

### Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/practical-dermatology-updates-in-skin-cancer/translating-40-gep-results-into-personalized-cscc-care/54651/>

### ReachMD

www.reachmd.com  
info@reachmd.com  
(866) 423-7849

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## Translating 40-GEP Results Into Personalized cSCC Care

Gaurav Singh:

So the four class results or the possible outcomes from the 40-GEP or gene expression profile test has been instrumental in having clear conversations, not only with patients but among colleagues and especially with multidisciplinary management that's critical to managing patients with high-risk cutaneous squamous cell carcinoma.

So, class 1A patients represent a low risk, about a 0-5% metastatic risk, and a class 1B patient represents moderate risk or about a 5-10% risk. Class 2A patients have over a 20% metastatic risk, what we consider to be high risk. And the highest risk patients of a class 2B result have over a 30% risk of metastasis. So when these exact numbers are provided not just to me as a clinician, but also to the patients themselves, patients can often visualize exactly what, for example, a 37% risk of metastasis might mean for them, and that can often encourage them to undergo additional treatment when that's indicated. On the other hand, oftentimes we will get a low-risk or a class 1A result in a tumor that was shown to be higher risk by traditional staging. And sometimes in some patients we may deescalate care and do other things that perhaps may otherwise have been done.

So it's a discussion, it's always a discussion with the patient that's at the center of these discussions, but having that exact risk that current staging systems don't always provide has been very beneficial in having these conversations with patients and other clinicians. So clinicians should expect to have discussions with patients and their colleagues to interpret metastatic risk, local recurrence risk, and benefit of adjuvant radiation within those four classes. We use the GEP test to have a risk-stratified decision-making that's personalized to the patient. So sometimes what that means is two patients with the same class result may actually undergo different treatments based on their individual goals of care. So that is the most important thing when interpreting these results is every single patient may get an individual result, and that's the point. Now that being said, there are some overall guidelines we tend to follow, if you will.

Class 2B results tend to be highest risk of metastasis, and there is a clear benefit for adjuvant radiation in these patients. So these patients may often have a class 2B result despite a stage one tumor, and that's often seen in NCCM very high-risk features or Brigham and Women's very high-risk features as well. A class 1A patient needs typical clinical following, and that may mean skin checks every six months, for example. It may be safe to defer imaging in these patients. In class 1B patients who have a moderate risk of metastasis and recurrence, increased surveillance is often warranted. In our clinical practice, what I like to do is see these patients perhaps every three months instead of six and teach them these signs of recurrence so that should a recurrence occur, we can see them much more closely. And in some cases, depending on the stage of the tumor, imaging can be considered.

For a class 2A patient with a high risk of metastasis, which is over 20%, increased surveillance is recommended with clinical lymph node exams at follow-ups. Imaging is also done for these patients in my practice, and a multidisciplinary consult at the tumor board is often used. And some of these patients will have a variety of those things based on the individualized discussion we have at the tumor board. So clinicians should expect to interpret these risks in the context of the patient. And of course, we like to individualize decision-making for our patients.