

# PUBLIC SUBMISSION

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**Docket:** NRC-2018-0230

Training and Experience Requirements for Different Categories of Radiopharmaceuticals

**Comment On:** NRC-2018-0230-0001

Training and Experience Requirements for Different Categories of Radiopharmaceuticals

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## Submitter Information

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## General Comment

See attached file(s)

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## Attachments

NRC reply

To Whom its May Concern:

I am a board eligible physician in my last year of training in Nuclear Medicine and Diagnostic Radiology.

Below are my answers (A) that follow the questions (Q) posed in the NRC-2018-0230.

A. Tailored Training & Experience Requirements

Q 1. Are the current pathways for obtaining AU status reasonable and accessible?

A 1. Yes, they are. At my current institution and after discussion with peers, there is no unreasonable backlog at facilities performing relevant services. Presently there are a large number of AU eligible physicians and trainees in nuclear medicine, diagnostic radiology, and radiation oncology who can meet the demand for any additional AUs as new RP therapies come into practice.

Q 2. Are the current pathways for obtaining AU status adequate for protecting public health and safety?

A 2. Yes, they are. Residency and fellowship training and board examinations in nuclear medicine, diagnostic radiology, and radiation oncology ensure sufficient competency in medical physics, radiation safety, and radiation biology that other specialties do not. New radiopharmaceutical therapies that are expected to enter practice in the near future will be based on theranostic principles that often require RP imaging based dosimetry calculations. The AU training & experience will likely become more more intense.

Q 3. Should the NRC develop a new tailored T&E pathway for these physicians?

A 3. No, the NRC should not develop tailored T&E pathways for various physicians. While a provider may have expertise in specific disease processes, surgical techniques, or conventional chemotherapies, an abbreviated AU pathway would not provide sufficient training in medical physics, radiation biology, or theranostic imaging interpretation and dosimetry to safely administer RP therapies.

Q 4. Should the fundamental T&E required of physicians seeking limited AU status need to have the same fundamental T&E required of physicians seeking full AU status for all oral and parenteral administrations under 10 CFR 35.300?

A 4. There should be no limited AU status as there is no demonstrated need or record of safe administration of medical isotopes by individuals with abbreviated training.

Q 5. How should the requirements for this fundamental T&E be structured for a specific category of radiopharmaceuticals?

A 5. In my opinion, there should not be a T&E pathway for specific categories of radiopharmaceuticals.

B. NRC's Recognition of Medical Specialty Boards

Q 1. What boards other than those already recognized by the NRC (American Board of Nuclear Medicine [ABNM], American Board of Radiology [ABR], American Osteopathic Board of Radiology [AOBR], Certification Board of Nuclear Endocrinology [CBNE]) could be considered for recognition for medical uses under 10 CFR 35.300?

A 1. To the best of my knowledge, no other specialty boards meet requisite expertise to provide minimal T&E for medical uses under 10 CFR 35.300.

Q 2. Are the current NRC medical specialty board recognition criteria sufficient? If not, what additional criteria should the NRC use?

A 2. Yes, the current criteria are sufficient.

#### C. Patient Access

Q 1. Is there a shortage in the number of AUs for medical uses under 10 CFR 35.300?

A 1. No. My opinion the most recent report from the American Board of Nuclear Medicine as provided to the NIH at the recent Theranostics Consensus Conference on November 8-9, 2018, as presented by Dr. Iagaru ([http://snmmi.files.cms-plus.com/Theranostics%20Consensus%20Conference\\_Nov%209.pdf](http://snmmi.files.cms-plus.com/Theranostics%20Consensus%20Conference_Nov%209.pdf)).

Q 2. Are there certain geographic areas with an inadequate number of AUs?

A 2. Not to my knowledge. Relaxing established safety regulations would be an imprudent and potentially harmful means to increase access to radiopharmaceuticals. Existing societies such as the American College of Radiology and the Society of Nuclear Medicine and Molecular imaging can help identify regions at risk and aid in physician recruitment to any region with inadequate access.

Q 3. Do current NRC regulations on AU T&E requirements unnecessarily limit patient access to procedures involving radiopharmaceuticals?

A 3. No, they do not.

Q 4. Do current NRC regulations on AU T&E requirements unnecessarily limit research and development in nuclear medicine?

A 4. No, they do not.

#### D. Other Suggested Changes to the T&E Regulations

Q 1. Should the NRC regulate the T&E of physicians for medical uses?

A 1. Yes, NRC must regulate the T&E of physicians for medical uses. This ensures the safest use of radiopharmaceuticals.

Q 2. Are there requirements in the NRC's T&E regulatory framework for physicians that are non-safety related?

A 2. Not to my knowledge.

Q 3. How can the NRC transform its regulatory approach for T&E while still ensuring that adequate protection is maintained for workers, the general public, patients, and human research subjects?

A 3. The NRC should continue to monitor the evolving fields of RP therapy and theranostics. T&E will likely require additional formal training and requisite experience in theranostic imaging interpretation and radiation dosimetry in addition to the current requirements.

Respectfully submitted for your consideration.