

Endometrial Cancer

Improving Care and
Driving Policy Change

Romania



KEY TAKEAWAYS

Endometrial Cancer in Romania

500

DEATHS ANNUALLY

Endometrial cancer is estimated to cause over 2,600 new cancer cases and 500 deaths annually in Romania.



LIMITED DATA & PRIORITY

Romania lacks a national cancer registry with nationally representative data on the endometrial cancer burden. This contributes to endometrial cancer remaining neglected in national health strategies and awareness initiatives.



LOW AWARENESS

Awareness on risk factors and signs of endometrial cancer is low, despite it being in the five most common cancers among women in the country.



GAPS IN MOLECULAR PROFILING

Testing for all three essential molecular markers - particularly POLE mutation with NGS testing - is currently not reimbursed. This hinders full utilization of personalized treatment.



RESTRICTED MEDICINE ACCESS

The current availability of novel therapies does not fully align with the latest recommendations in international clinical guidelines.

HIGH-LEVEL RECOMMENDATIONS



Integrate endometrial cancer into national health strategies



Improve data collection and availability



Raise awareness of risk factors and signs for early detection



Improve access to novel diagnostic and therapeutic technologies



Strengthen the provision of holistic cancer care and follow up

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BACKGROUND

In 2024, the Swedish Institute for Health Economics (IHE) published a comprehensive report titled *Endometrial Cancer - Improving Care and Driving Policy Change* (1). Drawing on published literature and the expertise of patient representatives, oncology nurses, and gynecologic oncologists, the report highlights unique challenges and opportunities for improving outcomes in this neglected cancer type. The report was also endorsed by the European Network of Gynaecological Cancer Advocacy Groups (ENGAGe) and the European Oncology Nursing Society (EONS).

Building on the content and findings of the main report, this policy brief focuses on the situation in Romania. It provides an overview of the burden of endometrial cancer and highlights key areas for improvement in care and policy response. Targeted literature searches were conducted to identify information on the state of care in Romania. In addition, a virtual workshop with local experts was held in June 2026 to verify and discuss challenges and opportunities specific to the care of endometrial cancer in Romania.

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 cancer¹) (1, 2).

Overweight and obesity are the most common modifiable risk factors, linked to around 40% of cases (1). Postmenopausal women with elevated estrogen level, as seen among obese women, have a two- to twelve-fold higher risk of endometrial cancer (3). Abnormal vaginal bleeding, such as postmenopausal bleeding, is the most common symptom (1). Endometrial cancer mostly affects postmenopausal women, with the median age of diagnosis being 63-66 years (3). Most cases are detected in early stages, leading to relatively high survival rates

¹ This policy brief 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 here. Based on data from the University Emergency Hospital of Bucharest (October 2016 - October 2021), endometrial cancer accounted for more than 93% of uterine cancer cases.

compared to patients with other gynecologic cancers (1). However, survival rates of endometrial cancer have not improved for almost three decades in most Western countries. This may reflect the lack of novel approaches to diagnose and treat this cancer type until recently (1).

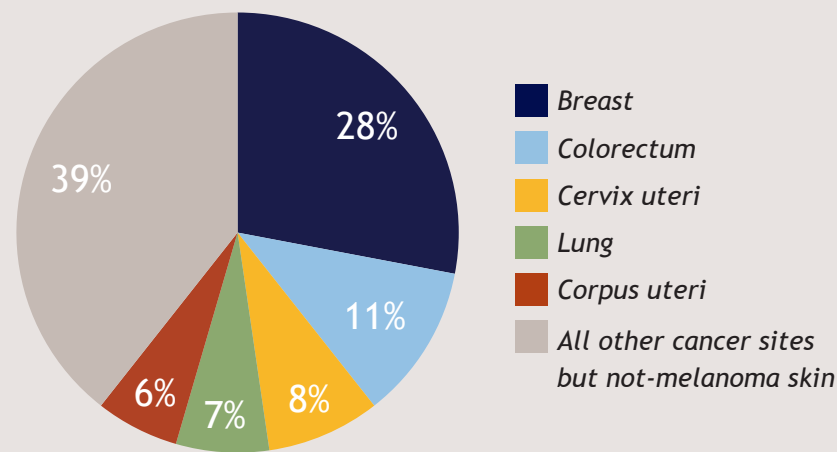
Unlike breast cancer and cervical cancer, endometrial cancer suffers from a lack of global policy initiatives and awareness. This is also true for Romania. The World Health Organization's notable focus on other cancer types contrasts with the neglect faced by endometrial cancer, leaving a gap in global women's health priorities despite the increasing burden of endometrial cancer.



DISEASE BURDEN

In 2024, an estimated number of 2,659 new cases of endometrial cancer were diagnosed in Romania. They accounted for 6% of all new cancer cases² in women and made endometrial cancer the fifth most common cancer among women of all ages in the country (4). Endometrial cancer deaths were estimated at 527 in the same year. Endometrial cancer is the fourth most common cancer among women 45-64 and 65+ in Romania, constituting 8% and 6% of all new cancer cases in these age groups respectively; similar to the EU27 numbers, i.e. 7% among women 45-64 and 5% among women 65+ (4). The aging population and high and rising overweight and obesity rates in Romania (5, 6), will likely increase the endometrial cancer burden in the country in the coming years and decades.

Leading causes of new cancer cases among women in Romania (2024)



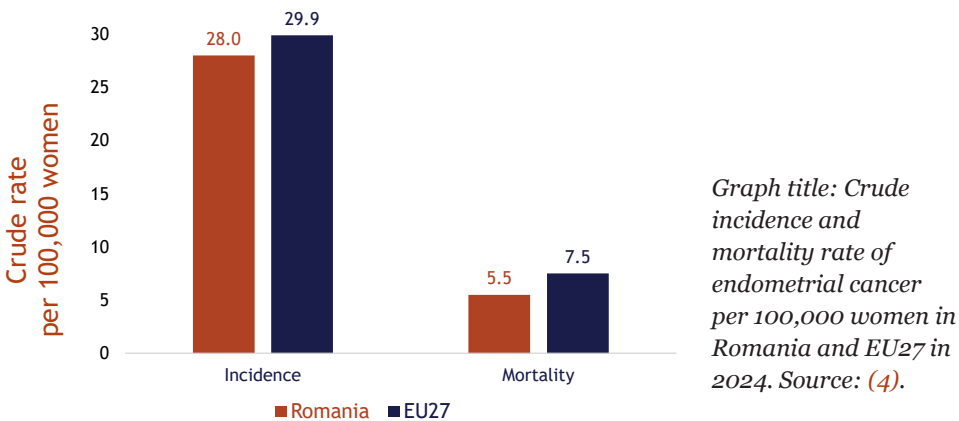
Graph title: Leading causes of new cancer cases among women in Romania in 2024. Source: (4).

² All cancers but non-melanoma skin cancer.

The real burden of endometrial cancer in Romania is unknown but seems to be increasing

Currently, Romania lacks a national cancer registry and consequently nationally representative data on the endometrial cancer burden. According to available estimates, the crude incidence rate of endometrial cancer stood at 28.0 new cases per 100,000 women in 2024, slightly lower than the EU27 average of 29.9 new cases per 100,000 women (4). In 2024, the crude mortality rate of endometrial cancer stood at 5.5 deaths per 100,000 women in Romania, and was also somewhat lower than the EU27 average of 7.5 deaths per 100,000 (4).

Incidence and mortality of endometrial cancer in Romania and EU27 (2024)



Information on long-term trends in the endometrial cancer burden in Romania is scarce due to the lack of a national cancer registry and reliable data over time. Historical data from Cluj county for the period 2008-2016 indicate that both endometrial cancer incidence and mortality increased over time; from 14.6 to 21.5 new cases per 100,000, and from 6.2 to 8.9 deaths per 100,000 respectively (7). Later data from October 2016 to October 2021, from the University Emergency Hospital of Bucharest, noted a slight decrease in uterine cancer incidence during this period (2).

Lack of survival and clinical data hinder the evaluation of performance in endometrial cancer care

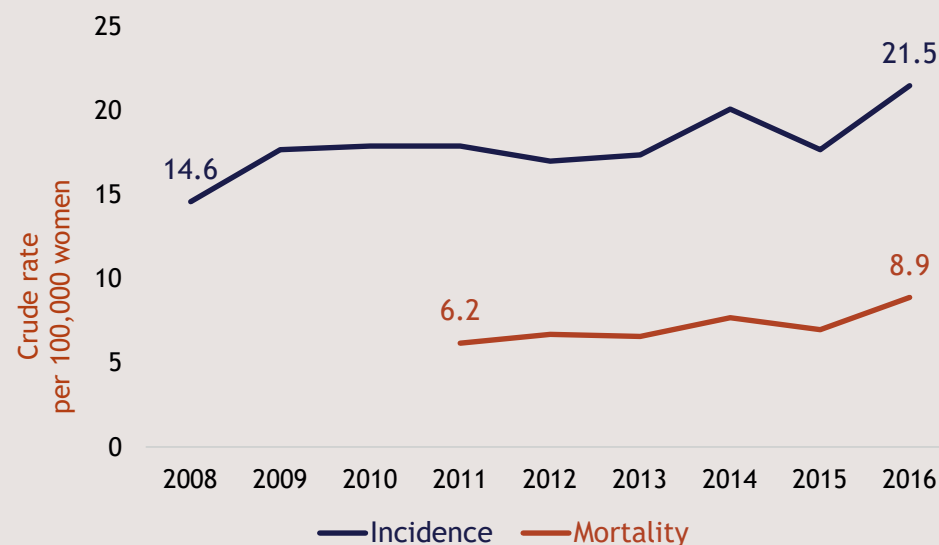
Country-wide survival or stage-at-diagnosis data are not available for Romania. This makes it difficult to assess the country's performance in diagnosing and treating patients as well as detecting cases as early as possible. This impairs the ability to have robust evidence to inform policy decisions and resource allocation.

According to the local experts, the majority of endometrial cancer cases are detected in early stages in Romania. This mirrors the situation in other countries, e.g., in Austria, Czechia, and England, around 60-66% of cases are localized or in stage I (1). Based on data from the University Emergency Hospital of Bucharest (October 2016-October 2021), uterine cancer patients had an average age of 64 years at diagnosis (2), which is similar as in other European countries (1).

Five-year survival rates of uterine cancer are around 80% in most Western countries, yet they have mostly remained stable between the 1990s up until the beginning of the 2020s (1). Survival rates are largely determined by stage-at-diagnosis and drop significantly in advanced disease. In England, five-year survival of uterine cancer for cancers diagnosed in 2018-2022 was 93% in stage I but fell to 15% in stage IV (8). Survival and stage at diagnosis also vary by ethnicity and socioeconomic status in Western countries (1), making the collection of data on socioeconomic characteristics important to monitoring and acting upon health disparities.



Incidence and mortality of endometrial cancer in Cluj county (2008-2016)



Graph title: Crude incidence and mortality rate of endometrial cancer per 100,000 women in Cluj county in 2008-2016. Source: (7).

ECONOMIC BURDEN

The total health expenditure (THE) in Romania was 5.9% of GDP in 2023, below the EU27 average of 10.1% (9). Cancer care expenditure were estimated to account for 7.7% of THE in the same year, with the per capita health spending on cancer being one of the lowest across European countries at €134 (PPP-adjusted) vs €268 in the EU27 (9).

The economic burden of endometrial cancer in Romania is unknown

As of the time of writing this policy brief, no comprehensive studies or reports evaluating the economic burden of endometrial/uterine cancer in Romania - either at a national or regional level - were identified. In addition, no publicly available data on healthcare system investments in the care of this cancer type were found. Estimates from Western countries suggest that uterine cancer accounts for 1-3% of all cancer care expenditure (1).

Apart from cancer care expenditure, indirect costs to society arise from the inability to work due to the disease (sick leave and early retirement) and lost earnings due to premature death before retirement age. Studies in Western countries have shown that the indirect costs of endometrial cancer are almost as high as the cancer care expenditure (1).



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).

Low awareness may hinder early detection of endometrial cancer

Symptom awareness is vital for timely intervention in endometrial cancer. Data on health literacy and awareness of endometrial cancer risk factors in Romania are scarce. Regional evidence from Northwestern Romania suggests a sufficient health literacy level for 59% of participants (10). Poorer health literacy is associated with lower level of education, older age, being a man, and poorer self-rated health (10). Local experts highlighted that poor health literacy and awareness constitute important challenges for the early detection of endometrial cancer, as women do not know enough about this cancer type and its signs. Although there is no screening program for endometrial cancer, evidence on cervical cancer suggests that lack of knowledge is associated with low participation in primary and secondary preventive programs, while health misconceptions may also affect screening participation (11, 12).

Sociodemographic disparities can cause inequities in healthcare seeking

Although there is a lack of evidence on endometrial cancer, studies on cervical cancer show that a large fraction of women in Romania postpone routine checks due to time and financial constraints (11). According to data from the Health Evaluation Survey carried out by the Romanian National Institute of Public Health (INSP) in 2022, lower education levels and income characterized the health profile of rural communities (13). This could impact health-seeking behavior, as higher level of education and income have been associated with higher screening participation in the context of cervical cancer (12). At the



same time, overweight and obesity, which constitute two of the most important and modifiable risk factors for endometrial cancer, were significantly more prevalent among women residing in rural areas (13). This signifies a potential risk for disparity in endometrial cancer prevalence and an opportunity for targeted health education interventions for at-risk populations.

Access to healthcare professionals may also contribute to disparities. In 2023, general practitioners (GPs) accounted for 18% of physicians in Romania, slightly below the EU average of 20% (14). Despite a small increase in the absolute number of GPs in the past decade, their share has fallen below the EU average since 2018. In addition, independent family medicine practices (61%) and GP practices (85%) are located in urban areas, alongside the majority of health professionals (15). The inequitable geographic distribution of health resources may hinder access to timely care, particularly for those living in rural communities and deepen health inequalities. Local experts highlighted that among women in remote areas reached through mobile units for cervical cancer screening, the mean time to seek medical consultation was 3-15 years. A study from Romania also found that more than half of participants would not get screened for cervical cancer by choice/demand if a mobile unit had not come to their city, with the need to travel to another city for screening identified as one of the reasons (11). Although there is no screening for endometrial cancer, the role of primary care providers remains significant in identifying relevant clinical symptoms and ensuring timely referral to specialists and necessary diagnostic services. In the Romanian reality, although a woman with symptoms of endometrial cancer should first visit a family doctor in order to be referred to a gynecologist, local experts noted that most women visit the emergency room first, indicating a need for strengthening the role of primary care and avoid overreliance on hospital services.

Genetic risk assessment for at-risk women is available but evidence on its uptake is scarce

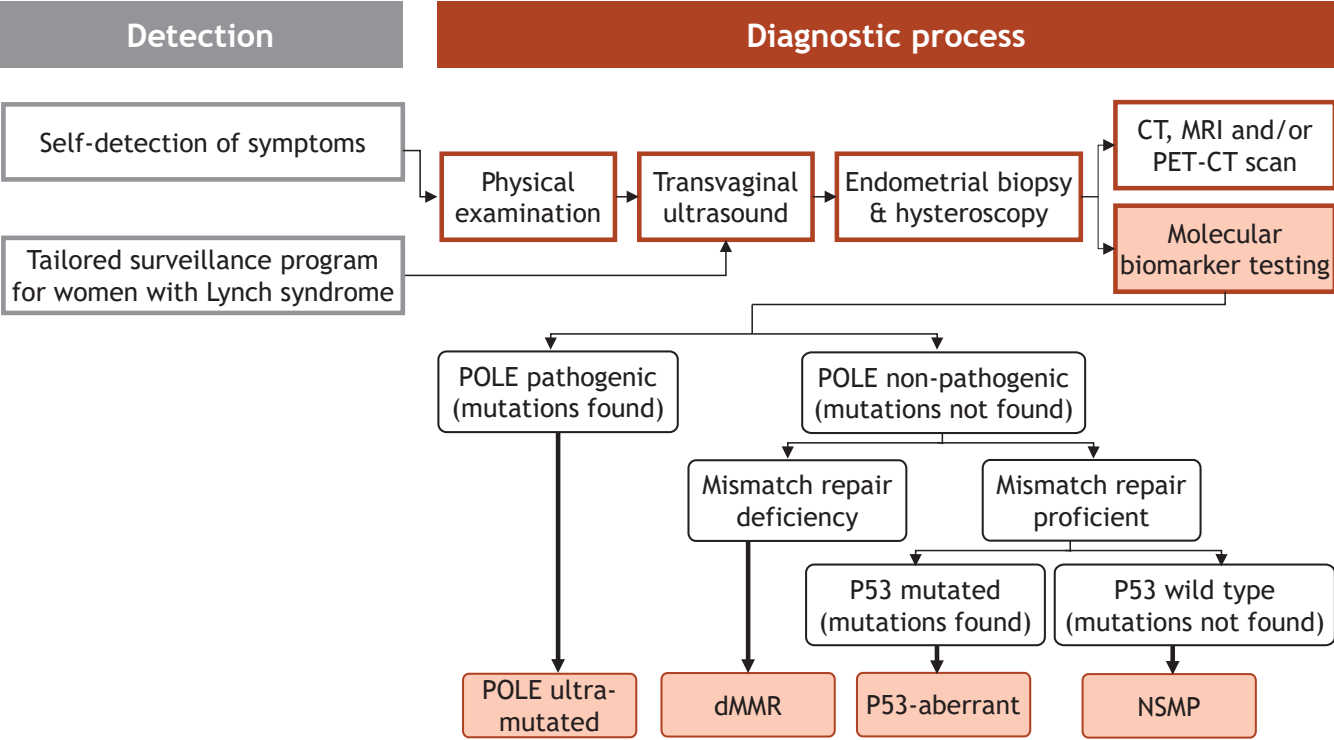
Women with Lynch syndrome (LS) have a lifetime risk of around 60% to develop endometrial cancer (16). Testing for LS is recommended for individuals who have a personal or family history suggesting an increased risk of developing Lynch syndrome-associated cancers (colon, endometrial, stomach, etc.) (17). Without proper genetic risk assessment, individuals at high risk of LS may remain unidentified, missing out on the opportunity for early detection and

preventative measures. Local experts explained that genetic counseling and germline testing for LS are available in Romania for eligible patients. Testing for LS is reimbursed by the Romanian Health Insurance House (CNAS) and may be conducted after surgery or if a woman visits a physician before the surgery. However, access, referral pathways and uptake may vary between centers. Overall, gynecologists and medical oncologists seem to be well equipped and can refer to labs for genetic testing. Nonetheless, national data on testing rates are lacking, posing a challenge in mapping the country's needs and evaluating if the full potential of genetic testing is utilized.

DIAGNOSIS

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 (present in 5-15% of patients), (ii) mismatch repair deficiency (dMMR) (25-30%), (iii) p53-aberrant (5-15%), and (iv) no specific molecular subtype (NSMP) (30-40%) (1). The prognosis of each subtype differs,

with highest survival chances in the POLE-ultra mutated subtype and lowest in the p53-aberrant subtype (1). This new classification, combined with staging insights and the introduction of novel medicines, enables more personalized treatment strategies tailored to each patient. Recently introduced medicines have focused especially on the dMMR subtype. Comprehensive molecular testing is required to facilitate this personalized approach. Specialized expertise is essential for integrating these advancements into clinical practice.



Graph title: Diagnostic algorithm for endometrial cancer.
Source: based on ESMO guidelines (18).

Reimbursement does not cover all biomarkers relevant to endometrial cancer

National guidelines for endometrial cancer diagnosis and treatment are developed by medical societies and up to date in Romania (latest version from 2022) (19), and follow international guidelines (ESGO, NCCN). However, these guidelines are not legally binding and only have recommendation status; therefore, their implementation may vary across healthcare institutions and regions. Molecular classification should be performed as early as feasible in the diagnostic and treatment pathway and should be available in a timely manner to support risk stratification and treatment decisions. In clinical practice, the timing of testing may vary between centers, and testing may be performed on biopsy or surgical specimens.

CNAS reimburses only some essential molecular testing - for LS and to classify the cancer according to the molecular profile. Currently, it covers testing immunohistochemistry for MMR and p53 but not testing for POLE for which NGS technology is required. For POLE testing with NGS to remain affordable to patients, EU projects or other projects are usually used for financing. Such projects can have a great impact on pricing; in one medical center POLE testing with NGS was offered at around EUR 400 through a project, lower than one-third of the original price (EUR 1,500). Gynecologic oncologists and medical oncologists are usually well equipped to refer patients to molecular testing.

Accessibility and availability of diagnostic services vary across the country

According to local experts, access to gynecologists is good and waiting time for consultation usually ranges from 1 to 2 weeks. In any case, women can also go to the emergency room and receive diagnosis there, see chapter on Early Detection above. Based on the ultrasound results, women are offered dilation and curettage (D&C), biopsy, or hysteroscopy. However, there is considerable variability across institutions and regions throughout the diagnostic pathway due to differences in infrastructure, referral pathways and accessibility of specialist services. The time needed to complete investigations and present a case to a multidisciplinary team (MDT) may vary from around 10 days to 4-6 weeks, depending on the medical center and the availability of diagnostic services.

There are no fully standardized diagnostic pathways across all oncology centers in Romania, leading to variation in the organization of biomarker testing, staging procedures, and referral processes. Multidisciplinary care is not implemented in all medical centers. In some centers, patients are managed through integrated multidisciplinary pathways, whereas in other oncologists take on a larger responsibility due to limited involvement of other specialties. Furthermore, diagnostic equipment remains unevenly distributed across the country, possibly posing a challenge to access for those residing in remote areas (6). An additional challenge is the difficulty in recruitment and retainment of non-medical staff (e.g. medical physicists, biochemists) in the public sector, which could affect waiting times for diagnostic services and results (6).



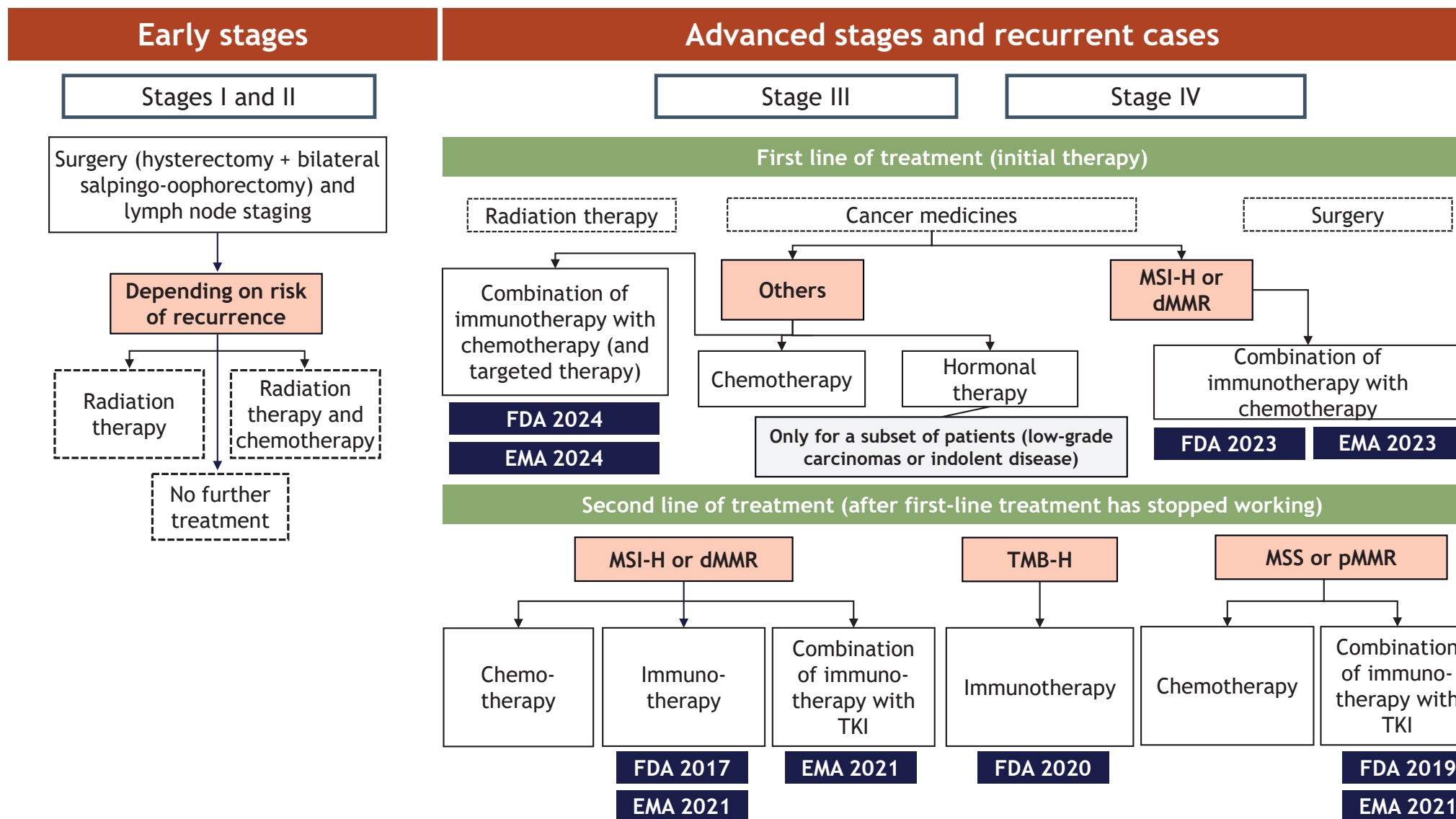
TREATMENT

The treatment of endometrial cancer depends on the stage at diagnosis, but typically comprises surgery, radiation therapy, and medicines. Surgery involves the removal of the uterus (hysterectomy) and affected lymph nodes, 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 therapy for decades, usually administered after surgery or as a standalone option for non-surgical candidates. Recent advancements, however, have introduced a wave of novel therapies, particularly immunotherapies and targeted therapies, designed to leverage the cancer's molecular profile (1). These therapies have started to 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 novel medicines, specialized expertise, and multidisciplinary care are essential for integrating these advancements into clinical practice.

National guidelines are up to date but some bottlenecks in the treatment pathway exist

National guidelines for endometrial cancer care are up to date (latest version from 2022) and follow international guidelines, as mentioned in the Diagnosis chapter (19). Furthermore, local experts noted that these guidelines were made in such a generic way that treatment can take place either in specialized or smaller hospitals. However, some issues remain in terms of the timing of molecular testing and staging, which are supposed to inform the optimal treatment approach, see chapter on Diagnosis above.





Title: Treatment algorithm for endometrial cancer. Source: based on ESMO and NCCN guidelines (18, 20). For more details, see Manzano et al. (2024) (1).

Prescription restrictions for cancer medicines create a need for efficient referral and specialist collaboration

In Romania, cancer medicines can only be prescribed by medical oncologists; gynecologic oncologists and surgeons may diagnose and surgically manage endometrial cancer patients but lack authorization to prescribe cancer medicines. This reality underlines the importance of efficient referral and collaboration between specialists to ensure optimal care coordination and treatment access.

Reimbursement of treatment options is mostly aligned with international guidelines

Romania has achieved improvements over time in the availability of newer medicines for endometrial cancer. The current reimbursement of novel treatments for advanced and recurrent endometrial cancer by CNAS (as of September 2026) mostly follows the latest approvals by the European Medicines Agency (EMA) and recommendations in clinical guidelines by ESGO-ESTRO-ESP and NCCN from 2025 (21, 22). Chemotherapy used to be the standard first-line treatment of advanced and recurrent endometrial cancer in Romania, but immunotherapy in combination with chemotherapy was recently first only reimbursed for the treatment of dMMR patients and more recently also got reimbursed in pMMR patients. In second-line treatment, immunotherapy is not reimbursed in Romania, although selected immunotherapy options may be reimbursed according to specific eligibility criteria and biomarker status. Local experts emphasized that reimbursement of new medicines should be in concordance with the expansion of reimbursed biomarkers in the country.

Table title: Reimbursement status in Romania of EMA-approved medicines in endometrial cancer recommended in ESGO-ESTRO-ESP 2025-guidelines.

Medicine	Line of therapy	ESMO MCBS	Reimbursement status in Romania (as of September 2026)
Dostarlimab	2L, MSI-H / dMMR	3	No
Pembrolizumab plus lenvatinib	2L	4	No
Pembrolizumab	2L, MSI-H / dMMR	3	No
Dostarlimab plus chemotherapy	1L dMMR	3	No
Dostarlimab plus chemotherapy	1L pMMR	4	No
Durvalumab plus chemotherapy	1L dMMR	2 4	Yes
Durvalumab plus chemotherapy and olaparib	1L pMMR	4	No
Pembrolizumab plus chemotherapy	1L	4 pMMR / 3 dMMR	Yes

Abbreviations: ESMO MCBS = European Society for Medical Oncology Magnitude of Clinical Benefit Scale; 1L = first line; 2L = second line; dMMR = mismatch repair deficiency, pMMR = mismatch repair proficiency; MSI-H = high microsatellite instability. Source: (21, 23-25).

Molecular testing could be used more to guide treatment approaches

The importance of better examination of lymph nodes was also highlighted by local experts, as well as taking histopathology into account to upscale or downscale treatment. For instance, comprehensive molecular classification, including POLE testing, can contribute to more accurate risk stratification and may influence the intensity of adjuvant treatment. Surgical lymph-node assessment should be individualized according to clinical, pathological and molecular risk factors and current international guidelines. However, this requires full molecular testing to be conducted before treatment initiation.

Multidisciplinary and holistic cancer care is not fully implemented in the country

According to local experts, the availability of medical specialists is generally adequate in major oncology centers; however, regional disparities and shortages of specific medical and non-medical professionals may affect timely access to multidisciplinary care. Despite the establishment of multidisciplinary tumor boards and discussion of treatment decisions in MDTs, post-treatment follow-up practices remain heterogeneous. Although medical oncologists are expected to coordinate follow-ups for many patients, in practice these responsibilities vary across institutions and depend on local organization; patients may be primarily monitored by medical oncologists, gynecologists/gynecologic surgeons or radiation oncologists. In addition, the composition of MDTs is not entirely uniform. Moreover, holistic cancer care is not fully provided. One aspect that is suboptimal is access to psychologists to address the psychological needs of cancer patients. In addition, access to fertility counseling and fertility preservation services is an aspect that needs strengthening so that endometrial cancer patients can make informed decisions about their treatment and reproductive future. Lastly, nutritional support by nutrition specialists is also suboptimal but would support the care process of patients. Although the country has historically faced a health workforce emigration wave, it has in recent years introduced new measures for the retainment of health professionals. This has positively impacted the annual emigration of physicians, which was reduced by two-thirds from 2012 to 2021 (26).



POLICY INITIATIVES

Endometrial/uterine 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 (27, 28), no similar large-scale strategies exist for endometrial cancer. International efforts, such as the Uterine Cancer Awareness Month (June) and World Gynecologic Oncology (GO) 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. This underscores the need for dedicated initiatives to reduce incidence, improve survival, and enhance the quality of care for endometrial cancer patients.

There are no specific targets related to endometrial cancer in the national cancer plan

The National Plan for the Prevention and Control of Cancer in Romania, adopted in 2022, does not set specific targets for endometrial cancer, though it states objectives related to cancer prevention, diagnosis and treatment and the improvement of cancer services generally, which are also relevant to endometrial cancer. Overall, there seems to be a lack of policy initiatives specifically targeting endometrial cancer in the country.

Patient advocacy gap for endometrial cancer

Advocacy initiatives have until now mostly focused on breast cancer (e.g. Race for the cure and other initiatives organized by Fundația Renașterea (29)) or cervical cancer, but no initiatives on endometrial or other gynecologic cancers are conducted systematically. Through the European Network of Young Gynaecologists (ENYGO) special awareness initiatives have taken place in Romania through social media in conjunction with the World GO Day on September 20.



RECOMMENDATIONS

Integrate endometrial cancer into national health strategies

Develop national goals with measurable targets that are specific to endometrial cancer, as well as funding mechanisms to ensure sustainability of initiatives over time.



Improve data collection and availability

Invest in data infrastructure and the development of a national cancer registry to enable the routine collection of epidemiological data and monitoring of the disease burden in the country. In addition, prioritize the collection and analysis of data of the care process, such as waiting times, use of molecular testing and medicines, that can inform targeted actions and investment.



Raise awareness of risk factors and signs for early detection

Partner with stakeholders to develop targeted education and outreach initiatives with special attention to women at-risk and those from underserved populations. Improve awareness of risk factors and signs of endometrial cancer and the pathway that should be followed if endometrial cancer is suspected.



Improve access to novel diagnostic and therapeutic technologies

Extend reimbursement of molecular testing to include POLE mutations with NGS testing to facilitate personalized treatment approaches. In parallel, establish clear guidelines to coordinate the collaboration between medical oncologists and radiotherapy specialists in using molecular classification results. Ensure access to novel therapies in line with international clinical guidelines. Introduce measures that will facilitate the conduct of clinical trials in the country to improve early access to new therapies.



Strengthen the provision of holistic cancer care and follow up

Promote multidisciplinary and holistic care in more centralized, high-quality (and/or accredited) cancer care centers. Care services should include psychological support, fertility counseling and preservation services, as well as nutritional support.



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