**External quality assessment demonstrates that PD-L1 22C3 and SP263 assays are systematically different.**

Andrew Dodson [1], Suzanne Parry [1], Birgit Lissenberg-Witte [2], Alex Haragan [3], David Allen [4], Anthony O’Grady [5], Emma McClean [6], Jamie Hughes [1], Keith Miller [1], Erik Thunnissen [7]

**Author Affiliations**

[1] UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation, UK.

[2] Department of Epidemiology & Biostatistics, Decision Modelling Centre, location VUmc, The Netherlands.

[3] Department of Pathology, Royal Liverpool and Broadgreen University Hospitals, UK.

[4] HSL-Advanced Diagnostics, UK.

[5] Department of Pathology, Royal College of Surgeons in Ireland, Beaumont Hospital, Ireland.

[6] Oncology, Haematology and Cellular Pathology Guy's and St Thomas' NHS Foundation Trust, UK.

[7] Department of Pathology, Amsterdam UMC, location VUmc, The Netherlands.

**Conflict of Interest Statement**

The authors declare no competing conflicts of interest.

**Abstract**

PD-L1 inhibitors are part of first line treatment options for patients with advanced non-small cell lung cancer. PD-L1 immunohistochemistry (IHC) assays act as either a companion or a complementary diagnostic. The purpose of this study is to describe the experience of external quality assurance (EQA) provider UK NEQAS ICC & ISH with the comparison of different PD-L1 assays used in daily practice.

In three EQA rounds (pilot, run A and B) were carried out by UK NEQAS ICC & ISH between March 2017 and January 2018. Formalin fixed paraffin embedded samples with sample sets covered a range of epitope concentrations, including ‘critical samples’ near to clinical threshold cut-offs.

An expert panel (n=4) evaluated all returned slides simultaneously and independently on a multi-header microscope together with the participants own in-house control material. The tonsil sample was evaluated as ‘acceptable’ or ‘unacceptable’, and for the other samples the percentage of PD-L1 stained tumour cells were estimated in predetermined categories (<1%, 1-<5%, 5-<10%, 10-<25%, 25-<50%, 50-<80%, 80-100%).

In the pilot and the two subsequent runs the number of participating laboratories was 43, 69 and 76, respectively. The pass rate for the pilot run was 67%; this increased to 81% at run A and 82% at run B. For two ‘critical samples’, in runs A and B, 22C3 IHC had significantly higher PD-L1 expression than SP263 IHC (p<0.001), whilst the PD-L1 scores for the other 6 samples were similar for all assays. In run A the laboratory developed tests (LDTs) using 22C3 scored lower than the commercial 22C3 tests (p=0.01).

After the initial testing, improvement in performance of PD-L1 IHC is shown for approved and LDT PD-L1 assays. Equivalency of approved PD-L1 22C3 and SP263 assays cannot be assumed: the scores cross the clinical relevant thresholds of 1% and 50% PD-L1 expression.

**Keywords**

External quality assessment, PD-L1, predictive testing, immunohistochemistry, non-small cell lung cancer, companion diagnostic assays

**Introduction**

Non-small cell lung carcinoma (NSCLC) is the most common cause of cancer-related death in the world. NSCLC is histologically a heterogeneous group of cancers and within the adenocarcinomas, there are different genetic changes present with associated treatment modality [1,2]. The recent introduction of immune checkpoint inhibitors has changed the standard of care for advanced and stage III NSCLC [3]. For patients with advanced NSCLC without driver mutations, nivolumab, pembrolizumab, and atezolizumab are available as second-line treatment. For pembrolizumab the PD-L1 assay is obligatory (companion diagnostic) while for the others the PD-L1 test is optional (complementary diagnostic) [4]. Pembrolizumab is also available for first-line monotherapy, but only in patients with high (>50%) PD-L1 expression.

A further development is that for NSCLC patients without EGFR or ALK mutations, PD-L1/PD-1 inhibition may be added to standard chemotherapy [5].

Most of the clinical trials involving these inhibitors have demonstrated an association between response rate, outcomes and amount of tumour cell PD-L1 expression (tumour proportion score; TPS), determined by immunohistochemistry (IHC). Currently, five different IHC assays have been developed in conjunction with pharmaceutical companies [6].

Since the introduction of PD-L1 as a predictive IHC biomarker, differences between diagnostic and clinical validation have become apparent [7]. For an *analytical/technical* validation of a diagnostic test the threshold of positivity is not relevant, whilst for *clinical* validation of a predictive test the threshold should be as close as possible to the test validated by clinical data. The latter is associated with a likelihood of response to a certain treatment. For optimal comparison so called ‘critical samples’ with a PD-L1 epitope concentration close to the threshold of this clinically validated test are useful [8].

In general, this can be achieved with external quality assessment (EQA) samples distributed by a provider to several centres to examine the performance of a test that is performed in daily pathology practice.

The purpose of this study is to describe the PD-L1 experience of EQA provider UK NEQAS ICC & IHC when comparing different assays used in daily practice with sample sets covering a range of epitope concentrations, including critical samples.

**Methods**

Three EQA rounds were carried-out between March 2017 and January 2018 at approximately equally spaced intervals. There was an initial single pilot assessment that was used to formulate the assessment criteria, followed by a further two assessments, here designated as runs A and B.

Samples distributed for assessment consisted of formalin fixed paraffin embedded (FFPE) NSCLC tissue, reactive tonsil tissue and FFPE cell lines [Horizon Discovery, Cambridge UK]. Samples consisted of NSCLC tumours with a range of expression levels for PD-L1, and also a set of cell lines of known expression.

Participants were provided with two unstained slides (one as a spare) and requested to cut their in-house control (not requested for the first pilot assessment) onto the same slides. The laboratory was then requested to perform their standard PD-L1 IHC assay on these slides. Subsequently, the PD-L1 stained slides were returned to UKNEQAS for assessment.

During a two-day session an expert panel (n=4) evaluated all returned slides simultaneously and independently on a multi-header microscope for the UK NEQAS ICC & ISH samples together with the participants own in-house control material. The tonsil sample was evaluated as either ‘acceptable’ or ‘unacceptable’, and each of the cell lines and tumour samples was visually assessed for the estimated percentage of PD-L1 stained tumour cells present (tumour proportion score, TPS). These estimates were assigned to predetermined categories: (‘Bins’ of <1%, 1-<5%, 5-<10%, 10-<25%, 25-<50%, 50-<80%, 80-100%). Finally, the assessment team provided a score for overall quality out of 5, where a score of ‘1’ indicated a completely uninformative preparation and a score of ‘5’ indicated the ideal staining result (see Table 1 for full categorisation). The mean of the 4 assessors formed the consensus score. In instances where there was a difference greater than 1 category between assessors, the assessment was reviewed by the panel, to harmonise to maximally 1 category difference.

At the time of the assessment four companion diagnostic (CDx) assays were available; based on the 22C3 and 28-8 primary antibody clones (Agilent Dako, California) and the SP142 and SP263 primary antibody clones (Roche Tissue Diagnostics, Arizona).

‘Gold standard’ slides stained by the commercial developers of the CDx assays were used as a reference to provide the PD-L1 TPS (and percentage immune cells (ICs) for the SP142 clone). These values were used by the assessment team to set the scoring criteria including the overall quality score. Participants’ slides were assessed in accordance with the assay they had used. Slides stained with a lab-devised protocol were assessed by comparing them to the validated assay of the same clone, where available; otherwise it was compared against 22C3.

Pathologists may favour the dark brown colour of SP263 IHC assay over the lighter brown colour of the 22C3 detection system. In the UK NEQAS assessment, the laboratories with light brown staining and low intensity did not receive a low score, as long as any background staining was below the positive intensity level. On the other end of the spectrum, if negative control samples contained too much background staining, resulting in precipitation in the cytoplasm of tumour cells, this was evaluated as false positive.

Statistical analyses (BW) [9] were carried out by SPSS for Windows and Mac version 22 (IBM Corp., Armonk, NY, USA). The significance level was set at 0.05.

**Results**

*PD-L1 testing in 3 rounds*

In the pilot and the two subsequent runs the number of participating laboratories was 43, 69 and 76, respectively. The performance of the participants deemed “Acceptable”, “Borderline” or “Failure” for the three runs is shown in Tables 2A-C, respectively. The pass rate (“Acceptable” and “Borderline”) increased after the pilot run from 67% to 81% for run A and for run B to 82%. For runs A and B the distribution of the antibodies and test type (categorised as approved or LDT) is shown in Table 2D.

TABLE1

TABLE 2A

TABLE 2B

TABLE 2C

TABLE 2D

*Effect of epitope concentration*

The approximate PD-L1 intensity of the distributed cell line and NSCLC tissue samples is shown in Figure 1. For the PD-L1 unequivocally strong positive and negative cell lines (B-D) and NSCLC tissue samples (E, H) no significant difference in outcome was observed between the approved assays and LDTs for the different PD-L1 clones, nor between the different approved assays themselves (data not shown, p-values ranging from 0.1-1.0). For the weak positive PD-L1 IHC sample (F), data for the two assays with highest frequency (22C3 and SP263) are shown in Table 3A and for the sample close to the strong positive plateau of IHC (G) in Table 3B. Note that for sample F as well as sample G, 22C3 had on average higher scores for PD-L1 expression than SP263 (p<0.001). In run A, for sample F, the LDT assays for 22C3 had lower TPS scores than the approved 22C3 assays. Figure 2 shows a graphical representation of the difference between the two assays.

FIGURE 1

FIGURE 2

TABLE 3A

TABLE 3B

**Discussion**

This study reports an improvement in performance of PD-L1 IHC after the initial testing for approved as well as LDT assays. On the samples with an epitope concentration close to the threshold of the clinically validated test, the SP263 stained repeatedly fewer tumour cells than the comparator IHC assay 22C3. Importantly, these differences c ross the clinical relevant thresholds of 1% and 50% PD-L1 expression.

Our study clearly shows the effect of epitope concentration in terms of informative and not-informative (negative or strongly PD-L1 positive) samples for comparison of PD-L1 IHC assays. In the studies examining the concordance rate of different PD-L1 assays the composition of the case set is crucial. The College of American Pathologists (CAP) [10] and Clinical & Laboratory Standards Institute (CLSI) [11] guidelines define that laboratories should achieve at least 90% overall concordance between a new test and the comparator test. If concordance is less than 90%, laboratories need to investigate the cause of low concordance10. The a-priori chance for 90% concordance will be high, if 55% PD-L1 negative samples [12] and 35% PD-L1 strongly positive samples are examined. The composition of the case set varies from resection specimen only, to a mixture of small samples (with or without cytology) and resections specimen. In all these studies the samples were based on preferential selection. For indirect clinical validation one may argue that the 90% concordance between two IHC test should hold in a series of consecutive cases, which is not a requirement for diagnostic validation.

This study demonstrates that PD-L1 expression in two samples close to the threshold repeatedly stain differently between approved SP263 and 22C3 assays. This seems in contrast to several studies comparing PD-L1 assays, where the message is put forward that 28.8, 22C3 and SP263 perform similarly [13-15]. However, a note of caution holds for the Blueprint 2 study: the supplementary data show only a concordance rate of 84% (43/51) between SP263 and 22C314. Taking the CAP guidelines into account this does not support the conclusion from the authors of “analytical evidence for interchangeability of the 22C3, 28-8, and SP263 assays”. Remarkably, other studies reported that SP263 had higher PD-L1 scores than 22C3 in several cases [16,17] or low correlation between these two assays [18], while Kim and colleagues shows more positive cases in 22C3 than in SP263 [19]. Interestingly, when looking at individual cases around the threshold of 1% PD-L1 positivity, comparison of 22C3 with SP263 shows in some cases higher staining for SP263 and in other cases higher for 22C3 [14,15]. Although the PD-L1 assays target the same protein, the test performance is different at least in some cases.

The statement “SP263 and 22C3 are interchangeable” is not demonstrably refuted by this study but remains in question at least until a series of consecutive cases large enough in power to provide significant findings have been examined. Noteworthy is that based on the test used patients are likely be treated differently at least on some samples.

Our report also shows a learning effect over time for PD-L1, which is in line with the reports of NordiQC [20,21]. False positivity is, in UK NEQAS ICC & ISH and NordiQC EQA experience, rare and false negativity is more frequent in approved assays as well as LDTs [21,22].

Factors affecting comparability between PD-L1 assays include the following: i) different antibody clones will target different epitopes [23], information about which may be proprietary and mostly not publicly available; ii) different detection systems [24] and automated staining platforms [25]; iii) post translational modification may be of influence [26]; iv) preanalytical factors, such as variation in type of fixative and duration of fixation can significantly influence the outcome of IHC procedures [27]. Delay in fixation has been repeatedly shown to affect the retention of certain proteins within tissues. One early report from the Dowsett group working with phospho-proteins in breast cancer tissues showed that there was an almost complete loss of reactivity for p-AKT and p-ERK in breast resection tissues in contrast to strong staining seen in matched core biopsies from the same samples [28]. Moreover, in a NSCLC model delayed formalin fixation (increases in time before start of fixation) caused significant loss of immunoreactivity [29]: for PD-L1 a reduction in the proportion of tumour cells showing positive membrane staining was reduced and that the effect was larger with increase in fixation delay. In addition, v) methods used to decalcify bony tissues and thus enable the preparation of sections from them can also significantly affect IHC results. This is particularly relevant in the context of PD-L1 demonstration in NSCLC as bone is a frequent site for metastasis of NSCLC. Both acid and ethylenediaminetetraacetic acid (EDTA) declacifiers reduce the proportion of PD-L1 positive cells stained and the intensity with which they stain. Acid decalcification is more deleterious and shows an effect sooner than EDTA [30].

The tissues and cell lines selected by UK NEQAS ICC & ISH for use in their EQA programmes were rigorously assessed and validated prior to their use. In regard to the PD-L1 NSCLC module, testing was conducted using two anti-PD-L1 clones (SP263, Ventana and 22C3, Agilent Dako) in a number of laboratories. Sections from multiple levels through the EQA blocks were stained to examine and control for heterogeneous expression.

For multiple examined antigens across a variety of modules, time delay between sectioning by UK NEQAS and staining in the participant laboratories has been examined for its effect on staining results with the consistent finding that, provided sections are stained by the participant soon after receipt, any amelioration is not present or is negligible (unpublished observations AD, SP) and is in line with literature on stability of histologic slide preparations [31].

Tissues with high epitope concentration may be positive in all tests. The most prominent example is placenta, an intended positive control in at least one US Food and Drug Administration (FDA) approved assay [32]. In the UKNEQAS PD-L1 external quality assessment (EQA) schemes, so far, negative PD-L1 IHC staining of placenta has not been seen, even in the instances where cases have failed due to a relatively low PD-L1 epitope concentration.

In summary, after initial testing, improvement in performance of PD-L1 IHC is documented for approved PD-L1 assays as well as LDT’s. As most diagnostic laboratories prefer to run only one PD-L1 IHC assay on often very limited tissue samples, the use of interchangeable assays would be advantageous. However, this EQA study shows that equivalency of approved PD-L1 assays cannot be assumed.

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**Author Contributions**

AD, SP and ET wrote the manuscript and AH critically revised it. SP collated and analysed the data. BL-W provided data analysis. DA, TOG, EM and JH contributed to the assessment of assay results.

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**Figure and Table Legends**

Figure 1. The relationship between epitope concentration and intensity is shown with the black line [33]. Critical samples are positioned around a threshold of the IHC test [7]. The approximate PD-L1 intensity of the 8 distributed EQA samples (A-H) is shown along the black line. Note that samples outside the critical range are less likely to result in a different outcome i.e. remain negative or positive.

Figure 2. A graphical display of the lines representing the likely difference between SP263 and 22C3 approved tests. The blue arrow denotes the threshold of the test distinction between positive (+) and negative (-). Note that the SP263 is positive at a slightly higher epitope concentration than 22C3.

Table 1. Consensus quality assessment score interpretation. Marks were lost for weak or false negative, false positive or inappropriate staining and morphological damage due to excessive pre-treatment.

Table 2A. The performance in the initial pilot run for the different assays is shown with number of participants (percentage in brackets). LDT = laboratory devised test.

Table 2B. The performance in run A for the different assays is shown with number of participants (percentage in brackets). LDT = laboratory devised test.

Table 2C. The performance in run B for the different assays is shown with number of participants (percentage in brackets). LDT = laboratory devised test.

Table 2D. The distribution of the different antibodies and test types, categorised as ‘Approved Assay’ and ‘LDT’, is shown for runs A and B. The percentages in brackets indicate proportional usage for each run within that category of test. LDT = laboratory devised test.

Table 3A. The distribution of PD-L1 is shown for 22C3 and SP263 for the sample close to the threshold (F) in runs A and B (the figures in brackets indicate proportion of scores within that assay type). P-values are shown for comparison between commercially approved assays (Approved Assay) and laboratory developed test (LDT) and between the two approved assays using the 22C3 and SP263 antibodies respectively. n/a = not assessable.

Table 3B. The distribution of PD-L1 is shown for 22C3 and SP263 for the sample close to the strong positive plateau of IHC (G) in runs A and B (the figures in brackets indicate proportion of scores within that assay type). P-values are shown for comparison between commercially approved assays (Approved Assay) and laboratory developed test (LDT) and between the two approved assays using the 22C3 and SP263 antibodies respectively. n/a = not assessable.

**Author Contact Details**

**Andrew Dodson,**

UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation. Office 127, Finsbury Business Centre, 40 Bowling Green Lane, London EC1R 0NE, UK. Telephone: +44(0)207 415 7065

**Suzanne Parry,**

UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation. Office 127, Finsbury Business Centre, 40 Bowling Green Lane, London EC1R 0NE, UK. Telephone: +44(0)207 415 7063

**Birgit Lissenberg-Witte,**

Department of Epidemiology & Biostatistics, Decision Modelling Centre, location VUmc, Medical Faculty, F-wing (souterrain), De Boelelaan 11117, 1081 HV, Amsterdam, The Netherlands. Telephone: +31 20 44 44639

**Alex Haragan,**

Department of Pathology, Royal Liverpool and Broadgreen University Hospitals, Liverpool L7 8XP, UK. Telephone: +44(0)151 706 2000 (Ext 11081)

**David Allen,**

HSL-Advanced Diagnostics, 19 Fitzroy Street, London W1T 4BP, UK. Telephone +44(0) 74 5689 3158

**Anthony O’Grady,**

Department of Pathology, Royal College of Surgeons in Ireland, Beaumont Hospital, Dublin, Ireland. Telephone: (353 1) 8093722

**Emma McClean,**

Oncology, Haematology and Cellular Pathology Guy's and St Thomas' NHS Foundation Trust, London SE1 9RS, UK. Telephone: +44(0)20 7188 2926 or x82926

**Jamie Hughes,**

UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation. Office 127, Finsbury Business Centre, 40 Bowling Green Lane, London EC1R 0NE, UK. Telephone: +44(0)207 415 7065

**Keith Miller,**

UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation. Office 127, Finsbury Business Centre, 40 Bowling Green Lane, London EC1R 0NE, UK. Telephone: +44(0)207 415 7065

**Erik Thunnissen,**

Department of Pathology, Amsterdam UMC, location VUmc, Amsterdam, The Netherlands. Telephone: +31 20 4444 048

TABLE 1.

|  |  |  |
| --- | --- | --- |
| **Quality Score** | **Quality Category** | **PD-L1 Demonstration** |
| 5 | Excellent | Staining of excellent quality, showing the expected level of expression |
| 4 | Acceptable | Staining of good quality, showing the expected level of expression (minor non-significant improvements are possible) |
| 3 | Borderline Acceptable | Staining suitable for interpretation. Samples showing expected level of expression. However, some technical issues noted, significant improvements needed. |
| 2 | Unacceptable | Staining of unacceptable quality for clinical interpretation. Significant technical improvements needed. |
| 1 | Unacceptable | No or almost no specific staining seen. Significant technical improvements needed. |

TABLE 2A.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assay** | **Acceptable** | **Borderline** | **Fail** | **Total** |
| Dako Agilent 22C3 Assay | 5 (72%) | 1 (14%) | 1 (14%) | 7 |
| Dako Agilent 22C3 LDT | 1 (9%) | 4 (36%) | 6 (55%) | 11 |
| Dako Agilent 28-8 Assay | 0 (0%) | 1 (100%) | 0 (0%) | 1 |
| Roche/Ventana SP263 Assay | 9 (70%) | 2 (15%) | 2 (15%) | 13 |
| Roche/Ventana SP142 Assay | 3 (100%) | 0 (0%) | 0 (0%) | 3 |
| SP142 LDT | 0 (0%) | 0 (0%) | 2 (100%) | 2 |
| Other antibodies LDT | 1 (17%) | 2 (50%) | 3 (33%) | 6 |
| **Total** | **19 (44%)** | **10 (23%)** | **14 (33%)** | **43** |

TABLE 2B.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assay** | **Acceptable** | **Borderline** | **Fail** | **Total** |
| Dako Agilent 22C3 Assay | 11 (79%) | 2 (14%) | 1 (7%) | 14 |
| Dako Agilent 22C3 LDT | 3 (6%) | 5 (46%) | 3 (18%) | 11 |
| Dako Agilent 28-8 Assay | 2 (100%) | 0 (0%) | 0 (0%) | 2 |
| Roche/Ventana SP263 Assay | 21 (75%) | 3 (11%) | 4 (14%) | 28 |
| Roche/Ventana SP263 LDT | 0 (0%) | 0 (0%) | 1 (100%) | 1 |
| Roche/Ventana SP142 Assay | 3 (100%) | 0 (0%) | 0 (0%) | 3 |
| Cell Signaling LDT | 0 (0%) | 3 (60%) | 2 (40%) | 5 |
| Method unknown | 1 (20%) | 2 (40%) | 2 (40%) | 5 |
| **Total** | **41 (59%)** | **15 (22%)** | **13 (19%)** | **69** |

TABLE 2C.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assay** | **Acceptable** | **Borderline** | **Fail** | **Total** |
| Dako Agilent 22C3 Assay | 15 (88%) | 0 (0%) | 2 (12%) | 17 |
| Dako Agilent 22C3 LDT | 6 (67%) | 1 (11%) | 2 (22%) | 9 |
| Dako Agilent 28-8 Assay | 0 (0%) | 2 (100%) | 0 (0%) | 2 |
| Roche/Ventana SP263 Assay | 26 (84%) | 3 (10%) | 2 (6%) | 31 |
| Roche/Ventana SP142 Assay | 1 (25%) | 2 (50%) | 1 (25%) | 4 |
| Abcam PD-L1 (28-8) LDT | 1 (33%) | 0 (0%) | 2 (67%) | 3 |
| Cell Signaling LDT | 2 (67%) | 1 (33%) | 0 (0%) | 3 |
| Diagomics PDL1 QR1 LDT | 0 (0%) | 0 (0%) | 1 (100%) | 1 |
| Method unknown | 1 (17%) | 1 (17%) | 4 (67%) | 6 |
| **Total** | **52 (68%)** | **10 (13%)** | **14 (18%)** | **76** |

TABLE 2D.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Run** | **Primary Antibody** | **Approved Assay** | **LDT** | **Totals** |
| **A** | 22C3 | 14 (30%) | 11 (65%) | 25 (39%) |
| 28-8 | 2 (4%) | 0 (0%) | 2 (3%) |
| SP263 | 28 (60%) | 1 (6%) | 29 (45%) |
| SP142 | 3(6%) | 0 (0%) | 3 (5%) |
| E1L3N | 0 (0%) | 5 (30%) | 5 (8%) |
| **Totals** | **47** | **17** | **64** |
| **B** | 22C3 | 17 (32%) | 9 (56%) | 26 (37%) |
| 28-8 | 2 (4%) | 3 (19%) | 5 (7%) |
| SP263 | 31 (57%) | 0 (0%) | 31 (44%) |
| SP142 | 4 (7%) | 0 (0%) | 4 (6%) |
| E1L3N | 0 (0%) | 3 (19%) | 3 (4%) |
| QR1 | 0 (0%) | 1 (6%) | 1 (1%) |
| **Totals** | **54** | **16** | **70** |

TABLE 3A.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Primary Antibody** | **TPS** | **Approved Assay** | **LDT** | **P-value (Approved Assay / LDT)** | **Primary Antibody** | **Approved Assay** | **LDT** | **P-value (Approved Assay / LDT)** | **P-value**  **Approved Assay, 22C3 / SP263** |
| **RUN A** |  |  |  |  |  |  |  |  |  |
| 22C3 | <1% | - |  | **0.01** | SP263 | **12 (43%)** | - | 0.069 | **<0.001** |
|  | 1 to 4% | **1 (7%)** | **7 (64%)** |  |  | **15 (54%)** | - |  |  |
|  | 5 to 9% | **5 (36%)** | **1 (9%)** |  |  | **1 (4%)** | - |  |  |
|  | 10 to 24% | **8 (57%)** | **3 (27%)** |  |  | - | - |  |  |
|  | 25 to 49% | - | - |  |  | - | - |  |  |
|  | 50 to 79% | - | - |  |  | - | **1 (100%)** |  |  |
|  | 80 to 100% | - | - |  |  | - | - |  |  |
| **RUN B** |  |  |  |  |  |  |  |  |  |
| 22C3 | <1% | **1 (6%)** | - | 0.85 | SP263 | **51 (16%)** | - | n/a | **<0.001** |
|  | 1 to 4% | **1 (6%)** | **2 (22%)** |  |  | **20 (65%)** | - |  |  |
|  | 5 to 9% | **3 (18%)** | **1 (11%)** |  |  | **2 (6%)** | - |  |  |
|  | 10 to 24% | **11 (65%)** | **6 (67%)** |  |  | **3 (10%)** | - |  |  |
|  | 25 to 49% | **1 (6%)** | - |  |  | **1 (3%)** | - |  |  |
|  | 50 to 79% | - | - |  |  | - | - |  |  |
|  | 80 to 100% | - | - |  |  | - | - |  |  |

TABLE 3B.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Primary Antibody** | **TPS** | **Approved Assay** | **LDT** | **P-value (Approved Assay / LDT)** | **Primary Antibody** | **Approved Assay** | **LDT** | **P-value (Approved Assay / LDT)** | **P-value**  **Approved Assay, 22C3 / SP263** |
| **RUN A** |  |  |  |  |  |  |  |  |  |
| 22C3 | <1% | - | - | 0.15 | SP263 | - | - | **0.034** | **<0.001** |
|  | 1 to 4% | - | - |  |  | - | - |  |  |
|  | 5 to 9% | - | - |  |  | - | - |  |  |
|  | 10 to 24% | - | - |  |  | **4 (14%)** | - |  |  |
|  | 25 to 49% | - | **3 (27%)** |  |  | **12 (43%)** | - |  |  |
|  | 50 to 79% | **10 (71%)** | **7 (64%)** |  |  | **12 (43%)** | - |  |  |
|  | 80 to 100% | **4 (29%)** | **1 (9%)** |  |  | - | **1 (100%)** |  |  |
| **RUN B** |  |  |  |  |  |  |  |  |  |
| 22C3 | <1% | - | - | 0.74 | SP263 | - | - | n/a | **<0.001** |
|  | 1 to 4% | - | - |  |  | - | - |  |  |
|  | 5 to 9% | - | - |  |  | - | - |  |  |
|  | 10 to 24% | **1 (6%)** | - |  |  | - | - |  |  |
|  | 25 to 49% | **0 (0%)** | - |  |  | **5 (16%)** | - |  |  |
|  | 50 to 79% | **2 (12%)** | **2 (22%)** |  |  | **23 (74%)** | - |  |  |
|  | 80 to 100% | **14 (82%)** | **7 (78%)** |  |  | **3 (10%)** | - |  |  |