



Annual

**Advances and Innovations in Endoscopic Oncology
and Multidisciplinary Gastrointestinal Cancer Care**

Integrating MCED Testing for Early Detection of GI Cancers

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Disclosures

Grant/Research Support from Adela.

This presentation and/or comments will be free of any bias toward or promotion of the above referenced companies or their product(s) and/or other business interests.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

This presentation has been peer-reviewed and no conflicts were noted.

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed [Assembly Bill \(AB\) 1195](#), which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed [AB 241](#), which states that as of January 1, 2022, all continuing education courses for a physician and surgeon must contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

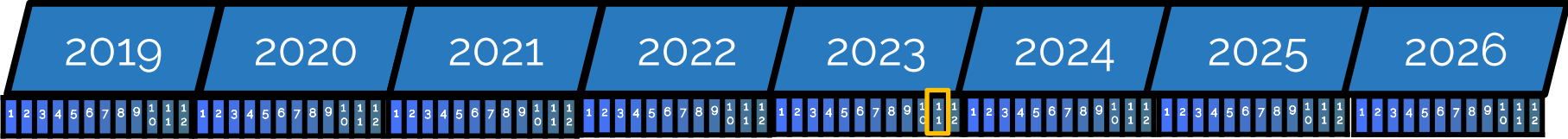
EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

The following CLC & IB components will be addressed in this presentation:

Differential access to early detection technologies & cultural beliefs and trust in screening & genomics.
Provider-level bias in offering novel screening & bias in risk assessment and interpretation.

Case
Presentation
Part 1



Evaluation/
Diagnosis

Right Lung Nodule

Right Lung Nodule Biopsy

Right Lung Adenocarcinoma

Treatment/
Surveillance

Right RUL Lobectomy

Cancer Surveillance

Molecular

Right Lung Cancer
EGFR p.L858R

INSPIRE Study
Germline Genetic Resting: Negative

Galleri Grail Liver/Bile Duct Cancer Signal

Galleri

Multi-cancer early detection test report

Patient

Name:
Patient ID:
DOB:
Bio Sex: Female

Sample

GRAIL ID: GAL7H63AK8
Sample Type: Whole Blood
Report Date: 22-NOV-2023 / 14:56 ET
Collection Date: 15-NOV-2023

Ordering Provider

Name: Ravi Salgia, MD
Location: City of Hope - Thoracic Medical
Oncology 2A Clinic
Address: 1500 E. Duarte Road
Duarte, CA 91010
Phone: 6262564673
Fax: 6262180122

DETECTION

Your Result



Cancer Signal Detected

The Galleri[®] test detected DNA methylation patterns that are often associated with cancer in your blood sample. In a clinical study³, on average, 4 out of 10 people with (Positive Pre d* result received a cancer diagnosis 43%).

✔ What this result means

The Galleri test looked for a signal often associated with cancer in your blood sample and found one. A healthcare provider should conduct an evaluation for cancer.

⊗ What this result does not mean

A "Cancer Signal Detected" result is NOT a diagnosis of cancer. Diagnostic testing by a healthcare provider is needed to confirm if you have cancer.

PREDICTION

Your Predicted Cancer Signal Origin

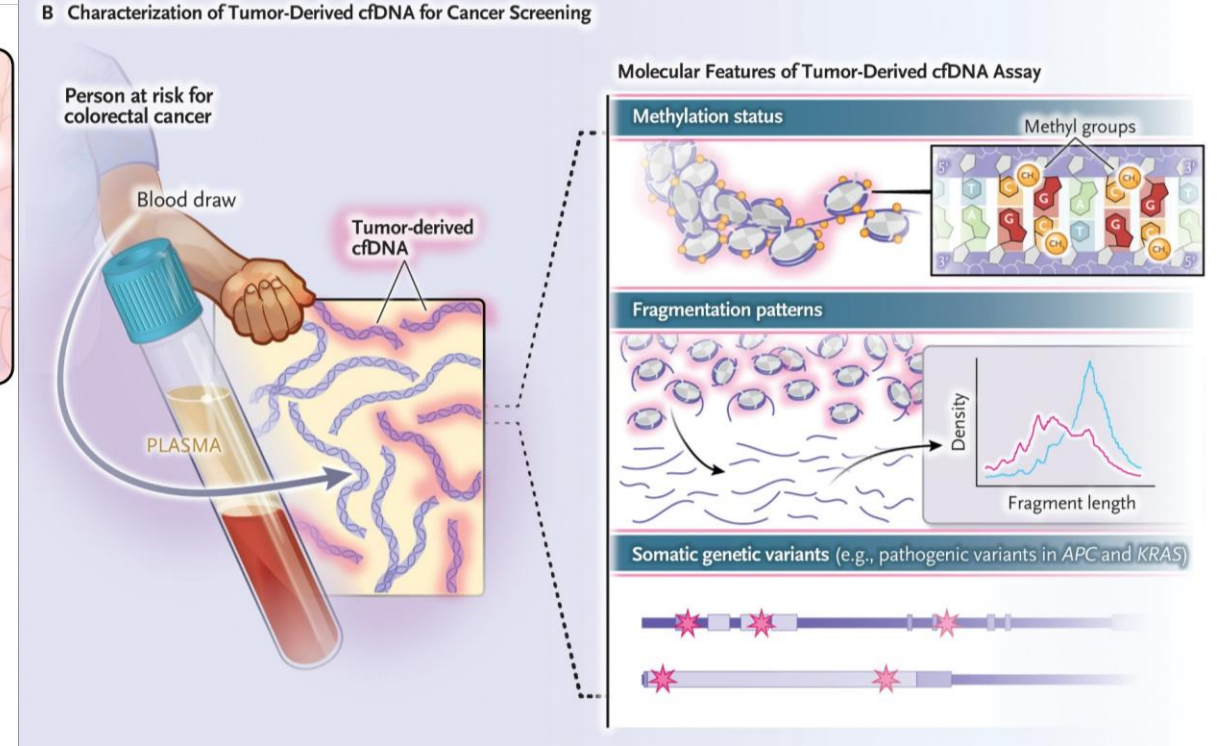
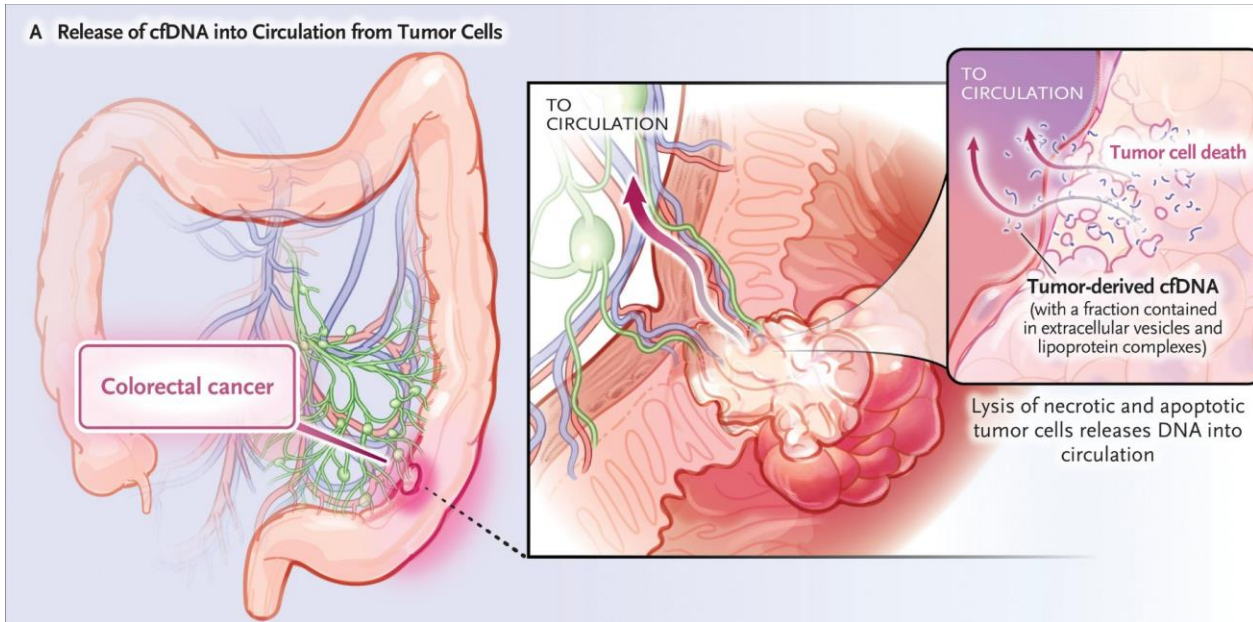
Cancer Signal Origin[®]

CSO PREDICTION
Liver, Bile Duct

CSO PREDICTION
Liver, Bile Duct
Liver, Intrahepatic Bile Duct.

To guide diagnostic evaluation, Galleri provides your Cancer Signal Origin (CSO) prediction. The CSO prediction offers information about the tissue type or organ associated with the Cancer Signal.

The biology explains the detection gap



Release of tumor DNA into blood

Small lesions may be visible endoscopically before a blood signal is detectable

Lo. NEJM 2024

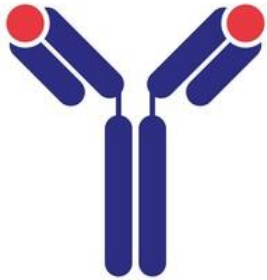
Molecular inputs and cancer signal prediction



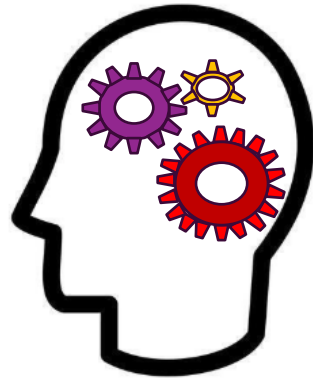
Genomic changes



Epigenomics



Protein Immunoassay



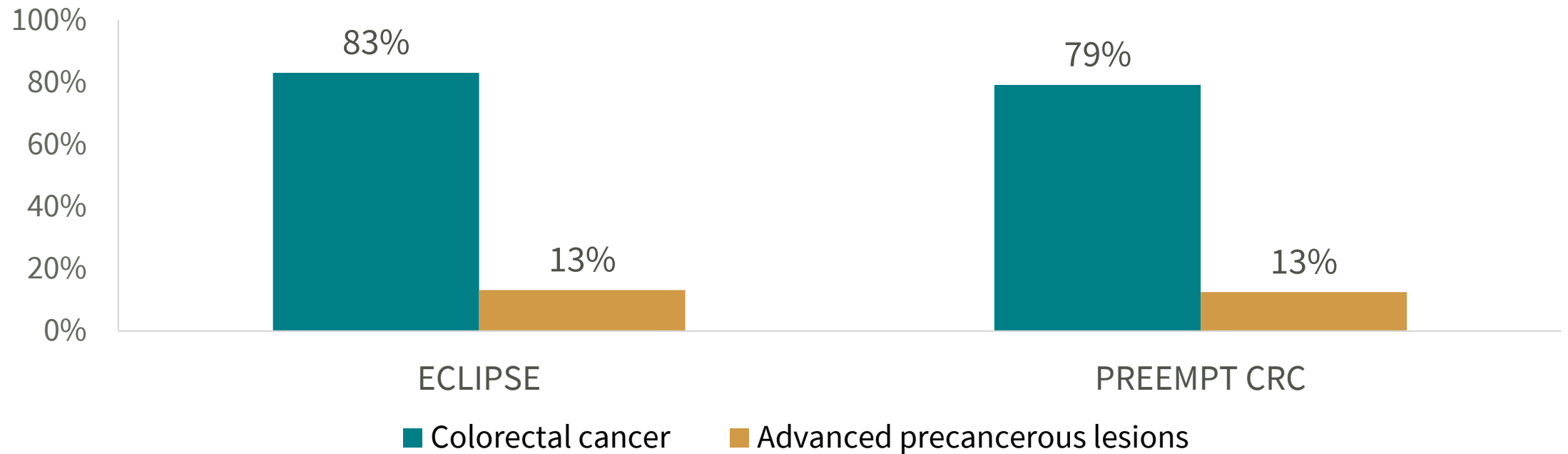
AI and
Machine Learning

Genomic changes and DNA methylation provide different molecular signals

Some platforms also incorporate protein biomarkers

The classifier predicts cancer signal origin to guide evaluation

Colorectal screening also aims to prevent cancer



Published ECLIPSE and PREEMPT CRC estimates. Independent studies, not a head-to-head comparison. Advanced precancerous lesions are defined by each trial.

Chung et al. NEJM 2024; Shaukat et al. JAMA 2025

Systematic review highlights the precursor gap

15 of 17

studies reported advanced-adenoma sensitivity below 25%

20 studies

Heterogeneous assays, populations, and definitions

Limited evidence for replacing established CRC screening

CRC-focused systematic review, not pooled MCED evidence. Search ended June 20, 2025.

Kahn et al. Int J Cancer 2026

PATHFINDER 2 demonstrated detection yield

Performance population	32,007
Positive results / confirmed cancers	287 / 173
Positive predictive value	60.3%
Specificity	99.64%
12-month episode sensitivity	39.3%
People screened per cancer detected	185 (95% CI 159–215)

Prospective MCED-V2 publication. Descriptive performance endpoints. NNS refers to detection, not prevention of a death.

Nabavizadeh et al. Nat Med 2026

NHS-Galleri did not meet its primary endpoint

Endpoint	Incidence rate ratio	Interpretation
Stage III–IV, 12 cancers	1.03 (0.92–1.14) P = 0.63	Primary endpoint not met
Stage IV, 12 cancers	0.86 (0.74–1.00)	Secondary finding
Cancer mortality	Follow-up needed	Benefit not established

Randomized MCED-V2 strategy, three annual rounds. The primary endpoint was not met.

Sasieni et al. NEJM 2026

FDA review of the PMA version

PMA-version measure	PATHFINDER 2	NHS-Galleri
12-month episode sensitivity	35.0%	31.6%
Specificity	99.85%	99.74%
Positive predictive value	77.0%	66.2%
Origin accuracy among true positives	94.3%	91.9%

Retrospective, weighted PMA analyses. NHS values use the first screening round. These differ from the prospective publications.

FDA presentation, slides 27, 31, 37 and 41

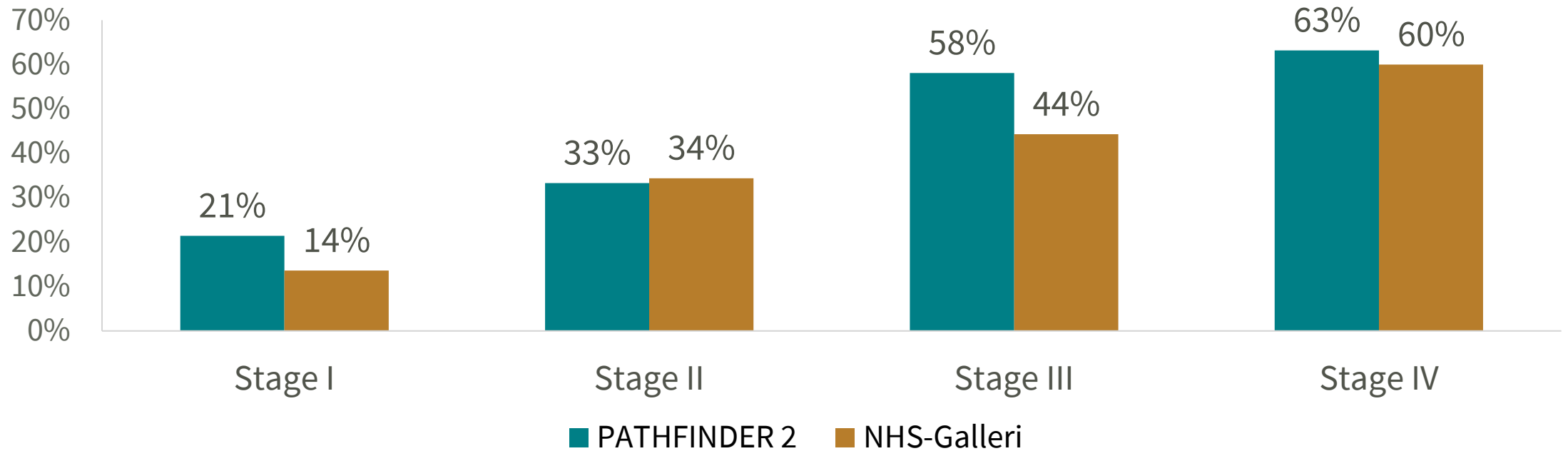
GI performance in the FDA analysis

Cancer group	Detected / total	Episode sensitivity (95% CI)
Colon / rectum	49 / 92	53.3% (43.1–63.1)
Esophagus	17 / 26	65.4% (46.2–80.6)
Stomach	4 / 7	57.1% (25.0–84.2)
Liver / intrahepatic bile duct	12 / 15	80.0% (54.8–93.0)
Pancreas / extrahepatic bile duct / gallbladder	12 / 31	38.7% (23.7–56.2)

NHS-Galleri PMA analysis, first round, all stages. Study not powered for individual cancer types.

FDA Executive Summary, Table 16, September 23, 2026

Early-stage detection remains limited



PMA-version 12-month episode sensitivity for new cancers, by stage at diagnosis. Stage at the blood draw is unknown.

FDA presentation, slide 46, September 23, 2026

The FDA advisory vote and its qualifications

Question	Yes	No	Abstain
Reasonable assurance of safety	10	0	0
Reasonable assurance of effectiveness	6	4	0
Benefits outweigh risks	7	2	1

Advisory recommendation, not FDA approval. Panel concerns included the “early” claim and long-term outcomes.

FDA 24 Hour Summary, September 23, 2026

Approval, coverage, and clinical adoption

Decision	Meaning for a clinical program
Galleri FDA status (October 11, 2026)	Advisory support. Final approval not granted
Medicare MCED pathway	Starts January 2029, requires CMS NCD
Guideline recommendation	Separate assessment of clinical use
Local implementation	Eligibility, diagnostic access, costs and follow-up

Payer coverage of the screening test and downstream workup must be checked separately.

Public Law 119-75 §6221; CMS CAG-00440R, June 8, 2026

The diagnostic workup is part of the intervention

PATHFINDER 2 safety outcome	Observed result
Positive participants with an invasive procedure	213 / 290 (73.4%)
Invasive procedures across the safety population	213 / 35,335 participants (0.6%)
Median resolution time, cancer diagnosed	37 days
Median resolution time, no cancer diagnosed	70 days
Serious study-related adverse events	None reported at this analysis

Prospective MCED-V2 safety analysis. Workup burden is concentrated among participants with positive results.

Nabavizadeh et al. Nat Med 2026

Choosing the clinical pathway

Patient context	Clinical pathway
Symptoms or concerning clinical findings	Diagnostic evaluation without waiting for a screening test
Average risk, due for CRC screening	Preferred stool or visual test; CRC blood test if declined or incomplete
Considering MCED in addition to usual screening	Counseling, defined eligibility, named clinician and navigator
Hereditary GI risk	Continue syndrome-specific surveillance; evaluate added testing prospectively

Before testing: confirm willingness to pursue workup, fitness for treatment, and likely costs.

Sources and clinical qualifications in speaker notes

Evaluation of a positive GI signal

Predicted origin	Initial evaluation	GI team role
Colon / rectum	Colonoscopy	Complete exam, tissue diagnosis
Stomach / esophagus	EGD	Careful inspection and biopsy
Pancreas / gallbladder	Pancreas CT or MRI/MRCP	Targeted EUS as indicated
Liver / bile duct	Multiphasic liver imaging	Hepatology and lesion review
Anus	Anoscopy or sigmoidoscopy	Directed examination / biopsy

Protocol-informed proposal. CSO prediction does not establish cancer or guarantee its location.

Nabavizadeh et al. Nat Med 2026

An unrevealing workup needs a documented plan

Review the predicted origin and adequacy of the first evaluation

Discuss unresolved cases at an early detection conference

Choose additional testing or observation deliberately

Document an owner, follow-up interval, and symptom safety net

MCED in hereditary GI cancer care

Higher cancer prevalence may increase positive predictive value

Tumor spectrum, age, and stage may change sensitivity

Lynch / polyposis: continue indicated endoscopic surveillance

Pancreatic risk: continue indicated MRI/MRCP and EUS

CAPS guidance; proposed application to MCED

An accountable clinical workflow

Order: counseling and current screening status

Result: structured signal and predicted origin

Action: clinician review and navigator work queue

Resolution: diagnosis, completed evaluation, or active follow-up

GRAIL announcement: April 7, 2026. Broad availability expected by year-end. Local activation requires confirmation.

GRAIL–Epic announcement, April 2026

Are we ready for prime time?

CRC blood screening has a defined role for selected average-risk adults

MCED merits selective use with prospective outcomes tracking

Routine population-wide net benefit remains unproven

GI prevention and hereditary surveillance remain essential

Clinical position based on evidence and regulatory information reviewed October 11, 2026.

ACS 2026; clinical synthesis

Thank you!



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