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/using-i40-gep-to-escalate-and-personalize-cscc-care/54652/

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Using i40-GEP to Escalate and Personalize cSCC Care

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The i40 GEP is really instrumental in deciding whether patients may need increased surveillance or increased imaging and perhaps may lead to multidisciplinary care referrals should one not be locally available. Class 2B patients benefit from multidisciplinary care. We know that patients with advanced cutaneous squamous cell carcinoma have better outcomes when multiple clinicians are involved.

These patients do also need additional imaging and increased surveillance as well. Sometimes these class 2B results occur with low-stage tumors and low-stage patients. So the class call can sometimes be independent of the stage that is predicted, and that's why it's so instrumental to have these individualized risk prediction tools. Class 2A patients do also need increased surveillance and oftentimes imaging as well. There's not been shown to be a benefit from adjuvant radiation, but it can be considered in some cases, especially if the patient has a high-stage tumor. Class 1B patients also do benefit from increased surveillance due to the 5-10% risk of metastasis and about a 10% risk of recurrence. We know that recurrence is oftentimes on the causal pathway to metastasis, but not always. And so detection of early recurrence leads to better outcomes, and that's where the 40-GEP test really fits in.

We can identify patients who are at higher risk and intervene earlier to give patients better outcomes. I find the 40-GEP test to be very valuable in escalating care. Oftentimes, patients that are predicted to be low-risk by traditional staging may actually have high biological risk of recurrence or metastasis. The example I always think of is if a patient comes into my office with a 1.8-centimeter, moderately differentiated cutaneous SCC on the ear, and perhaps they have a history of a liver transplant, I would consider that patient to be higher-risk and I would be concerned about that patient. However, based on traditional staging, in the absence of other risk factors, that patient may be considered to have stage 1 disease. So in that patient, I would like to use 40-GEP to get more information and see if that patient may benefit from additional imaging or closer follow-up, or perhaps even adjuvant radiation in the right circumstance.

Deescalation is always more uncomfortable to all clinicians, including myself. So if a patient meets criteria for adjuvant radiation based on ASTRO guidelines or NCCN guidelines, it is still worth considering radiation with a radiation oncologist. That being said, I do encounter a subset of patients that perhaps are declining radiation to begin with. And in those cases, GEP can sometimes be used to deescalate care in the appropriate clinical context. Of course, it is always uncomfortable deescalating care given our background and training and desire to do the right thing for the right patient at the right time. And ultimately, that's really where GEP fits in. Because it's an individualized result that takes into account tumor biology and patient risk factors, we can have shared decision-making with patients with their exact risk of recurrence and their exact risk of metastasis and make sure we get to a good outcome that's overall in their best interest.