skeletal tumor burden for prognostication of clinical outcome and hematological toxicity. *J Nucl Med.* 2018;59:596–602.
15. Torigian DA, Lopez RF, Alapati S, et al. Feasibility and performance of novel software to quantify metabolically active volumes and 3D partial volume corrected SUV and metabolic volumetric products of spinal bone marrow metastases on ^{18}F-FDG-PET/CT. *Hell J Nucl Med.* 2011;14:8–14.
16. Lapa P, Marques M, Costa G, Iagaru A, Pedroso de Lima J. Assessment of skeletal tumour burden on ^{18}F-NaF PET/CT using a new quantitative method. *Nucl Med Commun.* 2017;38:325–332.
17. Harmon SA, Perk T, Lin C, et al. Quantitative assessment of early [^{18}F]sodium fluoride positron emission tomography/computed tomography response to treatment in men with metastatic prostate cancer to bone. *J Clin Oncol.* 2017;35:2829–2837.
18. Lin C, Bradshaw T, Perk T, et al. Repeatability of quantitative ^{18}F-NaF PET: a multicenter study. *J Nucl Med.* 2016;57:1872–1879.
19. Schmuck S, von Klot CA, Henkenberens C, et al. Initial experience with volumetric ^{68}Ga-PSMA I&T PET/CT for Assessment of whole-body tumor burden as a quantitative imaging biomarker in patients with prostate cancer. *J Nucl Med.* 2017;58:1962–1968.
20. Taghanaki SA, Duggan N, Ma H, et al. Segmentation-free direct tumor volume and metabolic activity estimation from PET scans. *Comput Med Imaging Graph.* 2018;63:52–66.
21. Yoo J, Yoon H-J, Kim BS. Prognostic value of primary tumor SUVmax on F-18 FDG PET/CT compared with semi-quantitative tumor uptake on Tc-99m sestamibi breast-specific gamma imaging in invasive ductal breast cancer. *Ann Nucl Med.* 2017;31:19–28.
22. García García-Esquinas M, García-Sáenz JA, Arrazola García J, et al. ^{18}F-FDG PET-CT imaging in the neoadjuvant setting for stages II-III breast cancer: association of loco-regional SUVmax with classical prognostic factors. *Q J Nucl Med Mol Imaging.* 2014;58:66–73.

Erratum

The article "Exposure to Technologists from Preparing and Administering Therapeutic ^{131}I: How Frequently Should We Bioassay?" by Kopisch et al. (*J Nucl Med Technol.* 2011;39:60–62) contained a mathematical error that was addressed in a June 2011 Erratum. However, additional corrections in the article are required based on the mathematical error correction in the "Results" section. The corrected paragraphs appear below:

Results

From these data, one learns that an average air concentration of **2.4E–06 kBq/mL (6.4E–08 μCi/mL)** of air can be expected from the handling and administration of a dose of 5.74 GBq (155 mCi) of ^{131}I. The NRC assumption for its derived air concentration calculations is that an average worker inhales approximately 20 L of air per minute. A technologist utilizing a full 10 min of ^{131}I handling for a procedure would inhale about **200 L of air**. One could project a total ingestion for the technologist of **0.481 kBq/mL (0.013 μCi)** during such a procedure.

Discussion

First paragraph: Table 2 summarizes the number of procedures and the number of participating technologists at each of the study locations. The average number of ^{131}I procedures performed by each technologist in this study was 4. Therefore, the average ^{131}I dose a technologist in this study received in a year was **4 × 0.481 kBq (0.013 μCi), or 19.2 kBq (0.052 μCi),** well below the NRC monitoring guideline of 185 kBq (5 μCi) per year. The actual dose would probably be lower because this estimate assumes an average dose activity of 5.74 GBq (155 mCi).

Third paragraph: This small-scale study's results indicate a typical annual intake that is well below the level that the NRC advises as a trigger level for bioassay monitoring. The study results indicate that one would have to administer close to **2220 GBq (60,000 mCi)** of ^{131}I in 1 y to reach the NRC trigger limit for bioassay.

Conclusion

First paragraph: This small study showed an average ^{131}I inhalation intake of **0.481 kBq (0.013 μCi)** during administration of 5.74 GBq (155 mCi) of ^{131}I in capsule form. This value allows for a full 10 min to handle, assay, and administer the dose. On the basis of this small-scale study, a technologist would have to administer approximately **185 GBq (5,000 mCi)** of ^{131}I every month to trigger the NRC threshold of 10% ALI for ^{131}I. This is the trigger level the NRC recommends for bioassay of occupational workers.

In addition, the last column in **Table 1** requires corrections and should read:

^{131}I air concentration (Bq/mL)
6.73E–05
8.18E–05
6.03E–05
2.90E–03
1.05E–02
8.23E–04
2.13E–03