improving health-related quality of life and progression-free survival (*6*). One concern about amino acid infusion in carcinoid heart disease is volume overload in patients with cardiac insufficiency (*6*). Our institutional protocol of administering mixed amino acids over a relatively prolonged period of 7.5–8 h during PRRT has been particularly helpful in addressing this concern about volume overload and might be recommended to allow safe use of this treatment in patients with carcinoid heart disease. Furthermore, extending the infusion period of the amino acid solution to 10 h has been reported to further reduce the absorbed dose to the kidney by up to 39% (*6,7*).

The only definitive cure for severe right heart failure appears to be valve surgery. Mortality in patients with carcinoid heart disease is due to severe regurgitation because of morphologic defects in the right-side valves or, uncommonly, in the left-side valves (because of deactivation of the vasoactive substances in the lung parenchyma). Surgery on functioning metastatic disease increases perioperative morbidity and mortality unless there is appropriate preoperative management (*8*). The mortality rate in carcinoid heart disease patients undergoing surgical correction is now lower than previously. As evidenced in our case and the more recent literature (*9*), ^{177}Lu-DOTATATE not only can enhance quality of life and stabilize metastatic disease but also can improve cardiac status and make more patients eligible for surgery early in the course of carcinoid heart disease.

CONCLUSION

This teaching case study illustrates the potential role of PRRT as adjunctive therapy for patients who have inoperable metastatic carcinoid syndrome with symptomatic carcinoid heart disease. By substantially improving quality of life and disease control, PRRT would better the feasibility and outcome of risky surgical procedures in this challenging group of patients. The value of prolonged amino acid infusion during PRRT in carcinoid heart disease patients is also a noteworthy consideration.

DISCLOSURE

No potential conflict of interest relevant to this article was reported.

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Erratum

In the article "Pharmacologic Stress Testing with Myocardial Perfusion Imaging" by Pagnanelli and Camposano (*J Nucl Med Technol*. 2017;45:249–252), the "Dipyridamole" section incorrectly states that the dipyridamole dosage is "*0.142* μg/kg/min, or *0.57* μg/kg (*2*)." The corrected sentence should read "The dosage is *142* μg/kg/min, or *570* μg/kg (*2*)." In addition, the "Adenosine" section incorrectly states that the indicated dose for adenosine is "*0.14* μg/kg/min." The corrected sentence should read "The indicated dose for adenosine is *140* μg/kg/min." The authors regret the error.