Bridging the gap: ensuring equitable access to advancements in gynecologic cancer therapies

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The landscape of ovarian cancer treatment has dramatically changed since the introduction of poly ADP-ribose polymerase (PARP) inhibitors and bevacizumab, with several landmark trials showing a benefit in the upfront and recurrent settings.[1] Existing evidence demonstrates that inequities exist in the administration of targeted therapy across other disease sites, but this remains unknown in ovarian cancer.[2]

In this novel study, Dr Knisely and colleagues explore racial, socioeconomical, and regional disparities in the receipt of PARP inhibitors and bevacizumab therapy in patients with ovarian, fallopian tube, or primary peritoneal cancer using the Surveillance, Epidemiology, and End Results (SEER)-Medicare database. The study uses the SEER-Medicare database to identify patients aged >65 years with advanced-stage ovarian cancer diagnosed between 2010 and 2019 with the intent to analyze disparities in targeted therapy administration. The authors report that patients with lower socioeconomic status and those who reside in the Midwest are less likely to receive PARP inhibitor and bevacizumab therapy.[3] Additionally, non-Hispanic black patients are 18% less likely than non-Hispanic white patients to receive either of the targeted therapies.[3]

Although this study encompasses a large patient cohort, its generalizability falls short in two areas. First, by using an insurance-based dataset, the study fails to include underinsured or uninsured patients, whose barriers to access are probably even greater than those reported. Second, an inherent limitation of the SEER-Medicare database is its inability to determine whether differences in the receipt of targeted therapies lead to real-world differences in oncologic outcomes. Therefore, we are unable to determine if those who did not receive therapy were also those who were less likely to benefit from that therapy.

Despite these limitations, this study highlights critical issues that warrant further discussion. In 2022, the Food and Drug Administration (FDA) revised their indications for PARP inhibitors use in the management of ovarian cancer, restricting second-line use in germline or somatic BRCA- or HRD-positive patients.[4] Consequently, both germline and somatic testing have become critical companion tests to drive appropriate use of PARP inhibitors. Research shows an inherent disparity in the rates of genetic testing, with medically underserved and minority patients accessing testing at lower rates compared with other groups.[5] This is further exacerbated by Medicare's limited coverage and reimbursement of genetic counseling, further restricting access to targeted therapies despite a universal indication for testing with an ovarian cancer diagnosis. The authors aptly advocate policy changes to address issues limiting equitable access to these services.

As we continue to prolong survival outcomes through novel targeted therapies for patients with gynecologic cancers, it is critical that we plan and perform studies that expose inequitable benefit from our advances. There are probably more life-years to be gained by ensuring equitable access to existing therapeutic advances than those to be gained from the next drug prolonging progression-free survival. Research funding and priorities must balance therapeutic advances with mitigating access disparities in order to derive the greatest benefit for our patients.

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