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Timely Access to Pelvic Ultrasound for Women with Suspected Ovarian Cancer in Aotearoa New Zealand

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Purpose

This paper examines the clinical, patient-centred and health-system case for improving timely access to pelvic ultrasound for women who present with symptoms or clinical findings suggestive of ovarian cancer in Aotearoa New Zealand. This paper does not claim that immediate ultrasound has been shown to reduce ovarian-cancer mortality; the available evidence does not support that conclusion. Instead, it advances a narrower, more defensible proposition: **when ovarian cancer is clinically suspected, timely access to appropriate pelvic ultrasound can reduce diagnostic uncertainty, characterise pelvic and adnexal abnormalities earlier, identify women requiring urgent specialist assessment, facilitate further imaging and multidisciplinary planning, and potentially detect some cancers while disease burden is lower and complete surgical cytoreduction is more achievable** [1-11]. New Zealand should therefore ensure sufficient ultrasound capacity to make timely investigation a practical reality for every woman in whom ovarian cancer is reasonably suspected, regardless of geographic location, ethnicity, socioeconomic circumstances or ability to purchase private imaging.

Executive Summary

Ovarian cancer presents a particular diagnostic challenge because its symptoms are often non-specific. Abdominal distension or persistent bloating, pelvic or abdominal pain, early satiety, urinary symptoms, bowel changes, fatigue and unexplained weight changes may all have benign causes. Nevertheless, persistent, new or progressive symptoms warrant clinical assessment. Te Aho o Te Kahu identifies CA125 measurement and pelvic ultrasound as important components of ovarian-cancer assessment and referral pathways [1,2]. New Zealand already has an appropriate national policy foundation. The Te Aho o Te Kahu *Optimal Cancer Care Pathway for people with ovarian cancer* states that women with postmenopausal bleeding or clinical suspicion of a pelvic mass should be offered a pelvic ultrasound appointment **within two weeks of receipt of referral**. Where there is high suspicion of ovarian cancer, immediate referral to hospital specialist services is recommended, with high-suspicion referrals triaged within one to two working days [12]. The central policy question is no longer whether pelvic ultrasound has a role in investigating suspected ovarian cancer; that role is already recognised. The question is whether **ultrasound capacity is sufficient, equitable and appropriately prioritised to deliver the national standard consistently throughout New Zealand.**

There is evidence that this remains an important issue. Health New Zealand has acknowledged historically variable access to ultrasound across the country and has stated that matching increased demand with capacity will take time because of workforce and service constraints [13]. Earlier official Health NZ documentation reported that waiting times for a routine pelvic ultrasound of the same clinical priority could range from **four weeks to nine months**, depending on location [14]. A subsequent 2025 Health NZ stocktake continued to identify marked geographical variation in radiology access [15]. Contemporary patient and primary-care evidence reinforces this concern. The Ovarian Cancer Foundation New Zealand's *State of Ovarian Cancer in Aotearoa New Zealand* report found that **60.82% of surveyed GPs described access to ultrasound as difficult**, with ultrasound access identified as the most frequently reported barrier to timely diagnosis [16,17]. At the same time, New Zealand currently lacks publicly available national performance information showing whether the ovarian-cancer two-week ultrasound standard is actually being met. Health NZ's national diagnostic dashboard reports waiting times for CT, MRI, colonoscopy and angiography but does not currently publish ultrasound waiting times.

This produces an important policy and measurement gap: **New Zealand has defined what timely ultrasound access should look like for women with suspected ovarian cancer, but does not**

yet publish sufficient national ultrasound-specific performance information to establish whether that expectation is being achieved consistently and equitably. International evidence supports strengthening rapid symptom-triggered investigation. Ultrasound can establish whether pelvic or adnexal abnormalities are present, characterise their morphology, help distinguish benign from suspicious masses and identify women requiring CT imaging and specialist gynaecological-oncology assessment [4,7,8]. Recent evidence from the UK ROCkeTS programme is particularly relevant. Among women with high-grade serous ovarian cancer diagnosed through a symptom-triggered fast-track pathway, 25.2% were diagnosed at FIGO stage I or II, 64.7% had low-to-moderate disease distribution, and 61.3% achieved complete cytoreduction [6]. These findings do not prove that ultrasound itself produced these outcomes. They do, however, support the clinical rationale for avoiding unnecessary delay once symptoms justify investigation.

The principal recommendation of this paper is consequently straightforward:
New Zealand should ensure that every woman who meets nationally defined clinical criteria for suspected ovarian cancer has reliable access to appropriate pelvic ultrasound within the existing recommended timeframe, with accelerated access when clinical urgency requires it, and should publicly measure achievement of that standard.

1. The Diagnostic Problem in Ovarian Cancer

Unlike cancers for which a discrete external lesion or highly characteristic early symptom may trigger investigation, ovarian cancer frequently begins with symptoms that overlap with common gastrointestinal, urinary and gynaecological conditions. Symptoms may include abdominal distension, persistent bloating, pelvic or abdominal pain, early satiety, urinary urgency or frequency, bowel changes, fatigue and unexplained weight loss [1,2]. This creates the possibility of diagnostic diffusion. A woman may present repeatedly to primary care, undergo treatment for alternative explanations, have different diagnoses considered and only subsequently enter a cancer diagnostic pathway. A systematic review examining diagnostic pathways for gynaecological cancers found that diagnostic delay is multifactorial and can involve patient factors, clinician factors, referral processes and health-system barriers, including access to diagnostic investigation [9].
The appropriate response is not indiscriminate population screening of asymptomatic women. Rather, it is a **responsive diagnostic pathway once symptoms, examination findings, biochemical markers, risk factors or clinical judgement establish reasonable grounds for further investigation.**

Screening and symptom-triggered investigation are fundamentally different.

Population screening asks whether apparently healthy people should undergo testing.

Symptom-triggered investigation asks whether a woman who already has symptoms or findings of clinical concern can obtain appropriate investigation without unnecessary delay.
This paper concerns the latter.

2. The New Zealand Reality: The Standard and Actual Access

New Zealand has already established a clear clinical expectation for timely pelvic imaging.

The Te Aho o Te Kahu *Optimal Cancer Care Pathway for people with ovarian cancer* states that women with postmenopausal bleeding or clinical suspicion of a pelvic mass should be offered an appointment for pelvic ultrasound **within two weeks of the date on which the referral is received**. If there is high suspicion of ovarian cancer, referral to hospital specialist services should occur immediately; high-suspicion cancer referrals should be triaged within one to two working days [1]. This is an important starting point. The argument for enhanced ultrasound provision does not require the creation of a completely new clinical standard. A national expectation already exists. The more difficult question is whether this expectation is being achieved consistently in practice.

2.1. Health New Zealand has Acknowledged Variation in Access

In a September 2025 aide-mémoire to the Minister of Health specifically addressing **access to ultrasound in primary care**, Health New Zealand described ultrasound as an important diagnostic tool for cancer and acknowledged that access had historically varied across the country. Health NZ identified its Community Referred Radiology programme as the principal initiative intended to provide more consistent primary- and community-care access to ultrasound [13]. Significantly, the same briefing recognised that aligning increased diagnostic demand with available capacity would take time because of workforce and capacity constraints in hospital, specialist and private services [13]. This is important because increased referral rights without corresponding scanning capacity cannot, by themselves, ensure timely investigation.

2.2. Previous Official Data Illustrate the Scale of Variation

Official Health New Zealand papers released under the Official Information Act provide useful evidence of the historical scale of this variation. In a 2024 briefing concerning the expansion of Community Referred Radiology, Health NZ stated that diagnostic-radiology waiting times varied considerably across New Zealand and that some patients were waiting too long, particularly for routine ultrasound. Most notably, Health NZ reported that waiting times for the **same clinical priority**, using routine pelvic ultrasound as the example, ranged from approximately **four weeks to nine months** [14].

That figure requires careful interpretation.

It is historical evidence from before the subsequent national Community Referred Radiology reforms. It should therefore **not** be presented as the current national average waiting time for women with suspected ovarian cancer. It remains significant because it shows that geography has previously produced markedly different

patient experiences for examinations of the same type and clinical priority.

2.3. More Recent Health NZ Evidence Shows that the Problem has been Recognised

In a July 2025 briefing to the Minister of Health on implementation of Community Referred Radiology, Health NZ reported that a 2024 national stocktake had found that access to radiology services **varied greatly across the country**, including variability in referral pathways and urgent imaging access [15]. Health NZ has subsequently developed national Community Referred Radiology criteria and has stated that the programme is intended to provide consistent and clinically appropriate access to diagnostic imaging, including ultrasound. It projected full national implementation from July 2026 [18]. This represents significant system development and should be acknowledged positively. The current policy question, however, is whether those reforms have translated into consistent achievement of the specific ovarian-cancer diagnostic timeframe.

2.4. Contemporary GP Evidence Suggests Access Remains Difficult

The Ovarian Cancer Foundation New Zealand's *State of Ovarian Cancer in Aotearoa New Zealand* report, launched at Parliament in February 2026, adds important contemporary evidence from primary care and women with lived experience [17].

Among surveyed GPs:

- **60.82% Described Access to Ultrasound as Difficult;**
- 29.09% regarded access as adequate; and
- only 9.2% described access as easy.

The report identified poor access to ultrasound as the most commonly reported barrier to timely diagnosis. GP respondents described difficulties obtaining approval for scans, lengthy waits and circumstances in which women who could afford to do so were advised or chose to obtain imaging privately [17]. The report also records a lived-experience account from a woman who self-funded a private ultrasound after being advised that the potential public-system wait could be approximately five months. Again, that individual experience must not be mistaken for a national average. Its value is different: it demonstrates the practical consequences that lengthy or uncertain access can have for individual women.

2.5. National Ultrasound Waiting-Time Performance is not Presently Transparent

A further issue is the availability of national data.

Health New Zealand currently publishes a national diagnostic dashboard showing waiting-time information by region and district for:

- CT imaging;
- MRI;
- colonoscopy; and
- angiography [16].

Ultrasound is not presently included as a separately reported national waiting-time measure. Health NZ has described the national radiology dataset as still developing and has been working toward systems capable of reporting scan activity and waiting lists at district and examination level [15,16]. Consequently, it is currently difficult from publicly available national information to answer a basic quality-assurance question:

What proportion of New Zealand women referred for pelvic ultrasound because of clinical suspicion of ovarian malignancy actually receive that examination within the recommended 14-day period?

That information should be available.

2.6. The Implementation Gap

Taken together, the evidence reveals a clear distinction between **policy expectation and demonstrated delivery**.

New Zealand has:

- an established two-week pelvic-ultrasound expectation for women with postmenopausal bleeding or clinical suspicion of a pelvic mass [1].
- a national programme specifically designed to improve and standardise community access to ultrasound [13,15,18].
- substantial annual investment in community-referred radiology [14,18].
- documented historical evidence of considerable geographical variation [14,15].
- contemporary GP evidence that access remains problematic for many patients and
- no presently published national ultrasound-specific dashboard demonstrating compliance with the ovarian-cancer timeframe [16,17].

The resulting policy issue is therefore not simply one of creating additional referrals.

It is one of ensuring **capacity, access, measurement and accountability.**

3. Ultrasound Is a Diagnostic Gateway, Not a Stand-Alone Cancer Diagnosis

Pelvic ultrasound should not be portrayed as a definitive diagnostic test for ovarian cancer. Histopathological examination is generally required to establish a definitive cancer diagnosis.

Nevertheless, ultrasound occupies a critical position near the beginning of the diagnostic pathway.

The New Zealand pathway includes imaging and tumour markers in the assessment of suspected ovarian cancer and identifies elevated CA125 as an indication for pelvic ultrasound. It also recognises pelvic-ultrasound findings suggestive of cancer as grounds for high-suspicion specialist referral [1]. International guidance similarly places ultrasound near the beginning of the diagnostic process. Where ultrasound findings, CA125 and the clinical picture indicate possible ovarian malignancy, CT imaging can then be undertaken to establish disease extent and inform management [3,4].

Ultrasound consequently acts as an important **diagnostic gateway.** It can move a woman from an uncertain symptom complex toward one of several more clearly defined pathways:

- no significant pelvic abnormality identified, accompanied by appropriate clinical review and safety-netting;
- a likely benign abnormality requiring observation or non-oncological management;
- an indeterminate adnexal lesion requiring further assessment; or
- suspicious findings requiring expedited specialist gynaecological-oncology investigation.

That clarification has clinical value regardless of whether the eventual diagnosis is malignant or benign.

4. Ultrasound Can Distinguish Many Benign from Suspicious Adnexal Masses

The clinical value of ultrasound extends beyond identifying whether an ovarian mass is present.

Contemporary transvaginal ultrasound can assess:

- morphology;
- solid components;
- papillary structures;
- septations;
- vascularity;
- ascites; and
- other features associated with risk of malignancy.

In a large prospective International Ovarian Tumor Analysis validation study involving 1,938 women with adnexal masses, the IOTA Simple Rules produced a conclusive classification in approximately 77% of masses. Where the rules were conclusive, sensitivity for malignancy was approximately 92% and specificity approximately 96% [7]. Systematic evaluation of structured ultrasound-based adnexal assessment has similarly demonstrated high sensitivity for malignant masses, although performance varies with the population studied, operator expertise and diagnostic setting [8]. This has an important implication for health policy. Improved ultrasound access is not merely a mechanism for finding cancers. It can also assist clinicians to identify **women whose abnormalities are likely to be benign**, helping to avoid unnecessary cancer-pathway escalation while directing limited specialist resources toward those with suspicious findings.

5. Earlier Investigation May Identify Disease at a Lower Burden

The prospective Diagnosing Ovarian Cancer Early (DOvE) pilot investigated symptomatic women aged 50 years or older using CA125 and transvaginal ultrasound through an open-access diagnostic service [5]. Eleven invasive ovarian cancers were identified. Women diagnosed through the DOvE pathway had substantially lower median CA125 values than ovarian-cancer patients referred through the conventional pathway, suggesting comparatively lower disease burden. Eight of the eleven ovarian tumours diagnosed through DOvE were considered completely resectable, compared with 33 of 75 conventionally referred tumours, although this difference did not reach conventional statistical significance. The study also demonstrated an important limitation: some high-grade serous malignancies originated outside the ovary and produced relatively little ovarian abnormality on ultrasound. A normal ultrasound must therefore not automatically terminate clinical investigation where symptoms remain persistent, progressive or otherwise concerning. More recent evidence from the ROCkeTS programme adds substantially to the argument for rapid symptom-triggered investigation.

Among women with high-grade serous ovarian cancer diagnosed after entering a fast-track symptomatic pathway:

- **25.2% had FIGO stage I or II disease;**
- **64.7% had low-to-moderate disease distribution; and**
- **61.3% achieved complete cytoreduction [6].**

These findings should not be interpreted as proving that rapid ultrasound causes early-stage diagnosis.

They do, however, demonstrate that **symptom-triggered pathways incorporating ultrasound and tumour-marker assessment can identify a clinically important subgroup of women while disease burden is comparatively limited and potentially more amenable to complete surgical treatment.**

6. Earlier Imaging Improves the Speed and Quality of Clinical Decision-Making

For the individual woman, one of the immediate benefits of timely ultrasound is that clinical uncertainty becomes actionable information. Without imaging, persistent abdominal or pelvic symptoms may lead to repeated consultations, empirical treatment and sequential reassessment.

Once appropriate ultrasound has been performed, the clinician has substantially more information on which to base management. Where suspicious pathology is identified, ultrasound morphology, CA125, symptoms and clinical examination can be integrated to determine the urgency of specialist referral [1,4,7].

Where malignancy is suspected, the pathway can then progress to:

- CT staging;
- specialist gynaecological-oncology assessment;
- anaesthetic and fitness assessment where appropriate;
- multidisciplinary review; and
- treatment planning [1,4].

Conversely, where imaging demonstrates a benign explanation for symptoms, appropriate non-cancer management may proceed without unnecessary specialist-oncology referral.

Timely ultrasound therefore supports both **appropriate escalation and appropriate de-escalation.**

7. The Relationship Between Diagnostic Timing and Surgical Opportunity

Ovarian-cancer surgery differs from many other cancer procedures

because the amount of residual macroscopic disease after cytoreductive surgery is strongly associated with subsequent clinical outcomes. A meta-analysis involving 13,257 women with advanced ovarian cancer found that higher rates of complete cytoreduction to no gross residual disease were independently associated with improved cohort survival [10]. A subsequent systematic review and network meta-analysis involving more than 20,000 patients reinforced the prognostic importance of achieving no macroscopic residual disease after primary surgery [11]. These findings should not be interpreted to mean that prompt ultrasound itself guarantees successful cytoreduction. Disease biology, distribution, patient fitness, surgical expertise, systemic treatment and treatment strategy remain major determinants.

However, the evidence supports a rational clinical principle:
Where potentially significant disease is suspected, there is no therapeutic advantage in avoidable diagnostic delay. If investigation identifies a woman while disease distribution remains comparatively limited, an opportunity may exist for earlier specialist planning and potentially more complete surgical treatment. The ROCkeTS findings of lower disease burden and high rates of complete cytoreduction among women diagnosed through symptom-triggered pathways are consistent with this rationale [6,10,11].

8. CA125 and Ultrasound Should Be Regarded as Complementary

CA125 is useful but cannot safely function as a universal gatekeeper to imaging.

CA125 may be normal in some ovarian cancers, particularly earlier-stage disease and in some younger women [2]. International guidance has increasingly recognised the importance of integrating symptoms, age, laboratory findings and imaging rather than relying on a single universal biomarker threshold [3]. This has an important implication for New Zealand policy. Access to ultrasound should follow **appropriate clinical suspicion and nationally defined diagnostic pathways**, rather than requiring every woman to demonstrate a markedly abnormal tumour marker before imaging can be obtained. Clinical judgement, symptoms, examination findings, family or genetic risk, age, CA125 and ultrasound should operate as complementary components of a diagnostic pathway.

9. Shortening Diagnostic Uncertainty Is Itself a Patient-Centred Benefit

A cancer diagnostic pathway is experienced by the patient not as a sequence of administrative referrals but as a period of uncertainty. The woman knows that something may be wrong but does not yet know whether she has:

- a benign condition;
- a gynaecological disorder requiring treatment;
- another abdominal or pelvic disorder; or
- malignancy.

Avoidable intervals between clinical suspicion and appropriate imaging prolong that uncertainty.

The Te Aho o Te Kahu pathway explicitly places the person and whānau at the centre of cancer care and recognises the importance of timely investigation, communication and coordination [1].

Enhanced ultrasound availability therefore has value even when the eventual result is benign.

The goal is not merely to “find more cancers”.

It is to provide the woman with an appropriate clinical answer and the next step in her care as promptly as reasonably possible.

10. Equity Is Part of Diagnostic Quality

A national standard has limited practical meaning if it can readily be achieved by a woman able to purchase private imaging but not by another woman dependent upon publicly funded services.

Te Aho o Te Kahu identifies equity as a central principle of optimal cancer care and acknowledges that people can face barriers because of geography, personal circumstances and background [1].

The *State of Cancer in New Zealand 2025* similarly documents continuing inequities affecting Māori, Pacific peoples and people living in communities with greater socioeconomic deprivation [12]. The Ovarian Cancer Foundation New Zealand report raises the same concern from the perspective of ovarian-cancer diagnosis. Some GPs reported advising women to obtain private ultrasound where public access was difficult or delayed [17].

This introduces an important equity question.

If timely imaging influences the speed with which diagnostic uncertainty can be resolved and specialist assessment initiated, access to that imaging should not depend principally upon whether a woman can afford several hundred dollars for private investigation.

Enhanced ultrasound provision should therefore be considered not only a diagnostic-capacity intervention but also an **equity intervention**.

National monitoring should examine referral-to-ultrasound intervals according to:

- region;
- ethnicity;
- socioeconomic deprivation;
- rurality;
- public versus privately funded pathway; and
- relevant clinical priority.

The governing principle should be straightforward:
Clinical urgency—not postcode or personal purchasing power—should determine access to diagnostic imaging.

11. What Enhanced Ultrasound Provision Should Mean

Enhanced provision does not mean indiscriminate ultrasound scanning. Nor does it imply that every woman experiencing a transient gastrointestinal symptom requires urgent pelvic imaging. It means ensuring that when a clinician establishes that symptoms, physical findings, biochemical markers, genetic or family risk, or an identified pelvic abnormality create a reasonable suspicion warranting pelvic imaging, the system has sufficient capacity to perform that investigation within the nationally recommended timeframe. For the cohort covered by the existing Te Aho o Te Kahu pathway, **two weeks provides an established national benchmark** [1]. Where clinical findings indicate particularly high suspicion, acute deterioration or rapidly progressive disease, investigation should proceed more rapidly according to clinical need and specialist referral should not wait for completion of every sequential test. The availability of an ultrasound appointment should not itself become the rate-limiting step in an otherwise appropriate ovarian-cancer diagnostic pathway.

12. Proposed Policy Response

Recommendation 1 — Guarantee delivery of the existing two-week standard

Health New Zealand should ensure that women meeting the relevant clinical criteria for suspected ovarian cancer can consistently obtain pelvic ultrasound within two weeks of referral, as specified in the Te Aho o Te Kahu Optimal Cancer Care Pathway [1].

The emphasis should be on **delivery of an existing national standard**, rather than creation of a new one.

Recommendation 2 — Establish protected urgent pelvic-ultrasound capacity

Regional imaging services should maintain protected or flexibly expandable capacity for suspected gynaecological malignancy so clinically important referrals are not routinely displaced by lower-priority imaging demand.

Recommendation 3 — Maintain straightforward primary-care access

General practitioners and other authorised primary-care clinicians should have straightforward access to pelvic ultrasound for women meeting nationally defined criteria, reducing unnecessary intermediate appointments before imaging can be obtained.

This aligns with the objectives of Health NZ's Community Referred Radiology programme [13,15,18].

Recommendation 4 — Allow accelerated imaging when clinical urgency warrants it

The two-week benchmark should represent a maximum pathway expectation for the defined cohort, not a requirement to wait two weeks.

Where findings suggest high clinical urgency, faster imaging should be possible.

Recommendation 5 — Standardise the quality of pelvic-ultrasound assessment

Pelvic-ultrasound reporting for adnexal masses should use appropriate standardised morphological terminology and validated risk-assessment approaches where applicable, supported by suitable sonographer and radiologist expertise [7,8].

Recommendation 6 — Require clinical safety-netting after apparently reassuring imaging

A normal or apparently benign ultrasound should not automatically terminate clinical assessment where symptoms remain persistent, progressive or concerning.

Some high-grade serous malignancies may produce limited ovarian abnormality on ultrasound [5].

Recommendation 7 — Explicitly incorporate equity into service design

Performance should be examined by geography, ethnicity, socioeconomic deprivation and rurality.

Mechanisms such as coordinated booking, transport assistance, navigation and strategic use of public and contracted private capacity should be employed where access barriers exist [1,12,18].

Recommendation 8 — Establish a national ovarian-cancer ultrasound quality indicator

Health New Zealand should publicly report:

The proportion of eligible referrals for suspected ovarian cancer or clinically suspicious pelvic mass for which pelvic ultrasound is completed within 14 days of receipt of referral.

Reporting should include regional and equity stratification.

This would transform the existing clinical expectation into a measurable quality indicator.

Recommendation 9 — Report the entire diagnostic interval

Measurement should extend beyond the scan itself to include:

- referral-to-ultrasound interval;
- ultrasound-to-report interval;
- abnormal ultrasound-to-specialist-referral interval;
- specialist assessment interval;
- completion of CT or other staging;
- multidisciplinary review;
- treatment-planning interval; and
- patient-reported experience.

The objective should be to identify where delay is actually occurring rather than assuming that every delay originates in the same part of the pathway.

Recommendation 10 — Monitor declined or redirected referrals

Because access can also be delayed through rejection, redirection or requests for additional information, Health NZ should measure the proportion of pelvic-ultrasound referrals that are:

- accepted;
- declined;
- returned for additional information;
- redirected to another pathway; or
- subsequently undertaken privately.

This would provide a much clearer picture of genuine access than waiting-time statistics alone.

13. What This Proposal Does Not Claim

Scientific credibility requires the limits of the evidence and of this proposal to be explicit.

This paper does **not** claim that same-day pelvic ultrasound has been proven superior to ultrasound undertaken several days later.

It does not claim that ultrasound can exclude every ovarian cancer. It does **not** propose population ultrasound screening of asymptomatic women.

It does **not** claim that earlier ultrasound guarantees earlier-stage disease.

It does **not** claim that ultrasound alone improves surgical outcomes.

It does **not** claim that historical waits of four weeks to nine months represent present-day national waiting times. And it does not claim that a lived-experience report of a five-month public wait represents the typical experience of New Zealand women.

The proposition is narrower and better supported:

When symptoms or clinical findings warrant investigation for possible ovarian malignancy, unnecessary delay in obtaining appropriate pelvic ultrasound offers no diagnostic benefit, whereas timely ultrasound can provide clinically actionable information, stratify risk, direct specialist referral, facilitate subsequent staging and treatment planning, and in some women contribute to detection while disease burden remains comparatively limited [1,4-8].

14. A Practical New Zealand Policy Proposition

New Zealand already has much of the required framework.

It has:

- a national ovarian-cancer clinical pathway;
- a two-week expectation for relevant pelvic ultrasound;
- national Community Referred Radiology criteria;
- direct community referral mechanisms;
- substantial investment intended to reduce geographical inconsistency; and
- national cancer quality and equity objectives.

The principal opportunity is therefore to ensure **capacity and accountability match the pathway.**

A nationally supported approach to pelvic-ultrasound access for women with suspected ovarian cancer would not constitute a new population-screening programme.

It would be an **implementation, diagnostic-capacity and quality-assurance initiative.**

Its initial success could be measured by outcomes that are directly attributable to service delivery:

- the percentage of eligible women scanned within 14 days;
- median and 90th-percentile referral-to-scan time;
- variation between regions;
- ethnic and socioeconomic equity in access;
- proportion of referrals declined or redirected;
- time from suspicious ultrasound to specialist review;
- patient experience of the diagnostic process; and
- disease distribution and surgical outcomes among women ultimately diagnosed with ovarian cancer.

These indicators would allow New Zealand to determine objectively whether enhanced ultrasound capacity is delivering the intended clinical and patient benefits.

15. Conclusion

The case for enhancing access to pelvic ultrasound for women with suspected ovarian cancer does not depend upon making an unproven mortality claim. The case rests on more immediate and demonstrable clinical principles. Ovarian-cancer symptoms are frequently non-specific. Clinical examination and CA125 alone cannot reliably resolve the differential diagnosis. Pelvic and transvaginal ultrasound are established first-line investigations capable of identifying and characterising adnexal abnormalities and distinguishing many benign conditions from abnormalities requiring urgent specialist assessment [1-4,7,8]. Prospective symptom-triggered diagnostic studies demonstrate that rapid investigation pathways can identify women with comparatively lower tumour burden and can identify a meaningful proportion of women with high-grade serous disease while their cancer is early-stage or relatively limited in volume [5,6]. The importance of avoiding unnecessary delay is reinforced by the relationship between complete cytoreduction and ovarian-cancer outcomes. But the New Zealand evidence adds another dimension [10,11]. The country has already defined the expected pathway. Women with postmenopausal bleeding or clinical suspicion of a pelvic mass should be offered pelvic ultrasound within two weeks [1]. At the same time, official Health New Zealand documents demonstrate that ultrasound access has historically varied substantially across the country and that workforce and capacity constraints remain relevant to service development [13-15]. Contemporary evidence from primary care indicates that access remains difficult for many clinicians and their patients [17]. Yet New Zealand does not presently publish national ultrasound-specific waiting-time performance capable of demonstrating how consistently the ovarian-cancer two-week standard is being achieved [16]. This leads to a clear and achievable policy proposition:

Provide sufficient diagnostic-ultrasound capacity to deliver New Zealand's existing ovarian-cancer pathway consistently; enable faster imaging when clinical urgency requires it; protect equitable access regardless of geography or ability to self-fund; and publicly measure whether the 14-day standard is actually

being achieved. For the woman experiencing symptoms, timely ultrasound is not simply another technical investigation. It is often the point at which uncertainty begins to become information, information becomes a clinical decision, and a clinical decision becomes a pathway forward.

Declarations

Consent for Publication: The author consents to publication.

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Central Hypothesis: "Reduced repair reserve under autonomic constraint" is proposed as a hypothesis-generating conceptual model and is not presented as an established diagnostic entity.

Ethics and Consent: This policy paper did not involve human participants, an intervention or the systematic collection of research data; ethics approval and participant consent were therefore not required.

Data Availability: No original research dataset was generated or analysed. The paper draws on the publicly available sources listed in the references.

Generative AI and Assistive Communication Disclosure

ChatGPT (OpenAI) was used as an assistive communication and manuscript-preparation tool to support organisation, sentence construction, spelling, transcription and the conversion of the author's notes and arguments into academic prose. This use was intended to mitigate substantial dyslexia-related writing and sequencing barriers and cognitive fatigue. The author supplied and reviewed the substantive content, factual claims, interpretations, citations, arguments and conclusions; retained full editorial control; and accepts responsibility for the manuscript. The tool did not generate research data, determine findings or qualify for authorship.

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