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GI learning, personalised

Summary

Next generation of personalised management: Molecular pathology

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UEG Week Barcelona 2026 | Presentation

Oesophagus | Stomach & H. Pylori | Mechanisms & Personalised Medicine | Digestive Oncology

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The presentation reviewed targetable biomarkers for upper gastrointestinal malignancies and technical considerations for their diagnostic assessment, covering MSI, PD-L1, HER2, Claudin 18.2, and NGS-based markers across gastric, esophageal, pancreatic, and biliary cancers.

KEY POINTS

- MSI and NTRK are tumor-agnostic biomarkers; for esophageal and gastric cancer, PD-L1 combined positivity score is required, and for adenocarcinomas HER2 and Claudin 18.2 status must be assessed.
- PD-L1 assessment uses the combined positivity score (positive tumor cells plus positive immune cells relative to all viable tumor cells) and requires evaluation of the whole tumor, not hotspots, with at least 100 tumor cells needed; staining is highly heterogeneous across different tumor areas.
- HER2 low (1+ or faint staining in more than 5 cells) and ultra-low categories are now distinguished from negative; the speaker stated that ongoing trials show HER2-directed antibody-drug conjugates may work in HER2 low cases where traditional HER2 blockade is not supported.
- Claudin 18.2 requires 75% tumor positivity for current use (found in around 40% of cases), but the speaker noted emerging antibody-drug conjugate trials use a 25% cut-off, potentially expanding the treatable patient population if approved.
- For pancreatic cancer, somatic BRCA analysis is recommended as it is found in around 10% of cases and confers heightened sensitivity to platinum agents; wild-type cases (around 10%) are fusion-enriched and should be evaluated for NTRK or FGFR fusions.

– The speaker emphasized that pathologists require ongoing training and external quality assessment to address interobserver variability, particularly for PD-L1 scoring, and that positive controls are essential to validate antibody clone performance.

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