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February 13, 17

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PREAMBLE ISSUES FOR PATIENTS I WILL BE PRESENTING TO PET ACCESS

Dear Panel Members

I have yet to receive an acknowledgement or reply to my letter to PET ACCESS dated January 8th. This is unacceptable. It will definitely be unacceptable to the patients given the significant implications of the timeliness; your decision; and answers to the questions they will present to the PANEL.

KNOW THIS:

- The past 15 year pattern of CCO and MOH representatives of ignoring, and refusing to answer questions defending how PET has been accessed will no longer be tolerated. I will use any and all legal means and devices available to force those representing the government to answer each and every question fully and with appropriate documentation where required.
- It should not be necessary to remind Panel members that they are acting effectively as 'civil servants' on behalf of the Ministry of Health and Long-term Care. We are told we are living in an open, transparent and accountable democracy where ultimately Panel Members need to be responsive and accountable to the citizens of Ontario and ultimately liable for their actions should these actions not be defensible.

I will now be representing patients on behalf of their physicians to the PET ACCESS PANEL, and it's role in granting PET in Ontario in light of what Dr. Al Driedger said in 2009, was a process ***"bordering on immoral*** to discredit, delay and block PET for patients in Ontario. As I have stated before, but is worth re-emphasizing:

I have taken the position that Ontario physicians are being forced to practice not just substandard medicine, but medicine that would be considered incompetence or worse beyond our borders. Indeed in some cases, such as lymphoma, the Cancer Care Ontario indications, until very recently, would result in criminal charges in the US.

Patients in Ontario are entitled to full informed consent, and the right to ask questions about any proposed investigations, treatments, alternatives, risks and benefits.

- ***The time has come for those who have made the rules to be the ones who will now BE RESPONSIBLE FOR answering patients questions and do the informed consent.***

If Panel members have a problem answering relevant questions from patients who are very clearly impacted by your decisions, then please make your reasons very clear. I will then pass them on to the patients and their physicians for further consideration.

<u>WHAT EACH PATIENT AND PHYSICIAN WILL BE GIVEN:</u>

Each patient and their physicians will be given a package containing all the relevant information and supporting documentation so that they fully understand the role of PET beyond Ontario's borders with reference to their particular situation. The difference will be that the information will be based on the validated methods of science and medicine, as opposed to a Faith Based and Agenda driven decision-making process the Panel is currently using to assess the requests.

- ***I will make sure that the patients are given sufficient educational material to understand fully the basis of the questions that will be put to the panel members on their behalf as well as my discussion around the appropriate imaging based management of their diseases.***
- ***The questions asked by each patient will be very relevant to their case, and most importantly will help them understand how they have been exposed to what could be considered an 'obscene amount' of radiation from almost useless CT scans. (In one case the patient has had 23 and counting CT scans all as part of CCO 'seal of approval' standard of care)***
    - ***As I have previously stated, the answers regarding their radiation exposure MUST BE IN KEEPING WITH DR. ERIC HOSKINS STATED CONCERNS ABOUT OVER EXPOSURE OF PATIENTS TO RADIATION FROM IMAGING DEVICES.***

In addition, if it is of interest or relevant to any actions patients might decide to take in light of the answers they receive, or lack of information from PET ACCESS, I will

make available to them all the relevant documents that I have accumulated over the past 15 years of the 'fruitless efforts' of my colleagues and me to get the Liberal Government and it's medical experts to respond to questions submitted by various medical associations, physicians and by me.

- *As you might have guessed, I have several copies held in various secure places and by lawyers.*

And finally if I have any questions or issues specifically with respect to how Panel Members respond to the questions, I will send them to Dr. Rodney Hicks of Australia for his comments. As you know, he is fully aware of the 'tactics' used by the various CCO committees to 'establish their unique indications for PET' and an expert in how Health Technology Assessment has been used around the world to discredit, delay and block PET.

ESTABLISHED FACTS AT THIS POINT IN TIME:

1. There is **no scientific basis or validity** to justify the use of Health Technology Assessment [HTA] to determine the quality of evidence, or potential roles for PET or any other diagnostic piece of equipment.

    - *However, as mere 'mortal' non-Liberal government physicians, we are expected to use the standard and accepted methods of science and medicine to determine what is the current and most appropriate means of investigating and treating our patients.*
    - *Indeed the CMPA would demand this of practicing physicians.*
    - *In addition, in Dr. Hoskins response to me, he demanded that PET meet established science standards of sensitivity, specificity, accuracy, and very concerning issues about radiation exposure.*

    Yet of course CCO has established these critical pieces of information BY NOT USING THE ACCEPTED STANDARDS OF THE PRACTICE OF SCIENCE AND MEDICINE!

    - *Consider if a physician forced to act on the dictates of CCO, was to end up in court over a patient who died during a lung biopsy that could have been avoided using PET; and the patient's family and their lawyer were aware that the indication that was used to qualify for a PET scan in Ontario was the exact opposite of the entire world expert body of opinion; I suspect that the courts would not accept that Cancer Care Ontario physicians are 'above the mundane requirements' of using methods of science to advise the politicians on the most appropriate use for PET.*

Now that everyone is on the same page regarding the lack of use of standard

methods of science and medicine in assessing PET, it becomes critical ***FOR OUR PATIENTS AND PHYSICIANS to know exactly how PET ACCESS and the various CCO groups assessing PET, will assess the requests and information submitted to them as well as the follow-up questions from PET ACCESS before 'divining' whether the patient will be granted a PET scan.***

I recently received a letter from a key and founding member of the CCO groups designated to 'assess possible roles for PET for the Ontario government'. Patients will be given these communications, as well as the information related to claims that Cancer Care Ontario officials were told by a Minister of Health to discredit, delay and block PET, because the government wasn't going to pay for it.

- *When I was President of the Ontario Association of Nuclear Medicine [OANM] we hired a lobbyist, Mr. Michael McCarthy who handled the Hepatitis C crisis for the government.*
    i. ***He was present at the meetings where Cancer Care Officials were given their mandate as to how to handle PET in light of the Multidisciplinary Report's recommendations to begin coverage for PET scans in Ontario***

I asked the physician in question, that given we all agree there is no science to back the use of Health Technology Assessment to evaluate PET or any other imaging equipment, how did the committee he headed justify it's use? His response:

- ***"I believe there is a role for Health Technology Assessment in assessing PET."***

"I BELIEVE"!

So the CCO committees have approached this like a 'religion'? The only full and complete defence they need to offer up for their methodology is their 'Faith': ***I believe there is a role for HTA, and how dare anyone challenge the "Rights" of Liberal Governments physicians to believe this is true!*** Next they'll be using the Charter of Right to defend their beliefs!

So are we too assume that perhaps the various physicians dressed in the appropriate robes and adornments of a 'high priest' and then:

- *Faced the east and waved a dead chicken over their heads, or spread some animal bones on the sand to determine the roles for PET?*

<u>OR ARE CCO COMMITTEE DECISIONS BASED ON AN AGENDA?:</u>

As pointed out by Professor Rodney Hicks, acknowledged PET expert who has detailed in a medical journal how CCO 'massaged the data' to get the answers they

needed to presumably satisfy the demands of their 'political masters'.

- ***"Ontario has the most egregious and politically motivated agenda against PET in the world."***

Dr. Rodney Hicks 2016

It goes without saying that this **AGENDA** is not directed at the PET/CT machines!

- ***IT IS DIRECTED SQUARELY AT ONTARIO'S PATIENTS.***

WHAT WILL BE THE RESPONSE OF PET ACCESS TO THE PATIENTS QUESTIONS?

In spite of some 15 years of hearing how proud those involved with assessing PET are, ***for some reason no one has being willing to answer a single critical question regarding how PET has been assessed in Ontario.***

- *Could there be a clearer indication that there is indeed something very egregious, indeed "immoral", to hide from Ontario patients and their physicians.*
- *Either that, or the Canadian and International PET experts who have been openly naming and condemning Ontario since 2005 for what they have perpetrated on patients, have no idea what they are talking about.*
- ***It does beg the question as to why those who have been so badly maligned by Canadian and International PET experts, haven't already demanded the 2005 motion by the Canadian Association of Nuclear Medicine [CANM] to have a panel of Canadian experts in Ethics and Health Policy review the ETHICAL AND MORAL BASIS of how they evaluated PET be carried out? Surely this would be the ultimate litmus test to clear their names!***

My guess is that the Panel, and various CCO groups will also 'stonewall' the patients and their physicians.

- ***I WILL NOT ALLOW PATIENTS TO GET CAUGHT IN THE MIDDLE OF POLITICAL GAMES ANY LONGER.***

I would like to make the following suggestion:

- ***If the PANEL is NOT going to immediately answer the patients questions including a detailed explanation of how the Panel will use 'non-science' methods to form their opinion then:***
    - ***PUT YOUR STAMP OF APPROVAL ON EACH APPLICANT'S REQUEST FOR A PET SCAN given the critical need for a rapid response to their requests.***

Some on the panel may recall the breast cancer patient from Windsor who to be 'kind', was given the standard run around' by PET ACCESS. She went to the press, and curiously was given a PET immediately.

- ***Patients and their loved ones are beginning to understand that their already high stress levels, have been ramped up to absolutely unnecessary levels as they are made pawns and victims of CCO's 'delete expenses' mandate.***
- ***They are aware of and have been given all the relevant information with respect to the 'special efforts' CCO made to block women, such as the Windsor patient with more advanced breast cancer, from access to PET.***

- ***They will be given a copy of the 2005 CANM motions referred to above including the motions declaring the Ontario PET trials "unethical" and the demand they be halted. They will be made aware that the Minister of Health, Mr. George Smitherman and the CCO committee's assessing PET, dismissed these unprecedented and severe accusations.***

If the Panel refuses to respond to the patients questions, or fails to give the patient a response in keeping with the particular urgency of their need for a PET scan:

- *The patient and their physicians will be offered all the information and courses of action they might want to consider to ensure they both get the full explanations they are entitled to, as well as deal with a possible rejection of their request for a PET* ***that is not backed by the standards of science and medicine that their physicians will be expected to abide by****.*
- ***The 'I BELIEVE THE HTA TO BE USEFULL DEFENCE' WILL NOT BE ACCEPTABLE, nor will any rejections based on HTA based literature.***

It may be worth reminding the physician members of the Panel that as physicians we have all taken the Hippocratic Oath; "to first do no harm'. This will be the litmus test of your decisions of whether 'harm was done' and will play a significant role in how the patients review the answers and responses from PET ACCESS.

THE APPLICATION PROCESS TO PET ACCESS IS ABOUT TO CHANGE:

STARTING NOW:

The PET ACCESS PANEL 'routine' has been for a physician to send a request for a PET scan not covered by OHIP. Typically the panel will, as part of their job to delay PET, send back various questions and ask for blood tests, imaging data and various other requests.

Although I have sent the following information along in my previously unacknowledged communications, it is worth repeating, since it will part of the 'litmus test' the patients, their physicians and I will consider in evaluating your responses.

> *Your answers and responses and 'imaging investigation recommendations' **MUST** meet the criteria our Minister of Health, Dr. Eric Hoskins, laid out in his letter of August 2016, regarding the basis for funding for diagnostic imaging procedures through OHIP.*
>
> > *"In Ontario, PET diagnostic services must be:*
> >
> > - *Effective (sensitive, specific, accurate)*
> > - *Have the potential to impact patient management*
> > - *Have benefits over other tests/imaging"*

Presumably the PANEL MEMBERS would agree with his recommendations and should have no problem coming up with the literature backing the patient's investigations to date, and your recommendations. More importantly:

> Dr. Hoskins, and rightfully so, was very concerned about the consequences of exposing patients to radiation from medical imaging devices.
>
> *"You, as a clinician, would understand that the benefits of exposure to radiation from a diagnostic intervention such as PET scans must be considered along with risks and limitations of the result of the scan. It is essential that the ministry also strives to achieve the correct balance."*
>
> *Dr. Eric Hoskins August 2016*
>
> A copy of this letter will be appended and is in the possession of each patient and their physicians.
>
> - *The patients and their physicians are very concerned about radiation risks given the very real possibility of patients surviving their cancers only to develop a second cancer related to their exposure to mostly CT but also other medical imaging sources of radiation. All the relevant material to understand the impact of their current 'Cancer Care Ontario seal of approval' levels of radiation exposure from investigations will be made available.*
>
> - ***THEREFORE THE EXPECTATION OF THE PATIENTS IS THAT SPECIAL ATTENTION AND BACKING DOCUMENTATION BE GIVEN TO 'DEMONSTRATE THE BENEFITS OF' THE MEDICAL IMAGING DIAGNOSTIC RADIATION THEY HAVE BEEN EXPOSED TO SO FAR***

IN THEIR DISEASE MANAGEMENT.

SINCE THE PANEL WILL NOT BE USING VALIDATED METHODS OF SCIENCE AND MEDICINE TO ASSESS THIS INFORMATION:

- ***NO information beyond a history, previous treatments and investigations or documentation will be submitted until the PET ACCESS PANEL makes absolutely clear how each and every question and information that they have requested WILL BE EVALUATED.***

- ***And in addition, a simple yes you qualify for a PET, or no you don't will no longer be acceptable. The PET ACCESS PANEL will now take over the role of answering all the questions and concerns from patients and their physicians that they are entitled to.***

In this letter I will be outlining a standard set of questions from patients, and some specific questions relevant to patients and their cancers, regarding questions that they will be asking the Panel members to address.

- ***You can answer them now and I will give them to each patient and their physicians for their consideration; or you can take the 'standard approach' of refusing to answer my questions. I will then take appropriate steps to push for answers.***
    - ***Given the pressure of timely decisions for these patients, the methods that may necessary to have Panel member meet their obligation to Ontario citizens will necessarily need to be effective.***
- ***Or you can respond to each patient and their questions and concerns. To not respond will have it's own consequences.***

GENERAL OVERVIEW QUESTIONS:

1. Please provide detailed reasons and appropriate documentation to justify why the PET ACCESS PANEL members would use a non-scientifically based and non-validated method to assess PET indications for patients?
2. Given that no further information will be sent along with patients requests for a PET scan until they are provided with the requested information, ***please make it absolutely clear how the Panel members will set questions, and evaluate the responses and the various documents such as imaging***

reports and pathology results that they are demanding.

STATEMENT:

Ontario government physicians may not be required to use the standard and validated methods to form opinions and make statements and treatment recommendations to patient:

- ***The patient's expectation and that of their 'mere mortal' physicians would be that THIS PROCESS MUST BE BACKED BY THE VALIDATED STANDARDS OF SCIENCE AND MEDICINE:***
- ***Therefore we will not accept ANY RECOMMENDATIONS OR COMMENTS FROM PET ACCESS UNLESS ACCOMPANIED BY WHAT IS DEMANDED OF PRACTICING PHYSICIANS IN THE PROVINCE OF ONTARIO AND WOULD BE ACCEPTABLE IN A COURT OF LAW.***

In answering question three, keep in mind the following information that each patient and their physician will understand ***and above all in keeping with Dr. Hoskins expressed concern over radiation exposure to patients.***

I will also assume that panel members would recognize that if one were to insist that a patient being investigated for possible metastatic bone disease **HAD TO HAVE A SKELETAL SURVEY TO SEE IF THEY QUALIFIED TO HAVE A BONE SCAN,** would at a minimum indicate a 'fundamental ignorance of basic anatomical and functional imaging technology'.

- Each patient and physician will be made aware that a PET scan is performed in conjunction with a CT, and that the CT is, unless otherwise required as part of the patient's investigation, ***performed in low dose format and no possibility of contrast reaction.***
- That a CT scan has almost no ability to determine if a detected mass is cancer, or for example, scar tissue post successful therapy for their cancer.
- Given that a CT is an integral part of the PET exam, ***it will be able to detect all but the smallest of masses that would be indentified on the diagnostic CT.***
    i. ***However, by imaging the 'glucose metabolism' or other functional tracer content of the mass, the patient and their physicians have the best chance of making a decision on how to next proceed in their care and management. This was pointed out in a paper by Worsley et al; having the PET information helped oncologists make a more informed***

decision for patient management in over 80% of cases compared to the 'boiler plate CCO Standard investigations' of serial CT scans.

ii. ***THIS WOULD BE ACHIEVED AT A FRACTION OF RADIATION EXPOSURE CCO INISISTS THE PATIENT HAVE.***

- CT scan reports will not raise concerns about lymph nodes if they meet 'normal size criteria'. Not uncommonly PET ***demonstrates active FDG uptake and therefore even though 'normal size' are potential sites of metastasis.***
- Further, and you will see some examples, pathological findings are missed on CT and MR images given the hundreds of images a radiologist must view to report a study. Given that a PET/CT is acquired in both 3-D and tomographic format and because of the ***'metabolic nature of the images'***, a competent PET physician will have their attention drawn to areas of unexpected FDG uptake and thus focus on the areas of concern, which they can then correlate with the 'anatomical information' from the low-dose CT.
- That the radiation dose to patients from a PET/CT is similar in range to that from a diagnostic quality CT exam.

3. In light of the above information **WHY IS IT COMPULSORY** to have a diagnostic CT before even being considered for a PET/CT scan?

    - Be sure to cover the 'skeletal survey' analogy to qualify for a bone scan in your response making very clear the differences should you choose to insist they have an 'anatomical' high radiation dose exam to qualify for a PET.
    - Take special care and backing documentation to explain ***THE BENEFITS TO THE PATIENTS FROM THE COMPULSORY SERIAL CT SCANS AS FAR AS MAKING MANAGEMENT DECISIONS AS OPPOSED TO THE PET/CT.***

It is almost the norm for a cancer mass identified on CT to not be made up entirely of cancer cells, but of metabolically quiet scar tissue. A great advantage of the FDG PET/CT beyond Ontario's borders, is that PET can identify the most active metabolic sites to biopsy, and thus minimize the chances of a false negative or non-diagnostic biopsy:

4. Why would PET ACCESS not insist that the whole process from first identification of a mass, such as on a chest radiograph isn't by a PET/CT?

    - Again be very clear to include the appropriate and supporting literature meeting Dr. Hoskins 'motherhood and apple pie' criteria, **with special attention to total radiation doses and it's benefit to patient through the course of their disease.**

On average a PET/CT upstages 30% of patients compared to 'Cancer Care Ontario seal of approval' serial CT exams and other investigations. Very often this means that, for example that a lung cancer has already metastasized by the time it is first identified on a chest-xray. One of the main reasons PET was established as the world accepted standard for imaging management over 15 years ago is:

- ***By imaging directly the 'glucose metabolism' of the constituents of the mass it dramatically increases the probability that the lung mass is cancer versus non-cancer and thus whether a biopsy is required immediately, or the mass can be followed more conservatively.***
- ***Where there has been more distant metastasis, it points to what is often a much safer place to biopsy; points to the most likely site to get the right tissue for pathologist; and at the same time CORRECTLY ESTABLISHS THE STAGE OF THE PATIENTS CANCER compared to the 'Anatomical based Standard of imaging management' demanded by CCO experts.***
    - *You will have the opportunity to address the concerns and questions from a patient who had an incidental finding of a lung nodule.*
    - *In Quebec, or perhaps Argentina, the time from detecting the nodule to appropriate treatment for cancer if this is the case, and using PET could be as little as six to eight weeks.*
        - ***Yet because this woman lives in the 'PATIENTS FIRST' Health Care System of Ms. Kathleen Wynne and Dr. Eric Hoskins, it will be at a minimum of 1.5 to 2 years, and after multiple CT exams, and a COMPULSORY HIGH RISK BIOPSY of this finding, before she will even be considered a candidate for a PET.***
        - ***As you might appreciate, her 'stress levels' went through the roof once she was made aware of the 'reality of having the misfortune of living in Ontario' and not Quebec, not withstanding the requirements of the Canada Health Act.***

5. Why again would PET ACCESS DEMAND that a patient <u>MUST HAVE A COMPULSORY CT, AND IN THE CASE OF LUNG NODULES A POTENTIALLY HIGH RISK BIOPSY BEFORE THEY CAN EVEN BE CONSIDERED FOR A PET/CT?</u>

    - Each patient and physician will be made aware that a mere 'poster presentation' from a medical meeting claiming PET was not useful in lung cancer was:

        i. Used as **<u>THE EXCUSE</u>** for the Ontario government to overturn the recommendations of an independent Multidisciplinary Team, headed by Dr. Al Driedger in the late 90's, that concluded that at least 24,000 patients would immediately

benefit from a PET scan when there were only five indications for PET. The 'poster' was also used to form the basis of the first report from the 'governments experts' which concluded:

- ***ZERO PATIENTS WOULD BENEFIT FROM A PET SCAN DUE TO 'POOR QUALITY EVIDENCE'. THIS CONCLUSION BASED ONLY ON THE 'BELIEF' THAT THE HTA WAS APPROPRIATE TO EAVALUATE THE EVIDENCE.***

ii. That this 'poster' would be 'promoted' to a Level A evidence paper by CCO experts in what surely is as close to outright ***"fraud"*** as one can get, and that papers meeting ICES criteria for quality evidence, but favouring PET, ***were downgraded to unsatisfactory medical evidence.*** [Paper from Hicks and Wares in JNM detailing this process will given to patients and physicians.]

- That the resulting indications CCO recommends for the investigation of lung nodules and lung cancer ***are the exact opposite of the entire world PET expert body of opinion.***

i. The resulting impact on patients, is increased risks to unnecessary and unhelpful radiation from serial CT's; delays in management of their cancers with in some cases fatal consequences; exposure to unnecessary high-risk biopsies; being denied treatment that could have cured their cancer, because they were 'mis-staged' by the dictates of CCO; and ***above all the maximizing of the stresses experienced by the patient and their families, will be made clear***.

For non-oncological patients such as dementia, patients and physicians will be given the following information.

- In the 1990's most of what we understand about the intact whole brain function was by using PET. In fact at that time PET was used almost exclusively for delving into brain function and metabolism. The switch to its dominant use today in cancer was the incidental finding of a breast cancer lesion in a patient during her PET scan at John Hopkins University under Dr. Rich Wahl. (I have studied under Dr Wahl.)
- One of the indications for PET proposed by the Multidisciplinary Committee under Dr. Al Driedger was in the investigation dementia.

i. ***The first ICES report dismissed all the indications the***

independent medical experts had recommended, INCUDING THE USE IN THE INVESTIGATION OF DEMENTIA.

6. Therefore is the PET ACCESS PANEL prepared to make clear to the patients that I will be applying for a PET scan to investigate possible dementia and their physicians, and of course the neurosciences programs in universities around the world, ***that there is ZERO quality evidence to support the use of PET scanning in dementia or other significant CNS disease and conditions?***

SUMMARY:

The patients in Ontario who would otherwise be candidates for a PET scan in almost any civilized medical jurisdiction offering PET on the planet, will be asking you very specific and evidence and fact backed questions. They are entitled to answers to their questions and concerns, ***especially when it comes to the radiation exposures*** they have had during their cancer management. It is the duty of the PET ACCESS PANEL members to address each and every question and provide the specific documentation backing the Panel's opinion.

By the time most of these patients have gotten to the point where their doctors are approaching the PET ACCESS PANEL to consider a PET scan, they have been through a lot of debilitating treatments, on average, six to eight CT scans worth of radiation exposure, ***and above all a huge amount of personal stress.***

Keeping in mind that since I am a PET expert, having supervised and interpreted almost 5,000 PET scans; lectured on PET at three medical schools; an invited speaker at provincial meetings; and numerous lectures to lay groups:

- ***IF I AM APPLYING FOR A PET SCAN FOR A PATIENT, THE 'SCIENCE BASED' EVIDENCE WILL CLEARLY BE IN FAVOUR OF THE PATIENT HAVING A PET SCAN.***

- ***Are the PANEL MEMBERS prepared to ramp up the patients stress levels more, or be willing to immediately answer their questions, provide the backing documentation and 'graciously' grant them a scan?***

And one final reminder:

- *Until the Panel members are prepared to be absolutely clear and specific as to how they will determine questions and evaluate the information they are demanding:*

    - ***THE PET ACCESS PANEL WILL ONLY BE PROVIDED WITH A HISTORY, INVESTIGATIONS AND TREATMENTS, AND MY OPINION***

AS A PET/CT EXPERT THAT A PET/CT SCAN IS THE MOST APPROPRIATE TOOL TO ASSIST IN MAKING THE DECISIONS IN THE PATIENT'S MANAGEMENT WITH THE MINIMUM OF MEDICAL IMAGING RADIATION EXPOSURE TO THE PATIENT.

- ***That any answers and information you offer MUST meet the criteria established by Dr. Hoskins with special emphasis on the 'benefits' of the medical radiation exposure the patients will have already had from the serial CT exams THEY MUST HAVE before the Panel will even bother to consider the possibility of 'graciously' granting a PET scan to the patient.***

It may be useful to remind the Panel members of a previous ruling they had made.

PAST PET ACCESS RULING:

The breast cancer patient from Windsor will find the information, which I will provide her with, of interest.

- In her first application for a PET, that would have been routine in Quebec, or for that matter Turkey, PET ACCESS demanded she **MUST** have the *CCO STANDARD OF A CT EXAM before she could possibly be considered for a PET scan*.

    - ***She had a serious reaction to the IV contrast from the CT.***

- By the time this all resolved and some two months later, she and her physicians were no further ahead as to how to assess the findings on CT as active disease or not. They reapplied for a PET:
    - ***True to form, PET ACCESS demanded she have a more 'current CT' before they would possibly even grant her the privilege of their 'expert opinion' on whether she would now qualify for a PET scan!***

- Instead, she went to the press, and for some reason PET ACCESS immediately decided she was 'worthy' of a PET scan.

- ***No doubt she will find it valuable to know that CCO experts made a special effort to block women like her from a routine PET, and lead to the unprecedented motions in 2005 from the CANM.***

All communications and documents both to and from PET ACCESS will be shared

with the patient, their physicians, and whoever else they might choose to act on their behalf.

Respectfully Submitted.

Dave Webster MD FRCP