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https://reachmd.com/programs/cme/Role-of-Predictive-Biomarkers-in-Endometrial-Cancer/39293/

Released: 10/31/2025
Valid until: 10/31/2026
Time needed to complete: 1h 04m

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Role of Predictive Biomarkers in Endometrial Cancer

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Dr. Slomovitz:
Hi, I'm Dr. Brian Slomovitz. This is CE on ReachMD. Here with me today is Casey Cosgrove and Michelle Flint. Today, we're going to be talking about the role of predictive biomarkers in endometrial cancer.

Casey, I want to start with you. This is an area you're globally recognized for some of the work you've done with molecular subclassifications, and it's really phenomenal work. Talk to us a little bit about molecular characterization we do on newly diagnosed patients, not only when we do in the lab, but reflexively, what you're doing in the clinic.

Dr. Cosgrove:
Thanks, Brian. When we talk about molecular testing, we're kind of doing a lot of things. One thing is, we've known, historically speaking, what we see under the microscope doesn't always tell us the full story. But when we start breaking things down by their DNA, by mutations, and finding out other biological patterns, we get a much better understanding, a richer understanding about an individual's tumor to guide both prognostic and predictive guidance.

When we talk about prognostic guidance, we're talking about what's the chance that this cancer is going to come back? What's the chance that this cancer is going to be cured? When we look at that, we know that there are certain biomarkers that might tell us, gosh, this patient has a really good opportunity to not have this cancer return. There's other biomarkers that can tell us that maybe the cancer has a higher chance for returning, or a biomarker that tells us that the cancer has a higher risk for recurrence or spread, things like TP53 or p53 mutations. And so we're starting to incorporate some of this in terms of our intensity of therapy for guidance.

On the other hand, we're also looking at things like predictive biomarkers. This can be something like a mismatch repair deficiency or HER2/neu expression. And we have directed therapies like immunotherapy or these newer antibody-drug conjugates that can provide really precision medicine based off of this.

So really, we're at a time right now where we're trying to level the playing field with molecular biomarkers. We're deciding how intense therapy has to be, and we're also thinking about what the smartest therapies can be for individuals with endometrial cancer.

Dr. Slomovitz:
Yeah, that's so great.

Michelle, you and I, last week, we were seeing a patient in clinic, newly diagnosed patient, and we were screening her to see if she can go on to a HER2 antibody-drug conjugate. We have a path report. Nothing there about HER2. Tell us about your process. How are you

helping us to get the information we need to see if that patient could go on to that type of treatment?

NP Michelle Flint:
Yes, so for the HER2 ADC, we're really looking at the IHC, or immunohistochemistry, testing, so we're able to do that with our pathologists in house. So for my role, I would call up the pathology department, ask them if they can do the staining. And other staining they do in house is ER/PR testing. They do p53, and I know some centers can do POLE as well. So those we're able to do in the hospital.

We also will send out for more advanced stage disease, NGS testing. This patient population, we're completing the profiling early to prevent delays in treatment. And this comprehensive molecular profile allows us to screen them for both clinical trials and to see what standard of care options are available. Like Dr. Cosgrove was saying, we're really going more into biomarker-driven care. So we're looking at the biomarkers early to triage what treatments they can be on.

Dr. Slomovitz:
We have the drugs, we're just figuring the best patients where to use those drugs, and these predictive biomarkers we have are really changing the landscape of how we treat patients.

Casey, with a patient with recurrent disease, do you feel it's important to get a new biopsy and to retest? And what are your feelings about the changing molecular profile, and if it does happen in these tumors?

Dr. Cosgrove:
That's one of the million-dollar questions right now. We think that there's probably relatively high concordance between the hysterectomy specimens and recurrent specimens for many biomarkers. However, we do see subclonal evolution or changes subclonal populations that might have led to a metastasis.

And so what I personally have kind of advocated for is if you have no biomarker that was found on your initial sample, and you have targeted treatments that might be available, I strongly consider resampling their recurrence to see if they might have a biomarker that's available for more precision medicine.

Dr. Slomovitz:
Casey, Michelle, no more time on this seesion but thank you very much for your comments. Really, we're learning a lot here. Thank you.

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