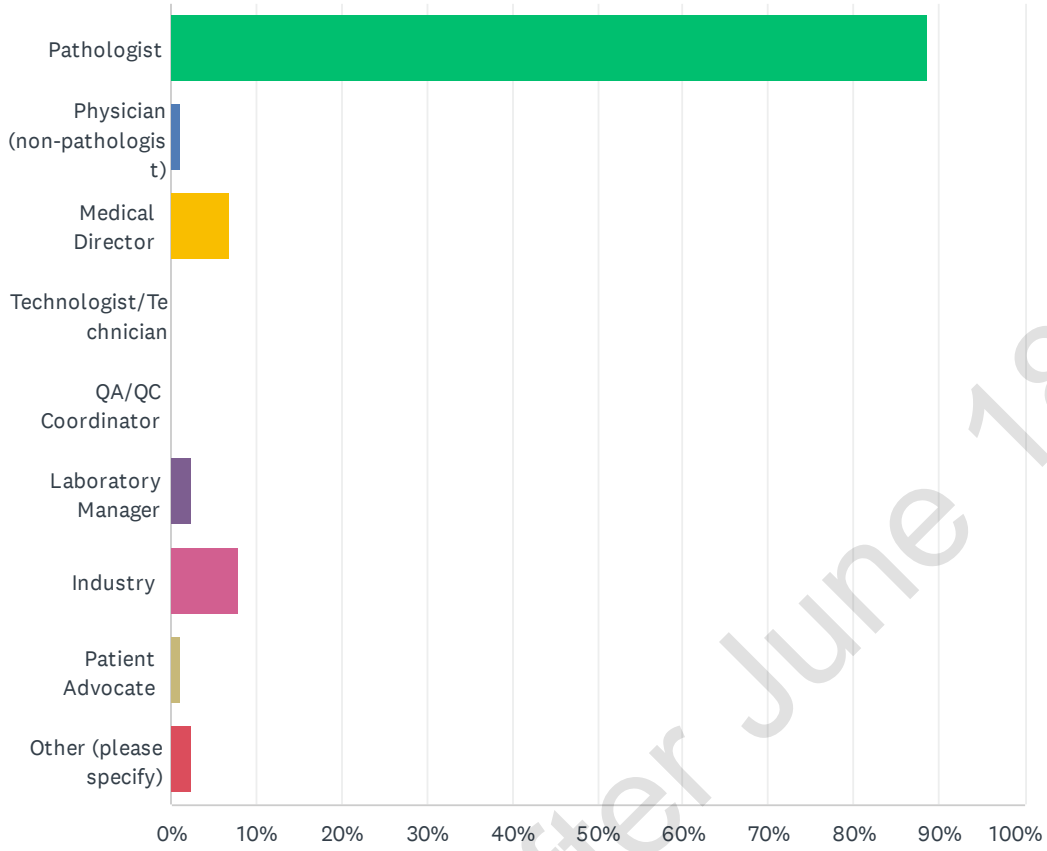
Q1 What is your occupation/role? (select all that apply)

Answered: 89 Skipped: 0



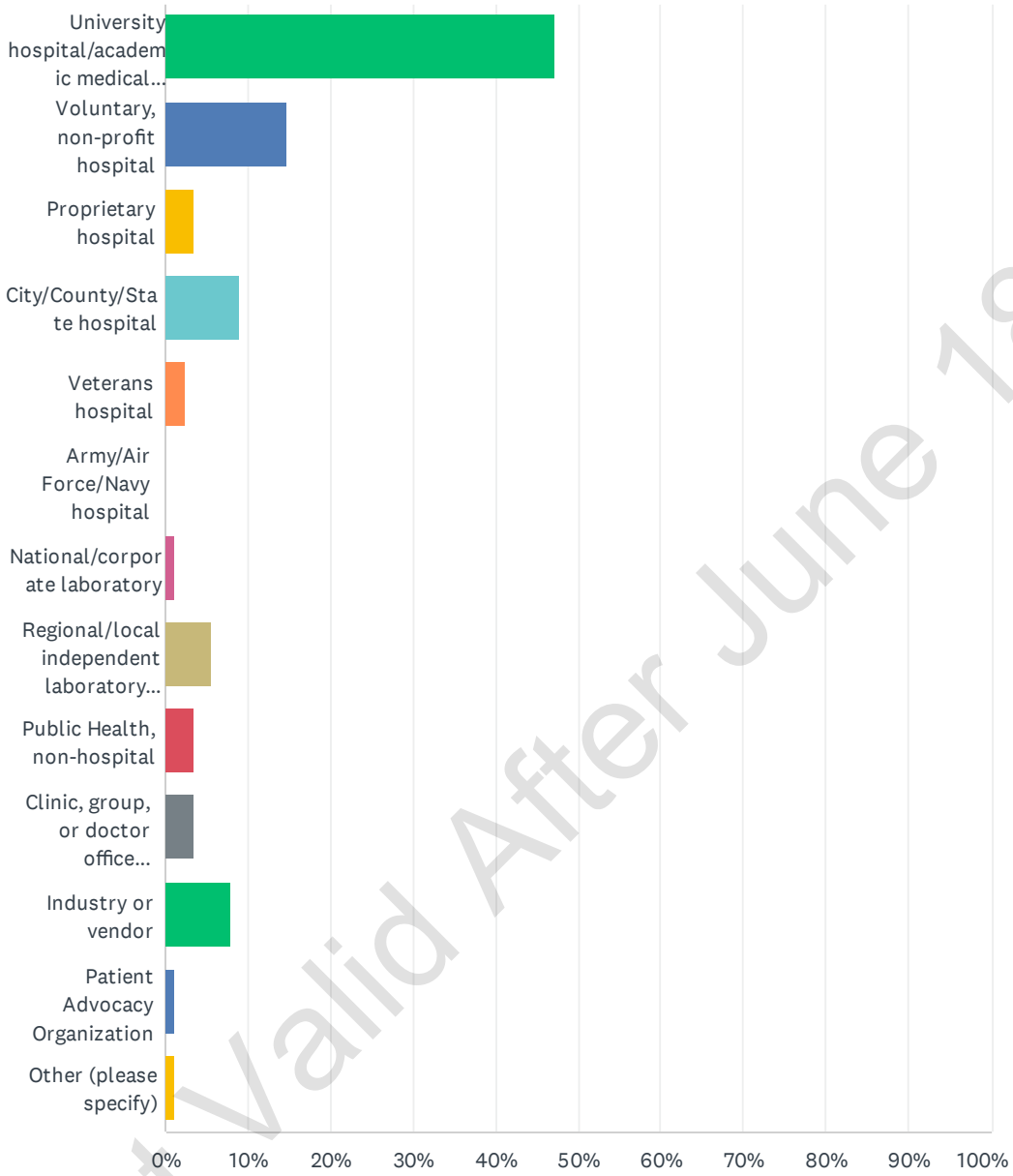
ANSWER CHOICES	RESPONSES	
Pathologist	88.76%	79
Physician (non-pathologist)	1.12%	1
Medical Director	6.74%	6
Technologist/Technician	0.00%	0
QA/QC Coordinator	0.00%	0
Laboratory Manager	2.25%	2
Industry	7.87%	7
Patient Advocate	1.12%	1
Other (please specify)	2.25%	2
Total Respondents: 89		

#	OTHER (PLEASE SPECIFY)	DATE
1	CAP	5/29/2025 11:39 AM

2	Pathology resident	5/28/2025 9:50 PM

Q2 Which of the following best describes your practice setting? (select one)

Answered: 89 Skipped: 0



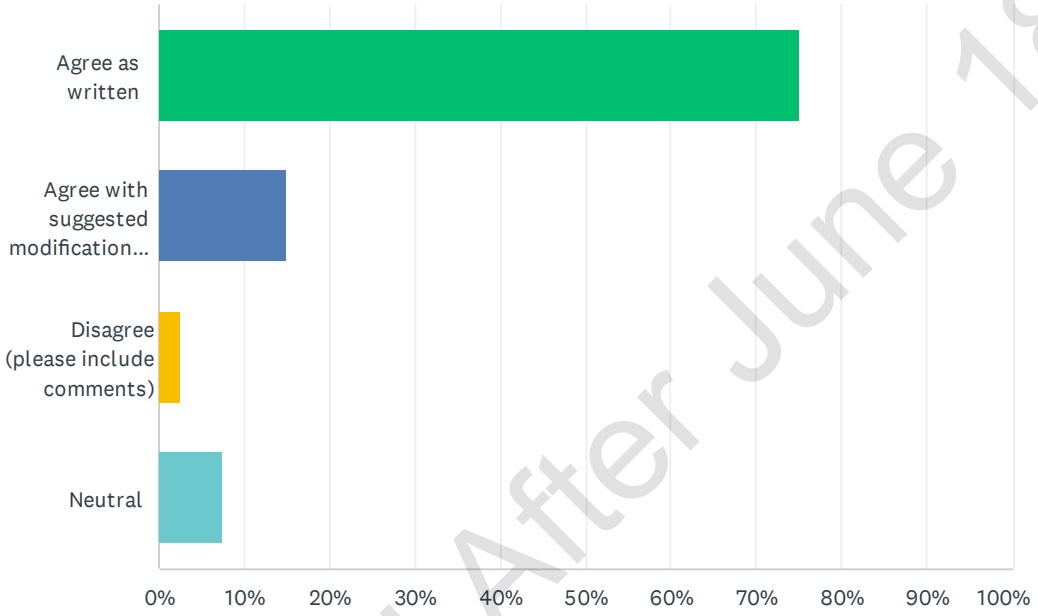
Disclaimer
The information, data, and draft recommendations provided by the College of American Pathologists are presented for informational and public feedback purposes only. The draft recommendations and supporting documents will be removed on June 25, 2025.
The draft recommendations along with the public comments received and completed evidence review will be reassessed by the expert panel in order to formulate the final recommendations. These draft materials should not be stored, adapted, or redistributed in any manner.
Please note: comments are not posted automatically. All comments will be posted on a weekly basis beginning June 4, 2025.

ANSWER CHOICES	RESPONSES	
University hospital/academic medical center	47.19%	42
Voluntary, non-profit hospital	14.61%	13
Proprietary hospital	3.37%	3
City/County/State hospital	8.99%	8
Veterans hospital	2.25%	2
Army/Air Force/Navy hospital	0.00%	0
National/corporate laboratory	1.12%	1
Regional/local independent laboratory (except clinic or group practice and not owned by a national corporation(s))	5.62%	5
Public Health, non-hospital	3.37%	3
Clinic, group, or doctor office laboratory	3.37%	3
Industry or vendor	7.87%	7
Patient Advocacy Organization	1.12%	1
Other (please specify)	1.12%	1
TOTAL		89

#	OTHER (PLEASE SPECIFY)	DATE
1	CAP	5/29/2025 11:39 AM

Q3 Draft Statement 1 – At initial diagnosis of advanced GEA, treating clinicians or pathologists should request HER2 testing on the highest quality tumor specimen (primary or metastasis). Pathologists should select the tissue block with the areas of lowest grade tumor morphology in biopsy, resection, or FNA specimens. More than one tissue block may be selected if different morphologic patterns are present.Note: Highest quality tumor for HER2 testing in GEA: highest neoplastic cellularity, minimal necrosis, artifact or treatment effect.(Strong Recommendation)

Answered: 40 Skipped: 49



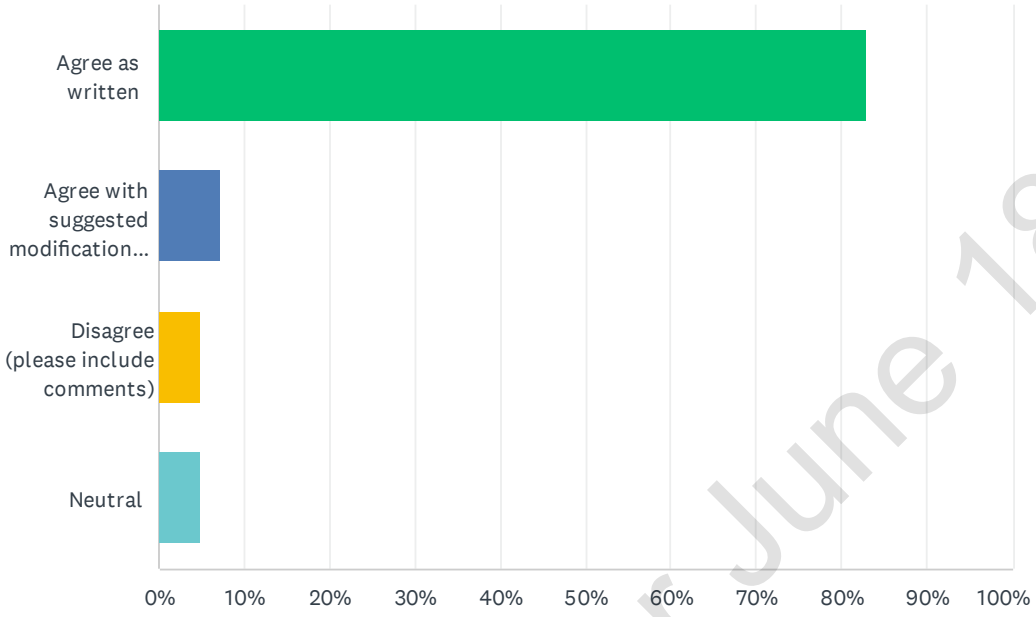
ANSWER CHOICES	RESPONSES	
Agree as written	75.00%	30
Agree with suggested modifications (please include comments)	15.00%	6
Disagree (please include comments)	2.50%	1
Neutral	7.50%	3
TOTAL		40

#	COMMENTS	DATE
1	As a patient advocate whose father had HER2-positive gastric cancer, I appreciate the emphasis on using the highest-quality specimen at diagnosis. In our experience, tumor quality and sampling approach can significantly influence HER2 results and downstream access to treatment. Acknowledging morphologic variability and allowing multiple blocks when needed is a strong and patient-centered recommendation.	6/10/2025 10:38 PM
2	the mention of lowest grade tumor morphology seems counterintuitive. The guidelines my just	6/5/2025 5:16 PM

	mention select areas of invasive adenocarcinoma. Areas of intestinal metaplasia, high-grade dysplasia, necrosis, or crush artifact should be avoided to prevent false-positive or uninterpretable results. In cases of tumor heterogeneity, regions with the most intense staining should be prioritized for scoring.	
3	Any evidence by choosing the areas of lowest grade tumor morphology to test? Although these areas are often positive, the prognosis is often associated with the poor differentiation.	5/30/2025 3:46 PM
4	suggest elaborating on the frequently challenging distinction of invasive carcinoma from high grade dysplasia, particularly for non-GI pathologists interpreting FISH results	5/30/2025 1:23 PM
5	the areas of best differentiated	5/29/2025 4:45 PM
6	Consider adding something along the lines that "If quality of all possible blocks is comparable, it is preferred that a metastasis is tested." We need to get away from testing primary tumors when possible.	5/28/2025 3:52 PM
7	"Pathologists should select the tissue block with the areas of lowest grade tumor morphology in biopsy, resection, or FNA specimens." should be modified. This pathologist would recommend "Pathologists should comprehensively evaluate HER2 statuse throughout the cancer by both HER2 FISH and IHC to exclude the possibility of "HER2 genomic heterogeneity" in the cancer.	5/28/2025 2:23 PM
8	Didn't know about selecting tissue with lowest grade tumor morphology - not stated in CAP biomarker protocol.	5/28/2025 2:21 PM
9	High grade areas	5/28/2025 2:18 PM

Q4 Draft Statement 2 – In specimens from patients with advanced GEA, pathologists should use IHC/ISH as the primary assessment for HER2 status. Genomic testing (liquid and/or solid) may be used concurrently or subsequently for clinical decision making.(Strong Recommendation)

Answered: 41 Skipped: 48



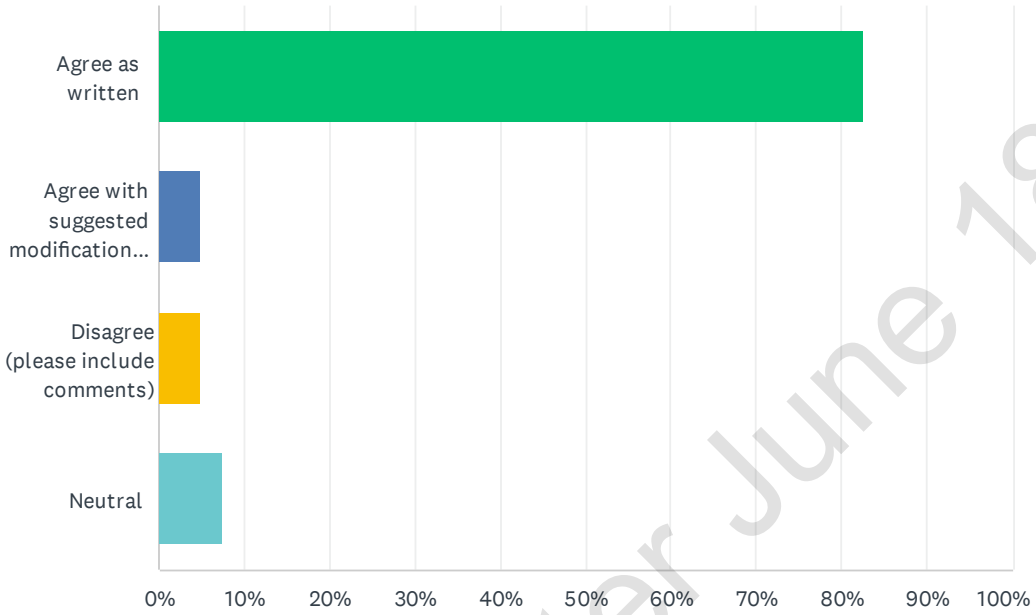
ANSWER CHOICES	RESPONSES	
Agree as written	82.93%	34
Agree with suggested modifications (please include comments)	7.32%	3
Disagree (please include comments)	4.88%	2
Neutral	4.88%	2
TOTAL		41

#	COMMENTS	DATE
1	While IHC/ISH should remain standard, it's important to clarify when genomic testing (solid or liquid) is warranted—especially for patients in community settings where access to repeat biopsy may be limited. I've seen too many patients fall through the cracks due to limited tissue or lack of retesting. Adding that genomic testing may help in ambiguous cases or where disease has evolved can guide more equitable care. Suggested addition: "Genomic testing (liquid and/or solid) may be considered concurrently or if tissue testing is inconclusive or inaccessible, particularly in cases of suspected tumor evolution."	6/10/2025 10:38 PM
2	Please more specific about genomic testing that it should include assessment of HER2 amplification.	5/28/2025 8:31 PM
3	The recommendations should be specific for HER2 testing. The NGS testing will include assessment of a wide range of genomic alterations, not just HER2 amplification. You can modify your wording to make it more specific for HER2	5/28/2025 8:09 PM

4	The NCCN panel recommends FISH only for cases with IHC 2+. Confusing when guidelines formulated in the same country by same/ similar experts have different recommendations.	5/28/2025 2:21 PM

Q5 Draft Statement 3 – In patients with advanced HER2-positive GEA being considered for subsequent therapy after disease progression, HER2 assessment may be performed on relapsed/recurrent tumor sample. Tissue is preferred but if not available/feasible, liquid testing may be performed.(Strong Recommendation)

Answered: 40 Skipped: 49



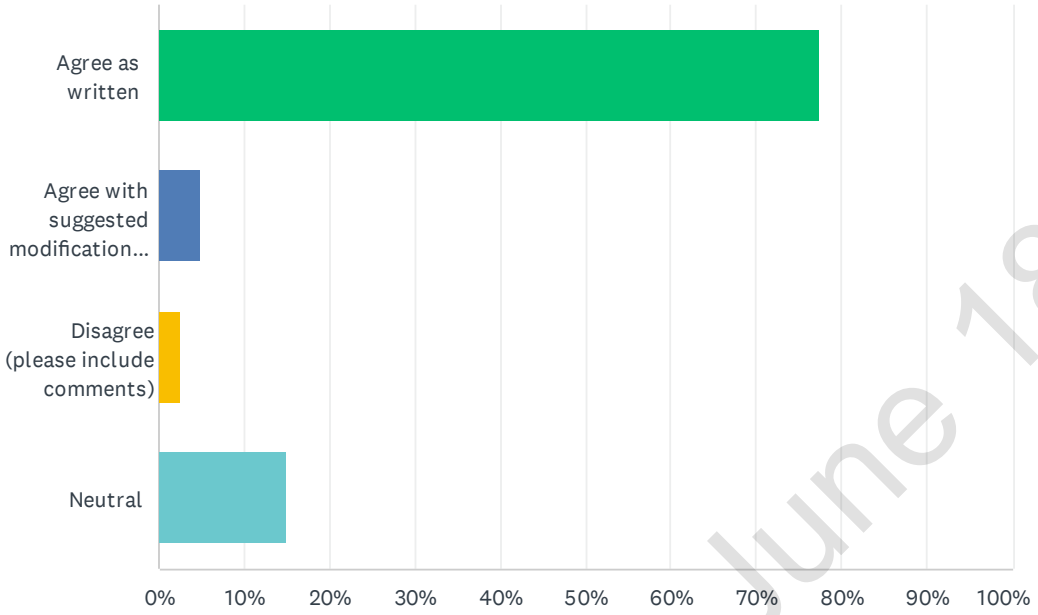
ANSWER CHOICES	RESPONSES	
Agree as written	82.50%	33
Agree with suggested modifications (please include comments)	5.00%	2
Disagree (please include comments)	5.00%	2
Neutral	7.50%	3
TOTAL		40

#	COMMENTS	DATE
1	I've supported many families who were unaware HER2 status could change over time. Emphasizing the importance of reassessment after progression is vital. However, for patients unable to undergo another biopsy, liquid biopsy should be framed as a valid—not just fallback—option. Suggested addition: "Liquid biopsy offers a less invasive and increasingly reliable alternative, particularly when tissue access is limited."	6/10/2025 10:38 PM
2	A statement about different accuracy profile of liquid testing would be wise.	5/31/2025 3:31 PM
3	liquid biopsy sensitivity for CNVs including amplification is suboptimal; suggest using IHC/ISH or tissue-based genomic testing in this setting	5/30/2025 1:23 PM
4	Using liquid biopsy for DNA assessment will (likely) under-estimate the level of HER2 gene amplification. Before adopting this policy comprehensive comparisons should be reviewed	5/28/2025 2:23 PM

related to HER2 status in both liquid biopsy and tissue samples from large series of patients.

Q6 Draft Statement 4 – Clinicians should check PD-L1 results in patients with advanced HER2-positive GEA to inform treatment decisions.(Strong Recommendation)

Answered: 40 Skipped: 49

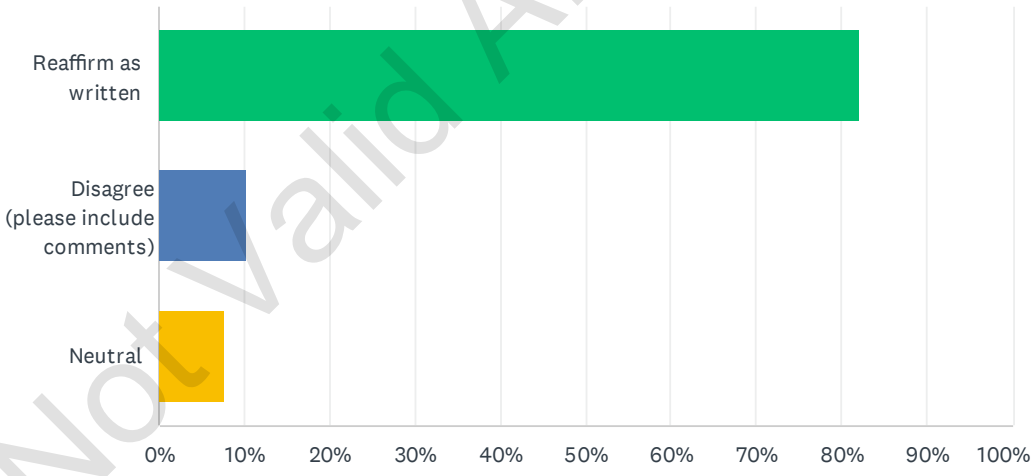


ANSWER CHOICES	RESPONSES	
Agree as written	77.50%	31
Agree with suggested modifications (please include comments)	5.00%	2
Disagree (please include comments)	2.50%	1
Neutral	15.00%	6
TOTAL		40

#	COMMENTS	DATE
1	I believe this could be paraphrased differently, as PD-L1 is frequently done as a reflex test in many instances. Also not sure why we are saying what clinicians should do? PD-L1 testing should generally be performed in patients with advanced gastroesophageal adenocarcinoma, but its utility in HER2-positive cases is less clear due to limited evidence, and further studies are needed to define its role in this population.	6/5/2025 5:16 PM
2	Is there a role for MSI by NGS or tumor mutation burden in GEA additionally or in lieu?	5/29/2025 6:08 AM
3	If we are commenting on the biomarker testing sequence, all GEA biomarkers should be included.	5/28/2025 9:08 PM
4	This might be better in a clinical guideline? This is a guide on HER2 testing specifically....	5/28/2025 2:19 PM

Q7 (Good Practice Statements)Draft Statement 5 – In patients with advanced GEA who are potential candidates for HER2-targeted therapy, the treating clinician should request HER2 testing on tumor tissue.Draft Statement 6 – Treating clinicians should offer combination chemotherapy and HER2-targeted therapy as the initial treatment for appropriate patients with HER2-positive tumors who have metastatic or recurrent GEA.Draft Statement 7 –Laboratories/pathologists must specify the antibodies and probes used for the test and ensure that assays are appropriately validated for HER2 immunohistochemistry (IHC) and in-situ hybridization (ISH) on GEA specimens.Draft Statement 8 –When GEA HER2 status is being evaluated, laboratories/pathologists should perform/order IHC testing first, followed by ISH confirmation when IHC result is 2+ (equivocal). Positive (3+) or negative (0 or 1+) HER2 IHC results do not require further ISH testing.Draft Statement 9 – Pathologists should use the Rüschoff-Hoffmann method for HER2 IHC scoring in GEA and apply standard ISH interpretation criteria when indicated.Draft Statement 10 – Laboratories should incorporate GEA HER2 testing methods into their overall laboratory quality improvement program, following the requirements of applicable local regulatory bodies and accreditation organizations.

Answered: 39 Skipped: 50

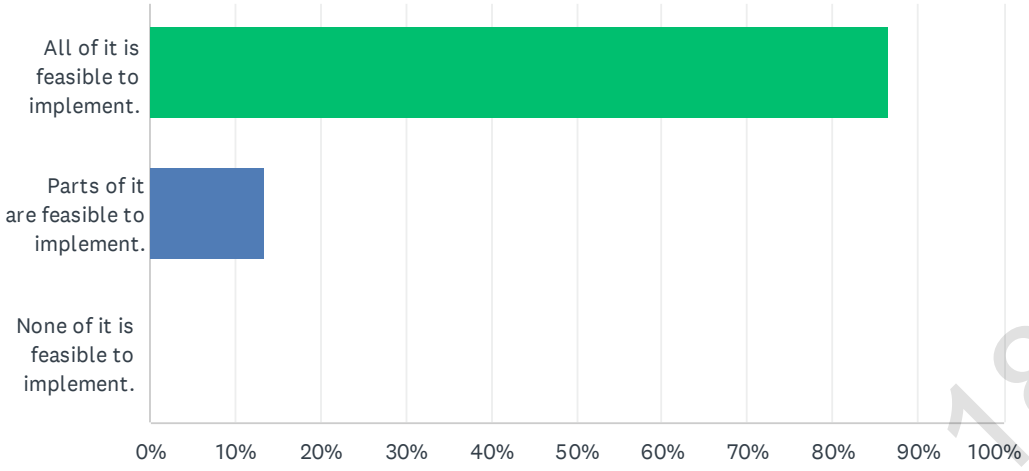


ANSWER CHOICES	RESPONSES	
Reaffirm as written	82.05%	32
Disagree (please include comments)	10.26%	4
Neutral	7.69%	3
TOTAL		39

#	COMMENTS	DATE
1	Sentences like clinicians should need to be revised. For example "ASCO" recommendation is combination chemotherapy and HER2-targeted therapy as the initial treatment for appropriate patients with HER2-positive tumors who have metastatic or recurrent GEA.	6/5/2025 5:16 PM
2	Draft Statement 8- Pathologists should be able to reflex ISH whenever they cannot assess the IHC staining for artefactual reasons and in the absence of possible testing on a different tissue specimen.	6/3/2025 9:49 AM
3	Please give a note to explain "Rüschoff-Hoffmann method for HER2 IHC scoring in GEA"	5/30/2025 3:46 PM
4	No opportunity to individually vote or comment on statements 5 thru 9	5/29/2025 6:08 AM
5	I disagree with Draft Statement 6 - I am not sure we need to tell clinicians what to do. The treatment plan should be individualized based on every patient's overall condition, per his/her oncologist' judgement.	5/28/2025 9:08 PM
6	#8 - Why is ISH/FISH being performed if there are no good data to suggest that these results are associated with treatment response or survival? In breast cancer, ISH/FISH for HER2 is significantly associated with survival/treatment response, so that is why this testing approach is used. Absent comparable data for gastric cancer, I don't understand why we are recommending that ISH/FISH be done.	5/28/2025 3:52 PM
7	"When GEA HER2 status is being evaluated, laboratories/pathologists should perform/order IHC testing first, followed by ISH confirmation when IHC result is 2+ (equivocal). Positive (3+) or negative (0 or 1+) HER2 IHC results do not require further ISH testing." FISH should be used for all evaluations. IHC has too many false-positives (IHC 3+ / FISH-negative) and false-negatives (IHC 0 or 1+ / FISH-positive) for patient management decisions.	5/28/2025 2:23 PM
8	Chemotherapy recommendations don't belong in a testing guideline.... What is "standard ISH interpretation criteria?" What is the Ruschoff-Hoffman method?	5/28/2025 2:19 PM

Q8 How feasible is it to implement this guideline?

Answered: 37 Skipped: 52

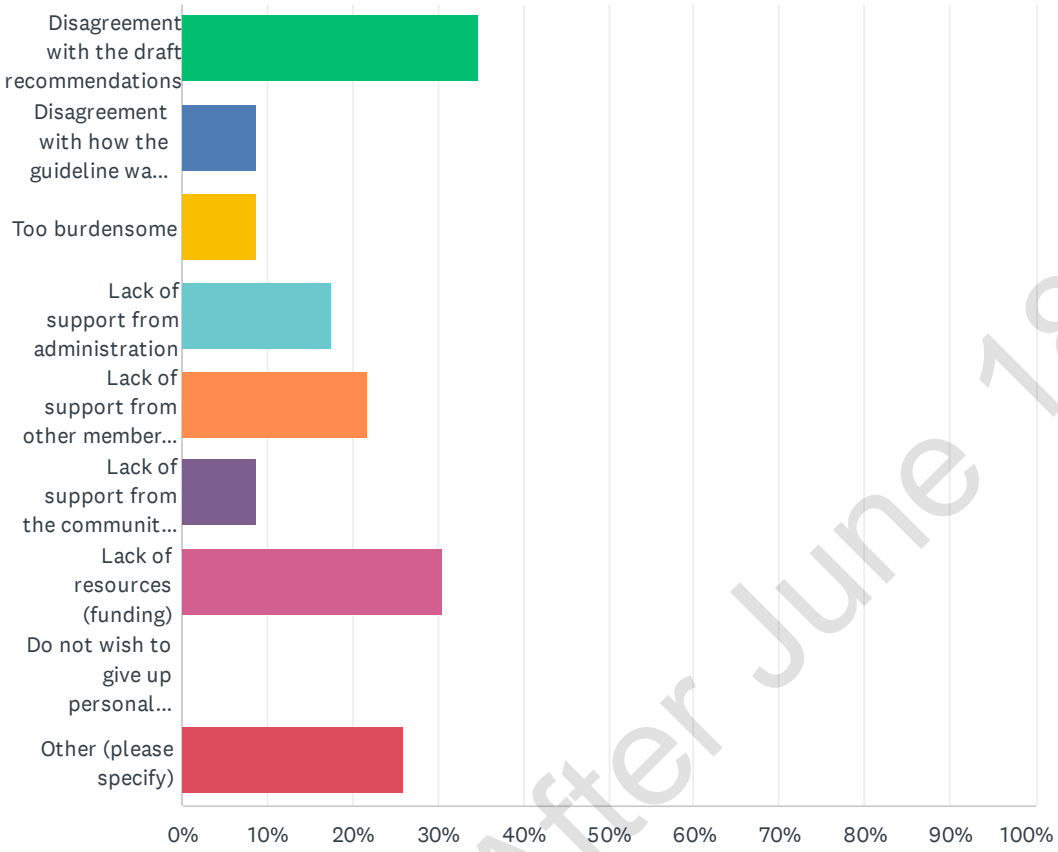


ANSWER CHOICES	RESPONSES	
All of it is feasible to implement.	86.49%	32
Parts of it are feasible to implement.	13.51%	5
None of it is feasible to implement.	0.00%	0
TOTAL		37

#	COMMENTS ABOUT THE FEASIBILITY OF IMPLEMENTING THE GUIDELINE:	DATE
1	While the technical components—such as IHC/ISH protocols and scoring—are feasible in academic and well-resourced centers, real-world implementation varies widely. Community hospitals and rural clinics may lack infrastructure for HER2 retesting, limited access to validated assays, or do not routinely perform liquid biopsy. Moreover, logistical and financial barriers (e.g., insurance denials, out-of-pocket costs) often delay HER2 testing or access to targeted therapy.	6/10/2025 10:42 PM

Q9 What barriers might impede adoption of the final guideline? (Choose all that apply.)

Answered: 23 Skipped: 66



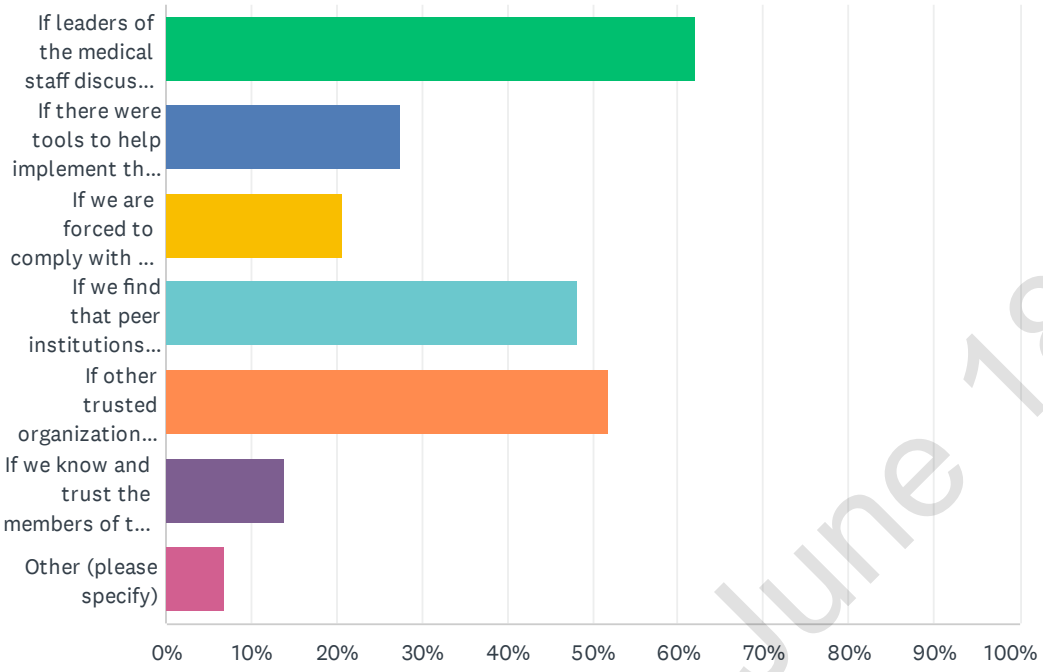
ANSWER CHOICES	RESPONSES	
Disagreement with the draft recommendations	34.78%	8
Disagreement with how the guideline was developed	8.70%	2
Too burdensome	8.70%	2
Lack of support from administration	17.39%	4
Lack of support from other members of the medical team	21.74%	5
Lack of support from the community (others outside your institution e.g., patients, industry)	8.70%	2
Lack of resources (funding)	30.43%	7
Do not wish to give up personal autonomy to follow the guideline	0.00%	0
Other (please specify)	26.09%	6
Total Respondents: 23		

#	OTHER (PLEASE SPECIFY)	DATE

1	One of the biggest barriers I've seen as a patient advocate is the disconnect between guideline intent and what patients actually receive—especially in lower-resourced or non-academic settings. Insurance denials for HER2 testing, delays in retesting after progression, and variability in pathologist familiarity with scoring methods all impact guideline uptake. Community hospitals often struggle to comply due to infrastructure and staffing gaps.	6/10/2025 10:42 PM
2	Paraphrasing of sentences in the guidelines. possibly slight lack of detailed knowledge on the topic.	6/5/2025 5:17 PM
3	Clinicians often want HER2 testing prior to knowing whether the tumor is advanced	6/1/2025 7:23 AM
4	No barriers	5/29/2025 1:09 AM
5	Disagree with Draft Statement 6	5/28/2025 9:09 PM
6	Unclear on who should initiate the testing - pathologists or clinicians	5/28/2025 2:22 PM

Q10 What facilitators might assist in your adoption of the final guideline? (Please select your top 3 facilitators.)

Answered: 29 Skipped: 60



ANSWER CHOICES	RESPONSES	
If leaders of the medical staff discussed adoption/adaption of the guideline for our practice setting	62.07%	18
If there were tools to help implement the guideline	27.59%	8
If we are forced to comply with the guideline by administration or an accreditation body	20.69%	6
If we find that peer institutions/practices adopt the guideline	48.28%	14
If other trusted organizations endorse the guideline	51.72%	15
If we know and trust the members of the panel members and/or organizations who developed the guideline	13.79%	4
Other (please specify)	6.90%	2
Total Respondents: 29		

#	OTHER (PLEASE SPECIFY)	DATE
1	Our practice is for the most part already following the final guideline.	6/4/2025 8:38 AM
2	do	5/29/2025 1:09 AM

Q11 Please provide any general comments or concerns:

Answered: 3 Skipped: 86

#	RESPONSES	DATE
1	This update is timely and necessary, especially with the evolving treatment landscape in HER2+ gastroesophageal cancer. As someone who advocates for patients daily—and whose father was HER2+—I deeply appreciate the clarity these statements provide. However, for this guideline to create meaningful impact across populations, implementation must consider real-world barriers such as insurance access, care setting disparities, and patient education. I encourage CAP to explore companion resources that address those systemic gaps and ensure the guideline is not just evidence-based—but also equitably applied.	6/10/2025 10:42 PM
2	Knowing that many newly approved tumors for anti-HER2 therapies necessitate an IHC scoring following the gastric scoring algorithm, do you think that these revised guidelines would be compatible to these applications.	6/3/2025 9:56 AM
3	Do not need facilitators	5/29/2025 1:09 AM