Investigation of Incidental Bowel FDG Uptake

Joseph C. Lee • Gemma F. Hartnett •
Aravind S. Ravi Kumar

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We were very impressed by the work of Shim et al.¹ in its thorough categorisation of findings—especially relating to the visual pattern of fluorodeoxyglucose (FDG) uptake, semi-quantitative scan analysis with standardised uptake values and cataloguing bowel lesions by size and grade. The cohort—comprising patients with gastric carcinoma—appears on the surface to be quite disparate from the group we studied.² Nevertheless, the inescapable common aetiological agents and risk factors of aerodigestive tract malignancies explain the parallel phenomenon of incidental colonic FDG uptake among a population dominated by malignancies of the pulmonary and naso-oro-pharyngeal trees.

These data also lead to the issue of whether patients with segmental FDG uptake in the bowel should be routinely evaluated with colonoscopy. Given the incidence of cancer

being 2 % across groups B and C (segmental uptake of FDG or none at all), are the risks of colonoscopy justified in this setting? On the one hand, the outcome may alter the treatment course of the patients—the majority of whom have defined malignancies already. As has been comprehensively reviewed,³ segmental uptake is most commonly nonspecific and benign. On the other hand, there remain infrequent but potentially catastrophic risks with colonoscopy such as perforation and splenic injury.^{4,5}

In line with our research, we agree with the authors that focal uptake is worth investigating and other patterns are not. However, a formal modelling and cost-effectiveness analysis may also be required in different health care systems with different policies for funding both FDG-PET scans and screening colonoscopies to properly justify the process.

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- J. C. Lee
Department of Nuclear Medicine, The Prince Charles Hospital,
Chermside, Queensland, Australia
- G. F. Hartnett
Department of Medical Oncology, Redcliffe District Hospital,
Anzac Avenue, Redcliffe, Australia
- A. S. Ravi Kumar
Department of Nuclear Medicine and Queensland PET Service,
Royal Brisbane and Women's Hospital, Herston, Queensland,
Australia
- J. C. Lee (✉) • A. S. Ravi Kumar
School of Medicine, University of Queensland, Brisbane,
Queensland, Australia
e-mail: Joseph_Lee@health.qld.gov.au