sensitivity and specificity in the detection of recurrent gastric cancers, with pooled sensitivity of 76% and 86% and specificity of 82% and 88%, respectively.[49,50]

Colorectal cancer
The standard imaging work-up includes CT for colonic cancer, and MRI and CT with or without endorectal ultrasound for rectal cancer. NCCN guidelines recommend the use of FDG PET/CT as a problem-solving tool in the initial staging of colorectal cancer (CRC).[11,51] It is particularly useful in characterizing indeterminate liver lesions on CT. There is emerging evidence to suggest the role of PET/CT in evaluating extrahepatic disease before the surgical resection of liver metastases. PET/CT is more sensitive than CT for detection of extrahepatic disease with equal specificity.[52] There has been conflicting evidence regarding the use of PET/CT for response assessment after neoadjuvant chemo-radiotherapy (NACT-RT) in locally advanced rectal cancer.[53,54] But a recent systematic review has shown that PET predicts early response to NACT-RT with high accuracy.[55] However, PET/CT has an undisputed role in the evaluation of recurrent CRC with elevated CEA (carcinoembryonic antigen) and often with equivocal/negative CT [Figure 3]. A recent meta-analysis has quoted pooled sensitivity of 94.1% and specificity of 77.2% of PET/CT for detection of recurrence.[56]

Gastrointestinal stromal tumors
FDG PET/CT has a definite role in staging and evaluation of the response to imatinib mesylate in gastrointestinal stromal tumors (GIST). CT-based Response Evaluation in Solid Tumors (RECIST) criteria are not very useful in assessing the treatment response as the size may not change in these tumors; whereas responses on PET/CT based on change in the metabolic activity are in tandem with the clinical response.[57‑59]

Anal cancer
PET/CT can be considered for staging of anal cancer as it alters the stage as compared to conventional imaging

Figure 3 (A-C): A case of carcinoma rectum post abdomino-perineal resection, 9 months post surgery with increasing CEA. (A) The MIP image of the PET scan shows a hypermetabolic focus in the pelvis (arrow) (B) Fused PET/CT image shows FDG-avid pre-sacral mass (arrow) suspicious for recurrent disease (C) CT image shows a pre-sacral mass. Indeterminate whether it is benign fibrosis or disease recurrence. Biopsy confirmed recurrence of adenocarcinoma.
modalities in 20-25% cases. The role of FDG PET/CT in RT planning in delineation of the target volume is evolving.

**Cervical cancer**

Lymph nodal involvement is an important prognostic factor in cervical cancer management. FDG PET/CT has a potential role in detection of lymph nodal metastasis in locally advanced cervical carcinoma (2IB2) in which extra-pelvic spread is common. PET can detect nodal metastasis when CT findings are normal. In a retrospective study, Grigsby et al. compared CT and FDG PET in the evaluation of nodal metastasis and demonstrated that PET picked up more number of nodal metastasis as compared to CT and also that PET is a better predictor of survival. PET/CT is valuable in treatment planning with external beam RT and brachytherapy. PET results in extension of the involved field radiation in about 18% of cases. In brachytherapy, PET improves the tumor coverage without increasing the dose to the surrounding critical structures. PET/CT has high accuracy of 92% in detection of recurrent disease with a sensitivity of 82% and specificity of 97%. The role of predictive volumetric parameters derived from PET, such as metabolic tumor volume and total lesion glycolysis, is evolving.

**Ovarian cancer**

CT is the primary imaging modality in the work-up of ovarian cancer. PET/CT has no additional benefit over CT in early ovarian cancer, but is useful in differentiating stage IIIIC-IV from other stages with a sensitivity of 100% and specificity of 91%, whereas CT has a sensitivity of 97% and specificity of 64%. PET has a higher sensitivity in the detection of peritoneal deposits and metastasis in normal-sized nodes. It is useful in the detection of recurrent ovarian cancer with increasing cancer antigen 125 (CA125) levels and negative CT or MRI, showing a high sensitivity and specificity of 94.5% and 100%, respectively. A recent meta-analysis has shown that PET/CT has the highest sensitivity of 91% when compared with CA125, CT, and MRI.

**Head and neck cancers**

FDG PET has a well-established role in the detection of distant metastasis and second primary in locally advanced head and neck cancers. In a recent meta-analysis, Xu et al. have shown PET and PET/CT to have a sensitivity of 83% and specificity of 96% for detection of distant malignancies, whereas for conventional imaging, the values are 44% and 96%, respectively. Detection of distant metastasis early in the work-up algorithm leads to change in the treatment plan and in prognosis. A negative PET/CT study has nearly 100% accuracy in predicting the absence of distant metastatic disease and second primary. Accurate response assessment after chemo-radiotherapy (CRT) is essential to plan salvage surgery in patients with advanced disease. PET/CT is not recommended before 8 weeks of completion of CRT because of high false-positive rates. The negative predictive value (NPV) of PET/CT done after 8–12 weeks is 95%. In a meta-analysis of 51 studies, Gupta et al. have reported an NPV of 95% for both primary and nodal disease for response assessment. In the post-treatment setting, the best timing for doing a PET/CT for response assessment is after 12 weeks of completion of treatment, but can be done sooner if there is clinical suspicion of recurrent disease, though not before 8 weeks. PET/CT is the best modality for detection of recurrence in head and neck cancers.

**Unknown primary**

It is important to identify the primary in patients who present with metastatic cervical adenopathy. Inability to detect the primary leads to futile tonsillectomies and untargeted neck dissections. Varying detection rates of 29-54%, with sensitivity ranging from 62 to 97% and specificities of 33–93% have been reported. PET/CT done prior to pan-endoscopy and biopsy reduces futile endoscopies and false-positive PET studies.

**Thyroid cancer**

Poorly differentiated and undifferentiated thyroid cancers are FDG avid due to over-expression of glucose transporter (GLUT) receptors and negative on radioiodine scintigraphy due to loss of sodium iodide symporter.
metastatic disease. It demonstrates very intense FDG uptake, which is 2-2.5 times higher than normal physiological uptake. It also has high sensitivity in differentiating PCNSL from glioblastoma and has important treatment implications. For undifferentiated and anaplastic thyroid tumors, FDG PET/CT is the imaging modality of choice. For undifferentiated and anaplastic thyroid tumors, FDG PET/CT is the imaging modality of choice.

CNS lymphoma
FDG PET/CT has a potential role in the detection of primary CNS lymphoma (PCNSL). Though PET is not very useful in the detection of metastatic lesions due to high physiological uptake of FDG in the brain parenchyma, PCNSL usually demonstrates very intense FDG uptake, which is 2-2.5 times higher than normal physiological uptake. It also has high sensitivity in differentiating PCNSL from glioblastoma and metastatic disease.

Lung cancer
FDG PET combined with CECT is an efficient modality for staging of lung cancers. PET/CT is the best modality to differentiate tumor from adjacent atelectasis, in identifying chest wall invasion, and in detection of pleural metastases. PET has a high sensitivity of 95%, positive predictive value (PPV) of 95%, accuracy of 92%, and moderate specificity of 67% in the detection of pleural metastasis. PET/CT has higher sensitivity and specificity in the mediastinal staging of lymph nodes with a sensitivity and specificity of 81% and 90%, respectively, as compared to CT which has a sensitivity and specificity of 59% and 79%, respectively. PET has the added advantage of detection of metastatic lesions < 1 cm, but with a low PPV of 64%. However, PET-positive nodes should still undergo mediastinoscopic sampling for confirmation of metastatic involvement. On the contrary, PET has a high NPV of 95% and invasive mediastinoscopy can be omitted in PET-negative nodes, except in centrally situated masses where perilesional mediastinal nodes can be masked due to high metabolic activity of the tumor. PET detects occult metastatic disease in about 29% of cases. It detects adrenal metastasis with a high sensitivity and specificity of >95% and >80%, respectively. An invasive biopsy can usually be obviated in most cases. In cases of isolated adrenal metastasis with equivocal PET/CT, a biopsy or adrenalectomy can be contemplated. A meta-analysis comparing FDG PET/CT, MRI, and bone scintigraphy has shown that PET/CT is the best modality for detection of bone metastasis, with a pooled sensitivity and specificity of 92% and 98%, respectively, for PET/CT, 77% and 92%, respectively, for MRI, and 86% and 88%, respectively, for bone scintigraphy. PET/CT-based RT planning reduces the inter-observer variability and leads to change in treatment plan in about 50% of patients, with enhanced tumor coverage.

PET is a better predictor of response to treatment and the metabolic response correlates with outcome. PET/CT detects recurrences with a high sensitivity and specificity of 93% and 89%, respectively, and an accuracy of 92%.

Small cell lung cancer
PET/CT has higher sensitivity and specificity in the detection of distant metastases of small cell cancer as compared to CT, except for brain metastasis. PET leads to change in stage of the disease in 17% of cases, when compared to conventional imaging modalities. PET-based RT planning also leads to change in radiation field in about 37% cases.

Malignant pleural mesothelioma
PET/CT is recommended for staging and restaging of malignant mesothelioma. It correctly differentiates between benign and malignant pleural lesions with a sensitivity of
95-97% and specificity ranging from 78 to 92%. FDG avidity with an SUVmax value >2.2 is helpful for this differentiation. PET/CT identifies more sites of nodal involvement and distant metastases, as compared to CT.

**Thymic tumors**

FDG PET/CT is recommended for the diagnosis and staging of thymic tumors. Studies have shown that PET can differentiate between low-risk thymomas (A, AB, B1 histological types), high-risk thymomas (B2, B3 histological types), and thymic carcinomas based on SUV values. The SUV values show an increasing trend from low to high-risk tumors. PET/CT is better in identifying involved nodes of size <1 cm.

**Esophageal cancer**

For initial tumor (T) staging of esophageal cancer, endoscopic ultrasound is the preferred modality of choice as it measures the depth of invasion most accurately. PET/CT lacks the spatial resolution to demarcate the depth of invasion. The sensitivity increases with increasing depth of invasion, the value being 83% for T2 tumors, 97% for T3, and 100% for T4 tumors. For detection of nodal disease, PET/CT has the highest sensitivity and specificity of 96% and 95%, respectively. PET/CT is the best modality for detecting distant metastasis and prevents unnecessary surgical explorations by detection of metastatic disease. In a study by Duong et al., PET/CT changed the clinical management from either curative to palliative or vice versa or changed the treatment modality in 40% of patients. In our own experience, PET/CT detects unsuspected distant metastases in 16% of patients, changing the plan of treatment from curative to palliative. PET/CT is useful in evaluating the response to therapy.

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**Figure 6 (A-D):** A 54-year-old male, diagnosed case of adenocarcinoma of the right lung. PET/CT scan done for initial staging shows hypermetabolic right lower lobe mass (arrows in A and B) and an unsuspected metastatic lesion in C2 vertebral body (block arrows in A, C, and D).

**Figure 7 (A-F):** A case of adenocarcinoma of the distal esophagus. (A) Pretreatment MIP image shows hypermetabolic mass in the distal esophagus (arrow) and hypermetabolic metastatic mediastinal nodes (dashed arrow). (C and E) Fused PET/CT images showing the same. (B) Response assessment PET scan done after three cycles of neoadjuvant chemotherapy (NACT) shows complete metabolic and morphologic regression of the mass with partial metabolic and morphologic regression of the mediastinal nodes (dashed arrow) on MIP. (D), (F) The same is depicted in fused PET/CT images (arrow in D and dashed arrow in F).
to NACT [Figure 7] and CRT by distinguishing residual viable tumor from fibrosis/necrosis based on the metabolic activity of the tumor.[124]

Prostate cancer
FDG PET has a limited role in the staging and diagnosis of prostate cancer (PC) because of overlap of FDG uptake in normal, benign, and malignant lesions in the prostate.[125,126] Few recent studies have shown increased FDG uptake in aggressive lesions as compared to the indolent ones, with a sensitivity of 80%.[127,128]

Renal cell cancer
FDG PET/CT has limited a role in staging of renal cell cancer (RCC), but is useful in the detection of metastatic disease and in restaging. Wang et al. have shown in a meta-analysis that the pooled sensitivity and specificity for detection of metastases is 91% and 88%, respectively.[129]

Urinary bladder cancer
FDG PET/CT has a limited role in staging of bladder cancer due to excretion of FDG via the kidneys and subsequent accumulation in the bladder, masking the uptake in the primary. Many interventions like hydration, delayed imaging, and diuretic administration are performed to enhance the visualization of FDG uptake in the primary, showing good results.[130,131] A recent meta-analysis has reported good diagnostic accuracy for detection of metastatic lesions with a pooled sensitivity and specificity of 82% and 89%, respectively, for restaging patients.[132]

Testicular cancer
Presence of viable tumor in residual masses after chemotherapy is a major problem in germ cell tumors (GCT). Currently FDG PET/CT is the best imaging modality to solve this problem. De Santis et al., in a study of 56 seminomatous GCT patients, have shown that PET is the best predictor of viable disease in residual masses with a sensitivity of 80% and specificity of 100%, in comparison to CT which has a sensitivity of 70% and specificity of 74%.[133] The accuracy is 100% for masses >3 cm and 95% for masses <3 cm. Similar results were confirmed by a recent meta-analysis.[134,135] The use of PET in non-seminomatous GCT (NSGCT) is controversial. In NSGCT, PET has a PPV of 91% and NPV of 62% in differentiating viable from non-viable disease. This means that PET can predict the presence of viable disease with a reasonable accuracy, but a negative PET study cannot exclude the presence of disease.[136] PET has a definite role in the evaluation of seminoma, but cannot predict the presence of disease in NSGCT with negative PET study.

Melanoma
FDG PET/CT is the best modality for N and M staging of advanced cutaneous melanoma[137] [Figure 8] and for detection of metastasis in mucosal melanomas of head and neck and anorectum. The indications for the use of PET/CT are summarized in Table 1.

Conclusion
It is evident that the appropriateness criteria for FDG PET/CT in various malignancies are constantly evolving. The impact of FDG PET/CT on treatment management, as evident by the National Oncologic PET
### Table 1: Indications of PET/CT

<table>
<thead>
<tr>
<th>Type of malignancy</th>
<th>Diagnosis</th>
<th>Staging</th>
<th>Restaging</th>
<th>Therapy evaluation</th>
<th>Follow-up/surveillance</th>
<th>Radiation planning</th>
<th>Remarks</th>
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<tbody>
<tr>
<td><strong>Hodgkin’s lymphoma</strong></td>
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<td>!!!</td>
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<td>!x</td>
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<td>8 weeks minimum for post RT evaluation</td>
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<td>IAEA considers appropriate across NHL</td>
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<td><strong>NHL follicular grade 1-2</strong></td>
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<td>x</td>
<td>x</td>
<td>Biopsy required if used for follow-up to confirm progression</td>
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<tr>
<td><strong>Non-gastric MALT lymphoma, marginal zone lymphoma (nodal, splenic), Burkitt lymphoma, lymphoblastic lymphoma, peripheral (non-cutaneous) T-cell lymphoma, primary cutaneous B-cell lymphoma, adult T-cell leukemia/lymphoma</strong></td>
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<td>NCCN recommends certain NHL subtypes</td>
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<td><strong>CLL/SLL</strong></td>
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<td>Directing nodal biopsy if Richter’s transformation is suspected</td>
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<td>Chemo-response to predict necrosis</td>
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<td><strong>Retroperitoneal and abdominal sarcoma and desmoid tumors</strong></td>
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<td>Up to 5 years follow-up</td>
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<td>Staging in LABC Locally advanced breast cancer</td>
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<td>May be useful to detect distant metastases in otherwise resectable disease</td>
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<td>When Tg&gt;2–5 ng/ml and I-131 imaging is negative in papillary, follicular, and Hurthle cell carcinoma and rising thyroglobulin level</td>
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<td>&gt;1 Brain metastases in occult primary, spinal metastases in known or unknown primary, PET-guided biopsy</td>
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Contd...
Registry (NOPR)[130,139] which is a collaboration of the American College of Radiology Imaging Network (ACRIN) to ensure access to Medicare reimbursement for various PET scan indications, has added a new dimension to the appropriateness criteria. The above recommendations provide an insight into the usefulness of PET/CT in oncology and can help the radiologist and clinician in choosing this hybrid technology appropriately to maximize information for optimal patient care.

Acknowledgement

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References


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**Table 1: Contd...**

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Harisinghani MG. Lymph node staging in esophageal adenocarcinomas with PET-CT based on a visual analysis and based on metabolic parameters. Abdom Imaging 2009;34:610-7.


