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State Health Coordinating Council
Micheala Mitchell, Chief
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RE: Carteret Health Care Petitions for PET/CT Simulator / Scanner Methodology or Policy Change

Dear Dr. Greene and Dr. Emmanuel,

This letter is in support of the alternative petitions submitted by Carteret Health Care to change the *2025 State Medical Facilities Plan* and permit midsize cancer centers like the one in Carteret County to get a PET scanner. I am a radiation oncologist certified by the American Board of Radiology. I have been the Medical Director of Radiation Oncology at Carteret Health since 2015 and am now one of two full-time radiation oncologists at the Carteret Health Community Cancer Center.

Maintaining ACR recognition as a Community Cancer Center requires serious commitment to quality and breadth of cancer care. It means that a center is treating 100 to 500 cancer patients a year. Qualifying to have two linear accelerators in North Carolina requires commitment to serve 500 annual patients on the linear accelerators alone in the third year of operation. By 2025, we expect 634 new cancer cases. PET scans are state of the art in cancer care. Mobile PET technology is too limited in timing and scope of isotopes. Any center offering radiation oncology on two linear accelerators should have a path to obtaining a fixed PET scanner.

The methodology in the Plan does not provide a way for any center in Eastern North Carolina to get a fixed PET scanner for a long time. Holding all 29 counties hostage until all existing scanners reach 80 percent capacity does not make sense today. Carteret Health proposes a viable alternative: one piece of equipment to provide two functions – simulator and PET scanner. Patients will win because they will get access to full-service PET scans and the center wins with the dual functions. Each regular CT simulation takes an average of an hour. Simulations performed with 4D technique, with IV contrast or when multiple sites are being treated take 90 minutes. The increasing demand for CT simulator time risks an operational bottleneck in radiation planning. A busy cancer center needs more than one but not necessarily two full-time simulators expanding use of stereotactic radiation for patients with oligometastatic disease and to the increasing use of dynamic and adaptive radiation planning. Using a dynamic and adaptive approach, we may re-simulate patients during treatment for a variety of reasons, including weight loss, tumor response or changes to their internal anatomy around the treatment target. Re-planning in these settings improves treatment accuracy and safety and optimizes the therapeutic ratio of radiation therapy.



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The mobile PET scanner restrictions on schedule and radiotracers means that half of our patients must go out of the county for their PET/CT imaging. Our Cancer Program Needs Assessment has repeatedly identified transportation to be one of the most significant barriers to care for patients in Carteret County, which is further exacerbated when the necessary diagnostic PET/CT imaging is unavailable or near where they live. This often leads to delays in care, particularly for patients with disability or those facing financial hardship. Even so, we provided almost 600 PET scans last year – about capacity for our mobile time.

With a fixed PET scanner, we could schedule patients for weekdays and could use specialized brain, breast, and prostate isotopes. In doing so, we would reduce delays in care and retain the 50% of patients who are currently leaving the county for their diagnostic PET scans. We estimate that full-time PET capacity would mean in the range of 450-500 additional annual PET scans.

Please act this year to provide a path for mid-size cancer centers like ours. The methodology proposal is simpler. Both the methodology and the policy petitions have sufficient qualifiers to prevent a flood of applications. Both have enough qualifiers to mitigate the need for a performance standard (annual required PET scans).

Thank you for your time and attention. I am happy to be available for any questions you may have.

Sincerely,



Kyle Fusthoven, MD
Radiation Oncologist