

**Table S1.** PSMA-RADS scores (version 2.0) [7].

<b>PSMA-RADS Score</b>	<b>Description</b>
PSMA-RADS 1 (benign)	<b>Benign lesion</b> characterized by biopsy or pathognomonic finding on anatomic imaging and with focal radiotracer uptake
PSMA-RADS 2 (likely benign)	<b>Equivocal</b> (focal, but low level such as blood pool) <b>uptake in soft-tissue site atypical of PCa involvement</b> (e.g., axillary or hilar lymph nodes); <b>equivocal uptake in bone lesion atypical of PCa involvement</b> (e.g., uptake fused to bone lesion and strongly suspected of being degenerative or another benign etiology). Upon follow-up, stable lesions without treatment are likely benign and could then be scored with PSMA-RADS 1 or 2
PSMA-RADS 3 (equivocal)	
PSMA-RADS 3A	<b>Equivocal uptake in soft-tissue site typical of PCa involvement</b> (e.g., pelvic or retroperitoneal lymph nodes). If targetable, biopsy may help confirm diagnosis. Alternatively, follow-up imaging (either anatomic or PSMA-targeted PET/CT) showing progression can establish diagnosis. We recommend an initial follow-up period of 3–6 months in oligometastatic patients (>5 metastases); it is at the reader's discretion to reclassify this lesion to PSMA-RADS 4 <sup>a</sup>
PSMA-RADS 3B	<b>Equivocal uptake in bone lesion not definitive but also typical of PCa on anatomic imaging</b> (i.e., pure marrow-based lesion with little, if any, surrounding bony reaction, lytic or infiltrative lesion, or classic osteoblastic lesion). Na18F-PET/CT or bone biopsy may be considered. Alternatively, follow-up imaging (either anatomic or PSMA-targeted PET/CT) with evidence of progression may confirm diagnosis. In oligometastatic patients (>5 metastases), it is at the reader's discretion to reclassify this lesion to PSMA-RADS 4 <sup>a</sup>
PSMA-RADS 3C	<b>Intense uptake in site highly atypical of all but advanced stages of PCa</b> , which requires further workup. Biopsy to confirm diagnosis histologically is often preferred, although organ-specific follow-up imaging may be considered (e.g., liver-protocol MRI to evaluate possible primary hepatocellular carcinoma)
PSMA-RADS 3D	<b>Any lesion on CT that requires further workup but does not show any tracer uptake.</b> Biopsy to confirm diagnosis is often preferred, although organ-specific follow-up imaging may be applicable
PSMA-RADS 4 (PCa highly likely)	<b>Intense uptake in site typical of PCa but lacking definitive findings on conventional imaging<sup>b</sup></b>
PSMA-RADS 5 (PCa almost certainly present)	<b>Intense uptake in site typical of PCa and having corresponding findings on conventional imaging<sup>b</sup></b> , although obtaining tissue for genomic analysis or other purposes may be useful
PSMA-RADS 5T (treated PCa metastasis)	<b>Previously identified metastases after treatment (e.g., irradiated sclerotic bone lesions) with or without uptake</b>
Overall RADS score	<b>Defined by the highest PSMA-RADS score of any of the individual target lesions</b>

CT—computed tomography; PC—prostate cancer; PET—positron emission tomography; PSMA-RADS—Prostate-Specific Membrane Antigen Reporting and Data System; RADS—reporting and data system.



<sup>a</sup> Lesion-based classification may be omitted in patients with large-scale metastases.

<sup>b</sup> Given the high specificity of PSMA expression in prostate cancer cells [20] and highly accurate detection rates for selected radiotracers [21,22], it is unlikely that biopsy confirmation will be needed.