BRIDGING THE GAP IN WOMEN'S CANCER CARE

- A Fact Sheet on Ovarian Cancer

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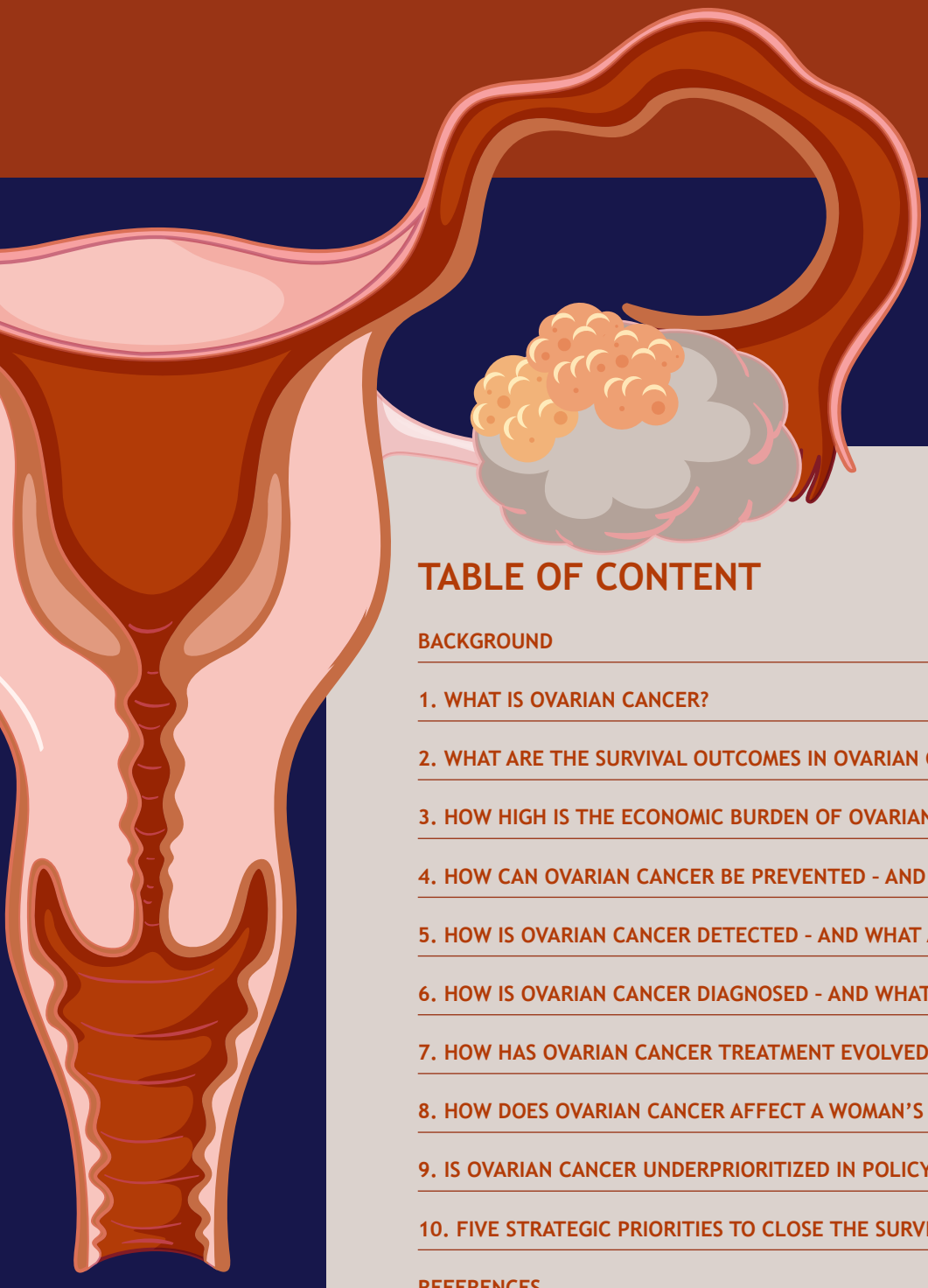

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BACKGROUND

In 2025, the Swedish Institute for Health Economics (IHE) published Bridging the Gap in Women's Cancer Care: A Global Policy Report on Disparities, Innovations, and Solutions (1). Endorsed by the Advanced Breast Cancer (ABC) Global Alliance, the International Gynecologic Cancer Society (IGCS), the International Gynecologic Cancer Advocacy Network (IGCAN), and the World Ovarian Cancer Coalition (WOCC), the report outlines the unique challenges and opportunities in improving outcomes for women's cancers.

This fact sheet provides a general overview of ovarian cancer. It describes the burden of disease, patterns of care, and recent innovations, with a focus on evidence from Europe and Northern America. It also highlights key areas where strengthened policies and targeted actions could improve outcomes. The fact sheet draws primarily on information presented in the global women's cancers report, complemented by targeted literature searches for newer information, in particular the evolution of therapeutic options.

1. WHAT IS OVARIAN CANCER?

Ovarian cancer develops in the ovaries, the fallopian tubes, or the peritoneum - the thin tissue lining the abdominal cavity (2, 3). Most ovarian cancers are epithelial tumors (about 90%), which are believed to begin in the cells at the end of the fallopian tubes before spreading to the ovary (2). Non-epithelial ovarian tumors account for about 10% of all ovarian cancers (4).

While ovarian cancer can occur at any age after puberty, the likelihood increases substantially after menopause. In Europe and Northern America, roughly half of all new ovarian cancer cases are diagnosed below age 65 and half at 65 years or older (5). The median age at diagnosis in the United States (US) was 63 years in 2017–2021 (6).

In its early stages, ovarian cancer usually causes no symptoms or only vague ones. Typical but vague signs include bloating, abdominal or pelvic pain, constipation, diarrhea, changes in urinary frequency, vaginal bleeding, abdominal distension, and fatigue (7, 8). These symptoms are common in many benign conditions and do not reliably signal cancer. Unlike cervical and breast cancer, there is no established screening method for ovarian cancer to enhance early detection. Consequently, most women are diagnosed at advanced stages (around 70% at FIGO stages III–IV) (9), where patient outcomes are poorer and the greatest unmet need exists.

Ovarian cancer develops in the ovaries, the fallopian tubes, or the peritoneum lining and the likelihood increases substantially after menopause. In the early stages, ovarian cancer causes little symptoms.

2. WHAT ARE THE SURVIVAL OUTCOMES IN OVARIAN CANCER- AND WHY ARE THEY LOW?

Ovarian cancer is the deadliest gynecologic cancer type in Western countries. Globally, ovarian cancer is the eighth most commonly diagnosed cancer and the eighth leading cause of cancer death among women (5, 10). In 2022, it accounted for a relatively small proportion of new cancer cases among women worldwide (4%), but a larger share of cancer deaths among women (5%), corresponding to an estimated 324,603 new cases and 206,956 deaths (5). In Western countries, ovarian cancer is the deadliest gynecologic cancer type, ranking fifth in cancer-related mortality among women in the European Union (EU) (5) and sixth in the US (11). This reflects low survival rates, which are in large part due to late detection, as effective options for early detection are lacking, and a high unmet need in the treatment of advanced disease stages.

Ovarian cancer is the deadliest gynecologic cancer type in Western countries.

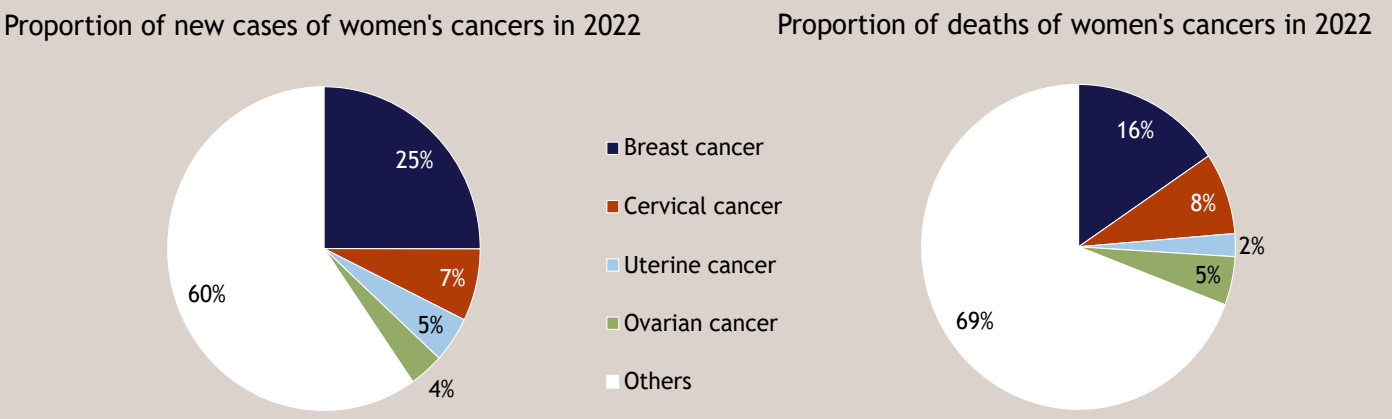

Figure 1: Proportion of new cancer cases and deaths of women's cancers among all cancers in women worldwide in 2022

Notes: "Others" include all other cancers excluding non-melanoma skin cancer. Source: (5, 10).

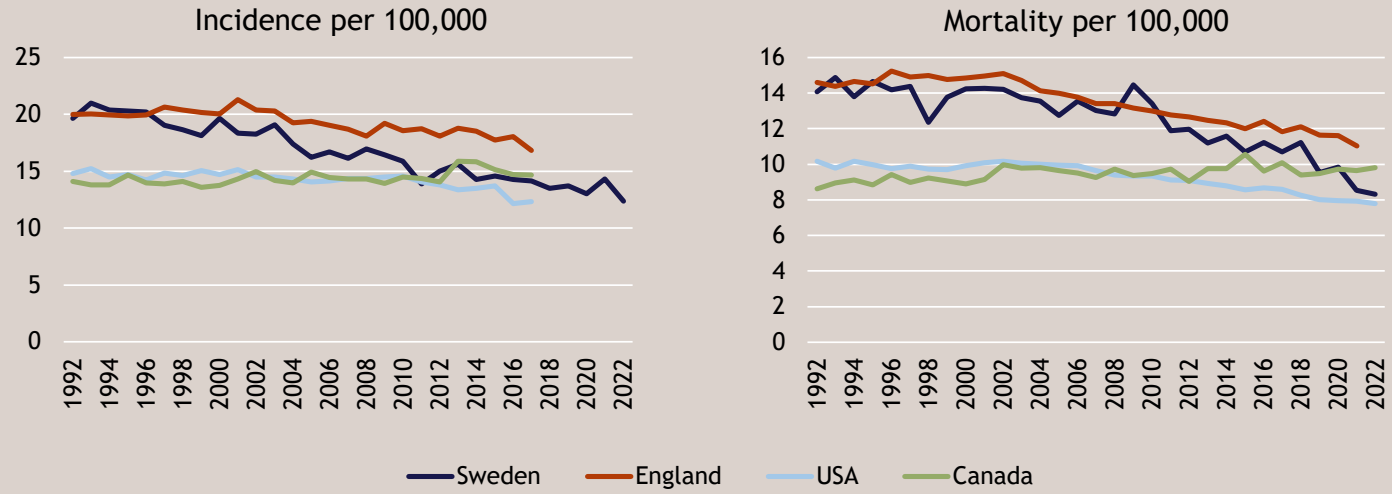

Figure 2: Trends in incidence and mortality of ovarian cancer in selected high-income countries, crude rates per 100,000 inhabitants, 1992–2022. *Source: (12).*

Ovarian cancer incidence and mortality have changed over time, with trends varying between countries. For example, incidence per 100,000 inhabitants (crude rates) has declined in Sweden and England over the past two decades (12). In the US, incidence has decreased more gradually, while Canada shows a largely stable pattern with a slight increase in recent years (12). Similarly, mortality rates have declined in Sweden and the UK, decreased more slowly in the US, and moderately increased in Canada (12). Overall, the long-term direction of change is generally downward in high-income countries, but the magnitude and consistency of decline differ between countries.

Ovarian cancer incidence and mortality have changed over time, with trends varying between countries. Although survival has improved over time, it is still the lowest among women's cancers.

Ovarian cancer has the lowest survival rate among women's cancers. According to the CONCORD-3 study, five-year survival in women diagnosed during the period 2010-2014 was below 50% in most high-income countries (13). Substantial variation was observed: for example, Sweden reported a five-year survival rate of 47%, whereas 12 European countries - including Italy and the United Kingdom (UK) - had survival estimates as low as 30–39% (13). More recent data (2015-2021) from the US shows that ovarian cancer had the lowest five-year relative survival rates among women's cancers at 52%, (e.g., breast cancer survival is at 92%) (14).

Survival in ovarian cancer has improved over time. Five-year relative survival in the US increased from 36% in women diagnosed in 1975-1977 to around 52% in 2015-2021 (11, 14). Similar long-term gains have been documented in the Nordic countries in Europe, where five-year relative survival rose from 23–34% in women diagnosed in 1974-1978 to 47–56% in 2019-2023 (15). Improvements in ovarian cancer survival over time are generally attributed to advances in treatment and care delivery - particularly improvements in surgery (increasing rates of complete tumor removal), more effective chemotherapy regimens, and, more recently, targeted therapies such as anti-angiogenic therapy and PARP (Poly (ADP-ribose) Polymerase) inhibitors (16-19). Looking ahead, further improvements in ovarian cancer survival may be possible as novel biomarker-driven therapies such as antibody–drug conjugates (ADC) and immunotherapy-based regimens are introduced and adopted in clinical practice (19, 20); see section 7.

Survival differs greatly by disease stage. Women diagnosed with localized ovarian cancer had a five-year relative survival rate of 92%, compared with 71% for regional disease, and only 32% when the cancer is diagnosed after metastasizing to other parts of the body, according to US data for the diagnosis period 2015-2021 (14). Although this survival pattern looks similar also in other women's cancers, most ovarian cancer cases are detected at an advanced disease stage unlike other women's cancer (see section 5, Figure 8). This leads to ovarian cancer having the worst overall survival. The steep survival decline by disease stage underscores the need for new approaches to support earlier detection as well as the need for more effective treatment options in advanced disease.

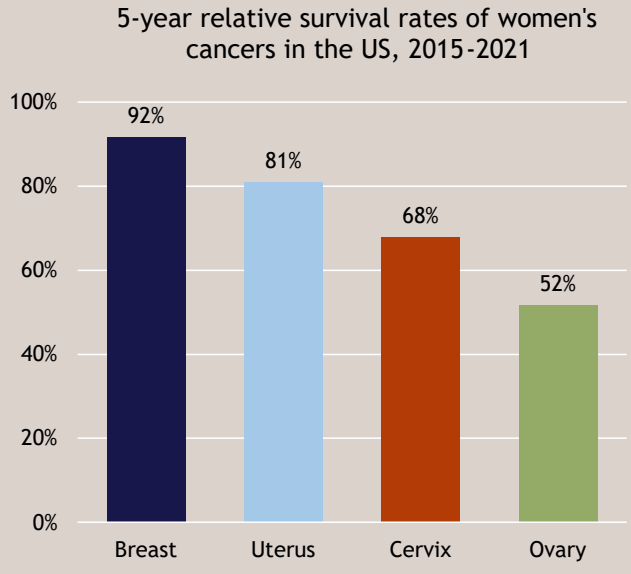

Figure 3: Five-year relative survival rates for women's cancers in the US, diagnosed 2015-2021. *Source: (14).*

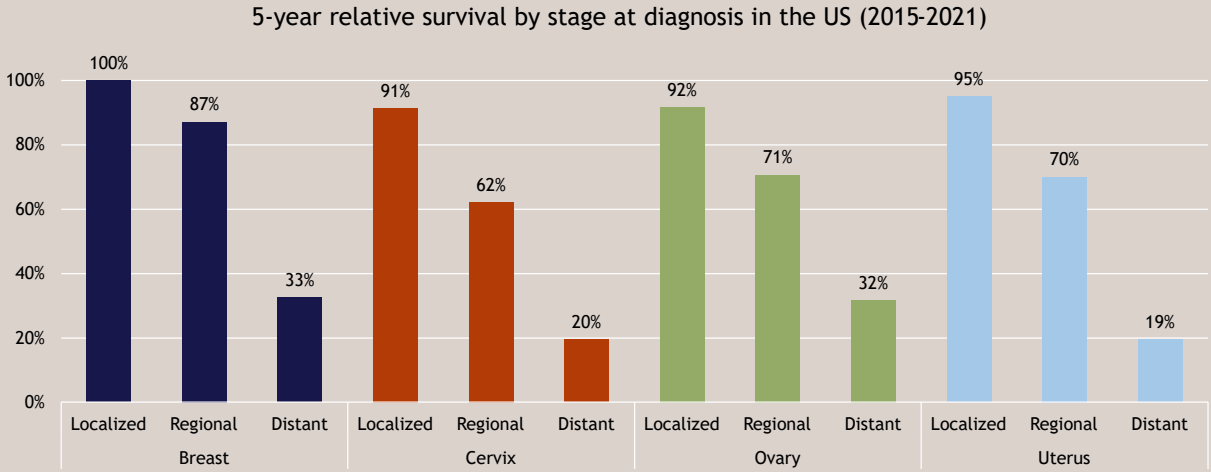

Figure 4: Five-year relative survival in women's cancers by stage at diagnosis in the US, diagnosed 2015-2021. *Source: (14).*

Survival outcomes vary by socioeconomic group. Studies consistently show that women from lower socioeconomic status (SES) groups tend to have worse survival rates than their more affluent counterparts. A Canadian analysis from 1990–2019 found that ovarian cancer mortality has become increasingly concentrated among lower-income and less-educated populations (21). Similarly, in the US, a comprehensive review found that ovarian cancer patients in the lowest SES group are significantly less likely to receive optimal, guideline-adherent treatment and face a higher risk of death than those in the highest SES group (22).

Ovarian cancer survival differs greatly by disease stage; it also varies between socioeconomic groups.

3. HOW HIGH IS THE ECONOMIC BURDEN OF OVARIAN CANCER?

Ovarian cancer imposes a substantial economic burden on society. A recent analysis by the World Ovarian Cancer Coalition across 11 high-, middle-, and low-income countries estimated that the total economic cost of ovarian cancer reached USD 70 billion in 2022, corresponding to 0.11% of gross domestic product (GDP) (23). This includes both direct (treatment-related) costs and "hidden" indirect costs which result from premature mortality and lost productivity among women of working age. Treatment-related expenditure for ovarian cancer can be disproportionate to its share of cancer incidence. In the US, for instance, it represented just 1% of all new cancer cases in 2022, yet it accounted for 3% of cancer expenditure in 2020 (5, 24). This discrepancy indicates that managing ovarian cancer requires higher use of resources than other cancer types, including high cost of diagnostics and treating advanced disease, substantial inpatient and outpatient care, and recurrent disease requiring multiple lines of therapy and specialized surgical and oncologic management (25, 26). US data confirm that patients with ovarian cancer have greater healthcare resource use, higher costs, and worse quality of life than the non-cancer population (27). Looking ahead, the impact of new early-detection technologies and more effective therapies that lead to "cure" of more patients could potentially reduce overall resource use.

Treatment costs increase dramatically with later-stage diagnosis. In the US, first-year treatment costs for stage IV ovarian cancer are nearly 18 times higher than for stage I disease (28). This gap is higher than for cervical cancer (10-fold difference between stage I and stage IV) and breast cancer (9-fold difference) (28). Part of the big discrepancy in ovarian cancer might relate to the recent introduction of new therapies in the advanced treatment setting but none in the early-stage setting (see also section 7). The sharp rise in treatment costs with advancing stage underscores the need and the potential clinical and economic value of new technologies that could facilitate earlier detection.

Ovarian cancer imposes a substantial economic burden on society, largely driven by indirect costs. Treatment costs increase dramatically with later-stage diagnosis.

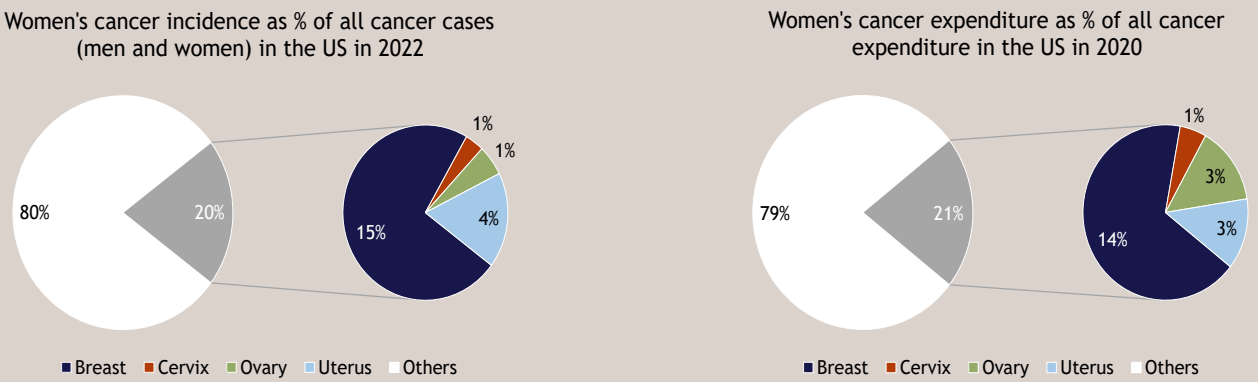

Figure 5: Cancer care expenditure and cancer cases of women's cancers in relation to all cancer care expenditure/cases. *Sources: (5, 24).*

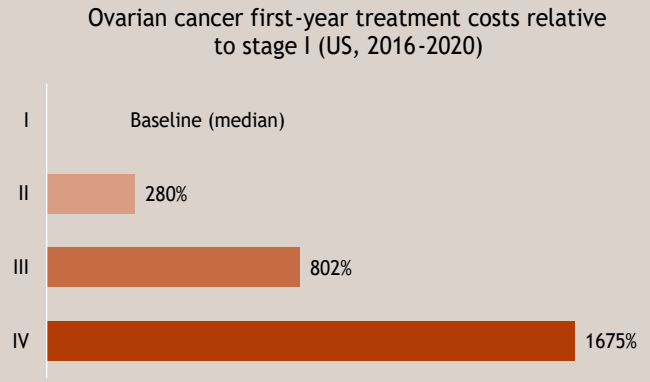

Figure 6: Ovarian cancer treatment costs in the US during the first year after diagnosis relative to stage I, diagnosed 2016-2020.

Notes: Figures reflect relative differences (%) in median treatment costs. Source: (28).

Indirect costs account for the vast majority of ovarian cancer's economic impact. Direct medical expenditures represent only the tip of the iceberg in the overall economic burden of ovarian cancer. Of the USD 70 billion total cost across 11 high-, middle-, and low-income countries in 2022, 91% was attributable to indirect costs linked to premature mortality and lost productivity (23), reflecting the fact that many working-age women get diagnosed and die. The large proportion of these "hidden" societal losses underscores the importance of adopting a broader, societal perspective when evaluating policies and new interventions.

4. HOW CAN OVARIAN CANCER BE PREVENTED – AND WHAT ARE THE CHALLENGES?

There is limited scope to prevent ovarian cancer. In high-income Western countries, only about 5–10% of ovarian cancer cases are attributable to modifiable lifestyle-related factors most notably excess body weight and, to a smaller extent, cigarette smoking (29, 30); this translates to the lowest potential to be prevented among women's cancers. Infertility, nulliparity (never having given birth to children), and estrogen hormone treatment have been reported to increase the risk of developing ovarian cancer and could account for the rising incidence of the disease in some countries (31), while oral contraceptive use and breastfeeding can reduce the risk (32). For the vast majority of women, there are no clear behavioral or environmental risk factors to target. Instead, prevention efforts focus on identifying women with a substantially elevated hereditary risk and offering risk-reducing interventions.

Genetic testing plays a central role in ovarian cancer prevention. Two types of inherited mutations – BReast CAncer gene (BRCA) 1/2 mutations and Lynch syndrome – increase the risk of developing ovarian cancer. In the US, harmful BRCA1/2 mutations are found in about 0.2–0.3% of the general population and raise lifetime ovarian cancer risk to 39–58% for BRCA1 carriers and 13–29% for BRCA2 carriers, compared with about 1.1% in women without these mutations (33). Lynch syndrome is present in about 0.36% of the US population and increases lifetime risk of developing ovarian cancer to 7–12% (34, 35). For women with such inherited mutations, preventive options include risk-reducing surgery (the removal of the ovaries and fallopian tubes) and certain medications that lower cancer risk (33). In addition, a recent study in the US involving over 450,000 women found that endometriosis entails a 4.2-fold increased risk for developing ovarian cancer (36). Although the absolute risk of ovarian cancer remains low (37), these findings highlight a subgroup of women who may benefit from targeted counselling, risk-reducing strategies, or inclusion in future screening and prevention studies.

Gaps in the identification of high-risk women limit the preventive impact of genetic testing. Many women with mutations in BRCA1/2 or other susceptibility genes do not have a known family history of ovarian (or breast) cancer and therefore are not offered genetic testing (38). Traditional family-history-based testing misses around 50% of BRCA carriers (39). Current challenges to implement more widespread genetic testing in high-income countries relate to regulation, integration, and equitable access (40).

Risk-reducing interventions are gaining momentum. As many cases of ovarian cancer are suspected to originate in the fallopian tubes, their preventive removal has become a potential strategy to reduce the risk of developing ovarian cancer. Since 2026, the European Society of Gynaecological Oncology (ESGO) indicates that opportunistic salpingectomy, the removal of the fallopian tubes during unrelated pelvic or abdominal surgery, is feasible and does not adversely affect short-term ovarian function nor lead to early menopause, as the ovaries are preserved (41). The procedure adds minimal operative time and does not increase perioperative risks and should be considered in women who are at average risk for ovarian cancer and do not plan on having more children.

There is limited scope to prevent ovarian cancer. Genetic testing is central but its impact on prevention is limited by gaps in the identification of high-risk women. Risk-reducing interventions (e.g. removal of the fallopian tubes) are gaining momentum.

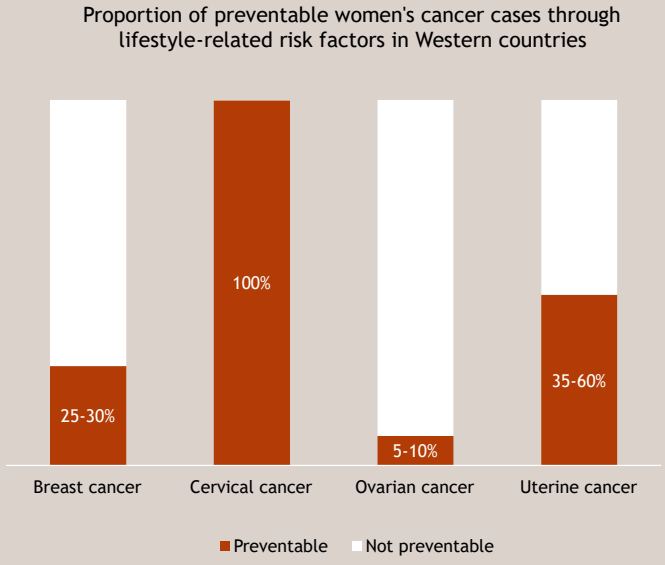

Figure 7: Proportion of women's cancer cases preventable through lifestyle-related risk factors in Western countries.

Notes: Data combine estimates from the UK from 2015 and the US from 2019. Preventable cases are defined as those attributable to modifiable lifestyle-related risk factors only. Sources: (29, 30).

5. HOW IS OVARIAN CANCER DETECTED – AND WHAT ARE THE CHALLENGES?

Most ovarian cancer cases are detected at a late stage. Around 70% of women are diagnosed at FIGO stage III–IV (9). In the US during 2015–2021, 54% of cases were diagnosed at a distant (metastatic) stage, 20% at a regional stage, and 19% at a localized stage (6). For comparison, only 6% of breast cancer cases were detected at a distant stage in the US in the same time period (6). The reason for the large proportion of late-stage diagnoses is a combination of a lack of an effective population-based screening method and common symptoms being rather unspecific and only appearing once the disease has progressed.

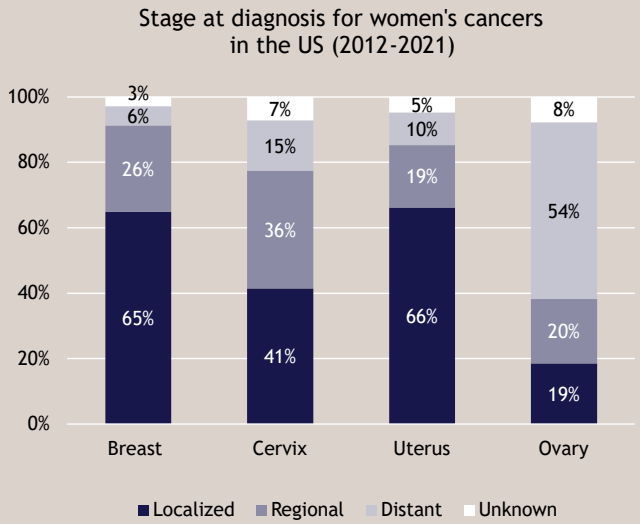

Figure 8: Stage at diagnosis for women's cancers in the US, 2012-2021

Notes: "Localized" cases represent cancer diagnoses confined to the organ, without any spread, "regional" cases indicate the cancer has spread to nearby structures, while "distant" cases denote cancer that has metastasized, i.e., spread to distant parts of the body. Figures are rounded. Source: (6).

There is no reliable screening method for ovarian cancer. While breast and cervical cancer benefit from established screening tools (42), ovarian cancer has no effective population-based screening method as demonstrated in the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS) trial which failed to achieve a reduction in mortality from applying different methods (9). Screening is therefore currently not recommended (43). Its biological characteristics mean the disease may progress rapidly without a prolonged detectable early-stage phase, limiting opportunities for identification while asymptomatic. This absence of screening helps explain why more than half of cases are diagnosed only after distant spread. Most women are diagnosed based on symptoms, with recognized symptoms including abdominal/pelvic pain, constipation, diarrhea, urinary frequency, vaginal bleeding, abdominal distension, fatigue, and in advanced disease stages also ascites and abdominal masses lead to bloating, nausea, anorexia, dyspepsia, and early satiety (7, 8). In the absence of effective screening tools, detection depends largely on women and healthcare professionals recognizing new or persistent symptoms, making symptom awareness and prompt diagnostic assessment critical.

Early detection improves outcomes only if followed by timely diagnosis and treatment. Early detection followed by swift diagnosis and effective treatment is crucial to ensure good outcomes, and it also entails lower treatment costs (see section 3). However, gynecologic cancer symptoms are often dismissed or attributed to benign conditions, either by women themselves or by healthcare professionals, which can delay timely diagnosis (44, 45). Ultimately, early detection of any cancer, including ovarian cancer, has little value unless patients can quickly receive a diagnosis and start effective treatment, and delays in this pathway contribute directly to worse outcomes (46).

Societal and structural barriers may further delay early detection of ovarian cancer. In a global survey of clinicians, delayed presentation was frequently linked to limited public awareness of ovarian cancer as well as geographical/logistical barriers to reaching diagnostic and specialist services, including in high-income settings (e.g., population dispersion and travel barriers) (47). Proposed responses included public education to strengthen symptom awareness and clearer diagnostic referral pathways (47).

There is no reliable screening method for ovarian cancer and most cases are detected at a late stage. Societal and structural barriers may further delay detection. Early detection can improve outcomes but only if followed by timely diagnosis and treatment.

6. HOW IS OVARIAN CANCER DIAGNOSED – AND WHAT ARE THE CHALLENGES?

The diagnostic pathway for ovarian cancer is complex and multi-step. Diagnosis typically begins with clinical evaluation, CA125 blood testing, and transvaginal ultrasound in women presenting with symptoms or a suspected pelvic mass (8). If malignancy is suspected, cross-sectional imaging such as CT or MRI is performed to assess disease extent, with PET or additional imaging used in advanced cases. Definitive diagnosis requires histopathological confirmation from a surgical specimen or biopsy (8). Biomarker assessment is now an integral part of this process: testing for BRCA1/2 mutations and homologous recombination deficiency (HRD) through next-generation sequencing (NGS) panels has been recommended in advanced cases to guide use of targeted therapy since 2020 in Europe (48). More recently, immunohistochemistry-based testing for Folate Receptor alpha (FRα) and Programmed Death-Ligand 1 (PD-L1) are expanding the biomarker work-up and play an important role in treatment selection in advanced cases following the latest regulatory approvals (see also section 7).

Despite its clinical importance, access to comprehensive biomarker testing remains inconsistent. In a global patient survey conducted across 44 countries and fielded in 2018, about half (51%) of women diagnosed with ovarian cancer within the past five years reported receiving genetic (germline) testing after diagnosis, with wide variation between countries (53). More recent US real-world data also suggest that testing remains incomplete: among women diagnosed in 2016–2023, only 52% received genetic (germline) and/or genomic (somatic) testing, or other standard biomarker testing within 60 days of diagnosis (54). More generally, companion diagnostics (i.e., biomarker tests required for the administration of therapies) are frequently not automatically reimbursed: a 2023 OECD survey found

that fewer than half of 28 countries provided automatic reimbursement, even when the corresponding therapy was covered (55). Although NGS panels cost far less than the therapies they inform, test prices exceeding USD 1,000 remain a barrier for many patients (56). Gaps in biomarker testing therefore limit equitable access to novel biomarker-guided therapies.

The diagnostic pathway for ovarian cancer is complex and multi-step and timely diagnosis can be hindered by specialist workforce shortages. Despite its clinical importance, access to comprehensive biomarker testing remains inconsistent.

Specialist workforce shortages can hinder timely diagnosis of ovarian cancer. Several high-income countries, including Finland, Canada, and Ireland, reported fewer than 10 gynecologists per 100,000 population in 2023, well below the OECD average of 17 per 100,000 (57). Access to genetic counselling may also be uneven: a US geospatial analysis of cancers associated with BRCA mutations, including ovarian cancer, found that although 71% of residents lived within a 30-minute drive of a genetic counsellor, this proportion was 82% in metropolitan areas but only 6% in nonmetropolitan areas (58). Workforce shortages in pathology services can also pose a barrier, as pathologists are essential for confirming malignancy and determining tumor characteristics needed to guide treatment. Workforce capacity constraints in pathology have been reported across multiple high-income countries (59-62). In the US, for example, a 2024 national laboratory workforce survey reported an anatomic pathology vacancy rate of 28.5%, the highest among the laboratory departments surveyed (63). US national workforce projections further suggest that supply will continue to lag behind demand: by 2038, projected demand for full-time equivalent pathologists (21,450) exceeds projected supply (17,930), implying a shortfall of 3,520 and an estimated shortage of about 16% (64). Such gaps may slow diagnostic evaluation and delay treatment initiation.

Info box 1. Genetic vs genomic testing and germline vs somatic mutations in cancer diagnostics

Genetic testing (inherited cancer risk)

- *What it tests: A person's inherited (germline) DNA variants that may increase cancer risk (e.g., BRCA1/2)*
- *Sample: Usually blood or saliva/cheek swab*
- *Why it matters: Identifies hereditary risk (relevant for the patient and family members) and can inform prevention, surveillance, and some management decisions*

Genomic testing (also called tumor testing, biomarker/molecular/genomic profiling)

- *What it tests: Genetic and/or protein changes in the cancer cells to help guide the use of targeted therapy or immunotherapy*
- *Sample: Most often tumor tissue from biopsy/surgery*

Germline vs somatic testing mutations (the key distinction)

- *Germline variant: Inherited, present in all cells, and may be passed from parents to offsprings*
- *Somatic variant: Acquired, present only in the tumor, and not inherited*
- *BRCA example: A BRCA variant detected in a tumor can be somatic or germline; tumor results alone may not confirm which, so confirmatory germline testing may be needed*

Why clinicians may use both in ovarian cancer:

Genetic testing primarily answers "is there inherited risk?" while tumor genomic testing answers "what treatment targets might be present?". Yet genetic testing can also give information on treatment targets like germline BRCA. Using both testing approaches can reduce missed opportunities for targeted treatment and for identifying hereditary cancer risk in family members.

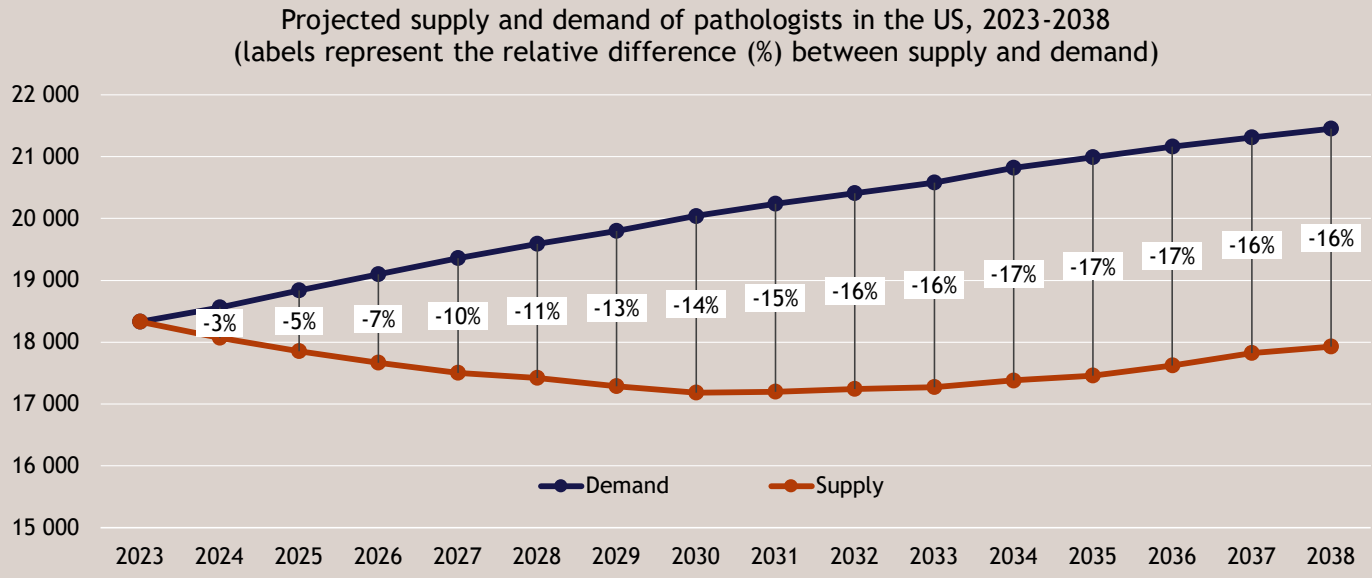

Figure 9: Projected mismatch between supply and demand of pathologists in the US, 2023-2038

Notes: Projections from the US Health Resources and Services Administration (HRSA) Health Workforce Projections Dashboard (National Center for Health Workforce Analysis). Supply and demand of pathologists are expressed as the number of full-time equivalents (FTEs). Labels represent the relative difference (%) between projected supply and demand. Source: (64).

7. HOW HAS OVARIAN CANCER TREATMENT EVOLVED IN RECENT YEARS?

Treatment of ovarian cancer typically involves a combination of surgery and systemic therapies. Treatment of ovarian cancer has historically centered on surgery, with the aim of removing the tumor and any cancer cells in the abdominal cavity (16). Over time, chemotherapy emerged as the systemic backbone of treatment, and for decades the standard approach became a combination of surgery and platinum-based chemotherapy. In current practice, treatment typically involves this combination of surgery and systemic therapies. Women with early-stage resectable disease who are fit for surgery usually undergo primary cytoreductive surgery to remove all visible tumors within the abdomen, followed in most cases by platinum-based chemotherapy (8, 18, 65). For advanced-stage cases, pre-operative (neoadjuvant) chemotherapy followed by interval debulking surgery may be performed to remove as much residual tumor as possible, followed by post-operative (adjuvant) systemic therapy (8, 18, 65). Radiation therapy has a limited role and is mainly used for palliative management of localized symptoms (e.g., pain or bleeding) (65). While advances over time initially reflected treatment refinement (such as better patient selection, supportive care, and optimization of delivery) rather than the introduction of new therapeutic classes (16), this paradigm has changed in the past decade.

Progress in systemic treatment options over the last decade. Treatment options have expanded substantially over the last decade, particularly in systemic therapies. The first major shift came with the introduction of anti-angiogenic therapy (bevacizumab) in the early 2010s, approved for use in combination with platinum-based chemotherapy in the first-line advanced disease setting and in relevant regimens continued thereafter (17). This was followed by the introduction of PARP inhibitors in the mid-2010s (olaparib, followed by niraparib and rucaparib) (17). These agents have been incorporated into maintenance strategies following response to and/or after completion of platinum-

Info box 2. How common are key biomarkers in ovarian cancer?

BRCA 1/2 pathogenic variants (inherited or tumor)

- *Overall, ~15-20% of ovarian cancers have a BRCA1/2 variant (70), with higher proportions (~30%) reported in selected advanced high-grade trial populations (70, 71). Around 11-15% have a germline BRCA1/2 variant and ~7% have a somatic BRCA1/2 mutation in high-grade serous tumors (72, 73).*

Homologous recombination deficiency (HRD)

- *HRD prevalence, which includes BRCA-mutated tumors plus other DNA-repair defects, is commonly estimated at ~41-50% (73, 74).*

Folate receptor-a (FRa) expression

- *FRa is overexpressed in ~60-100% of ovarian cancers (19, 75-77). Around 35-40% of evaluated ovarian cancer cases are classified as FRa-high (commonly defined as moderate-to-strong receptor staining on ≥75% of viable tumor cells) (75, 78-80).*

Programmed Death-Ligand 1 (PD-L1) expression

- *Pooled prevalence of positive PD-L1 expression across ovarian cancer studies is ~38%, with subgroup estimates of ~46% in Europe and ~33% in the US (81). Higher proportions (~72%) are reported in selected platinum-resistant trial populations (82).*

Note: Percentages vary across the literature because studies differ in histology mix and - especially for FRa and PD-L1 - in test methods and positivity cut-offs.

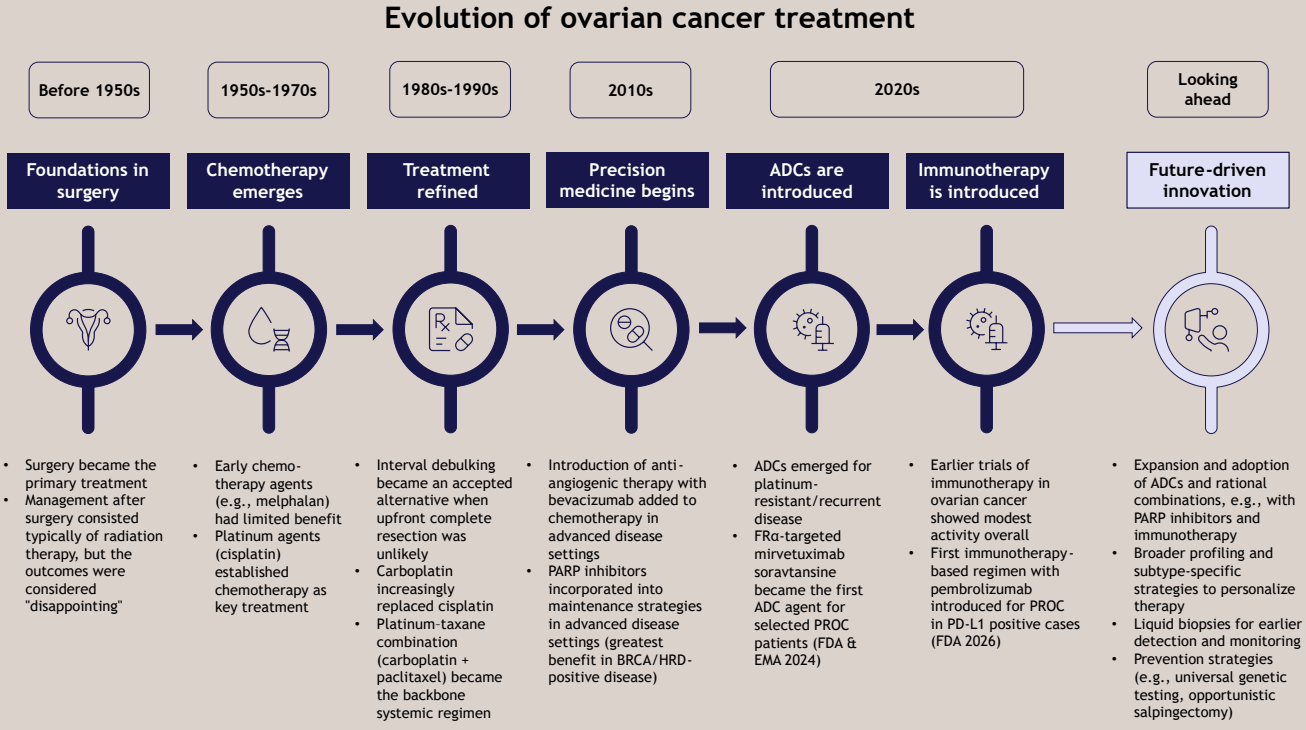

Figure 10: Evolution of ovarian cancer treatment

Notes: ADC = antibody-drug conjugate, PARP = Poly (ADP-ribose) Polymerase, BRCA = BReast CAncer gene, HRD = homologous recombination deficiency, FRa = Folate Receptor alpha, PROC = platinum-resistant ovarian cancer, FDA = U.S. Food and Drug Administration, EMA = European Medicines Agency. Source: (16-20, 66, 67).

based chemotherapy for advanced disease, with the greatest benefit observed in BRCA1/2-mutated and HRD-positive (homologous recombination deficient) cases (8, 18).

Major unmet needs and emerging options. Platinum-resistant ovarian cancer (PROC) remains a major unmet need, as available treatments in the first-line advanced disease setting often provide low response rates and short-lived benefit (17-19). A growing challenge is the management of disease that progresses after PARP inhibitor exposure, particularly once resistance to both platinum-based chemotherapy and PARP inhibitors develops (17, 19). In recent years, new modalities have entered the platinum-resistant and recurrent setting, including an FRα-targeted ADC (mirvetuximab soravtansine; approved by FDA and EMA in 2024) (66, 67), an immune checkpoint inhibitor for PD-L1-positive cases (pembrolizumab; FDA 2026) (20), and a first-in-class glucocorticoid receptor antagonist (relacorilant; FDA 2026) (68, 69). Relacorilant represents a novel treatment mechanism related to glucocorticoid receptor signaling and the role of cortisol in cancer (69). Looking ahead, earlier and broader molecular profiling and the development and adoption of additional subtype-specific therapies and rational combinations – including further ADCs - are expected to continue the personalization of treatment and drive the next wave of innovation (19).

Treatment in ovarian cancer typically involves a combination of surgery and systemic treatment. The options have expanded over the last decade, particularly in systemic treatments. Platinum-resistant ovarian cancer (PROC) remains an unmet need but new therapies are emerging.

8. HOW DOES OVARIAN CANCER AFFECT A WOMAN'S QUALITY OF LIFE?

Women with ovarian cancer often experience substantial physical burdens. Physical burdens during treatment include fatigue, pain, and reduced ability to carry out daily activities. Those diagnosed at advanced stages or receiving chemotherapy report marked declines in physical and role functioning during treatment, reflecting the combined impact of disease severity and treatment toxicity (83). Real-world evidence from the US Medical Expenditure Panel Survey similarly found that patients with ovarian cancer had worse quality of life than women without cancer (27). Beyond the acute phase, many women continue to face persistent cognitive and social functioning impairments, particularly those treated with chemotherapy (83). These long-term difficulties can affect concentration, memory, and social engagement, with effects that extend well beyond the completion of treatment. In premenopausal women, the surgical removal of both ovaries leads to early menopause, which in turn carries additional long-term health risks, including increased cardiovascular disease, cognitive decline, osteoporosis, and sexual dysfunction (84).

Women with ovarian cancer face a substantial and long-lasting psychosocial burden. Depression and anxiety are common, particularly in the first year after diagnosis when women cope with aggressive treatments and uncertainty. A large Danish cohort study found that women with ovarian cancer have a four-fold increased risk of depression in the first year after diagnosis compared to women without cancer, and importantly, this elevated risk persists for up to eight years, longer than for other gynecologic cancers (85). Advanced disease is the strongest predictor of depression, reflecting the emotional strain associated with poorer prognosis and repeated treatment cycles. Lower educational level also increases vulnerability, suggesting that social resources may shape coping capacity.

Ovarian cancer places a financial burden on both patients and their families. The financial burden of ovarian cancer arises due to both reduced income and increased care needs. Patients often rely heavily on family members: In the US, caregivers for ovarian cancer patients spend an average of 10.3 hours of daily informal care (86). Their responsibilities include attending appointments, managing symptoms, providing emotional and financial support, assisting with daily activities, and arranging transportation. In 2023, ovarian cancer patients received an average of 33 days of informal caregiving annually, with an estimated economic value of USD 471.6 million across 11 countries (23). Employment disruption is common: In the US, 21% of gynecologic cancer patients experience job loss within one year of diagnosis, with a threefold higher risk of employment disruption than women without cancer (87). These difficult circumstances point to a need for greater support including from ovarian cancer advocacy groups, such as the Ovarian Cancer Research Alliance (OCRA) and the Society for Gynecologic Oncology (SGO) Foundation for Women's Cancer in the US (88, 89).

Women with ovarian cancer often experience both physical and psychosocial burdens. The disease also places a finacial burden on patients and their families.

9. IS OVARIAN CANCER UNDERPRIORITIZED IN POLICY AND RESEARCH?

Ovarian cancer receives limited attention in global health policies. For women's cancers, the World Health Organization launched two major global initiatives with concrete and measurable targets: the Cervical Cancer Elimination Initiative in 2020 and the Global Breast Cancer Initiative in 2021 (90, 91). No comparable large-scale strategy exists for ovarian cancer, despite its considerable disease and economic burden. Policy activities for ovarian cancer are therefore largely constrained to national cancer control programs or national initiatives on women's health. Awareness efforts remain largely advocacy-driven, aiming to improve symptom recognition and highlight unmet needs in research, diagnosis, and treatment. These include Ovarian Cancer Awareness Month, observed in September in Canada and the US (92, 93) and in March in the UK (94), as well as the World Ovarian Cancer Day on May 8th (95). Ultimately, the absence of a dedicated global strategy means ovarian cancer does not benefit from the same coordinated international targets, visibility, or policy momentum as cervical and breast cancer.

Public research funding for ovarian cancer remains comparatively low. Public research funding is essential for enabling high-risk, high-reward studies that drive progress in cancer care, yet funding patterns suggest that gynecologic cancers – including ovarian cancer - remain underprioritized relative to their mortality-related burden and compared to other cancers. For example, an analysis of US National

Cancer Institute (NCI) funding (2007–2014) using a "funding-to-lethality" metric found that ovarian cancer ranked 10th of 18 cancer types analyzed and received about $97,000 in research dollars per person-years of life lost per 100 new cases, compared to $1,812,000 for prostate cancer and $1,803,000 for breast cancer (ranked first and second, respectively) (96). Similarly, more recent NCI figures from the 2021 fiscal year show that ovarian cancer received disproportionately low research funding when measured against indicators such as deaths, years of life lost (YLL), and disability-adjusted life years (DALYs) (97).

Ovarian cancer receives limited attention in global health policies and research funding remains comparatively low.

10. FIVE STRATEGIC PRIORITIES TO CLOSE THE SURVIVAL GAP IN OVARIAN CANCER

Improving outcomes in ovarian cancer requires clear strategic priorities and coordinated action across the entire care continuum. The five priority areas translate the evidence presented in this fact sheet into actionable policy directions. Together, they outline what must improve – and who must act to reduce mortality, close equity gaps, and strengthen the overall response to ovarian cancer.

PRIORITY AREA	WHAT NEEDS TO IMPROVE	KEY ACTIONS	WHO SHOULD ACT
1 STRENGTHEN PREVENTION THROUGH GENETIC RISK IDENTIFICATION AND RISK-REDUCING STRATEGIES	Many women with hereditary risk (e.g., BRCA1/2, Lynch syndrome) remain unidentified. Uptake of new preventive interventions varies.	• Expand access to genetic (germline) testing beyond strict family-history criteria and ensure reimbursement for genetic counselling and testing. • Consider integrating opportunistic salpingectomy into national surgical guidelines where appropriate. • Develop structured counselling pathways for women with elevated-risk conditions (e.g., endometriosis).	• Ministries of Health • Payers • Professional societies • Clinical guideline bodies
2 ACCELERATE RESEARCH AND INNOVATION IN EARLY DETECTION	No effective screening method exists. Most cases are diagnosed at advanced stage. Research investment remains low relative to mortality burden.	• Increase dedicated funding for ovarian cancer research, particularly for early detection methods. • Support translational research on multi-marker, genomic, and AI-based detection strategies.	• Governments & research councils • Philanthropic organizations • Academic institutions
3 STRENGTHEN DIAGNOSTIC, MOLECULAR TESTING, AND SPECIALIST CAPACITY	Uptake and reimbursement of biomarker testing remain incomplete. Pathology and gynecologic oncology workforce shortages delay diagnosis and treatment.	• Integrate NGS-based biomarker testing into standard diagnostic pathways for advanced disease. • Expand pathology and molecular laboratory capacity. • Increase training positions in gynecologic oncology and pathology. • Ensure joint reimbursement of companion diagnostics and therapies.	• Ministries of Health • Professional societies • Hospitals and cancer centers • Payers/HTA bodies
4 ENSURE EQUITABLE AND TIMELY ACCESS TO EFFECTIVE AND EMERGING TREATMENTS	Treatment options in advanced disease stages are growing, but gaps exist in rapid access to novel therapies across regions and centers.	• Centralize complex ovarian cancer surgery in high-volume, multidisciplinary centers. • Standardize national care pathways across centers. • Ensure timely reimbursement and uptake of novel and effective therapies.	• Regulators • Professional societies • Hospitals and cancer centers • Payers/HTA bodies
5 IMPROVE SURVIVORSHIP, PSYCHOSOCIAL, AND SOCIETAL SUPPORT	Women experience long-term physical, psychological, and cognitive burdens. Early menopause and cardiovascular risks require structured follow-up. Informal caregiving and employment disruption impose major societal costs.	• Implement structured survivorship programs (mental health, menopause and cardiovascular care, return-to-work). • Routinely screen for psychosocial needs and also strengthen informal caregiver support services & possibilities. • Incorporate a societal perspective in policy and economic evaluations.	• Ministries of Health • Social insurance agencies • Employers • Patient organizations

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