The Netherlands. (1) Fifteen percent of patients referred for MPI are specifically referred for diagnostic workup of heart failure; in addition, these patients first undergo cardiac catheterization, and if CAD is extensive, ischemia and viability are assessed by stress-rest perfusion imaging and in some cases also FDG imaging. Patients with normal coronary arteries on angiography are not routinely referred for perfusion imaging. (2) Stress-only imaging is not performed in the department. The resting images are always acquired also. (3) In patients presenting with ventricular tachycardia/ventricular fibrillation (outside the setting of acute myocardial infarction), a nuclear stress-rest perfusion study is always part of the diagnostic workup (Borger vd Burg et al. *Am J Cardiol* 2003). In patients undergoing CABG, assessment of ischemia and viability is performed when patients present with heart failure only (without angina). In these patients, perfusion imaging (and sometimes FDG imaging) is part of the diagnostic workup.

Jeroen J. Bax, MD

Ernst E. van der Wall, MD

United States

New York. (1) About 20% of patients are referred for MPI for a workup of heart failure in our laboratories. Most patients with heart failure and CAD undergo MPI. (2) Most patients in our laboratories are imaged with a 1-day rest-stress sestamibi protocol. Large patients (male weight >290 lb, female weight >250 lb, jacket size >50 inches, bra size $\geq$ DD) undergo a 2-day protocol. In those patients the stress portion is done first and the rest portion is cancelled when the stress portion is totally normal. This occurs rarely. Of note, we do not use attenuation correction in our laboratories; hence recent communications regarding the feasibility of stress-only imaging with attenuation correction do not apply to our laboratories. (3) For these patients, an MPI is the study of

choice in our laboratories and is rarely followed by other noninvasive imaging studies.

Florence Prigent, MD

CALENDAR

October 2-4, 2003. 24th Panhellenic Congress of Cardiology, Rhodes, Greece.

October 13-15, 2003. Contemporary Nuclear Cardiology: Case Studies/Practical Concepts, Licensing and Certification to be held in Seattle, Wash. A CME activity co-sponsored by the American College of Cardiology (ACC). For further information and registration, contact the ACC Resource Center. Phone: 1-800-253-4636, ext 694; Web site: www.acc.org/education/programs/programs.htm.

October 26, 2003. Certification examination in nuclear cardiology conducted by the Certification Board of Nuclear Cardiology at the Donald Stephens Convention Center, Rosemont, Ill. For information, write to CBNC, 9929 Main St, Suite C, Damascus, MD 20872, or visit the Web site: www.cbnc.org.

January 30–February 1, 2004. The 19th Annual Clinical Nuclear Cardiology: Case Review with the Experts to be held in Los Angeles, Calif. A CME activity co-sponsored by the ACC. For further information and registration, contact the ACC Resource Center. Phone: 1-800-253-4636, ext 694; Web site: www.acc.org/education/programs/programs.htm.

May 3-4, 2004. Symposium on Cardiovascular Molecular Imaging to be held in Bethesda, Md, at the National Institutes of Health. Conference is co-sponsored by ASNC (Conference Administration), ABC, ACC, AHA, AMI, ASE, and SNM. For program information, contact ASNC, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; phone: +301-493-2360; fax: +301-493-2376; e-mail: admin@asnc.org; Web site: www.asnc.org/meetings/imaging.cfm.

CORRECTION

Figure 2 on page 400 in the article "Noncardiac findings on dual-isotope myocardial perfusion SPECT" (July/August 2003;10:395-402) by Kim A. Williams, MD, Kalisha A. Hill, MD, and Candace M. Sheridan, BS, was printed upside down. It is here printed correctly.