

Endometrial Cancer – Improving Care and Driving Policy Change

A Case Study on Canada

BACKGROUND. Endometrial cancer is the most common gynecological cancer in high-income countries, with rising incidence and mortality attributed partly to increasing rates of obesity. Unlike breast and cervical cancers, which benefit from global awareness and policy initiatives, endometrial cancer remains underrepresented in both international and national health agendas, including in Canada.

The Swedish Institute for Health Economics (IHE) published a comprehensive report titled *Endometrial Cancer - Improving Care and Driving Policy Change* in 2024. Endorsed by the European Network of Gynaecological Cancer Advocacy Groups (ENGAGe) and the European Oncology Nursing Society (EONS), the report highlights unique challenges and opportunities for improving outcomes in this neglected cancer type.

Building on the findings of the main report, this case study focuses on the situation in Canada. It provides an overview of the burden of endometrial cancer and identifies key areas for improvement in care and policy response.



Negative endometrial cancer trends. In 2019, the incidence and mortality rates were 37.6 and 6.8 per 100,000 women, respectively, compared to 22.4 and 4.0 in 2000 (2, 6). *In 2024, around 8,600 new cases of endometrial cancer are expected – more than the combined numbers of cervical and ovarian cancers – along with 1,600 deaths*, making it the 4th most commonly diagnosed cancer and the 7th most common cancer-related death among Canadian women (7).

Provincial differences in the disease burden of endometrial cancer are notable. In 2024, incidence rates per 100,000 women are expected to range from 46.0 in Manitoba to 30.8 in British Columbia, while mortality rates range from 6.7 in Manitoba to 4.7 in Prince Edward Island (7).

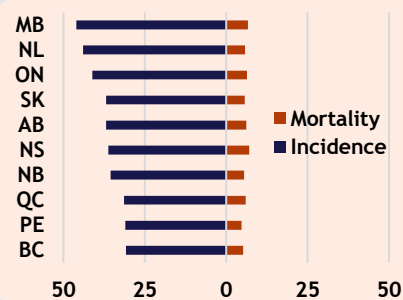
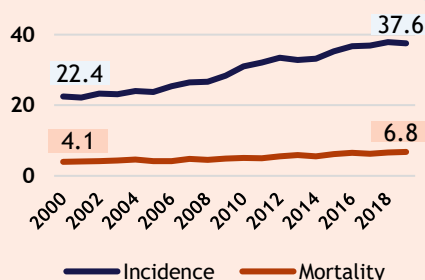
1 WHAT IS ENDOMETRIAL CANCER? Endometrial cancer originates in the inner lining of the uterus (womb), called the endometrium, and accounts for around 90% of all cancers in the body of the uterus (also referred to as uterine cancer or corpus uteri cancer)* (1). Overweight and obesity are the most common modifiable risk factors, linked to more than 40% of cases (1). Abnormal vaginal bleeding (i.e., bleeding between menstrual periods or after menopause) is the most common symptom (1). In Canada, most cases are diagnosed in women aged 55-74 (2). Approximately 74% of Canadian patients with a known disease stage are identified in early stages (I-II) (3).

2 DISEASE BURDEN. Canada is witnessing a growing number of endometrial cancer cases, influenced by an ageing population and rising obesity rates (4, 5).

Endometrial cancer trends

Notes: Incidence and mortality crude rates per 100,000 women in Canada (excluding Quebec).

Source: StatCan



Endometrial cancer by province in 2024

Notes: Projected age-standardized incidence and mortality rates per 100,000 inhabitants in Canada.

Source: Brenner et al., CMAJ 2024

Progress in endometrial cancer care has stalled in the last three decades. Although five-year survival rates of endometrial cancer are relatively high (>80%) compared to other gynecological cancers, they remain lower than for breast cancer (1). In contrast to most other cancer types, survival rates have not improved in recent years. In Canada, five-year net survival shows a negative trend, declining from 83.7% during the 1992-1994 diagnosis period to 82.5% in 2015-2017 (8). However, recent advancements in treatment options in advanced disease hold promise for improving future survival outcomes (1).

*This case study focuses on endometrial cancer; however, where specific data are unavailable, statistics for uterine cancer (corpus uteri cancer) are used instead. Hence, uterine cancer and endometrial cancer are used interchangeably in this case study.

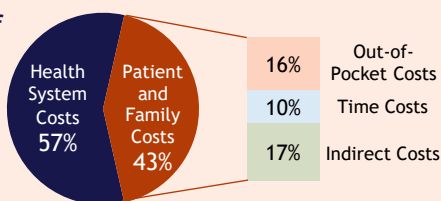
The disease burden of endometrial cancer is impacted by ethnic background and socioeconomic status. National data from 2006 to 2016 show that the proportion of uterine cancer cases varies among ethnicities in Canada. Women of South Asian descent have the highest proportion (9.5% of their total cancer incidence), followed by Latin, Central, and South American (7.6%), Caribbean (7.2%), East Asian (7.1%), European (6.5%), West Central Asian and Middle Eastern (6.0%), African (5.8%), and Non-Indigenous North American (5.7%) descent (9). In terms of uterine cancer-related deaths, Caribbean women rank highest (7.8% of cancer deaths), followed by Latin, Central, and South American (6.4%), African (5.6%), South Asian (5.2%), West Central Asian and Middle Eastern (4.4%), East Asian (3.5%), European (2.9%), and Non-Indigenous North American women (2.2%) (9). A study from Ontario further showed that patients from the most marginalized communities – defined by material deprivation, ethnic concentration, and residential instability – have poorer five-year survival rates than those from the least marginalized communities, at 77% vs. 83% (10).

3 ECONOMIC BURDEN. The economic burden of uterine cancer in Canada was estimated to be CA\$ 618 million in 2021, with 57% attributed to health system costs and 43% to patient and family costs (11).^A

Endometrial cancer claims a small share of cancer care expenditure. Health expenditure on uterine cancer care accounts for about 2% of total cancer care expenditure in Canada (CA\$353 million) (11), which is lower than its share among all new cancer diagnoses (3%) (7). Breaking down the patient and family costs composition, indirect costs make up 17% of the economic burden of uterine cancer, followed by out-of-pocket costs (16%), and time costs (10%).^B

Composition of the economic burden of uterine cancer Canada, 2021

Source: Garaszczuk et al., *Curr Oncol.* 2022

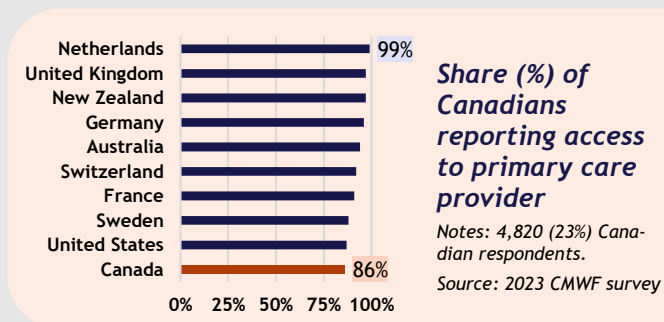


4 EARLY DETECTION. Early detection of endometrial cancer increases the chances of successful treatment, improves survival rates, and reduces treatment costs (1). Unlike breast and cervical cancer, there is no established screening method for endometrial cancer. The condition is typically identified through symptoms – such as abnormal vaginal bleeding – noticed by the patient, making early detection heavily reliant on symptom awareness combined with easy access to healthcare services and prompt medical assessment by a gynecologist (1).

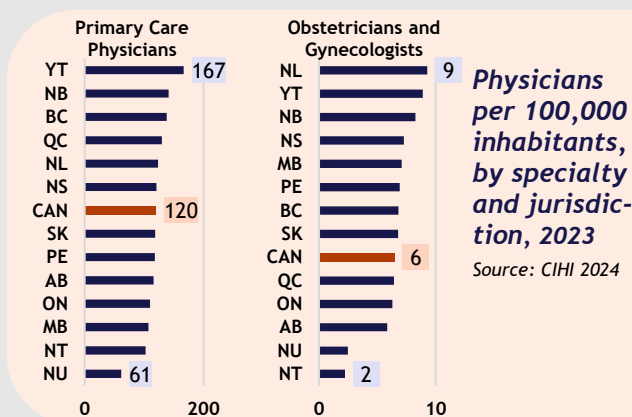
Both patients and healthcare providers lack awareness of endometrial cancer and its symptoms. A qualitative study in Toronto found that 14 out of 15 patients interviewed did not recognize abnormal bleeding as a potential sign of endometrial cancer (12). Moreover, none of the participants were aware that obesity is a major risk factor for endometrial cancer until after their diagnosis (12). Some patients reported that their primary care providers also failed to identify

abnormal or postmenopausal bleeding as a warning sign, leading to delayed referrals to gynecologists (12). Patients with morbid obesity reported experiencing stigma and poor communication from healthcare providers, with some feeling that their weight influenced the quality of care and treatment options offered (12). These barriers likely complicate early detection (as well as diagnosis and access to appropriate care) and may impact patient outcomes.

Access to primary healthcare is challenging in Canada. The 2023 Commonwealth Fund (CMWF) survey showed that only 86% of Canadians reported access to a primary care provider, down from 93% in 2016 and the lowest among surveyed countries (13). Limited access to primary care might delay cancer detection.



Canada faces a shortage of primary care physicians and obstetricians/gynecologists. There were, on average, 120 primary care physicians per 100,000 inhabitants in 2023, with significant geographic variation ranging from 61 in Nunavut to 167 in Yukon (14). Among the most populous provinces, Ontario and Alberta fall below the national average, with 110 and 116 per 100,000, respectively, while British Columbia and Quebec have higher availability, at 138 and 130. Obstetricians and gynecologists are in limited supply, averaging 6 per 100,000 nationwide, ranging from 2 in the Northwest Territories to 9 in Newfoundland and Labrador (14). Such disparities in key healthcare providers pose additional challenges for early detection and diagnosis of endometrial cancer.

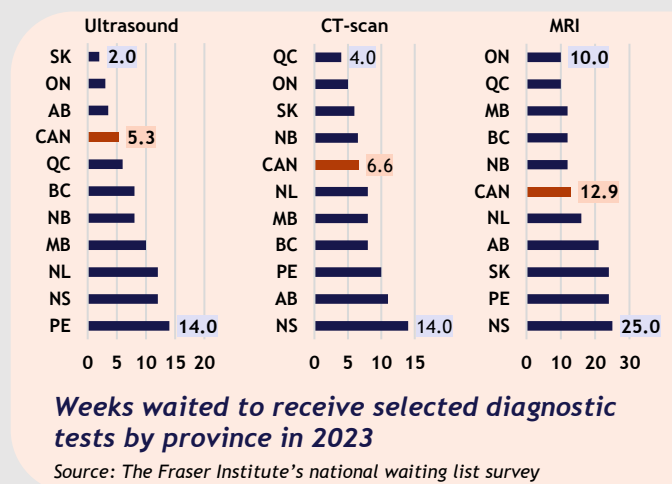


Wait times for specialist appointments have increased significantly over the past decades. The median wait between referral by general practitioners (GPs) and specialist appointments rose from 3.7 weeks in 1993 to 14.6 weeks in 2023, with notable provincial variations ranging from 12.3 weeks in Quebec to 28.3 weeks in Nova Scotia (15). For gynecologist appointments specifically, the median wait in Canada jumped from 3.1 weeks in 1993 to 22.2 weeks in 2023, highlighting a critical delay in the detection process of endometrial cancer.

A: Health system costs = costs of services provided in the hospitals by physicians and some prescription drugs. Patients and family costs = out-of-pocket costs, time costs, and indirect costs. B: Indirect costs = lost income due to the patient's condition. Time costs = time spent traveling for care, waiting for care, and receiving care. Out-of-pocket costs = costs of drugs, home care, equipment, and other patient-incurred costs.

Patients from marginalized communities are more likely to be diagnosed at advanced stages. A study in Ontario found that patients in the most marginalized communities are more likely to present with advanced disease compared to those from the least marginalized, even when adjusted for age, obesity, and comorbidities: 29% vs. 25% for material deprivation; 29% vs. 24% for ethnic concentration; 30% vs. 27% for residential instability (16). These disparities highlight the potential impact of social and structural barriers on detection. Among Indigenous populations, historical traumas and systemic racism have created mistrust in the healthcare system, often resulting in delayed diagnosis and treatment (17). Culturally safe care and increased awareness of Indigenous-specific challenges are essential to fostering trust and improving early detection efforts. Beyond health outcomes, delayed diagnosis is also associated with a financial burden. Evidence from England indicates that endometrial cancer patients diagnosed at stage III incur approximately 2.5 times higher healthcare costs than those diagnosed at stage I (per patient-year) (18). This further reinforces the need for equitable access to early detection.

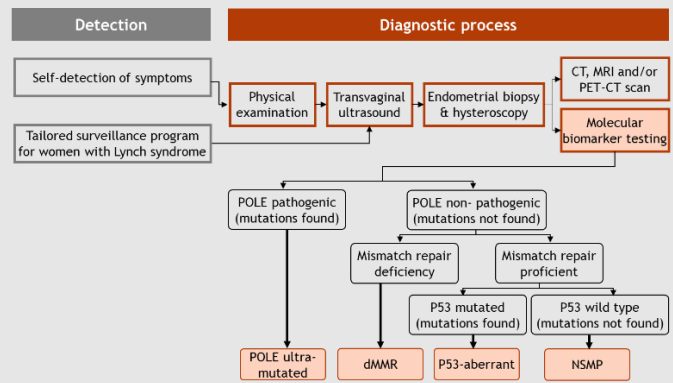
the longest delays, averaging 12.9 weeks and peaking at 25.0 weeks in Nova Scotia (15). These prolonged wait times, coupled with limited access to gynecologists and lengthy referrals from primary care providers (see Section 4, “Early Detection”), are likely to pose significant challenges to the diagnostic process of endometrial cancer.



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DIAGNOSTIC PROCESS. Endometrial cancer diagnosis involves a multi-step process (visualized below), including physical exams, imaging, biopsies, and molecular biomarker testing, which collectively guide staging and treatment decisions (1). Historically, classification relied on histology, categorizing cases into Type I (estrogen-related, slower progression) and Type II (aggressive, poorer prognosis). Since 2021, a molecular classification has redefined endometrial cancer into four subtypes—(i) POLE-ultra mutated, (ii) dMMR, (iii) p53-aberrant, and (iv) no specific molecular subtype (NSMP) (1). This new classification, combined with staging insights and the introduction of novel medicines, enables more personalized treatment strategies tailored to each patient. Comprehensive biomarker testing is required to facilitate this personalized approach. Equitable access to diagnostic tools, biomarker testing, and specialized expertise is essential for integrating these advancements into clinical practice, especially as new medicines continue to emerge.

Inequities and systemic barriers in molecular biomarker testing. Comprehensive molecular biomarker testing, essential for personalized cancer treatment, generally relies on the availability of resources such as diagnostic laboratory capabilities, trained medical professionals, funding, and standardized protocols (1). As highlighted during the 2023 Colorectal Cancer Resource & Action Network (CCRAN) Biomarker Conference – a gathering of cancer advocacy groups and healthcare professionals – biomarker testing across multiple cancer types^c in Canada faces significant barriers that limit its accessibility and, potentially, its effectiveness (19):



Limited awareness of biomarker testing. Many clinicians in Canada may fail to discuss biomarker testing with patients due to factors such as limited awareness and the complexity of the topic. Furthermore, oncologists often focus only on biomarkers linked to actionable treatments, while overlooking others that could inform future clinical trials or emerging therapies. At the same time, patients are often unaware of genomic medicine and lack understanding of biomarkers’ role in guiding treatment decisions. This issue has been documented in cancers such as colorectal, lung, ovarian, and stomach, where active advocacy groups have highlighted the need for improved education. Endometrial cancer patients are particularly disadvantaged in this sense, having no organized advocacy group despite the recent advancements in diagnostics and treatment options. These gaps in awareness may hinder the integration and uptake of biomarker testing.

Long and inequitable waiting times for diagnostic imaging. Canadian patients face significant delays and provincial disparities in access to key diagnostic imaging services. In 2023, the average wait for ultrasounds was 5.3 weeks, ranging from 2.0 weeks in Saskatchewan to 14.0 weeks in Prince Edward Island. Computed tomography (CT) scans averaged 6.6 weeks, with waits spanning from 4.0 weeks in Quebec to 14.0 weeks in Nova Scotia. Magnetic resonance imaging (MRI) scans faced

Geographic and socioeconomic disparities hinder equitable access to biomarker testing. In Canada, advanced testing facilities are concentrated in urban academic centers, leaving rural and remote patients with limited access. Most provinces also lack mechanisms to fund companion diagnostic tests alongside new targeted therapies, creating financial barriers for patients without private insurance or the means to cover out-of-pocket costs. These disparities disproportionately affect patients from lower socioeconomic backgrounds, likely limiting equitable access to biomarker testing.

Systemic inefficiencies contribute to delays in testing and reporting. The absence of standardized national guidelines and reflex testing protocols results in fragmented care

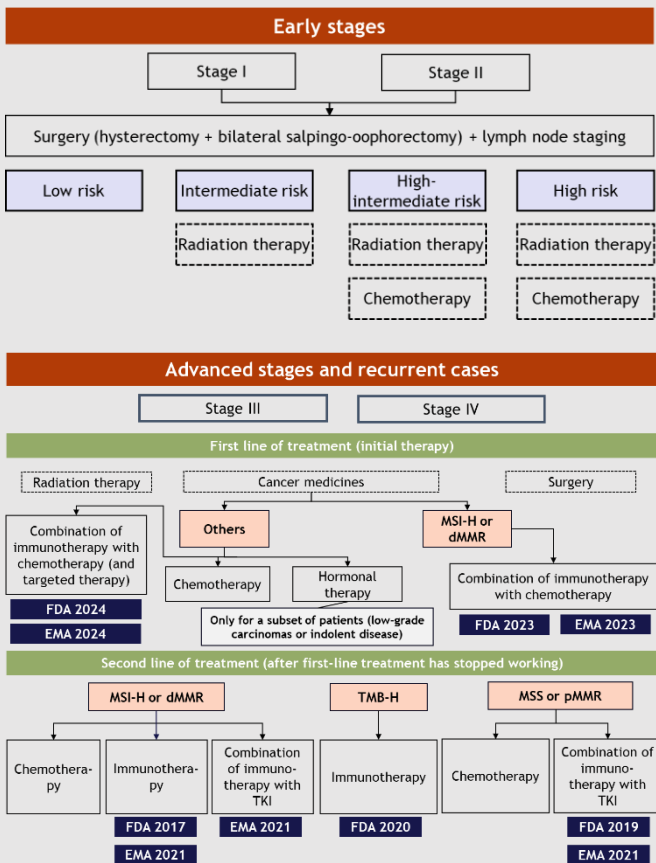
C: The 2021 CCRAN Biomarker Conference included advocacy groups for several cancer types, excluding endometrial cancer due to the lack of a dedicated group in Canada. However, the findings reflect broader and provincial challenges in biomarker testing applicable to endometrial cancer as well.

pathways. Moreover, the lack of integration between diagnostic labs and healthcare systems slows the processing of results, delaying diagnosis (and thus, treatment decisions).

There are shortages of specialized human resources. Many laboratories lack enough technologists for tissue handling and testing, as well as trained bioinformaticians, molecular pathologists, and medical geneticists, driven by high demand for these skills. These shortages may hinder the expansion of biomarker testing and the integration of innovative diagnostic technologies into clinical practice.

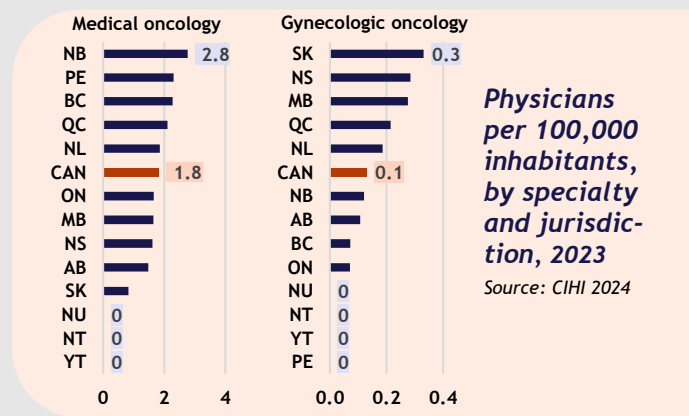
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TREATMENT. The treatment of endometrial cancer depends on the stage at diagnosis, but typically comprises surgery, radiation therapy, and systemic therapies. Surgery involves the removal of the uterus (hysterectomy) and often also the removal of the fallopian tubes and ovaries. Radiation therapy is commonly used to target residual cancer cells after surgery or as a standalone option for non-surgical candidates (1). Chemotherapy has been the cornerstone systemic therapy for decades, usually administered after surgery or as a standalone option for non-surgical candidates. Recent advancements, however, have introduced a wave of innovative therapies, particularly immunotherapies and targeted therapies, designed to leverage the cancer's molecular profile (1). These therapies transform the management of advanced and recurrent endometrial cancer cases. Treatment algorithms for early-stage and advanced/recurrent-stage endometrial cancer (based on ESMO and NCCN guidelines) are presented below (1). Comprehensive, timely and equitable access to innovative medicines, specialized expertise, and multidisciplinary care is essential for integrating these advancements into clinical practice.



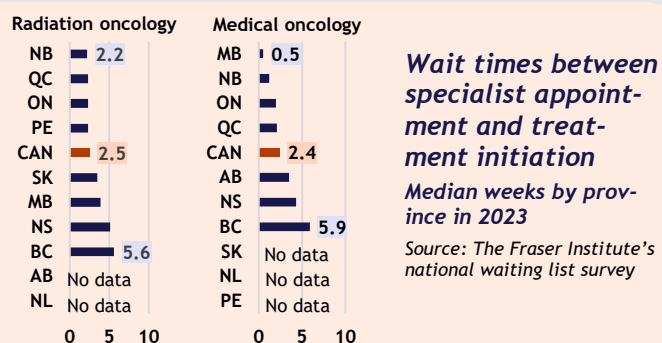
Insufficient and inequitable number of multidisciplinary specialists. The optimal treatment of endometrial cancer requires a multidisciplinary team comprising at least a gynecologic oncologist (or a trained surgeon specialized in gynecologic cancers), a radiologist, a radiation oncologist, a medical oncologist, and a pathologist (20). Gynecologic oncologists play a pivotal role in treatment outcomes, with evidence showing that these specialists are associated with higher overall survival rates (21). For instance, there has been evidence that surgeries performed by gynecologic oncologists are associated with better survival outcomes for high-risk patients, as compared to surgeries done by other types of surgeons (22).

Canada faces notable geographic disparities in access to all relevant specialists required for the treatment of endometrial cancer. As of 2023, there were on average of 1.8 medical oncologists per 100,000 inhabitants, with the highest availability in New Brunswick (2.8 per 100,000) and none in the three territories (14). Geographic disparities are even more pronounced for gynecologic oncologists, with a national average of just 0.1 per 100,000 inhabitants (14), where Saskatchewan reports the highest availability (0.3 per 100,000) and Prince Edward Island and the three territories report none. Notably, in British Columbia, a study found that only 57%-79% of ovarian cancer patients diagnosed in 2005-2008 were assessed by gynecologic oncologists, varying by health region (23). A similar trend may impact endometrial cancer patients due to unequal specialist distribution. For patients in provinces and territories with an insufficient number of specialists, accessing care can require long-distance travel, adding further barriers to timely treatment. For example, the average out-of-pocket cost for rural patients in British Columbia traveling to seek healthcare is estimated at CA\$2,044 per person per condition (24). Out-of-pocket costs included transportation, accommodation, healthcare, meals, and other expenses.



Human capital shortages extend to other key providers, including radiologists, radiation oncologists, pathologists, and nurses, all of whom are essential in cancer care (14, 25). The lack of nurses further compounds these challenges, as they are pivotal in managing patient care, administering treatments, and providing critical support throughout the care pathway (1). An insufficient number of key providers along with geographic disparities in access to specialized expertise makes it difficult to ensure equitable, timely and high-quality care for all endometrial cancer patients.

Inequitable wait times to receive treatment. In Canada, the median wait time between a specialist appointment and radiation oncology treatment was 2.5 weeks in 2023, with notable provincial variations ranging from 2.2 weeks in New Brunswick to 5.6 weeks in British Columbia (15). Similarly, the median wait time between a specialist appointment and medical oncology treatment is 2.4 weeks, with provincial variations ranging from 0.5 weeks in Manitoba to 5.9 weeks in British Columbia. These provincial disparities constrain efforts to deliver timely and equitable care for all Canadian patients.



Socioeconomic/ethnic disparities in access and timeliness of treatment. A study analyzed 20,228 cases of endometrial cancer between 2009 and 2017 in Ontario, of which 14,423 patients underwent primary hysterectomy. Patients from the most marginalized communities – defined by material deprivation, ethnic concentration, and residential instability – were less likely to receive surgery compared to those in the least marginalized communities (89% vs. 93%) (26). They also faced treatment delays, with only 27% undergoing surgery within six weeks of diagnosis compared to 32% in the least marginalized, and 78% within 12 weeks compared to 84% (26). While later diagnosis may partly explain lower surgery rates, it does not account for the longer delays experienced by marginalized patients who undergo surgery. Such disparities undermine efforts to deliver equitable and timely treatment to all endometrial cancer patients and may contribute to poorer health outcomes among those in marginalized communities.

Changing landscape of novel medicines. Recent advancements have significantly expanded treatment options for advanced and recurrent endometrial cancer, particularly through the introduction of immunotherapies and targeted therapies tailored to specific molecular characteristics (1). These therapies include options for patients with distinct tumor profiles, such as those exhibiting dMMR/MSI-H mutations or TMB-H. Importantly, some medicines now extend treatment options to patients regardless of their dMMR/MSI-H status, offering broader applicability. They have also moved from second-line to first-line treatment options (1). However, integrating these novel treatments may require additional system readiness. In Canada, many gynecologic oncologists are primarily surgical specialists^D and may not have the same training in systemic therapies as medical oncologists, highlighting the need for specialized education and multidisciplinary collaboration to support effective implementation.

Complex drug approval and reimbursement processes hinder timely and equitable access to novel cancer medicines. While Canada performs well in the regulatory approval of new medicines, it has ranked among the slowest OECD-20 nations

for public reimbursement. For cancer medicines approved between 2011 and 2016 and launched or reimbursed by 2018, the time from local regulatory approval to public reimbursement in Canada was 581 days at best (20% of public plan beneficiaries), compared to the OECD-20 median of 382 days (27). Such delays stem from Canada's multi-step reimbursement process involving federal and provincial/territorial authorities. After Health Canada approves a drug's safety, efficacy, and quality, the Health technology assessment (HTA) bodies provide non-binding reimbursement recommendations based on health economic evaluations – CDA-AMC for most provinces/territories and INESSS for Quebec (28, 29). Positive HTA recommendations lead to price negotiations between the pan-Canadian Pharmaceutical Alliance (pCPA) and manufacturers (30). However, provinces and territories ultimately make independent funding decisions, contributing to delays that vary widely across jurisdictions (31-33). Such delays have tangible consequences for cancer patients, as timely access to innovative treatments is critical to improving outcomes (34). The type of medicine also influences access disparities. Per the Canada Health Act, cancer medicines administered in hospitals are funded through hospital budgets and provided free to patients once provincially approved (35). Conversely, take-home medicines (e.g., oral drugs) are subject to a fragmented financing system involving public programs, private insurance, and out-of-pocket costs, which vary across provinces.

The adoption of treatment advances in clinical practice remains unclear. Canada does not have a national clinical cancer registry, making it challenging to determine whether novel medicines for endometrial cancer are being prescribed in accordance with clinical guidelines. Chemotherapy has historically been the cornerstone of systemic therapy (36), and may still be considered the standard of care by many oncologists. While clinical guidelines play a critical role in shaping treatment practices, oncologists in Canada express mixed attitudes toward them. Many value guidelines for supporting decision-making and standardizing care but raise concerns about their timeliness, applicability to diverse patient populations, and evidence quality (37). Non-adherence to clinical guidelines by oncologists can lead to inconsistencies in patient care, delays in adopting effective therapies, and compromised patient outcomes, ultimately hindering patient access to advancements in endometrial cancer treatment.

7 POLICY INITIATIVES. Endometrial cancer has traditionally received limited attention in global and national health policies compared to other women's cancers like breast and cervical cancer (1). While global initiatives such as the WHO's Global Breast Cancer Initiative and the Cervical Cancer Elimination Initiative demonstrate the potential for ambitious, coordinated action (38, 39), no similar large-scale strategies exist for endometrial cancer. International efforts, such as the Uterine Cancer Awareness Month (June) and World Gynecologic Oncology Day (September 20), have recently begun to address this gap, focusing on raising awareness and improving care. However, significant disparities remain in prioritization, funding, and research, underscoring the need for dedicated initiatives to reduce incidence, improve survival, and enhance the quality of care for endometrial cancer patients.

D: Personal communication from MSD Canada.

Endometrial cancer is absent from the national cancer strategy. The Canadian Strategy for Cancer Control (2019–2029) sets a national framework to address the cancer burden, focusing on five priority areas: prevention, early detection, high-quality care, equitable access to care, and comprehensive support systems (40). While the strategy highlights some gynecologic cancers – such as cervical cancer through initiatives addressing HPV-related risks and ovarian cancer in the context of preventive surgeries – it omits endometrial cancer. This absence creates a significant gap in addressing the unique challenges associated with the most common gynecologic cancer in Canada.

Policy initiatives targeting gynecologic cancers. Canada has implemented targeted initiatives for specific gynecologic cancers, providing valuable examples of focused policy frameworks and a potential roadmap for addressing other underrepresented cancers, such as endometrial cancer:

The *Action Plan to Eliminate Cervical Cancer in Canada (2020–2030)*, part of the *Canadian Strategy for Cancer Control*, is a national effort aligning with the WHO’s global strategy for cervical cancer (39, 41). It seeks to eliminate cervical cancer in Canada by 2040 through comprehensive prevention, screening, and follow-up strategies (41). Special attention is given to addressing care disparities, particularly for disadvantaged groups, through culturally appropriate and community-specific initiatives.

The *Gynecologic Cancer Initiative* (GCI) is a five-year strategic plan representing a provincial effort based in British Columbia, aimed at improving outcomes for gynecologic cancer patients through innovative research, molecular diagnostics, and equitable care delivery (42). A core objective of the GCI is to raise C\$100 million over five years to support its implementation. For endometrial cancer, the GCI promotes advancements in molecular classification and prognostic subgroup identification, driving improvements in diagnostics and personalized treatment (42). However, while the GCI outlines comprehensive strategies for cervical, ovarian, vaginal and vulvar cancers, its efforts for endometrial cancer remain undefined, with specific research priorities and objectives still under development.

Lack of patient/advocacy groups for endometrial cancer. While Canada has a robust and active network of advocacy organizations for other cancers (19), no national advocacy group exists for endometrial cancer. Advocacy groups play a critical role in raising awareness, supporting patients, influencing research priorities, and driving policy changes (1). Advocacy for ovarian cancer, led by Ovarian Cancer Canada (OCC), demonstrates the transformative impact such efforts can achieve (43). Public awareness campaigns such as the bold and provocative “Ladyballs” initiative launched in 2015 significantly increased visibility for ovarian cancer, reducing stigma and igniting national conversations about the disease (43). On the research front, OCC’s OvCAN initiative secured CA\$10 million in federal funding in 2019 after years of persistent advocacy and collaboration (43). Researchers, clinicians, and patients came together under a clear, credible plan, meeting extensively with policymakers and leveraging personal connections to build a strong coalition of support. This strategic collaboration was instrumental in overcoming funding barriers and advancing ovarian cancer research. Beyond

awareness and funding, OCC fostered a sense of community among patients, researchers, and clinicians. The *Patient Partners in Research* (PPIR) initiative empowered patients to actively contribute to research decisions, ensuring their voices shaped the future of ovarian cancer care (43). The absence of a similar advocacy group for endometrial cancer does not indicate a lack of concern but rather reflects historical underfunding and prioritization differences in cancer policy (1). Nonetheless, it creates a significant gap in raising public awareness, advancing research priorities, and fostering a united community in Canada. Inspiration on how structured advocacy, awareness campaigns, and policy initiatives can drive progress for endometrial cancer can be drawn from international efforts (44–48).

Limited research investment in endometrial cancer. Research investment differs considerably by cancer type in Canada (49). Of the approximately \$480 million in total cancer research investment in 2015, 59% was allocated to specific cancer sites, with the remainder invested in general cancer research (49). Leukemia, prostate, and breast cancer collectively accounted for 51.3% of site-specific funding, while uterine, pancreatic, and ovarian cancer combined received only 7.8%. In fact, uterine cancer received the lowest funding at just 0.6% of total research investments, making it the least funded cancer relative to its incidence share and the second least funded relative to its mortality share, indicating a mismatch between research funding and its disease burden (49). These funding discrepancies may hinder progress in understanding and addressing endometrial cancer, emphasizing the need for a more equitable allocation of research resources to reflect its growing impact.

What Canada Needs To Do



Integrate endometrial cancer into national and regional health strategies. Develop specific goals, initiatives, and funding mechanisms to address its growing disease burden.



Enhance early detection and diagnostics. Raise awareness of symptoms and risk factors, and ensure equitable access to diagnostic tools, including comprehensive biomarker testing, and specialists to improve timely and accurate diagnosis.



Ensure equitable and optimal care delivery. Prioritize multidisciplinary team decision-making, ensure access to innovative treatments, and tackle disparities in specialist availability and wait times for care to reduce inequities.



Support advocacy and patient voices. Establish a national advocacy group for endometrial cancer to raise awareness, influence research priorities, and ensure patient involvement in shaping care policies.



Expand research funding and collaboration. Allocate proportional research funding to endometrial cancer that reflects its disease burden. Foster collaboration across provinces to drive innovation in prevention, diagnostics, and treatment.

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