APPENDIX

Supplementary Table 1. List of panel members		
Panel member	**Geographic location**	**Discipline**
1. Aly-Khan Lalani	Hamilton, ON, Canada	Medical Oncology
2. Mina Swiha	London, ON, Canada	Nuclear Medicine
3. Frédéric Arsenault	Québec, QC, Canada	Nuclear Medicine
4. Kim N. Chi	Vancouver, BC, Canada	Medical Oncology
5. Di Maria Jiang	Toronto, ON, Canada	Medical Oncology
6. Urban Emmenegger	Toronto, ON, Canada	Medical Oncology
7. Sebastien J. Hotte	Hamilton, ON, Canada	Medical Oncology
8. Daniel Juneau	Montreal, QC, Canada	Nuclear Medicine
9. David T. Laidley	London, ON, Canada	Nuclear Medicine
10. Patrick Martineau	Vancouver, BC, Canada	Nuclear Medicine
11. Cynthia Ménard	Montreal, QC, Canada	Radiation Oncology
12. Scott C. Morgan	Ottawa, ON, Canada	Radiation Oncology
13. Scott North	Edmonton, AB, Canada	Medical Oncology
14. Frédéric Pouliot	Québec, QC, Canada	Urologic Oncology
15. Fred Saad	Montreal, QC, Canada	Urologic Oncology
16. Patrick Veit Haibach	Toronto, ON, Canada	Nuclear Medicine
17. Ricardo A. Rendon	Halifax, NS, Canada	Urologic Oncology

Supplementary Table 2. Summary of consensus results for the clinical questions				
Number	**Question**	**Results**	**Consensus (% agreement)**	**Statement**
High-risk localized disease				
1	What is the optimal staging investigation for high-risk and very high-risk localized prostate cancer (assuming access is not a limiting factor)?	• CT/MRI + bone scan – 2 • PSMA PET + CT/MRI – 10 • Both – 3 • Abstain – 0	Consensus (87%, PSMA PET with or without bone scan)	Statement 1: Clinical staging for high-risk and very high-risk localized prostate cancer should be performed with PSMA PET/CT, preferably with MRI
2	In patients with very high-risk localized prostate cancer (NCCN definition) who are candidates for definitive local treatment of the	• Yes, in all patients – 8 • Yes, but only in selected patients – 4 • No – 2 • Abstain – 1	Consensus (86%, yes in all or selected patients)	Statement 2: In patients with high-risk or very high-risk localized prostate cancer (NCCN definition) who are candidates for definitive local therapy

	primary tumor (radical prostatectomy or radiotherapy) and have negative conventional imaging, do you recommend performing a PSMA PET?			and have negative conventional imaging, PSMA PET/CT should be performed in all patients if feasible
3	What is the optimal staging investigation for unfavorable intermediate-risk localized prostate cancer (assuming access is not a limiting factor)?	• CT/MRI + bone scan – 7 (58%) • PSMA PET/CT – 5 • Both – 0 • Abstain – 3	Not reached	—
4	In the majority of patients with clinically high-risk localized or locally advanced prostate cancer and one PSMA PET positive bone lesion without a correlate on the CT component of the initial PSMA PET, what do you recommend as the next investigation?	• Correlative conventional imaging (e.g., MRI, X-rays, or bone scan) – 13 • Biopsy if feasible – 1 • No further investigation, treat as M0 – 1 • No further investigation, treat as M1 – 0 • Abstain – 0	Consensus (87%)	Statement 3: In patients with high-risk or very high-risk localized prostate cancer and a single PSMA-avid bone lesion on PET/CT without a correlate on the CT component, correlative conventional imaging should be performed as the next investigation
5	In patients with unfavorable intermediate-risk localized prostate cancer (NCCN definition) for whom radical prostatectomy is planned, and who have a negative	Yes, in all patients – 1 Yes, but only in selected patients – 2 No – 2 Abstain – 10	Not reached (after discussion, the question was revised and voted on again; re-vote results are listed below)	—

	PSMA PET (N0M0), do you recommend a pelvic lymphadenectomy (limited/extended)?			
5 (re-vote)	In patients with unfavorable intermediate-risk localized prostate cancer (NCCN definition) for whom radical prostatectomy is planned, would a negative PSMA PET (N0M0) change your approach to pelvic lymph node dissection?	Yes – 0 No – 8 Abstain – 6	Consensus (100%)	Questions 5-8 were merged to develop Statement 4: The planned approach to management of pelvic lymph nodes (lymph node dissection/radiotherapy to nodes) should not be altered based on a negative PSMA PET/CT (N0 M0) in patients with unfavorable intermediate-risk, high-risk, or very high-risk localized prostate cancer (NCCN definition) undergoing surgery or radiotherapy with curative intent
6	In patients with high/very high-risk localized prostate cancer (NCCN definition) for whom radical prostatectomy is planned, would a negative PSMA PET (N0M0) change your approach to pelvic lymph node dissection?	Yes – 0 No – 11 Abstain – 4	Consensus (100%)	Questions 5-8 were merged to develop Statement
7	In patients with unfavorable	Question 7 was merged with	Consensus (100%)	Questions 5-8 were merged to develop

	intermediate-risk localized prostate cancer (NCCN definition) for whom radiation therapy is planned, and who have a negative PSMA PET (N0M0), do you recommend radiation to the pelvic lymph nodes?	questions 5, 6, and 8 after the panel agreed that a negative PSMA PET would not alter the approach to treatment.		Statement
8	In patients with high/very high-risk localized prostate cancer (NCCN definition) for whom radiation therapy is planned, and who have a negative PSMA PET (N0M0), do you recommend radiation to the pelvic lymph nodes?	Question 8 was merged with questions 5, 6, and 7 after the panel agreed that a negative PSMA PET would not alter the approach to treatment.	Consensus (100%)	Questions 5-8 were merged to develop Statement
9	In general, if patients have negative conventional imaging and positive PSMA PET, do you stage and treat as per PSMA PET findings?	• Yes – 7 (54%) • No – 6 • Abstain – 2	Not reached	—
10-11 merged	What is your preferred treatment recommendation for the majority of	• Radiation therapy prostate plus pelvis plus long-term ADT – 6	Not reached	—

	prostate cancer patients with cN0 disease on conventional imaging and positive pelvic lymph nodes on PSMA PET (M0), regardless of whether they meet the STAMPEDE (high-risk, locally advanced M0) definition (node-positive or node-negative with at least two of these: PSA >40 ng/mL, Gleason 8-10, or T3-T4 tumor stage)?	(50%) • Radiation therapy prostate plus pelvis plus long-term ADT plus abiraterone for 2 years – 4 • Surgery, recognizing that it may be part of a multimodality approach – 2 • Abstain – 3		
Biochemically recurrent				
12-13 merged	In patients with biochemical recurrence (BCR) following radical prostatectomy, at what PSA threshold should PSMA PET/CT be performed, and does this threshold differ between low-risk patients (no ISUP grade group 4–5 and PSA doubling time ≥1 year) and high-risk patients (ISUP grade group 4–5 and/or PSA doubling time <1 year)?	• Any detectable PSA – 1 • PSA of 0.1 ng/mL – 4 • PSA of 0.2 ng/mL – 2 • PSA 0.2 to 0.3 ng/mL – 0 • PSA 0.4 to 0.5 ng/mL – 2 • PSA 0.5-1.0 ng/mL – 3 • PSA >1 ng/mL – 0 • Never – 0 • Abstain – 3	Not reached (The group did not agree on a specific PSA number to trigger performing PSMA PET)	—
14	For patients with	The panel agreed a	Consensus	Questions 14-15 were

	PSA persistence post radical prostatectomy and pN0 on extended/limited PLND and no evidence of risk factors (risk factors: R1, pT3, ISUP grade group 4–5, PSA-DT of < 1 year) and a negative postoperative PSMA PET that you treat with salvage radiation therapy, do you recommend radiation to the pelvic lymph nodes in addition to the prostate bed?	negative PSMA PET would not alter their approach to treatment.	(100%)	merged to develop Statement 6: In patients with PSA persistence or biochemical failure following radical prostatectomy (pN0 on extended or limited PLND, with or without high-risk factors) undergoing salvage radiotherapy, a negative postoperative PSMA PET/CT should not determine the decision to include pelvic lymph nodes in the radiotherapy treatment volume
15	For patients with PSA persistence post radical prostatectomy and pN0 on extended/limited PLND and evidence of high risk factors (risk factors: R1, pT3, ISUP grade group 4–5, PSA-DT of < 1 year) and a negative postoperative PSMA PET that you treat with salvage radiation therapy, do you recommend radiation to the	The panel agreed a negative PSMA PET would not alter their approach to treatment.	Consensus (100%)	Questions 14-15 were merged to develop Statement 6

	pelvic lymph nodes in addition to the prostate bed?			
16	For patients with low risk (no risk factors: ISUP grade group 4–5, PSA-DT <1 year, interval recurrence within 18 months) BCR post radiation therapy, at what PSA value do you recommend PSMA PET/CT?	• At PSA of 2.0 ng/mL above the nadir – 11 (100%) • Never (only when high-risk factors identified) – 0 • Abstain – 4	Consensus (100%)	Questions 16-18 were merged to develop Statement 7: In patients with biochemical recurrence following primary radiotherapy, including those treated with radiotherapy plus systemic therapy (ADT ± ARPI), PSMA PET/CT should be performed as soon as biochemical recurrence is established according to the Phoenix definition (PSA ≥2.0 ng/mL above nadir), regardless of baseline risk features
17	Should all patients with high risk (risk factors: ISUP grade group 4–5, PSA-DT < 1 year, interval recurrence within 18 months) BCR post radiation therapy, undergo a PSMA PET/CT?	The panel considered this question to be addressed by Question 16 and agreed the same PSA threshold would apply to high-risk patients.	Consensus (100%)	Questions 16-18 were merged to develop Statement 7
18	In patients who have received radical radiation therapy plus systemic therapy (ADT ± ARPI) for localized/locally advanced prostate cancer, at what	There was verbal agreement that the approach would be the same as Question 16.	Consensus (100%)	Questions 16-18 were merged to develop Statement 7

	point do you recommend imaging in case of a rising PSA from a nadir of <0.2 ng/mL in the context of normal testosterone?			
Oligometastatic disease				
19	In patients with high-risk prostate cancer being evaluated for radical therapy and oligometastatic disease (1-5 lesions) in conventional imaging, do you recommend PSMA PET/CT?	• Yes, in all patients – 3 • Yes, in select patients – 12 • No – 0 • Abstain – 0	Consensus (80%)	Statement 8: In patients with high-risk or very high-risk prostate cancer being considered for radical therapy and found to have oligometastatic disease (1–5 lesions) on conventional imaging, PSMA PET/CT should be performed in selected patients who are candidates for metastasis-directed and/or primary tumor-directed therapy
Advanced disease				
20	In patients with mCSPC on therapy (ADT + ARPI) and biochemical progression, do you recommend PSMA PET/CT?	• Yes – 6 • No, conventional imaging only – 8 (57%) • Abstain – 0	Not reached	—
21	In patients with mCSPC on therapy (ADT + ARPI) with biochemical progression and no progression on conventional imaging, do you recommend PSMA PET/CT?	• Yes – 8 (62%) • No – 5 • Abstain – 1	Not reached	—

22	In patients with mCSPC on therapy (ADT + ARPI) and biochemical progression with oligoprogressive disease on conventional imaging (oligoprogression 1-5 mets), do you recommend PSMA PET/CT?	• Yes – 11 • No – 3 • Abstain – 0	Near consensus (79%)	— see re-vote results below
22 (re-vote)	In patients with mCSPC on therapy (ADT + ARPI) and biochemical progression with oligoprogressive disease on conventional imaging (oligoprogression 1-5 mets), do you recommend PSMA PET/CT?	• Yes – 12 • No – 2 • Abstain – 0	Consensus (86%)	Statement 9: In patients with mCSPC receiving ADT plus an ARPI who develop biochemical progression without polymetastatic disease on conventional imaging, PSMA PET/CT should be performed when metastasis-directed therapy is considered
23	Do you recommend a PSMA PET in patients who have biochemical progression on ADT + ARPI in the nmCRPC setting and conventional imaging remains negative?	• Yes – 9 (69%) • No – 4 (31%) • Abstain – 1	Near consensus (69%)	—
24	Do you recommend a PSMA PET in patients who have radiographic progression on ADT + ARPI in the	• Yes – 4 (29%) • No – 10 (71%) • Abstain – 0	Near consensus (71%)	—

	mCSPC setting?			
25	Do you recommend a PSMA PET in patients who have progressed on ADT + ARPI + chemotherapy (triplet or sequential)?	• Yes – 14 • No – 0 • Abstain – 0	Consensus (100%)	Statement 10: In patients whose disease progresses on ADT plus ARPI and post chemotherapy (triplet or sequential therapy), PSMA PET/CT should be performed when ^{177}LuPSMA-617 therapy is considered
26	Is it appropriate to recommend lutetium-PSMA therapy in patients with mCSPC outside of a clinical trial?	• Yes – 1 • No – 12 • Abstain – 1	Consensus (92%)	Statement 11: Currently, ^{177}Lu-PSMA-617 is appropriate for patients with mCSPC only in the context of a clinical trial
27	When do you recommend FDG PET to be performed alongside or after a PSMA PET before lutetium therapy?	• Mostly if low PSMA avidity – 1 • Mostly patients with low PSA levels (discordant to conventional imaging findings) – 7 (50%) • All patients – 4 • Never – 2 • Abstain – 0	Not reached	—
28	For the majority of patients with bone-only on conventional imaging mCRPC with no DDR alteration identified, what is your treatment recommendation on progression after they have received ADT + ARPI + docetaxel?	• Taxane – 0 • ^{223}Ra – 4 • ^{177}Lu-PSMA – 7 (50%) • Depends on PSMA avidity – 3 • Abstain – 0	Not reached	—
29	Are you confident	• Yes – 11	Near	—

	about the effectiveness of ^{223}Ra after prior treatment with ^{177}Lu-PSMA?	• No – 3 • Abstain – 0	consensus (79%)	
30	Are you confident about the safety of ^{223}Ra after prior treatment with ^{177}Lu-PSMA?	• Yes – 12 • No – 2 • Abstain – 0	Consensus (86%)	Statement 12: The use of ^{223}Ra following prior treatment with ^{177}Lu-PSMA-617 is feasible in appropriately selected patients with bone-dominant or bone-only metastatic disease
31	Are you confident about the effectiveness of ^{177}Lu-PSMA after prior treatment with ^{223}Ra?	• Yes – 11 • No – 3 • Abstain – 0	Near consensus (79%)	—
32	Are you confident about the safety of ^{177}Lu-PSMA after prior treatment with ^{223}Ra?	• Yes – 12 • No – 2 Abstain – 0	Consensus (86%)	Statement 13: The use of ^{177}Lu-PSMA-617 following prior treatment with ^{223}Ra is feasible in appropriately selected patients
33	For the majority of patients starting ^{177}Lu-PSMA in the mCRPC setting, do you recommend continuation (or re-use) of a prior ARPI in combination with ^{177}Lu-PSMA (assuming no funding concerns)?	• Yes, in the majority of patients – 2 (18%) • Yes, but only in selected patients – 1 (9%) • No – 8 (73%) • Abstain – 3	Consensus (82% for no treatment or treatment only in selected patients)	Statement 14: Routine continuation or re-introduction of a prior ARPI in combination with ^{177}Lu-PSMA-617 is not generally recommended for most patients with mCRPC, but can be used in special circumstances
34	In the majority of patients with mCRPC (no DDR alteration) progressing on or	• ^{177}Lu-PSMA – 3 • ^{177}Lu-PSMA reduced administered activity – 2	Consensus (100% for ^{177}Lu-PSMA alone, with reduced	Statement 15: In patients with mCRPC (without homologous recombination repair [HRR] alteration)

	after an ARPI and docetaxel with relevant impaired bone marrow function (hemoglobin <90 g/L and/or neutrophils <1.5 x 10^9/L and/or platelets <100 x 10^9/L), and where ^{177}Lu-PSMA is being considered, what do you recommend?	• Transfusion support with ^{177}Lu-PSMA – 3 • ^{177}Lu-PSMA reduced administered activity with transfusion support – 2 • Abstain – 4	administered activity, transfusion support, or both)	whose disease progresses on or after an ARPI and docetaxel, who have impaired bone marrow function due to extensive PSMA-avid bone marrow/skeletal involvement, and in whom ^{177}Lu-PSMA-617 is being considered, proceed with ^{177}Lu-PSMA-617 with transfusion support as needed, with consideration for dose reduction as clinically appropriate
35	Do you recommend re-treatment with ^{177}Lu-PSMA (if relevant PET criteria are met) in the disease course in patients who have previously responded to 6 cycles of ^{177}Lu-PSMA treatment?	• Yes – 1 • Yes, but only if response of >6 months – 1 • No – 9 • Abstain – 3	Consensus (82%)	Statement 16: Re-treatment with ^{177}Lu-PSMA-617 in eligible patients who have previously responded to 6 cycles should not be routinely recommended
36	In the majority of patients with mCRPC and impaired renal function (GFR 30–49 mL/min), where ^{177}Lu-PSMA is being considered, what do you recommend?	• ^{177}Lu-PSMA – 9 • ^{177}Lu-PSMA reduced administered activity – 2 • Abstain – 3	Consensus (82%)	Statement 17: In patients with mCRPC and impaired renal function (eGFR 30–49 mL/min) and no correctable causes, ^{177}Lu-PSMA-617 can be administered when clinically indicated
37	In the majority of patients with mCRPC and stable/chronic	• ^{177}Lu-PSMA – 3 • ^{177}Lu-PSMA reduced administered	Consensus (82% for ^{177}Lu-PSMA with or	Statement 18: In patients with mCRPC and stable/chronic impaired renal

	impaired renal function (GFR <30 mL/min), where ^{177}Lu-PSMA is being considered, what do you recommend?	activity – 6 • Do not recommend treating with ^{177}Lu-PSMA – 2 • Abstain – 3	without reduced administration activity)	function (eGFR <30 mL/min) and no correctable causes in whom ^{177}Lu-PSMA-617 is being considered, treatment may be reasonable in carefully selected patients, most commonly with reduced administered activity on an individualized basis, and with multidisciplinary decision-making
Monitoring				
38	In the majority of patients that you evaluate for ^{177}Lu-PSMA therapy eligibility, what imaging do you routinely recommend assuming all scans are readily available?	• PSMA PET plus FDG PET (like in the TheraP study) – 4 • PSMA PET and bone scan (like in the VISION study) – 1 • PSMA PET and add FDG PET selectively for equivocal cases – 3 • PSMA PET and CT +/- bone scan – 6 • Abstain – 0	Not reached	—
39	In the majority of patients on treatment with ^{177}Lu-PSMA, do you recommend imaging for response monitoring during ^{177}Lu-PSMA treatment in the	• Yes, in all patients – 11 • Yes, but only in selected patients – 1 • No – 2 • Abstain – 0	Consensus (86%)	Statement 19: In patients receiving ^{177}Lu-PSMA-617, imaging to monitor for response during treatment in the absence of clinical progression is supported in the majority of patients

	absence of clinical progression?			using molecular imaging (PSMA PET/CT and/or post-therapy SPECT/CT) in addition to contrast-enhanced CT of the thorax, abdomen, and pelvis
40	In the majority of patients on treatment with ^{177}Lu-PSMA, which imaging modality do you recommend for response monitoring?	• Conventional imaging – 3 • PSMA PET (no iodine iv contrast) – 1 • PSMA PET plus diagnostic CT (with iv iodine contrast) – 2 • LuPSMA SPECT/CT – 4 • LuPSMA SPECT plus diagnostic CT (with IV contrast) – 3 • Abstain – 1	Near consensus (77% for PSMA PET or LuPSMA SPECT with or without CT)	—
41	In the majority of patients with response (PSA and/or clinical and/or radiological) to ^{177}Lu-PSMA therapy after 2-3 cycles, do you recommend completion of the 6 cycles?	• Yes, in the majority of patients – 12 • Yes, but only in selected patients – 2 • No – 0 • Abstain – 0	Consensus (86%)	Statement 20: In patients demonstrating a significant PSA, clinical, and/or radiographic response after 2–3 cycles of ^{177}Lu-PSMA-617, completion of the planned 6 cycles is appropriate for the majority of patients
42	In the majority of patients with response (PSA and/or clinical and/or radiological) to ^{177}Lu-PSMA therapy after 4	• Yes, in the majority of patients – 2 (18%) • Yes, but only in selected patients – 1 (9%) • No – 8 (73%) • Abstain – 0	Near consensus (73%)	—

	cycles, do you recommend completion of the 6 cycles if PSMA-based imaging shows no remaining uptake (as defined by the treating physician)?			
43	Can the data generated by PSMAfore and VISION with lutetium-PSMA-617 be extrapolated to lutetium-PSMA with alternate PSMA ligands?	• Yes, for all PSMA ligands – 2 (15%) • Yes, but only for PSMA-I&T – 1 (8%) • No – 10 (77%) • Abstain – 1	Near consensus (77%)	—
44	In a patient with mCRPC planned for Lu-PSMA with symptomatic metastases, do you refer for the addition of palliative radiotherapy?	• Yes – 13 • No – 0 • Abstain – 0	Consensus (100%)	Statement 21: In patients with mCRPC planned for ^{177}Lu-PSMA-617 who have symptomatic metastases, referral for palliative radiotherapy is appropriate

Definitions: Consensus: ≥80%; Near consensus: 65%-79%; Consensus not reached: <65%.

Supplementary Table 3. Summary of nuclear medicine consensus results				
Number	**Question**	**Results[a]**	**Consensus (% agreement)**	**Statement**
1	Solitary PSMA-avid lesion without a CT or MRI correlate should generally be interpreted as:	A. Likely benign unless high SUVmax – 1 B. Insignificant if bone scan is negative – 0 C. Interpreted according to patient risk, lesion location and uptake pattern – 6 D. Posttraumatic/degenera	Consensus (100%)	Statement 22: A solitary PSMA-avid lesion without a CT or MRI correlate should generally be interpreted

		tive uptake by default – 0		according to patient risk, lesion location, and uptake pattern
2	Which clinical factors most increase your suspicion for a solitary metastatic lesion?	A. High PSA and Grade Group 3-5 – 0 B. ≥ cT3 – 0 C. Rapid PSA doubling time – 0 D. All the above – 6	Consensus (100%)	Statement 23: High PSA and Grade Group 3–5 disease, clinical stage ≥cT3, and a rapid PSA doubling time are clinical factors that increase suspicion for a solitary metastatic lesion.
3	Which imaging feature most favors a false-positive PSMA lesion in absence of anatomic correlate?	A. Multiple lesions in pelvis and spine with no CT correlate – 0 B. Solitary lesion in the ribs or periarticular lesions – 6 C. Fusiform/elongated uptake in a rib – 0 D. High SUV max or PSMA score 2-3 – 0	Consensus (100%)	Questions 3 was integrated into the statement developed for Questions 8 and 9
4	For [^{18}F]F-PSMA-1007, what SUVmax cutoff is commonly recommended for diagnosing metastatic disease?	A. ≥ 4.0 – 1 B. ≥ 6.0 – 0 C. ≥ 11.0 – 1 D. ≥ 15.0 – 0 E. Never – 3 (60%) F. Abstain – 1	Not reached	—
5	A solitary rib lesion with SUVmax < 7.2 on [^{18}F]F-PSMA-1007 and no CT correlate is most likely:	A. Metastatic disease – 0 B. Indeterminate but suspicious – 2 C. Benign – 2 D. Progressing disease – 0 E. Never – 1 F. Abstain – 1	Not reached	—
6	Which uptake pattern	A. Linear uptake across	Consensus	Statement 24:

	in the ribs is more suspicious for metastasis?	consecutive ribs – 0 B. Solitary focal uptake – 1 C. Elongated/fusiform uptake – 5	(83%)	An elongated or fusiform pattern of PSMA uptake in the ribs is more suspicious for metastatic disease
7	Which CT feature favors a benign rib lesion?	A. Dense sclerosis – 1 B. Fusiform expansion – 1 C. Intramedullary ring or arc-shaped sclerosis – 6 D. Cortical erosion – 0	Consensus (100%)	Statement 25: An intramedullary ring- or arc-shaped pattern of sclerosis on CT favors a benign rib lesion
8	In a low-risk patient, a single rib mild focal uptake on [^{68}Ga]Ga-PSMA-11 without sclerosis or lytic change should most often be classified as:	A. Definite M1b disease – 0 B. Indeterminate – 1 C. Post-traumatic or benign – 5 D. Physiologic – 0	Consensus (83%)	Questions 8 and 9 were merged to develop Statement 26: A solitary mild focal rib uptake on ^{68}Ga-PSMA-11 PET/CT without sclerosis, lytic change, or an anatomic correlate should be interpreted according to patient risk. In low-risk patients, it is likely post-traumatic or benign. However, in intermediate-

				or high-risk patients, it should be considered indeterminate and follow-up is recommended
9	In intermediate- or high-risk patients, an isolated mild focal rib uptake on [^{68}Ga]Ga-PSMA-11 without CT correlate should usually be:	A. Definite M1b disease – 0 B. Ignored – 0 C. Classified as indeterminate with follow-up recommended – 5 D. Post-traumatic or benign – 1	Consensus (83%)	Questions 8 and 9 were merged to develop Statement 26
10	Which feature best helps distinguish ganglia from nodal metastases?	A. High SUVmax – 1 B. Unilateral rounded morphology – 1 C. Bilateral elongated structures in typical locations – 6 D. Association with bone cortical changes – 1	Consensus (100%)	Statement 27: Bilateral elongated structures in typical anatomic locations best distinguish ganglia from nodal metastases
11	Which physiologic variant most commonly mimics nodal disease in the retroperitoneum and pelvis on PSMA PET?	A. Vascular structure – 0 B. Ureteric activity – 6 C. Muscle uptake – 0 D. Bowel activity – 0	Consensus (100%)	Statement 28: Ureteric activity is the physiologic variant that most commonly mimics nodal disease in the retroperitoneum and pelvis on PSMA PET/CT
12	With equivocal lesions on PSMA PET, which factor	A. Lesion size and location – 0 B. Clinical likelihood of	Consensus (100%)	Statement 29: Lesion size and location,

	most influences interpretation?	metastatic disease – 0 C. PROMISE v2 Criteria – 0 D. All the above – 6		the clinical likelihood of metastatic disease, and application of PROMISE V2 criteria all influence interpretation of equivocal lesions on PSMA PET/CT
13	After 3 months post-treatment (RP or PR), any focal PSMA uptake within the prostate bed/prostate should generally be:	A. Ignored – 0 B. Considered post treatment changes – 0 C. Considered suspicious until proven otherwise – 6 D. Attributed to inflammation – 0	Consensus (100%)	Statement 31: After 3 months post-treatment (radical prostatectomy or prostate radiotherapy) and in the presence of biochemical recurrence, any focal PSMA uptake within the prostate bed/prostate should generally be considered suspicious until proven otherwise.
14	Which benign or inflammatory process commonly causes false-positive PSMA uptake in bone?	A. Paget's disease – 0 B. Degenerative and post traumatic changes – 0 C. Enchondromas – 0 D. All the above – 6	Consensus (100%)	Statement 30: Paget's disease, degenerative and post-traumatic changes, and enchondromas and non-

				aggressive fibro-osseous lesions are recognized benign or inflammatory processes that commonly cause false-positive PSMA uptake in bone
15	When do you think delayed pelvic acquisition on PSMA PET should be done?	A. Routinely done in all patients – 1 B. Negative scan – 1 C. Equivocal pelvic lesions – 3 D. Not routinely indicated – 3	Consensus (100%) After discussion there was verbal agreement for D.	Statement 32: Delayed pelvic acquisition on PSMA PET/CT is not routinely indicated but may be reasonable in selected cases where additional clarification would meaningfully impact clinical decision-making

Consensus: ≥80%; Consensus not reached: <65%. [a]When voting on the nuclear medicine questions, respondents were allowed to select more than one answer.