**Policy Statement**

The use of interim fluorodeoxyglucose positron emission tomography positron emission tomography scans to determine response to tyrosine kinase inhibitor treatment in patients with gastrointestinal stromal tumors may be considered medically necessary.

The use of positron emission tomography (PET) scans to determine early response to treatment ( positron emission tomography scans done during a planned course of chemotherapy and/or radiotherapy) in patients with gastrointestinal stromal tumors on palliative or adjuvant therapy, as well as all other cancers, is considered investigational.

**Policy Guidelines**

There is no specific coding for positron emission tomography (PET) scans to determine early response to treatment. CPT codes for PET or PET/computed tomography (CT) imaging (78811-78816) would be used.

There is an HCPCS modifier created by Medicare that might be helpful:
- Modifier PS: PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors when the beneficiary’s treating physician determines that the PET study is needed to inform subsequent antitumor strategy.

**Description**

Positron emission tomography (PET) scanning has many established roles in oncology. One potential use of PET scanning is to assess treatment response early in the course of therapy, with the intent of potentially altering the regimen based on PET scan results. While several types of PET scanning are used for interim detection of cancer, we refer to fluorine 18 fluorodeoxyglucose positron emission tomography (FDG-PET) unless otherwise noted.

**Related Policies**

- Cardiac Applications of Positron Emission Tomography Scanning
- Miscellaneous (Noncardiac, Nononcologic) Applications of Fluorodeoxyglucose F 18 Positron Emission Tomography
- Oncologic Applications of Positron Emission Tomography Scanning

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of the FDA-approved technologies on the basis of medical necessity alone.
Regulatory Status

A number of PET scan platforms have been cleared by the U.S. Food and Drug Administration (FDA) through the 510(k) process since the Penn-PET scanner was approved in 1989. These systems are intended to aid in detecting, localizing, diagnosing, staging, and restaging of lesions, tumors, disease, and organ function for the evaluation of diseases and disorders such as, but not limited to, cardiovascular disease, neurologic disorders, and cancer. The images produced by the system can aid in radiotherapy treatment planning and interventional radiology procedures.

PET radiopharmaceuticals have been evaluated and approved as drugs by the FDA for use as diagnostic imaging agents. These radiopharmaceuticals are approved for specific conditions. In December 2009, the FDA issued guidance for Current Good Manufacturing Practice for PET drug manufacturers and, in August 2011, issued similar Current Good Manufacturing Practice guidance for small businesses compounding radiopharmaceuticals. An additional final guidance document issued in December 2012 required all PET drug manufacturers and compounders to operate under an approved new drug application or abbreviated new drug application, or investigational new drug application, by December 12, 2015.

Table 1 lists some of the radiopharmaceuticals granted the FDA approval for use with PET for oncologic-related indications.

Table 1. Radiopharmaceuticals Approved for Use with PET for Carcinoma-Related Indications

<table>
<thead>
<tr>
<th>Agent</th>
<th>Brand Name</th>
<th>Manufacturer</th>
<th>Date Approved</th>
<th>NDA No.</th>
<th>Carcinoma-Related Indication with PET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbon 11 choline</td>
<td>NA</td>
<td>Various</td>
<td>2012</td>
<td>203 155</td>
<td>Suspected prostate cancer recurrence based on elevated blood PSA after therapy and noninformative bone scintigraphy, CT, or MRI</td>
</tr>
<tr>
<td>Fluorine 18 fluorodeoxyglucose</td>
<td>NA</td>
<td>Various</td>
<td>2000</td>
<td>203 06</td>
<td>Suspected or existing diagnosis of cancer, all types</td>
</tr>
<tr>
<td>Fluorine 18 fluciclovine</td>
<td>Axumin™</td>
<td>Blue Earth Diagnostics</td>
<td>2016</td>
<td>208 054</td>
<td>Suspected prostate cancer recurrence based on elevated blood PSA levels after treatment</td>
</tr>
<tr>
<td>Gallium 68 dotatate</td>
<td>NETSPOT™</td>
<td>Advanced Accelerator Applications</td>
<td>2016</td>
<td>208 547</td>
<td>Localization of somatostatin receptor positive NETs in adult and pediatric patients</td>
</tr>
</tbody>
</table>

CT: Computed Tomography; MRI: Magnetic Resonance Imaging; NA: Not Applicable; NDA: New Drug Application; NETs: Neuroendocrine Tumors; PET: Positron Emission Tomography; PSA: Prostate-Specific Antigen.

Rationale

Background

Positron Emission Tomography

Positron emission tomography (PET) scans are based on the use of positron emitting radionuclide tracers coupled to other molecules, such as glucose, ammonia, or water. The radionuclide tracers simultaneously emit 2 high-energy photons in opposite directions that can be simultaneously detected (referred to as coincidence detection) by a PET scanner, which comprises multiple stationary detectors that encircle the region of interest.

A variety of tracers are used for PET scanning, including oxygen 15, nitrogen 13, carbon 11, and fluorine 18. The radiotracer most commonly used in oncology imaging has been fluorine 18, coupled with deoxyglucose to form fluorodeoxyglucose (FDG), which has a metabolism related...
to glucose metabolism. FDG has been considered potentially useful in cancer imaging, because tumor cells show increased metabolism of glucose.

This evidence review focuses on the use of PET to determine early treatment response for cancer, i.e., assessment of therapy response during cancer treatment. The purpose of the PET scan at this particular interval is to determine whether the treatment should be maintained or changed. Such a treatment strategy has been called “risk-adapted” or “response-adapted” treatment. This evidence review addresses detecting early response during short-term therapy (e.g., during cycle[s] of chemotherapeutic agents and/or a course of radiotherapy) and not response during use of long-term agents (e.g., tamoxifen).

The technique of using PET for early treatment response assessment involves comparing PET images before treatment and at some interval after the initial course of treatment. Many intervals have been used in various studies, and there appears to be no standard interval. Comparison of the pre- and mid-treatment PET images can either be performed qualitatively or quantitatively. If a quantitative technique is used, the most common quantity measure is the standardized uptake value, calculated for a specific region of the image. Various methods are used to compare standardized uptake values between 2 images, and a specific cutoff value is selected to determine whether the patient is responding to therapy. A change in standardized uptake value between 40% and 60% often has been used in studies of early treatment response. Other metabolic parameters measured are total lesion glycolysis and metabolic tumor volume.

In 2009, Hillner et al published results of a survey of physicians who had registered patients in the National Oncologic PET Registry, assessing the impact of PET on clinical management decisions for their patients with cancer. PET scans were most frequently ordered for patients with ovarian cancer (14%), followed by pancreatic cancer (8%), non-small-cell lung cancer (7%), and small-cell lung cancer (7%). Physicians considered the patients’ prognoses as better (42%), unchanged (31%), or worse (26%) compared with the prognosis assessment before receiving information from PET. Physicians reported changing the management plan (switching therapy, adjusting the dose or duration of therapy, or switching to observation or supportive care) in 41% of their patients whose prognosis assessment was better based on PET results, in 35% of patients whose prognosis did not change based on PET results, and in 79% of patients whose prognosis was worse based on PET results.

Use of interim PET to guide therapy decisions is to be distinguished from uses of PET in the initial diagnosis and staging of cancer and other uses after treatment, such as routine surveillance, detection of progression, or recurrence. (The use of PET for diagnosis, staging, and surveillance in patients with cancer is addressed in Blue Shield of California Medical Policy: Oncologic Applications of Positron Emission Tomography Scanning) This use also differs from what has been called “response assessment” or “treatment response” in some reports, which refers to imaging done after completion of therapy for prognosis and future treatment planning. Some differentiate between PET during and after treatment by referring to PET during cancer treatment as “interim treatment response” or “interim staging” and PET at the conclusion of treatment as “restaging.”

Literature Review
This evidence review discusses only studies that explicitly stated positron emission tomography (PET) was used to guide therapeutic decisions in cancer patients.

Most studies that evaluate PET during treatment have analyzed the association between PET findings and various intermediate end points, such as pathologic or clinical response at the end of treatment, PET findings at the end of treatment, or long-term results. Although associations between PET and all these end points have consistently been found for a number of cancers, whether such associations lead directly to improved patient outcomes depends on the specific context of the treatment decisions being made in response to PET findings and available alternatives. Therefore, direct evidence of the utility of PET-directed treatment is incomplete.
Evaluation of these types of treatment protocols would require direct evidence of utility from randomized controlled trials (RCTs). Thus, conclusions about efficacy could not follow directly from observational studies of PET. The following sections summarize published literature on the use of PET during treatment for several major cancers.

Assessment of a diagnostic technology typically focuses on 3 categories of evidence: (1) technical reliability (test-retest reliability or interrater reliability); (2) clinical validity (sensitivity, specificity, and positive and negative predictive value) in relevant populations of patients; and (3) clinical utility (i.e., demonstration that the diagnostic information can be used to improve patient outcomes).

**Positron Emission Tomography**

**Clinical Context and Test Purpose**
The purpose of FDG-PET scanning in patients with cancer who have initiated treatment is to determine early treatment response and guide decisions on maintaining or changing treatment. The question addressed in this evidence review is: Does the use of FDG-PET to assess early treatment response improve the net health outcome in individuals with cancer?

The following PICOTS were used to select literature to inform this review.

**Patients**
The population of interest includes patients with cancer who have initiated treatment.

**Interventions**
The intervention of interest is interim PET scan, performed to guide therapy.

**Comparators**
The comparator of interest is a computed tomography (CT) scan, performed to guide therapy.

**Outcomes**
The general outcomes of interest are quality of life, overall survival (OS), and progression-free survival (PFS).

Both false-positive test results and false-negative results can lead to incorrect treatment recommendations, such as continuing treatment that is ineffective, stopping treatment that is effective, and/or delaying initiation of more appropriate therapy.

**Timing**
The timing is during cycles of chemotherapeutic agents and/or a course of radiotherapy (RT).

**Setting**
The setting is an outpatient imaging center equipped with a PET scanner.

**Breast Cancer**

**Clinical Validity**

**Systematic Reviews**
In 2017, Lindenberg et al published a systematic review on the use of imaging (fluorine 18 fluorodeoxyglucose PET [FDG-PET] and dynamic contrast-enhanced magnetic resonance imaging [MRI]) to monitor response to neoadjuvant therapy in patients with breast cancer. The literature search, conducted through March 2015, identified 15 observational studies for inclusion. Studies were assessed for quality using the Quality Assessment of Diagnostic Accuracy Studies (QUADAS) tool, and all included studies had scores of 8 or higher. Reviewers provided descriptions of the imaging methods (type of imaging, monitoring interval) and results (sensitivity, specificity, negative and positive predictive values) by breast cancer subtype: estrogen receptor (ER)–positive and human epidermal growth factor receptor 2 (HER2)–negative, triple-
negative, HER2-positive, ER-positive and HER2-positive, and ER-negative and HER2-positive. Sensitivity estimates ranged from 18% to 89%, specificity estimates ranged from 52% to 100%, positive predictive value estimates ranged from 0% to 100% and negative predictive values ranged from 10% to 84%. Meta-analyses were not performed due to heterogeneity across studies. Studies differed by neoadjuvant chemotherapy regimen and definition of pathologic complete response (pCR). While reviewers intended to determine the best performing imaging technique by breast cancer subtype, selected articles showed that there is a lack of evidence with adequate statistical power to draw conclusions by each subtype.

Clinical Studies
Several clinical studies of breast cancer in the neoadjuvant setting have demonstrated associations between early or interim PET and recurrence, response, or survival outcomes. Quantitative indexes of PET findings used to identify response vs nonresponse on PET or PET plus CT may depend on the type of chemotherapy and tumor phenotype. For example, van Ramshorst et al (2017) found that for patients with triple-negative tumors (n=45) receiving neoadjuvant systemic therapy, FDG-PET/CT of the breast can predict pCR, while patients with HER2-positive tumors (n=60) may need both FDG-PET/CT of the breast and axilla for a more accurate pCR.

In a larger study by Schmitz et al (2017), 188 women with stages II or III breast cancer underwent MRI and FDG-PET/CT before and after neoadjuvant chemotherapy. Analyses were stratified by tumor type: HER2-positive, ER-positive and HER2-negative, and triple-negative. The primary outcome was pCR defined as no or only small numbers of scattered invasive tumor cells. Results showed that for HER2-positive tumors, MRI was a significantly better predictor of pCR than FDG-PET/CT. For ER-positive and HER2-negative tumors, combining MRI and FDG-PET/CT may provide the best monitoring of treatment, though results were not statistically significant. For triple-negative tumors, the 2 imaging techniques performed equally in predicting pCR.

Clinical Utility
Randomized Controlled Trials
Early results of the AVATAHER (Addition of beVAcizumab to neoadjuvant docetaxel and trastuzumab [HER]) trial were published in 2014. This randomized, open-label, multicenter phase 2 trial enrolled women (≥18 years) with early stage human epidermal growth factor receptor 2-positive breast cancer from 26 oncology centers in France. A total of 142 patients were enrolled between 2010 and 2012. Patients initially received 2 cycles of neoadjuvant docetaxel plus trastuzumab. Before the first and second cycles, change in standardized uptake value (SUV) measured by FDG-PET was used to predict pathologic complete PET responders continued to receive standard therapy. FDG-PET nonresponders were randomly assigned (2:1) to receive 4 cycles of docetaxel and trastuzumab plus bevacizumab or to continue on docetaxel plus trastuzumab alone (standard therapy). Investigators and patients were unblinded, but the pathologist in charge of central surgical sample and lymph node reviews was blinded. The primary end point was centrally assessed pathologic complete response according to the Chevallier classification.

Of the 142 patients, 69 were PET responders after 2 cycles of treatment and 73 were nonresponders. Pathologic complete responses were noted in 37 (54%) of the FDG-PET responders. In the randomized participants (PET nonresponders), 27 (37%) of 73 achieved pCR, as did 21 (43.8% 95% CI, 29.5% to 58.8%) of those in PET-directed therapy group, and 6 (24.0% 95% CI, 9.4% to 45.1%) of those in standard therapy group. Incidences of grade 3 or 4 adverse events were similar in both groups, with the most common grade being neutropenia and febrile neutropenia. Fifteen serious adverse events were reported in 11 (15%) of 73 patients. No deaths occurred during the trial. OS or PFS results were not available at reporting.

Nonrandomized Studies
Very little data are available on the use of FDG-PET or FDG-PET/CT to guide management decisions. A 2014 case series of breast cancer in 30 men reported on the use of interim FDG-
PET/CT to alter management decisions in 6 (20%) subjects, but the investigators did not show any data on subsequent survival or other health outcomes. In a prospective study (2015) of all 38 biopsy-confirmed female patients diagnosed with locally advanced breast cancer receiving chemotherapy from April 2013 to May 2014 in India, 14 patients had FDG-PET/CT to assess response following initial chemotherapy. The authors reported that response assessment resulted in a change of treatment regimen in 14% of patients.

Section Summary: Breast Cancer
Evidence for the clinical validity of interim FDG-PET for monitoring disease in patients with breast cancer includes a systematic review and many observational studies. Results from the systematic review showed wide ranges in sensitivities, specificities, positive predictive values, and negative predictive values. The wide ranges may be due to small sample sizes, use of different definitions of the primary outcome (pCR), and differences in breast cancer subtype of the populations. Data from observational studies have suggested a need for considering breast cancer subtype and the type of treatment in creating criteria for assessing early prediction of response with PET. Evidence for the clinical utility of interim FDG-PET or PET/CT to evaluate early response in breast cancer is limited and consists of early results of an RCT that included patients identified as nonresponders by interim PET randomized to more intensive chemotherapy or standard care. The results showed higher response rates in the more intensive group, but clinical outcomes such as PFS or OS were not available. As yet, the evidence does not permit conclusions on whether PET improves health outcomes because data are not available showing that response-adaptive therapy leads to improved outcomes.

Esophageal Cancer
The current treatment strategy for patients with esophageal cancer depends on cancer stage. Patients who do not have lymph node involvement and have no evidence of metastases usually undergo surgery alone. Patients with locally advanced disease are often offered neoadjuvant treatment (chemotherapy and/or chemoradiotherapy) followed by esophagectomy. The goal of using interim FDG-PET is to determine if the tumors would respond to the neoadjuvant therapy. Knowing whether tumors would respond to treatment would inform the decision to offer neoadjuvant therapy or proceed directly to surgery.

Clinical Validity
Systematic Reviews
In 2016, Cong et al published a meta-analysis on the predictive value of FDG-PET for the pathologic response during and after neoadjuvant chemoradiotherapy (NCRT) in patients with esophageal cancer. The literature review, conducted through January 2016, identified 15 publications for inclusion in the meta-analysis. Four studies (n=192 patients) conducted PET during NCRT, and 11 studies (n=490 patients) conducted PET after NCRT. Study quality was assessed using QUADAS scores, which ranged from 9 to 12 (total points, 14) in the included studies. Only 5 studies described blinding of the pathology reviewers to FDG-PET data and other test results. The pooled sensitivity, specificity, and diagnostic odds ratio for the studies conducting PET during NCRT were: 85% (95% CI, 76% to 91%), 59% (95% CI, 48% to 69%), and 6.8 (95% CI, 2.3 to 20.7), respectively. The pooled sensitivity, specificity, and diagnostic odds ratio for the studies conducting PET after NCRT were: 67% (95% CI, 60% to 73%), 69% (95% CI, 63% to 74%), and 6.3 (95% CI, 2.1 to 19.3), respectively. Subgroup analyses on studies that conducted PET after NCRT and included only patients with squamous cell carcinoma (4 studies, 129 patients), showed higher pooled sensitivity, specificity, and diagnostic odds ratio: 90% (95% CI, 80% to 96%), 69% (95% CI, 56% to 80%), and 17.3 (95% CI, 3.1 to 95.4), respectively. Reviewers concluded that FDG-PET should not be used routinely to guide treatment strategies in patients with esophageal cancer based on the low pooled estimates; however, PET may be considered for the subset of patients with squamous cell carcinoma.

Nonrandomized Studies
In 2017, van Rossum et al published a study evaluating the use of FDG-PET before and after induction chemotherapy to predict response to subsequent chemoradiotherapy in patients with...
adenocarcinoma.\textsuperscript{25} Patients who were to receive a 3-step treatment strategy of induction chemotherapy, followed by chemoradiotherapy and then surgery (N=70), underwent FDG-PET before and after the induction chemotherapy phase of the treatment. PET identified 27 patients with poor pathologic responses to the induction chemotherapy (defined as <26\% reduction in total lesion glycolysis [TLG] after chemotherapy). After a median follow-up duration of 48 months (range, 15-99 months), PFS was significantly lower among patients identified by PET as poor responders compared with patients identified by PET as good responders.

In 2017, Hagen et al published a study evaluating the predictive value of FDG-PET before and 2 weeks after chemoradiotherapy in 106 patients with esophageal cancer who then underwent potentially curative surgery.\textsuperscript{26} The outcome of metabolic response, stable disease, or progression was assessed using Positron Emission Tomography Response Criteria in Solid Tumors (PERCIST). Patients were followed until disease recurrence or death. Minimum follow-up of surviving patients was 60 months. Five-year disease-free survival rates for patients determined by FDG-PET as having metabolic response, stable disease, or progression were 66\%, 53\%, and 67\%, respectively. These rates did not differ statistically. The authors concluded that FDG-PET should not be used as a prognostic tool for these patients.

**Retrospective Studies**

In 2017, Manoharan et al published a study evaluating the use of FDG-PET before and after neoadjuvant therapy in patients with resectable distal esophageal cancer (n=21) and gastric adenocarcinoma (n=14).\textsuperscript{27} Maximum and percent change of both SUV and metabolic tumor volume (MTV) were measured and correlated with tumor regression and survival to assess predictive value. The best PET-based biomarker for predicting pathologic response and survival was percent change in maximum SUV (SUVmax). Patients with 70\% or more change in SUVmax had lower risks of death and recurrence than patients with less than 70\% SUVmax.

**Clinical Validity**

No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered with interim FDG-PET.

**Section Summary: Esophageal Cancer**

Evidence for the clinical validity of FDG-PET as an adjunct to CT to determine early treatment response for patients with esophageal cancer consists of a meta-analysis and 3 studies published after the meta-analysis. Results were inconsistent among the studies. Results from the meta-analyses showed low pooled sensitivities and specificities, indicating FDG-PET may be a poor guide for treatment strategies in patients with esophageal cancer. One of the nonrandomized trials published after the meta-analysis supported this conclusion. However, a subgroup analysis in the meta-analysis that included only studies of patients with squamous cell carcinoma, and 2 studies published after the meta-analysis, reported that FDG-PET could adequately predict responders to neoadjuvant therapy. No evidence was identified examining the clinical validity of FDG-PET for patients with esophageal cancer.

**Gastrointestinal Stromal Tumors**

**Clinical Validity**

A 2009 National Comprehensive Cancer Network (NCCN) task force report identified a small retrospective study of 20 patients with gastrointestinal stromal tumors (GIST) who were treated with imatinib and underwent PET, CT, and PET/CT imaging.\textsuperscript{28} PET/CT was more accurate than either PET or CT alone for detecting tumor response at 1, 3, and 6 months after initiation of imatinib. Based on this study, the task force recommended PET for response assessment to targeted GIST therapy.

A 2012 systematic review\textsuperscript{29} of studies of FDG-PET for evaluating treatment response to imatinib and other drugs in GIST included the retrospective study identified by the NCCN. Reviewers concluded that “FDG PET allows an early assessment of treatment response and is a strong predictor of clinical outcome.” This conclusion was based on 19 studies (n=192 patients) that
showed associations between PET as early as 1 week after initiation of tyrosine kinase inhibitor (imatinib, sunitinib, masitinib) therapy and survival outcomes, and 2 studies (n=44 patients) that did not show this association. None of the reviewed studies assessed the impact of PET-directed treatment changes on net health outcome. A chain of evidence was identified; in patients with borderline resectable GIST involvement, rapid assessment of treatment response can guide clinical decision making regarding surgical approach or addition of second line treatment.28,30

Clinical Utility
No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered with interim FDG-PET.

Section Summary: Gastrointestinal Stromal Tumors
There were no studies identified to provide support for long-term PET-guided treatment of patients with gastrointestinal tumors.

Evidence for the clinical validity of the use of interim FDG-PET as an adjunct to CT to evaluate treatment response in patients with GIST consists of a systematic review of 19 studies. Seventeen of the studies found that interim FDG-PET adequately measured tumor response to tyrosine kinase inhibitors (imatinib, sunitinib, masitinib), and could be a strong predictor of clinical outcome as early as 1 month after initiating treatment. While CT detects anatomic changes in the tumor, FDG-PET detects changes in metabolic activity of the tumor. Because metabolic changes precede anatomic changes by several weeks or even months, FDG-PET can detect treatment response earlier, compared with CT's size-based criteria. PET is therefore preferred if a rapid read-out of response to targeted therapy is needed to guide treatment decisions.

Head and Neck Cancer
Clinical Validity
In 2017, Min et al published a systematic review of the predictive value of functional imaging (MRI, CT, PET) in patients with mucosal primary head and neck cancer treated with RT.31 The literature search, conducted through March 2015, identified 99 studies for inclusion, 7 of which used interim PET/CT and 9 which used different radiotracers with PET (fluorine 18 misonidazole, fluorine 18 thymidine, fluoroazomycin arabinoside, and methionine carbon 11). Study quality assessment was not mentioned in the review. Five of the 7 studies using PET/CT confirmed the predictive value of PET for disease-free survival and OS. The non-FDG-PET studies had small sample sizes and inconsistent results. One study showed that fluorine 18 thymidine may have better predictive value than FDG.

In 2016, Castelli et al published a systematic review of the predictive value of FDG-PET/CT for patients with head and neck cancer who are treated with chemoradiotherapy.32 The literature search, conducted through March 2016, identified 45 studies for inclusion. Most studies evaluated the predictive value of FDG-PET for diagnosing head and neck cancer. Seven of the studies (n=374 patients) investigated interim FDG-PET in patients receiving RT with or without chemotherapy. Five of the 7 studies overlapped with those identified in the 2017 Min systematic review. Study quality assessment was not mentioned in the review. Six of the 7 studies reported a correlation between PET measurements (SUVmax, TLG, MTV) and clinical outcomes (disease-free survival, OS). The optimal time to perform FDG-PET during treatment is unclear, though most of the studies used PET after 3 weeks of treatment. Meta-analyses were not conducted.

In 2016, dos Anjos et al published a systematic review of the effectiveness of FDG-PET/CT for patients with head and neck squamous cell carcinoma who are receiving induction chemotherapy.33 The literature search, conducted through May 2016, identified 7 articles for inclusion (n=207 patients). Based on an Agency for Healthcare Research and Quality checklist for assessing the quality of observational studies, the articles were considered to have a moderate risk of bias. Methodologic limitations included incomplete explanations of confounding variables and absence of follow-up. Six of the 7 articles reported that FDG-PET/CT
provided an adequate early response prediction of survival. Meta-analysis could not be conducted due to the heterogeneity in response criteria, SUVmax thresholds, and outcomes.

**Clinical Utility**

No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered with interim FDG-PET.

**Section Summary: Head and Neck Cancer**

Evidence for the clinical validity of interim FDG-PET as an adjunct to CT in predicting disease-free survival and OS in patients with head and neck cancer consists of several systematic reviews. Most studies showed that FDG-PET used during RT, with or without chemotherapy, can adequately predict disease-free survival and OS. Meta-analyses could not be performed in any of the systematic reviews due to the heterogeneity in the methods used across the studies to determine response. Most studies used SUVmax, however, thresholds varied across the studies. No studies were identified that could provide evidence for the clinical utility of interim FDG-PET for patients with head and neck cancer.

**Lymphoma**

**Clinical Validity**

**Systematic Reviews**

In 2016, Adams and Kwee published a systematic review and meta-analysis calculating false-positive rates of FDG-PET during and at end of treatment, using biopsy as the reference standard in patients with lymphoma and FDG-avid lesions. Overall methodologic study quality was moderate, as assessed by the QUADAS-2 tool. Table 2 shows the pooled false-positive rates.

**Table 2. Pooled False-Positive Rates**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Condition</th>
<th>No. of Studies</th>
<th>Percentage</th>
<th>95% CI, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim FDG-PET</td>
<td>Hodgkin lymphoma</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim FDG-PET</td>
<td>Non-Hodgkin lymphoma</td>
<td>4</td>
<td>83</td>
<td>72 to 90</td>
</tr>
<tr>
<td>End-of-treatment FDG-PET</td>
<td>Hodgkin lymphoma</td>
<td>3</td>
<td>23</td>
<td>5 to 65</td>
</tr>
<tr>
<td>End-of-treatment FDG-PET</td>
<td>Non-Hodgkin lymphoma</td>
<td>2</td>
<td>31</td>
<td>4 to 84</td>
</tr>
</tbody>
</table>

CI: Confidence Interval; FDG-PET: Fluorine 18 Fluorodeoxyglucose Positron Emission Tomography.

Reviewers questioned the use of FDG-PET for assessing lymphoma treatment due to these high false-positive rates. FDG-PET exposes patients to potentially harmful levels of radiation and may provide misinformation leading to incorrect treatment changes and/or unnecessary biopsies.

**Retrospective Studies**

In 2017, Wong-Sefidan et al published a study evaluating the predictive value of FDG-PET/CT on survival in patients with follicular lymphoma. Among 1289 patients in the National LymphoCare Study, 447 underwent FDG-PET/CT following rituximab induction therapy. After a median follow-up of 7.6 years, the 5-year OS rate for PET-negative patients (n=292) was 88%, and the PFS rate was 65%. For PET-positive patients (n=155), the 5-year OS rate was 78% and the PFS rate was 51%.

**Clinical Utility**

**Systematic Reviews**

A Cochrane systematic review of interim FDG-PET-adapted therapy following first-line treatment in Hodgkin lymphoma was published in 2015. The search strategy included RCTs comparing PET-adapted therapy to nonadapted therapy in patients with previously untreated Hodgkin lymphoma of all stages and ages published in Cochrane Central Register of Controlled Trials, MEDLINE, or presented at conference proceedings from 1990 to 2014. Reviewers found 2 publications and 1 abstract for a total of 3 eligible trials (total N=1480 participants). The quality of the evidence for the primary outcome of PFS was considered moderate. In all 3 trials, PET-adapted therapy included no RT after PET-negative results following initial chemotherapy. The pooled estimate of PFS was shorter in participants with PET-adapted therapy (without RT)
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than in those receiving standard treatment with RT (hazard ratio [HR], 2.38; 95% confidence interval [CI], 1.62 to 3.50; \(p<0.001\)). The authors were unable to draw conclusions about OS due to the small number of deaths reported in the 3 trials. The studies included little to no data on response rates, treatment-related mortality, quality of life, or short- and long-term adverse events.

**Randomized Controlled Trials: Interim PET-Negative**

Patients with PET-negative results following induction chemotherapy tend to have a good prognosis. The goal of PET-directed therapy is to achieve similar efficacy concerning PFS while avoiding unnecessary exposure to radiation, which can have toxic side effects, including late secondary cancers\(^{40,41}\) and cardiovascular disease\(^{42,43}\) or to reduce the side effects of additional chemotherapy by decreasing the number of cycles or chemotherapeutic agents.

Five RCTs have compared PET-directed therapy with standard therapy in patients who had lymphoma and had negative interim PET findings after an initial course of chemotherapy. Three studies were evaluated in the Cochrane review (previously described). Characteristics of the studies are summarized in Table 3 and briefly below.

Picardi et al (2007) reported on a trial of PET-directed therapy vs standard therapy in 160 patients (median age, 31 years; 55% men) with newly diagnosed bulky Hodgkin lymphoma.\(^{38}\) PET scans were performed using a dedicated tomography scanner (Advanced NXi, General Electrics). Negative PET was defined as no evidence of uptake, and positive PET was defined as increased uptake in a focus within an abnormal area. Patients having negative PET scans following induction chemotherapy with 6 cycles of VEBEP (vinblastine, etoposide, bleomycin, epirubicin, and prednisone) were randomized to observation (PET-directed therapy) or 32 gray (Gy) RT (standard therapy). The study was powered to detect a 10% risk difference (RD) in event-free survival, defined as relapse, secondary malignancies, or death from any cause; the specific hypothesis (superiority vs noninferiority) was not reported.

In 2014, Raemaekers et al published a preplanned interim futility analysis of the European Organization for Research and Treatment of Cancer/Lymphoma Study Association/Fondazione Italiana Linfomi (EORTC/LYSA/FIL) Intergroup H10 trial.\(^{39}\) The trial randomized patients who had previously untreated stage I or II Hodgkin lymphoma to PET-directed therapy or standard therapy. Standard therapy was additional ABVD (doxorubicin, bleomycin, vinblastine, dacarbazine; 1 cycle for favorable and 2 cycles for unfavorable) plus 30-Gy radiation. PET images were scored according to the International Harmonisation Project criteria, with a negative PET corresponding to scores 1 (no uptake) and 2 (uptake \(\leq\) mediastinum) on the 5-point Deauville scale. Patients in the PET-directed therapy arm who had a negative early PET scan (after 2 chemotherapy cycles) did not receive RT but received additional cycles of ABVD (2 cycles for favorable, 4 cycles for unfavorable). Patients with favorable or unfavorable prognostic factors were analyzed separately. The trial design was noninferiority, with margins for the hazard ratios of 3.2 and 2.1 for favorable and unfavorable, respectively.

The 2015 RAPID study recruited 602 patients (53.3% male; median age, 34 years) with newly diagnosed stage IA or stage IIA Hodgkin lymphoma, of whom 571 patients received 3 cycles of chemotherapy comprising ABVD and then PET scanning performed on full-ring PET or PET with CT cameras.\(^{37}\) A Deauville score of 1 or 2 indicated negative findings and a score of 3, 4, or 5 indicated positive findings. A total of 420 patients with negative PET findings were randomly assigned to receive involved-field RT (standard therapy) or no further treatment (PET-directed therapy). This trial assessed the noninferiority of no further treatment, designed to exclude a difference in the 3-year PFS rate of 7 or more percentage points from the assumed 95% PFS rate in the RT group.

The trial reported in 2016 by Johnson et al randomized 937 newly diagnosed advanced classic Hodgkin lymphoma patients (median age, 33 years; 55% men) who had an interim negative PET coupled with CT scan after an initial 2 cycles of ABVD to receive continued ABVD for 4 cycles.
(ABVD group; standard therapy) or to omit bleomycin (AVD [doxorubicin, vinblastine, dacarbazine] group; PET-directed therapy). A Deauville score of 1, 2, or 3 was regarded as indicating negative PET findings, and a score of 4 or 5 as indicating positive PET findings. The trial evaluated the noninferiority of omitting bleomycin for 3-year PFS with a 5 percentage point margin for the RD.

A phase 2 RCT published in 2017 by Casasnovas et al evaluated the use of interim FDG-PET in the treatment of 200 patients with diffuse large B-cell lymphoma. FDG-PET was conducted after cycles 2 (PET2) and 4 (PET4) of induction therapy. Patients who were PET4-positive (n=100) were advised to proceed with a salvage regimen followed by autologous cell transplantation; the final treatment decision was made by the patients and their clinicians. Patients who were PET4-negative (n=100) were given different therapies depending on whether the PET2 was negative or positive. PET2- and PET4-patients (n=52) were treated with 2 cycles of high-dose methotrexate, then 4 cycles of rituximab, ifosfamide, and etoposide, then 2 cycles of cytarabine. PET2-positive and PET4-negative patients (n=48) were treated with 2 cycles of high-dose methotrexate, then a high-dose therapy (carmustine, etoposide, cytarabine, and melphalan), followed by autologous cell transplantation.

### Table 3. Summary of Key RCT Characteristics of PET-Guided Therapy in PET-Negative Patients

<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Key Eligibility Criteria</th>
<th>PET-Directed Therapy, n</th>
<th>Standard Therapy, n</th>
<th>Primary Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picardi et al (2007)</td>
<td>NR</td>
<td>Belgium, CH, Croatia, Italy, Denmark, France, SR, Netherlands</td>
<td>158</td>
<td>2000-2006</td>
<td>Untreated bulky HL</td>
<td>80</td>
<td>80</td>
<td>EFS</td>
</tr>
<tr>
<td>Raemaekers et al (2014)</td>
<td>EORTC/LYSA/FIL H10</td>
<td>Belgium, CH, Croatia, Italy, Denmark, France, SR, Netherlands</td>
<td>158</td>
<td>2006-2011</td>
<td>Untreated stage I/II HL</td>
<td>221 favorable prognoses</td>
<td>233 favorable prognoses</td>
<td>PFS</td>
</tr>
<tr>
<td>Johnson et al (2016)</td>
<td></td>
<td>UK, Italy, Australia, NZ, Norway, Sweden, Denmark</td>
<td>138</td>
<td>2008-2012</td>
<td>Untreated stage IIA (with adverse features) or IIB-IV HL</td>
<td>465</td>
<td>470</td>
<td>PFS</td>
</tr>
</tbody>
</table>

CH: Switzerland; DLBCL: diffuse large B-cell lymphoma; EFS: event-free survival; HL: Hodgkin lymphoma; NR: not reported; OS: overall survival; PET2/4: 2 or 4 cycles of positron emission tomography; PFS: progression-free survival; RCT: randomized controlled trial; SR: Slovak Republic; NZ New Zealand.

a Favorable prognosis: age <50 y with <3 involved nodal areas, absence of mediastinal bulk (mediastinum-to-thorax ratio <0.35), and ESR <50 mm without B symptoms or ESR <30 mm with B symptoms; Unfavorable prognosis: age ≥50 y, >4 involved nodal areas, presence of mediastinal bulk (mediastinum-to-thorax ratio ≥0.35), or ESR ≥50 mm without B symptoms or ESR ≥30 mm with B symptoms.

The results of these 5 RCTs for PET-directed therapy in PET-negative lymphoma patients are summarized in Table 4 and below.

In the Picardi trial, all 80 patients were included in the analysis with a median of 40 months of follow-up. Events were more common in the PET-directed arm. Eleven (14%) events vs 3 (4%) events were reported, corresponding to an event-free survival rate of 86% in the PET-directed arm vs 96% in the standard arm (HR for standard therapy, 3.32; 95% CI, 1.13 to 9.76; p=0.03). Twenty percent of patients in PET-directed vs 22% in standard therapy experienced a hematologic toxicity of at least World Health Organization grade 2. The nonhematologic toxicity...
(including pneumonitis, cardiovascular abnormality, and peripheral neuropathy) of at least World Health Organization grade 2 was 5% in both groups. No deaths were reported.

The EORTC/LYSA/FIL H10 trial performed a prespecified interim analysis including 1124 randomized patients (favorable group, n=441; unfavorable group, n=683) with median follow-up of 1.1 years. Progression or death was more common among patients in PET-guided therapy arms than in standard therapy arms of both groups (5% vs 0.5%, respectively, in the favorable group; 6% vs 3%, respectively, in the unfavorable group). Estimated HRs for progression or death were 9.4 (80% CI, 2.5 to 35.7) in the favorable group and 2.4 (80% CI, 1.4 to 4.4) in the unfavorable group. Based on these findings, futility was declared, and accrual to the early PET-negative experimental arm was discontinued.

In the RAPID trial, with a median of 60 months of follow-up, 8 instances of disease progression occurred in the RT group (standard therapy), and 8 patients had died (3 with disease progression, one of whom died from Hodgkin lymphoma); 20 instances of disease progression occurred in the group with no further therapy (PET-directed therapy), and 4 patients had died (2 with disease progression and none from Hodgkin lymphoma). The 3-year PFS rate was 95% (95% CI, 91.5% to 97.7%) in the RT group and 90.8% (95% CI, 86.9% to 94.8%) in the group that received no further therapy; the absolute RD was -3.8 percentage points (95% CI, -8.8 to 1.3) and the CIs included the noninferiority margin.

In the Johnson trial, median follow-up was 41 months. There were 68 vs 74 events of disease progression, relapse, or death in the ABVD group vs the AVD group, respectively (HR with AVD=1.13; 95% CI, 0.81 to 1.57; p=0.48). Three-year PFS rate was 85.7% (95% CI, 82.1% to 88.6%) in the ABVD group and 84.4% (95% CI, 80.7% to 87.5%) in the AVD group (RD=1.6 percentage points; 95% CI, -3.2 to 5.3); CIs included the noninferiority margin. Three-year OS rates were similar in both 2 groups: 97.2% (95% CI, 95.1% to 98.4%) with ABVD and 97.6% (95% CI, 95.6% to 98.7%) with AVD. Grade 3 and 4 respiratory adverse events were more severe in the ABVD group than in the AVD group, and the difference in change in the diffusing capacity of the lung for carbon monoxide from baseline to the completion of therapy was -7.4% (95% CI, -5.1% to -9.7%; p<0.001).

In the Casasnovas trial, median follow-up was 45 months (range, 1-63 months). Of the 100 patients who were PET4-negative, 55 progressed or relapsed and 39 died. There was no significant difference in 4-year PFS or OS between the 2 treatment groups. The authors propose that the flawed criteria were used to determine PET-positive and -negative classifications. The International Harmonisation Project criteria were used because these criteria were accepted at the time of the trial launch. The International Harmonisation Project criteria are now known to generate high false-positive results. The authors suggested that SUVmax may guide treatment decisions more effectively.

Table 4. Summary of Key RCT Trial Results of PET-Guided Therapy in PET-Negative Patients

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Primary Outcome</th>
<th>Results (95% CI)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Picardi et al (2007) | EFS | EFS: 69 (86%) vs 77 (96%)  
HR for ST, 3.32 (1.13 to 9.76) |          |
| EORTC/LYSA/FIL H10 (2014) | PFS (favorable: n=188 vs n=193; unfavorable: n=251 vs n=269) | Favorable:  
PFS at 1 y: 94.9% vs 100%  
9 vs 1 events<sup>b</sup>  
HR for ST, 9.36 (2.45 to 35.73)  
Unfavorable:  
PFS at 1 y: 94.7% vs 97.3%  
16 vs 7 events<sup>b</sup>  
HR for ST, 2.42 (1.35 to 4.36) | Recruitment stopped early after interim analysis suggested futility for noninferiority |
| RAPID (2015) | PFS (n=211 vs n=209) | 3-y PFS: 90.8% (86.9% to 94.8%) vs 94.6% (91.5% to 97.7%)  
HR for PET-directed, 0.51 (0.15 to 1.68) | Unable to show noninferiority (RD margin, 7%) |
Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Primary Outcome</th>
<th>Results (95% CI)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Johnson et al (2016) | PFS (n=470 vs n=465) | • 3-y PFS: 84.4% (80.7% to 87.5%) vs 85.7% (82.1% to 88.6%)  
• HR for ST: 1.13 (0.81 to 1.57)  
• RD for ST: 1.6 (-3.2 to 5.3) | Unable to show noninferiority (RD margin, 5%) |
| Casasnovas et al (2017) | PFS and OS (n=48 vs n=52) | 4-y PFS:  
• PET2+: 85% (71.1% to 92.6%)  
• PET2-: 75% (60.9% to 84.5%)  
4-y OS:  
• PET2+: 90.4% (81% to 95.1%)  
• PET2-: 89.6% (85% to 92.2%) | |


Randomized Controlled Trials: Interim PET-Positive

The goal of PET-directed therapy for PET-positive patients is to intensify therapy for those at highest risk of treatment failure to improve PFS or OS. As previously described, the EORTC/LYSA/FIL H10 trial (2014) randomized 1925 patients who had previously untreated stage I or II Hodgkin lymphoma to PET-directed therapy or standard therapy; patients in the PET-directed therapy arm who had a positive early PET scan (after 2 ABVD chemotherapy cycles) received intensification of chemotherapy with BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone). Available results were presented at the 13th International Conference on Malignant Lymphoma in June 2015. These preliminary results indicated improvement in 5-year PFS rates in the PET-directed arm (91%) vs standard arm (77%; HR=0.42; 95% CI, 0.23 to 0.74; p=0.002) and were confirmed in final results from the trial, published by André et al in 2017.

Both the RAPID trial (2015) and the Johnson trial (2016) included observation of patients with an interim positive PET after initial induction chemotherapy, although neither trial had a randomized comparison in the PET-positive group. In the RAPID trial, 145 patients with positive PET findings received a fourth cycle of ABVD and involved-field RT. After a median of 62 months of follow-up, there were 18 events of progression, relapse, or death for a PFS rate in the PET-positive patients of 87.6% (precision not given). In the Johnson trial, 182 patients with a positive PET received accelerated BEACOPP (BEACOPP-14) or escalated BEACOPP. There were 55 events of disease progression, relapse, or death in the PET-positive group. The 3-year PFS rate was 67.5% (95% CI, 59.7% to 74.2%) and the OS rate was 87.8% (95% CI, 81.5% to 92.1%).

The trial by Casasnovas et al (2017) described in the PET-negative section above also included patients who were PET-positive after induction chemotherapy. For patients who were PET-positive after induction therapy, guidance was given to proceed with a salvage regimen followed by autologous cell transplantation, though the final treatment decision was left to the patient’s clinician. The 4-year PFS rate was lower in patients who were PET-positive (72.9% 95% CI, 63.1% to 80.6%) than in patients who were PET-negative following induction therapy (79.8% 95% CI, 79.4% to 86.4%). The 4-year OS rate was also lower in PET-positive patients (80% 95% CI, 69.0% to 87.5%) than in PET-negative patients (88.9% 95% CI, 82.1% to 94.4%).

Other Clinical Studies

Some single-arm early-phase trials, observational studies, and secondary analyses of RCT data that have assessed outcomes of patients with Hodgkin lymphoma and diffuse large B-cell lymphoma who received treatment changes based on interim PET/CT scans suggest that some...
chemotherapeutic regimens can be intensified or switched to less-toxic regimens without harm.\textsuperscript{48-57}

Conclusions of single-arm and retrospective studies may be limited by selection and lead-time bias and lack concurrent comparators. Given the potential for biases, comparative trials would be necessary to determine the efficacy of such a strategy.

**Section Summary: Lymphoma**

Evidence for the validity of using interim FDG-PET as an adjunct to CT consists of a systematic review, which showed high false-positive rates for patients with Hodgkin or non-Hodgkin lymphoma. Evidence for the utility of interim FDG-PET for guided treatment in patients with lymphoma consists of a Cochrane review and several RCTs. The Cochrane review reported lower PFS in patients receiving PET-guided therapy compared with patients receiving standard care. Two retrospective studies published after the review evaluated interim FDG-PET in patients with follicular lymphoma and T-lymphoblastic leukemia/lymphoma; the studies showed that PET may have potential in predicting survival in these specific lymphomas. In the RCTs comparing PET-guided therapy with standard therapy, results did not show noninferiority.

**Non-Small-Cell Lung Cancer**

**Clinical Validity**

Eleven studies have been identified that evaluated a potential association between interim FDG-PET analyses during various treatments and OS or PFS in patients with non-small-cell lung cancer (NSCLC).\textsuperscript{58-69} The studies included patients with various stages of NSCLC, receiving various lung cancer treatments: chemotherapy (e.g., gefitinib, carboplatin/paclitaxel, erlotinib, cisplatin/etoposide, docetaxel/cisplatin), chemoradiotherapy, chemotherapy with or without nitrogen patches, and low-dose fractionated radiotherapy with concurrent chemotherapy. Eight of the studies were small, with study populations less than 50. The remaining 3 studies had populations between 50 and 100. Most studies found correlations between early metabolic response detected by FDG-PET and survival, thereby proposing that FDG-PET might be used to personalize treatment for patients with NSCLC. Generalizability of these results is limited due to the heterogeneity across studies, which included patients at various stages of the disease, undergoing various treatment regimens, and receiving FDG-PET during different cycles of treatment.

**Clinical Utility**

No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered with interim PET.

**Section Summary: Non-Small-Cell Lung Cancer**

Evidence for the clinical validity of interim FDG-PET as an adjunct to CT, following various treatments for NSCLC, consists of many small observational studies. The studies were heterogeneous, with different patient populations, different therapies, and different timings of PET assessments. Most studies concluded that FDG-PET may adequately detect responders and nonresponders, which may predict OS and PFS. However, early prediction of survival does not translate to patient benefit unless decisions based on those predictions result in improved patient outcomes by either extending OS or improving quality of life.

**Ovarian Cancer**

**Clinical Validity**

In 2017, Suppiah et al published a systematic review on the accuracy of PET/CT and PET/MRI in managing patients with ovarian cancer.\textsuperscript{70} The literature search, conducted through December 2016, identified 9 articles that addressed the use of PET/CT for treatment response and provided hazard ratios for the prediction of recurrence. Outcomes of the studies were metabolic parameters (SUV\textsubscript{max}, MTV, and/or TLG). Six of the 7 studies that measured SUV\textsubscript{max} (n=750 patients) reported that it was not a significant indicator of survival. Two of the 3 studies that measured MTV (n=129 patients) reported that it was not a significant indicator of survival. All 4
studies that measured TLG (n=304 patients) reported that it was a significant predictive factor for prognosis. Meta-analyses were not performed.

**Clinical Utility**

No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered based on interim PET measurements.

**Section Summary: Ovarian Cancer**

Evidence for the use of PET as an adjunct to CT for assessing treatment response in patients with ovarian cancer consists of a systematic review of nonrandomized studies. Although TLG as measured by interim PET appeared to be associated with response and may be better than other methods of prognosis, these studies did not demonstrate whether such improved prediction lead to improved patient outcomes. No case series or comparative trials of risk-adapted treatment for ovarian cancer were identified.

**Other Malignant Solid Tumors**

**Clinical Validity**

The 2007 and 2009 NCCN task force reports assessed other malignant solid tumors for interim PET. The 2007 report cited a small study of patients with colorectal cancer that showed an association between PET and tumor response to 5-fluorouracil after 1 month of therapy.63 The British National Health Service review (2007) also assessed other cancers for PET during treatment.71 For colorectal cancer, 1 study showed that PET after 1 month of chemotherapy predicted outcome, but predictive accuracy was low. For head and neck cancer, esophageal cancer, and melanoma, only studies that evaluated PET after treatment were identified. In total, the British National Health Service review found 22 studies of PET during treatment. The authors concluded that many studies were small and evaluated different treatments using a diversity of response targets and monitoring methods. There was little evidence of change in patient management, even anecdotally, and no published evidence of successful applications to drug development.

The 2009 NCCN report reviewed cancers not discussed in the 2007 report.28 For most cancers (e.g., bladder, prostate, thyroid), evidence for interim PET was not cited. Although the task force included a recommendation for PET to assess response to liver-directed therapies in patients with localized hepatocellular carcinoma, the recommendation was based on studies of PET after transcatheter chemo-embolization and/or radiofrequency ablation (i.e., not interim PET).

Since the NCCN and the National Health Service reports, other studies have been reported in patients with colon cancer demonstrating associations between early or interim PET and recurrence or survival outcomes.72,73 Evidence in rectal or colorectal cancer was mixed,74-83 and studies of early (during or after 1 or 2 neoadjuvant chemotherapy cycles) PET to predict axillary lymph node response reported conflicting results.84,85 Studies have also reported on associations between early or interim PET during treatment and recurrence or survival outcomes in bladder cancer,86 malignant pleural mesothelioma,87,88 squamous cell carcinomas of the head and neck,89-92 pancreatic cancer,93 and bone or soft tissue sarcoma.94,95

Conversely, evidence for advanced renal cell carcinoma was mixed.96-99 Method of measurement of quantitative parameters and cutpoint thresholds for PET-positivity varied across studies within the same cancer. No study demonstrated the impact of PET-directed treatment on net health outcome.

**Clinical Utility**

No RCTs or observational studies were identified that evaluated outcomes of patients whose treatments were altered with interim PET.
Section Summary: Other Cancers
Evidence for the use of interim PET during treatment of other cancers, such as bladder, colorectal, prostate, and thyroid consists of NCCN reports and mostly single-arm observational studies. Results were inconsistent for the use of interim PET for patients with colorectal cancer and renal cell carcinoma. While some studies reported on associations between interim PET and recurrence or survival, the lack of comparative trials of risk-adapted treatment was identified.

Summary of Evidence
Breast Cancer
For individuals with breast cancer who receive interim FDG-PET as an adjunct to interim computed tomography (CT), the evidence consists of a systematic review, an RCT, and several observational studies. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbidity events, and treatment-related morbidity. Results from the systematic review showed wide ranges in sensitivities, specificities, positive predictive values, and negative predictive values. The wide ranges might be due to small sample sizes, the use of various definitions of the outcome measure (pathologic complete response), and differences in breast cancer subtype populations. One RCT was identified in which therapy decisions were guided by FDG-PET results. Nonresponders, determined by PET measures, were given more intensive chemotherapy. Clinical outcomes such as progression-free survival and overall survival are not yet available for this RCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

Esophageal Cancer
For individuals with esophageal cancer who receive interim FDG-PET as an adjunct to interim CT, the evidence includes a meta-analysis and 3 studies published after the meta-analysis. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbidity events, and treatment-related morbidity. Results on clinical validity were inconsistent across the studies. The meta-analysis reported low pooled sensitivities and specificities, while a subgroup analysis including only patients with squamous cell carcinoma and 2 studies published after the meta-analysis reported an adequate potential in predicting responders to neoadjuvant therapy. No evidence was identified that examined the clinical utility of PET for patients with esophageal cancer. The evidence is insufficient to determine the effects of the technology on health outcomes.

Gastrointestinal Stromal Tumors
For individuals with gastrointestinal stromal tumors receiving palliative or adjuvant therapy who receive interim FDG-PET as an adjunct to interim CT, the evidence includes a systematic review. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbidity events, and treatment-related morbidity. The systematic review included 19 studies, 2 of which reviewed FDG-PET scans more than 6 months after the start of treatment. CT is currently recommended for standard long-term follow-up and surveillance of gastrointestinal stromal tumors. FDG-PET is equivalent to CT in the detection of treatment response when follow-up is long term. No studies were identified that tested outcomes following PET-guided treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with gastrointestinal stromal tumors treated with tyrosine kinase inhibitors for 6 months or less who receive interim FDG-PET as an adjunct to interim CT, the evidence includes a systematic review. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbidity events, and treatment-related morbidity. The systematic review included 19 studies, 17 of which showed that FDG-PET detected an early response to tyrosine kinase inhibitor therapy, which was a strong predictor of clinical outcomes. FDG-PET detected treatment response as early as 1 week after initiation of treatment. While CT detects anatomic changes in the tumor, PET detects changes in metabolic activity of the tumor. Because metabolic changes precede anatomic changes by several weeks or sometimes months, PET can detect treatment response earlier than CT. PET is therefore preferred if a rapid
read-out of response to targeted therapy is needed to guide treatment decisions (e.g., change in targeted therapy or surgery). While no studies were identified that tested outcomes following PET-guided treatment, it is possible to construct a chain of evidence demonstrating improved patient outcomes. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Head and Neck Cancer**
For individuals with head and neck cancer who receive interim FDG-PET as an adjunct to CT, the evidence includes three systematic reviews. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbid events, and treatment-related morbidity. There was an overlap of studies among the systematic reviews. Most studies included in the reviews showed that FDG-PET used during radiotherapy, with or without chemotherapy, can adequately predict disease-free and overall survival. Meta-analyses to determine response could not be performed in any of the systematic reviews due to the heterogeneity in the methods across the studies. Most studies used maximum standardized uptake volume, however, threshold values to determine response varied across studies. No studies were identified that provided evidence for the clinical utility of PET. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Lymphoma**
For individuals with lymphoma who receive interim FDG-PET as an adjunct to interim CT, the evidence includes systematic reviews with meta-analyses and RCTs. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbid events, and treatment-related morbidity. The systematic review evaluating the validity of interim FDG-PET showed high false-positive rates for both Hodgkin and non-Hodgkin lymphomas. After the systematic review, 2 studies were published; one focused on patients with follicular lymphoma and the other on patients with T-lymphoblastic leukemia/lymphoma. These studies showed a potential for FDG-PET to predict survival rates for these specific lymphomas. Evidence for the clinical utility of interim PET for guiding treatment in patients with lymphoma consists of a Cochrane review and several RCTs. The review reported lower progression-free survival rates in patients who received PET-guided therapy. The RCTs that compared PET-guided therapy with standard therapy did not demonstrate noninferiority. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Non-Small-Cell Lung Cancer**
For individuals with non-small-cell lung cancer who receive interim FDG-PET as an adjunct to interim CT, the evidence includes many small observational studies. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbid events, and treatment-related morbidity. While most studies showed correlations between FDG-PET measurements and progression-free and overall survival, the generalizability of the results is limited. The studies were small, with most population sizes fewer than 50 patients. The studies were also heterogeneous, including patients at different stages of the disease, undergoing different treatment regimens, and receiving PET at different times during treatment cycles. No studies were identified that evaluated outcomes after PET-guided therapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Ovarian Cancer**
For individuals with ovarian cancer who receive interim FDG-PET as an adjunct to interim CT, the evidence includes a systematic review. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbid events, and treatment-related morbidity. The systematic review identified 9 studies that calculated hazard ratios for various FDG-PET parameters (e.g., maximum standardized uptake value, metabolic tumor volume, tumor lesion glycolysis). The only parameter consistently showing prognostic value was tumor lesion glycolysis. However, no studies were identified that evaluated outcomes after PET-guided therapy. The evidence is insufficient to determine the effects of the technology on health outcomes.
Other Cancers
For individuals with other malignant solid tumors (e.g., bladder, colorectal, prostate, thyroid) who receive FDG-PET as an adjunct to interim CT, the evidence includes a National Comprehensive Cancer Network task force report and single-arm observational studies published after the task force report. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, morbidity events, and treatment-related morbidity. Results have been inconsistent on the use of interim FDG-PET among the various cancers. While some have reported associations between interim FDG-PET and recurrence or survival, there is a lack of comparative trials evaluating outcomes in patients whose treatments were altered based on PET measurements. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Clinical Input from Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests from Blue Cross Blue Shield Association, input was received from 1 physician specialty society and 5 academic medical centers in 2011. In general, there was agreement with the conclusions of this policy from those providing input. Most disagreement related to use of positron emission tomography scans during a planned course of treatment for patients with Hodgkin lymphoma. Some reviewers felt current data were sufficient to show benefit; others commented that additional studies needed to evaluate this issue.

Practice Guidelines and Position Statements
American College of Radiology and Society for Pediatric Radiology
In 2016, the American College of Radiology and the Society for Pediatric Radiology updated their joint practice guidelines for performing fluorine 18 fluorodeoxyglucose positron emission tomography (FDG-PET) coupled with computed tomography (CT) in oncology. The guidelines stated that FDG-PET/CT imaging in oncology patients “should only be performed when there is reasonable expectation that the results will have an impact on patient care.” Examples of indications for imaging included “Monitoring response to therapy to include determining whether residual abnormalities identified with another imaging modality represent persistent viable tumor or post-treatment changes (inflammation, fibrosis, or necrosis)” and “Guiding specific clinical strategies, such as radiation therapy planning or directed biopsy.” Further clarification was not provided.

National Comprehensive Cancer Network
Current National Comprehensive Cancer Network recommendations for interim PET scanning during treatment to assess early response in a variety of cancers are summarized in Table 5.

Table 5. Recommendations for Interim PET Scanning
<table>
<thead>
<tr>
<th>Guideline</th>
<th>Version</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder cancer</td>
<td>5.2017</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>2.2017</td>
<td>“Studies of functional imaging [for monitoring metastatic disease], such as radionuclide bone scans and PET imaging, are particularly challenging when used to assess response... PET imaging is challenging because of the absence of a reproducible, validated, and widely accepted set of standards for disease activity assessment.”</td>
</tr>
<tr>
<td>CNS cancers</td>
<td>1.2016</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
</tbody>
</table>
| Cervical cancer | 1.2017  | “For patients with International Federation of Gynecology and Obstetrics (FIGO) stage IB2 or patients who required postoperative
<table>
<thead>
<tr>
<th>Guideline</th>
<th>Version</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon cancer</td>
<td>2.2017</td>
<td>PET/CT should not be used to monitor progress of therapy. PET/CT scans should not be used to assess response to chemotherapy because a PET/CT scan can become transiently negative after chemotherapy. False positive PET/CT scan results can occur in the presence of tissue inflammation after surgery or infection.</td>
</tr>
<tr>
<td>Esophageal and EGJ cancers</td>
<td>1.2017</td>
<td>PET/CT may be useful in determining response to neoadjuvant chemotherapy for lesions that are larger than 3 cm, firm, deep (not superficial). PET may give an indication of imatinib activity after 2-4 weeks of therapy, when rapid readout of activity is necessary.</td>
</tr>
<tr>
<td>Soft tissue carcinoma</td>
<td>2.2017</td>
<td>PET/CT may be performed at 3-6 months after completion of treatment. ‘‘Patients with stage II-IV, whole body PET/CT is preferred or chest/abdomen/pelvic CT with contrast within 3-6 months of completion of therapy.’’</td>
</tr>
<tr>
<td>Head and neck cancers</td>
<td>2.2017</td>
<td>After either radiation therapy or chemoradiation, post-treatment evaluation with imaging (i.e., CT and/or MRI with contrast, FDG-PET/CT) guides the use of neck dissection. If PET/CT is used for follow-up, the first scan should be performed at a minimum of 12 weeks after treatment to reduce the false-positive rate.</td>
</tr>
<tr>
<td>Hepatobiliary cancers</td>
<td>2.2017</td>
<td>PET/CT is not recommended for detection of HCC because of limited sensitivity. When an HCC is detected by CT or MRI and has increased metabolic activity on PET/CT, higher intralesional standardized uptake value is a marker of biologic aggressiveness and might predict a less optimal response to locoregional therapies.</td>
</tr>
<tr>
<td>Hodgkin lymphoma</td>
<td>1.2017</td>
<td>PET scans are increasingly being used to assess treatment response during therapy. Interim PET scans may be useful to identify a subgroup of patients with early-stage disease that can be treated with chemotherapy alone. The NCCN Guidelines emphasize that the value of interim PET scans remains unclear for many clinical scenarios and all measures of response should be considered in the context of management decisions. The NCCN PET Task Force and the NCCN Guidelines recommend PET scans for evaluating residual masses at the end of treatment. ‘‘Suggested treatment regimens for stage I-II unfavorable or stage III-IV disease: ‘‘ABV (2 cycles) followed by AVD (4 cycles), if PET scan is negative after 2 cycles of ABVD. Patients with positive PET scan after 2 cycles of ABVD need individualized treatment.’’</td>
</tr>
<tr>
<td>Melanoma</td>
<td>1.2017</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
<tr>
<td>MPM</td>
<td>2.2017</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>3.2017</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma: B-cell</td>
<td>3.2017</td>
<td>‘‘Interim PET scan is not recommended to be used to guide changes in therapy for DLBCL and T-cell lymphoma.’’</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma: T-cell</td>
<td>2.2017</td>
<td>‘‘PET/CT scans at interim restaging can lead to increased false positives and should be carefully considered in select cases. If a PET/CT scan is performed and is positive, repeat biopsies are needed before changing the course of treatment.’’</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma: PCBCL</td>
<td>2.2017</td>
<td>‘‘Additional imaging studies during the course of treatment are not needed for PCCL.’’</td>
</tr>
<tr>
<td>NSCLC</td>
<td>8.2017</td>
<td>Interim PET for assessing response to ongoing treatment is not addressed.</td>
</tr>
</tbody>
</table>
Interim PET for assessing response to ongoing treatment is not addressed.

Prostate cancer

“PET-CT should not be used to monitor progress of therapy. CT with contrast or MRI is recommended.”

Rectal cancer

“PET-CT should not be used to monitor progress of therapy. CT with contrast or MRI is recommended.”

SCLC

Interim PET for assessing response to ongoing treatment is not addressed.

Thyroid carcinoma

Interim PET for assessing response to ongoing treatment is not addressed.

Uterine neoplasms

Interim PET for assessing response to ongoing treatment is not addressed.


a This statement is a footnote to gastrointestinal stromal tumor treatment recommendations and is uncited.
b This statement is a footnote to epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer treatment recommendations and is uncited.

International Harmonization Project in Lymphoma

A consensus statement released in 2007 by the International Harmonization Project in Lymphoma stated that use of PET for treatment monitoring during a course of therapy should only be done in a clinical trial or as part of a prospective registry. This statement also commented on the need for clinical trials to demonstrate improved patient outcomes. The document otherwise proposed a strong endorsement for PET at the conclusion of therapy.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

The national coverage determination on FDG-PET for oncologic conditions (220.6.17) makes the following coverage decisions:

“Three FDG PET scans are nationally covered when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy. Coverage of more than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy shall be determined by the local Medicare Administrative Contractors.”

Ongoing and Unpublished Clinical Trials

Currently unpublished trials that might influence this review are listed in Table 6.

Table 6. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Multicenter Clinical Study With Early Treatment Intensification in Patients With High-Risk Hodgkin Lymphoma, Identified As FDG-PET Scan Positive After 2 Conventional ABVD Courses</td>
<td>450</td>
<td>Oct 2015 (ongoing)</td>
</tr>
</tbody>
</table>
### 6.01.51  Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT00784537</td>
<td>Early Salvage With High Dose Chemotherapy and Stem Cell Transplantation in Advanced Stage Hodgkin's Lymphoma Patients With Positive PET After Two Courses of ABVD (PET-2 Positive) and Comparison of RT Versus no RT in PET-2 Negative Patients</td>
<td>520</td>
<td>Jan 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT01132807</td>
<td>Phase II Trial of Response-Adapted Chemotherapy Based on Positron Emission Tomography for Non-Bulky Stage I and II Hodgkin Lymphoma</td>
<td>149</td>
<td>Jun 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT01356680</td>
<td>HD17 for Intermediate Stages - Treatment Optimization Trial in the First-Line Treatment of Intermediate Stage Hodgkin Lymphoma</td>
<td>1100</td>
<td>Dec 2019</td>
</tr>
<tr>
<td>NCT00622120</td>
<td>A Phase II Trial of Response-Adapted Therapy of Stage III-IV Hodgkin Lymphoma Using Early Interim FDG-PET Imaging</td>
<td>230</td>
<td>Apr 2020</td>
</tr>
<tr>
<td>NCT00736320</td>
<td>HD16 for Early Stages - Treatment Optimization Trial in the First-line Treatment of Early Stage Hodgkin Lymphoma; Treatment Stratification by Means of FDG-PET</td>
<td>1150</td>
<td>May 2020</td>
</tr>
<tr>
<td>NCT00943423</td>
<td>A Randomised Phase III Trial to Determine the Role of FDG-PET Imaging in Clinical Stages IA/IIA Hodgkin’s Disease</td>
<td>602</td>
<td>Dec 2030</td>
</tr>
<tr>
<td>NCT01478542</td>
<td>Randomized Phase III Study Evaluating the Non-inferiority of a Treatment Adapted to the Early Response Evaluated With 18F-FDG PET Compared to a Standard Treatment, for Patients Aged From 18 to 80 Years With Low Risk (aa IPI = 0) diffuse Large B-cells Non Hodgkin’s Lymphoma CD 20+</td>
<td>420</td>
<td>Dec 2020</td>
</tr>
<tr>
<td>NCT01285765</td>
<td>Randomized Phase III Study Using a PET-driven Strategy and Comparing GA101 OR Rituximab Associated to a Chemotherapy Delivered Every 14 Days (ACVBP or CHOP) in DLBCL CD20+Lymphoma Untreated Patients From 18 to 60 Presenting With 1 or More Adverse Prognostic Factors of the Age-adjusted IPI</td>
<td>670</td>
<td>Feb 2019</td>
</tr>
<tr>
<td>NCT01659099</td>
<td>A Multicenter, Phase III, Randomized Study to Evaluate the Efficacy of Response-adapted Strategy to Define Maintenance After Standard Chemoimmunotherapy in Patients With Advanced-stage Follicular Lymphoma</td>
<td>602</td>
<td>Dec 2020</td>
</tr>
<tr>
<td>NCT02063685</td>
<td>Improvement of Outcome and Reduction of Toxicity in Elderly Patients With CD20+ Aggressive B-Cell Lymphoma by an Optimized Schedule of the Monoclonal Antibody Rituximab, Substitution of Conventional by Liposomal Vincristine, and FDG-PET Based Reduction of Therapy</td>
<td>1152</td>
<td>Oct 2019</td>
</tr>
<tr>
<td>NCT017890190</td>
<td>Phase III Study of Individualized Adaptive Radiotherapy Based on PET/CT And 3DCRT/IMRT in Combination With Chemotherapy for Locally Advanced Non-Small Cell Lung Cancer (NSCLC)</td>
<td>400</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>NCT02507518</td>
<td>Role of 18FDG PET in the Evaluation of Early Response to Maintenance Treatment With Bevacizumab or Pemetrexed in Advanced Non-small-cell Lung Cancer</td>
<td>80</td>
<td>Mar 2019</td>
</tr>
<tr>
<td>NCT02485834</td>
<td>Impact of Early FDG-PET Directed Intervention on Preoperative Therapy for Locally Advanced Gastric Cancer: A Random Assignment Phase II Study</td>
<td>162</td>
<td>Jun 2019</td>
</tr>
<tr>
<td>NCT01718873</td>
<td>Randomized Phase 3 Study on the Optimization of Bevacizumab With mFOLFOX/mOXXEL in the Treatment of Patients With Metastatic Colorectal Cancer</td>
<td>230</td>
<td>Jun 2018</td>
</tr>
<tr>
<td>NCT01659099</td>
<td>A Multicenter, Phase III, Randomized Study to Evaluate the Efficacy of Response-adapted Strategy to Define Maintenance After Standard Chemoimmunotherapy in Patients With Advanced-stage Follicular Lymphoma</td>
<td>602</td>
<td>Dec 2020</td>
</tr>
</tbody>
</table>
Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT02125448</td>
<td>Preoperative Identification Of Response to Neoadjuvant Chemoradiotherapy for Esophageal Cancer (PRIOR)</td>
<td>50</td>
<td>Nov 2016 (ongoing)</td>
</tr>
<tr>
<td>NCT01142778</td>
<td>A Study of Avastin (Bevacizumab) Added to Herceptin (Trastuzumab) Plus Docetaxel in the Neoadjuvant Setting in Patients With Early Stage HER2-Positive Breast Cancer</td>
<td>152</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>NCT02469922</td>
<td>Prospective Study Assessing Predictive Value of 18FDG Positron Emission Tomography During Radiochemotherapy for Locally Advanced Epidermoid Carcinoma of the Head and Neck</td>
<td>123</td>
<td>Jan 2019</td>
</tr>
</tbody>
</table>

**Breast cancer**

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01358747</td>
<td>Randomized Phase III Study of a Treatment Driven by Early PET Response Compared to a Treatment Not Monitored by Early PET in Patients With Ann Arbor Stage III-IV or High Risk IIIB Hodgkin Lymphoma</td>
<td>NR</td>
<td>NR (complete d)</td>
</tr>
</tbody>
</table>

**Head and neck cancer**

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT00554164</td>
<td>Positron Emission Tomography Guided Therapy of Aggressive Non-Hodgkin's Lymphomas (PETAL)</td>
<td>1073</td>
<td>Mar 2017 (complete d)</td>
</tr>
</tbody>
</table>

**Unpublished**

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01287390</td>
<td>Adaptive, Image-guided, Intensity-modulated Radiotherapy for Head and Neck Cancer in the Reduced Volumes of Elective Neck: a Multicenter, Two-arm, Randomized Phase II Trial</td>
<td>100</td>
<td>May 2015 (complete d)</td>
</tr>
</tbody>
</table>

**Hodgkin lymphoma**

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01358747</td>
<td>Randomized Phase III Study of a Treatment Driven by Early PET Response Compared to a Treatment Not Monitored by Early PET in Patients With Ann Arbor Stage III-IV or High Risk IIIB Hodgkin Lymphoma</td>
<td>NR</td>
<td>NR (complete d)</td>
</tr>
</tbody>
</table>

**Non-Hodgkin lymphoma**

| NCT01287390  | Adaptive, Image-guided, Intensity-modulated Radiotherapy for Head and Neck Cancer in the Reduced Volumes of Elective Neck: a Multicenter, Two-arm, Randomized Phase II Trial | 100                | May 2015 (complete d)    |

**Squamous cell cancer of the head and neck**

| NCT01065818  | Early Prediction of Pathologic Response of Chemoradiotherapy With Fluoro-L-Thymidine (FLT) Positron Emission Tomography (PET) | 100                | Aug 2014 (unknown)       |

**Esophageal cancer**

<table>
<thead>
<tr>
<th>NCTNo.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01358747</td>
<td>Randomized Phase III Study of a Treatment Driven by Early PET Response Compared to a Treatment Not Monitored by Early PET in Patients With Ann Arbor Stage III-IV or High Risk IIIB Hodgkin Lymphoma</td>
<td>NR</td>
<td>NR (complete d)</td>
</tr>
</tbody>
</table>

**References**


randomised, open-label, phase 3 non-inferiority trial. Lancet. May 12 2012;379(9828):1791-1799. PMID 22480758


6.01.51  Interim Positron Emission Tomography Scanning in Oncology to Detect Early Response During Treatment

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**Documentation for Clinical Review**

**Please provide the following documentation (if/when requested):**
- History and physical and/or consultation notes including:
  - Indication for PET scan
  - Previous treatment and response
- Previous Imaging reports (e.g., CT, MRI, SPECT)
- Pathology report (if applicable)

**Post Service**
- PET report

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.
The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>78811</td>
<td>Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)</td>
</tr>
<tr>
<td>CPT</td>
<td>78812</td>
<td>Positron emission tomography (PET) imaging; skull base to mid-thigh</td>
</tr>
<tr>
<td>CPT</td>
<td>78813</td>
<td>Positron emission tomography (PET) imaging; whole body</td>
</tr>
<tr>
<td>CPT</td>
<td>78814</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)</td>
</tr>
<tr>
<td>CPT</td>
<td>78815</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh</td>
</tr>
<tr>
<td>CPT</td>
<td>78816</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body</td>
</tr>
</tbody>
</table>

| HCPCS  | See Policy Guidelines |

<table>
<thead>
<tr>
<th>ICD-10 Procedure</th>
<th>CB32KZZ</th>
<th>Positron Emission Tomographic (PET) Imaging of Lungs and Bronchi using Fluorine 18 (F-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Procedure</td>
<td>CB32YZZ</td>
<td>Positron Emission Tomographic (PET) Imaging of Lungs and Bronchi using Other Radionuclide</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>CB3YYZZ</td>
<td>Positron Emission Tomographic (PET) Imaging of Respiratory System using Other Radionuclide</td>
</tr>
</tbody>
</table>

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/31/2014</td>
<td>BCBSA Medical Policy adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>11/01/2016</td>
<td>Policy title change from Interim PET Scanning in Oncology to Detect Early Response During Treatment</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>11/01/2017</td>
<td>Policy revision with position change</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>

**Definitions of Decision Determinations**

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance
with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.