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ASIA EDITION

If More than Half the World's Cancer Is in Asia, At Least Half the Solutions Must Be Born Here

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There was a time when getting something from another country felt special. Now it's ordinary: a few taps, a delivery update, and you'll find a package at the door within days. COVID briefly reversed that instinct. We looked closer to home. We celebrated local businesses. We learned that resilience isn't just about what you can bring in, it's about what you can build locally with homegrown experts at the helm.

Our approach to cancer care deserves that same mindset. Asian patients need solutions and treatments designed for them, led by researchers who understand the realities on the ground. In a region that disproportionately carries nearly half of the world's cancer burden, we cannot rely on an imported playbook from the west to tackle this deadly reality that is robbing millions of their lives.

Asia's differences stem from more than just biology

We know that the uniqueness of our Asian genetics puts our populations at a higher risk of cancers that may not be as common in Western populations. For example, nearly between 30-50% of the Asian population harbours the EGFRm gene, putting them at risk for non-small cell lung cancer. This is significantly higher than the 14% to 17% prevalence observed in Western (Caucasian) populations. In the clinic, we see this translated into real life with middle-aged women diagnosed with

lung cancer having never smoked a day in their lives.

But that's not where the differences between our patients and their Western counterparts end. Across the region, diagnoses tend to be delayed, resulting in poorer outcomes. Patients also experience different care pathways, with varying access to care and resources influencing their cancer journey. Culture, financial status and social stigma are all factors that physicians must consider when creating multidisciplinary treatment plans.

These realities are only truly appreciated by the clinicians that are having these daily conversations with patients, who make it a point to delve deep into the nuances such as their clinical histories, the financial realities that could impede their treatment selection and whether they are able to even reach the hospitals to receive their treatments. That context should not stay in the consultation room. It needs to be translated into research questions, trial designs, and care models that can be tested in routine practice and improve outcomes at scale.

Solutions here are critical for global progress against cancer

Research generated in Asia, led by Asian investigators in partnership with Asian communities, is not a regional niche. It is essential to global cancer progress for three key reasons: it changes what we know, it changes what gets used, and it changes how fast effective treatments reach patients.

First, representation changes results because it directly shapes better treatment approaches. Cancer is not evenly distributed, and neither is treatment response. Across Asia, disease patterns, risk exposures, and pharmacogenomics differ in ways that materially affect care. When Asian populations are adequately represented in trials and real-world datasets, clinicians can determine the right therapy for the right patient with greater confidence. That means clearer evidence on which biomarkers to test for, which regimens work best in practice, how to tailor dosing, how to anticipate toxicity, and how to sequence therapies for patients who may present later or with different comorbidities. Representation in research is not about optics; it is about getting the treatment strategy right.

Second, relevance drives adoption. Asia-led studies ask the questions that determine whether a breakthrough becomes a benefit: affordability, access, diagnostic capacity, workforce constraints, and culturally attuned patient navigation. Pragmatic trials, implementation science, and real-world evidence generated in our hospitals and communities do not compete with discovery research. They complete it. They are the bridge between an intervention that works in controlled settings and a solution clinicians can use tomorrow in systems with different resources and realities.

Third, scale accelerates impact, and Asia has it. Our health systems are varied but increasingly connected. Testing innovations across languages, geographies, and resource levels can produce guidance that is more robust, more generalizable, and ultimately more useful everywhere. To realize this potential, we need more Asian-led consortia and multicenter pragmatic trials, bilingual protocols and consent, locally adapted endpoints, and data infrastructures that make cross-border collaboration routine. Journals, funders, regulators, and conferences must also prioritize Asian investigators on panels and editorial boards and expand pathways for trainees to contribute early. Global platforms that showcase, test, and scale Asian work are equally vital. With major international meetings such as 2026 ASCO Breakthrough now opening abstract submissions and registration, this is a timely chance to bring more Asia-led work to the global stage, strengthen the evidence base, and accelerate better cancer care worldwide.

This is a moment of responsibility and opportunity. With nearly half the burden of disease here, we need to generate at least half of the insights that shape global oncology, from prevention and early detection to drug development, trial design, and survivorship. That is not a quota. It is a practical standard for building evidence that is accurate, applicable, and safe at a global scale.

Patients in Asia cannot wait for imported playbooks to catch up. Let's ensure the next decade of oncology is built with Asia, tested in Asia, and led by Asia so that the science the world relies on is science that truly fits the people it is meant to serve.