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*Current Policy Effective Date: 5/1/25
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Title: Serum Biomarker Human Epididymis Protein 4 (HE4)

Description/Background

OVARIAN CANCER

Ovarian cancer is the fifth most common cause of cancer mortality in U.S. women. According to Surveillance Epidemiology and End Results data, in 2024, an estimated 19,680 women will be diagnosed with ovarian cancer and 12,740 women will die of the disease.[1] The stage at diagnosis is an important predictor of survival; however, most women are not diagnosed until the disease has spread. For the period 2014 to 2020, 50.9% of women with ovarian cancer were diagnosed when the disease had distant metastases (stage IV), and this was associated with a 5-year relative survival rate of 31.4%. In contrast, 19% of women diagnosed with localized cancer (stage 1) had a 5-year survival rate of 91%. Epithelial ovarian tumors account for 85% to 90% of ovarian cancers.[2]

Research from the Ovarian Cancer in Women of African Ancestry (OCWAA) consortium reports that Black women with ovarian cancer have worse survival outcomes than White women.[3] Contributors to this disparity may include education level, nulliparity, smoking status, body mass index, diabetes, and postmenopausal hormone therapy duration.

Treatment

The standard treatment for epithelial ovarian cancer is surgical staging and primary cytoreductive surgery followed by chemotherapy in most cases. There is a lack of consensus about an optimal approach to the follow-up in individuals with ovarian cancer or during primary treatment. Individuals undergo regular physical examinations and may have imaging studies. In addition, managing individuals with serial measurement of the biomarker cancer antigen 125 (CA 125) to detect early recurrence of disease is common. A rising CA 125 level has been found to correlate with disease recurrence and has been found to detect recurrent ovarian cancer earlier than clinical detection. However, a survival advantage of initiating treatment based on early detection with CA 125 has not been demonstrated to date. For example, a

2010 randomized controlled trial in women with ovarian cancer that was in complete remission did not find a significant difference in overall survival when treatment for remission was initiated when CA 125 concentration exceeded twice the limit of normal compared to delaying treatment initiation until symptom onset.[4]

Human epididymis protein 4 (HE4) is a protein that circulates in the serum and has been found to be overexpressed in epithelial ovarian cancer, lung adenocarcinoma, breast cancer, pancreatic cancer, endometrial cancer, and bladder cancer. HE4 is made up of 2 whey acidic proteins with a 4 disulfide core domain and has been proposed as a biomarker for monitoring individuals with epithelial ovarian cancer.

Evaluation of Adnexal Masses

This evidence review also addresses use of the HE4 as a stand-alone test for evaluating women with ovarian masses who have not been diagnosed with ovarian cancer. Such individuals undergo a diagnostic workup to determine whether the risk of malignancy is sufficiently high to warrant surgical removal. In individuals for whom surgery is indicated, further evaluation may be warranted to determine if surgical referral to a specialist with expertise in ovarian cancer is warranted. The Risk of Ovarian Malignancy Algorithm (ROMA) test combines HE4, CA 125 and menopausal status into a numeric score. The ROMA test has been cleared by U.S. Food and Drug Administration FDA for predicting risk that an adnexal mass is malignant; this test and other combination biomarker tests are considered separately in the policy "Multimarker Serum Testing Related to Ovarian Cancer (eg, OVA1®, Overa™and ROMA™ Testing."

Regulatory Status:

Multiple HE4 test kits have been cleared by the FDA through the 510(k) process and summarized in Table 1. The FDA determined that this device was substantially equivalent to a CA 125 assay kit for use as an aid in monitoring disease progression or recurrence in patients with epithelial ovarian cancer. The FDA-approved indication states that serial testing for HE4 should be done in conjunction with other clinical methods used for monitoring ovarian cancer and that the HE4 test is not intended to assess the risk of disease outcomes.

Table 1. Serum HE4 Tests Cleared by the U.S. Food and Drug Administration

Test	Manufacturer	Location	Date Cleared	510(k) No.
HE4 EIA Kit	Fujirebio Diagnostics	Malvern, PA	06/09/2008	K072939
ARCHITECT HE4 assay (CMIA)	Fujirebio Diagnostics	Malvern, PA	03/18/2010	K093957
ELECSYS HE4 (CMIA)	Roche Diagnostics	Indianapolis, IN	09/10/2012	K112624
Lumipulse G HE4 Immunoreaction Cartridges	Fujirebio Diagnostics	Malvern, PA	11/24/2015	K151378

CMIA: chemiluminescent microparticle immunoassay; HE4: human epididymis protein 4; EIA: enzymatic immunoassay.FDA product code: OIU.

Medical Policy Statement

There is insufficient evidence that the diagnostic accuracy of HE4, alone or in combination with CA 125, is superior to CA 125 alone. There is no established cutoff for determining when a HE4 test is positive to use for monitoring disease progression/recurrence and insufficient evidence that HE4 is an effective screening tool for identifying ovarian cancer in asymptomatic women. Therefore, the measurement of HE4 is considered **experimental/investigational** for all indications.

Inclusionary and Exclusionary Guidelines

N/A

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

N/A

Other codes (investigational, not medically necessary, etc.):

86305

Rationale

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Biomarker Human Epididymis Protein 4 Testing in Individuals with Ovarian Cancer

Clinical Context and Test Purpose
The purpose of testing serum biomarker HE4 levels is to provide an alternative to or an improvement on existing testing in individuals with ovarian cancer.

The following PICO was used to select literature to inform this review.

Populations
The relevant population of interest is individuals with epithelial ovarian cancer who have had primary treatment.

Interventions
The test being considered is testing serum biomarker HE4 levels. These levels are used to monitor for surveillance of progression (response to primary treatment) or recurrence in individuals with ovarian cancer

Comparators
Comparators of interest include measurement of the cancer antigen 125 (CA 125) test and measurement of combination CA 125 plus HE4. Typically, individuals undergoing primary chemotherapy after cytoreductive surgery will also have monitoring for a response with a computed tomography scan. After the completion of primary treatment, individuals may have other monitoring imaging studies such as positron emission tomography.

Outcomes
The general outcomes of interest are overall survival (OS), disease-specific survival, test accuracy, test validity, and other test performance measures. Change in disease status Is also an outcome of interest in individuals with ovarian cancer.

The timing of follow-up after testing HE4 serum levels in individuals with ovarian cancer is based on the stage of the disease, type of prior therapy and guideline recommendations.

Study Selection Criteria
For the evaluation of clinical validity of HE4 testing, studies that meet the following eligibility criteria were considered:
- Reported on the accuracy of the marketed version of the technology.
- Included a suitable reference standard.
- individual/sample clinical characteristics were described.
- individual/sample selection criteria were described.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).
Review of Evidence

Systematic Review

Han et al (2021) published a systematic review and meta-analysis on the value of HE4 in predicting chemotherapy resistance in patients with ovarian cancer.[5] An analysis of 8 studies (I^2=74%) found that preoperative HE4 had a sensitivity of 80% (95% confidence interval [CI], 65% to 90%) and specificity of 67% (95% CI, 54% to 77%) in predicting resistance to platinum

chemotherapy. After the third cycle of chemotherapy (5 studies; I^2=49%), the sensitivity and specificity were 86% (95% CI, 72% to 94%) and 85% (95% CI, 70% to 93%), respectively.

Food and Drug Administration Pivotal Studies

The U.S. Food and Drug Administration (FDA) documents included information on the diagnostic performance of HE4 for monitoring the progression and recurrence of ovarian cancer. The FDA materials addressed the noninferiority rather than the superiority of HE4 tests to CA 125. A study reported in the 510(k) substantial equivalence determination decision summary for the HE4 enzyme immunoassay (EIA) evaluated whether this test is noninferior to the CA 125 test. The study included samples from 80 women with epithelial ovarian cancer who were undergoing serial surveillance of cancer progression.[6] Blood samples were obtained from a large cancer center in the U. S.; they were not drawn specifically for this study. A total of 354 samples were obtained for the 80 women (women had multiple visits over time). Receiver operating characteristic curve analysis was used to compare the two assays, and clinical evidence of progression was used as the reference standard. When a positive change in HE4 level (ie, to indicate disease progression) was defined as a value at least 25% higher than the previous value of the test, the sensitivity of the test was 76 (60.3%) of 126, and the specificity was 171 (75%) of 228. (Note that the unit of analysis was the number of samples rather than the number of women.) The area under the receiver operating characteristic curves were found to be similar (HE4=0.725 vs CA 125=0.709), with an overlap in the confidence intervals; according to the authors, this indicated that the HE4 assay was not inferior to the CA 125 assay for detecting cancer progression.

Another analysis estimated the cutoff values and specificities for the HE4 and CA 125 assays across a range of fixed sensitivities, where the sensitivities of the HE4 and CA 125 assays were set at the same values. The specificity values for CA 125 and HE4 did not differ statistically at the respective cutoffs and sensitivities. These data were also said to confirm that the HE4 EIA test was not inferior to the CA 125 test for detecting ovarian cancer progression.

The 510(k) substantial equivalence determination decision summary for the ARCHITECT HE4 assay reported data from a retrospective study using remnant serial samples from 76 women diagnosed with EOC being monitored after completion of chemotherapy.[7] The eligibility criteria included the availability of at least 3 serial specimens; samples could have been drawn during and/or after treatment. Clinical determination of disease progression was used as the reference standard. A positive test was defined as an HE4 level that was 14% higher than the previous reading. Using this cutoff, the sensitivity of the assay for detecting progressive disease was 53 (53.5%) of 99 events. The specificity of the assay was 260 (78.5%) of 331. Of note, the sensitivity is lower than that previously reported for the HE4 EIA test at a similar specificity, when a cutoff of a 25% increase was used (sensitivity, 60.3%; specificity, 75%).

The FDA documents note that there is no clinically accepted cutoff for monitoring cancer progression in EOC patients using the HE4 assays. As mentioned, a study included in the HE4 EIA assay materials defined a positive test as a level that is 25% higher than a previous measurement, and a study on the ARCHITECT HE4 test defined a positive test as an increase of at least 14% in the level of HE4. FDA documents further stated that clinicians may decide whether to use the cutoffs in the studies or another cutoff that reflects personal preferences in the tradeoff between sensitivity and specificity.

Published observational studies on the diagnostic performance of HE4 for monitoring progression and/or recurrence of EOC are described next.

Nonrandomized Observational Studies

Nassir et al (2016).[8] published an analysis of data from an earlier study by Braicu et al (OVCAD study, 2013) The OVCAD study evaluated 275 patients with advanced primary ovarian cancer who underwent cytoreductive surgery and adjuvant platinum-based chemotherapy at a specialized clinic. Ninety-two (33%) of 275 patients, who had preoperative and follow-up plasma samples for analyzing HE4 and CA 125, were included in the analysis; however, 13 preoperative HE4 samples and 10 postoperative CA 125 samples were missing. Both preoperative HE4 and CA 125 values significantly predicted 12-month recurrence or death. Among responders, median OS was worse among patients for whom both biomarkers were elevated (hazard ratio, 17.96; 95% CI, 4.00 - 80.85; p<0.001) compared with patients for whom no biomarker was elevated. The CI for the OS analysis was wide, indicating an imprecise estimate. There was no significant association with median OS when only 1 biomarker was elevated; the sample size may have been inadequate for this analysis.

Vallius et al (2017) reported a study that was designed to assess fluorodeoxyglucose-positron emission tomography/computed tomography imaging and serum tumor markers in epithelial ovarian cancer staging and chemotherapy response. A substudy analysis evaluated the use of HE4 profiles to predict treatment outcomes during the first line of chemotherapy after primary cytoreductive surgery.[9] HE4 and CA 125 were measured in patients with the Federation of International Gynecology and Obstetrics III/IV EOC who received primary debulking surgery followed by platinum-based chemotherapy or neoadjuvant chemotherapy followed by interval debulking surgery. HE4 at the time of diagnosis was not associated with progression-free survival (PFS) (p=.24), whereas lower CA 125 at the time of diagnosis predicted longer PFS (HR, 1.45, 95% CI, 1.09 to 1.94; p=.01). When patients who underwent either surgical approach were combined (n=40), those with no macroscopic residual disease after cytoreductive surgery were more likely to have lower postoperative HE4 values. Both HE4 and CA 125 nadir values were associated with a greater complete response to chemotherapy. Tables 2 through 5 summarize findings for this study.

Potenza et al (2020) retrospectively assessed 78 patients with EOC to determine whether HE4 and CA 125 measured at diagnosis and before each platinum-based chemotherapy cycle could predict lack of response to chemotherapy and disease recurrence.[10] The proportions of patients who were sensitive, partially resistant, and refractory to chemotherapy were 73%, 16.6%, and 6.4%, respectively. After a median follow-up of 10 months, both HE4 and CA 125 had a positive correlation to PFS when measured after the third chemotherapy cycle (both p=.0001). At the time of diagnosis, HE4 and CA 125 levels lower than the population mean value were also positively correlated to PFS (both p<.05).

Salminen et al (2020) conducted a prospective observational study in 143 women with histologically confirmed high-grade serous carcinoma (a common and aggressive form of EOC) to assess biomarkers, including CA 125 and HE4, for treatment monitoring and prognostic stratification.[11] Included patients received primary treatment with either primary debulking surgery followed by chemotherapy (n=58) or neoadjuvant chemotherapy with

interval debulking surgery plus adjuvant chemotherapy (n=85). Chemotherapy regimens consisted of carboplatin plus a taxane (n=125), carboplatin alone (n=16) or other/unknown (n=2). Follow-up times ranged between 1.5 months to 10.2 years. At the time of progression, multivariate analysis showed that HE4 concentration elevations greater than 199.20 pmol/L were significantly associated with a reduction in overall survival (HR, 5.85; 95% CI, 2.07 to 16.51; p=.0001); elevations in CA 125 greater than 162.00 U/mL were not (HR, 1.39; 95% CI, 0.59 to 3.28; p=.45). Serum HE4 concentrations were also found to be significantly higher at baseline in patients with a higher tumor burden compared to those with less extensive tumor growth (p<.0001) while CA 125 concentrations were not (p=.067). At baseline after cytoreductive surgery, neither CA 125 (p=.641) or HE4 (p=.054) concentrations were significantly associated with the amount of residual disease. Nadir CA 125 and HE4 levels were both found to be significantly elevated in patients who developed platinum-resistant disease (p<.0001).

Rong et al (2021) conducted a retrospective study that assessed the prognostic value of HE4 and CA 125 in 89 patients with EOC.[12] All patients received 6 to 8 cycles of platinum-based chemotherapy after surgery. HE4 (cutoff, 70 pmol/L) and CA 125 (cutoff, 35 U/mL) were measured before treatment, after each cycle, and at the time of recurrence. After a median follow-up of 35 months, 73 patients were platinum-sensitive and 16 patients were platinum-resistant. The sensitivity and specificity of HE4 in predicting platinum responsiveness after the third chemotherapy cycle were 75% and 80.8%, respectively. HE4 had a positive predictive value (PPV) of 54.5% and negative predictive value (NPV) of 93.7%. The sensitivity, specificity, and PPV, and NPV of CA 125 after the first chemotherapy cycle were 75%, 71.2%, 36.4%, and 92.9%, respectively. The combination of both biomarkers had a sensitivity and specificity for predicting platinum responsiveness of 50% and 94.5%, respectively, with a PPV of 66.7% and NPV of 89.6%. HE4 predicted 2-year PFS after the third and sixth chemotherapy cycles (p=.001 and p=.011, respectively). CA 125 predicted 2-year PFS only after the first chemotherapy cycle (p=.023). Prolonged PFS and OS were significantly associated with HE4 after the third cycle (p<.0001) and CA 125 after the first cycle (p<.0001).

Samborski et al (2022) retrospectively examined the utility of HE4 in comparison to CA 125 in women undergoing surveillance after treatment for EOC between January 1997 to October 2010.[13] A total of 129 women with a diagnosis of EOC were identified and included in the analysis, of which 11 women had stage I disease (8.5%), 12 had stage II disease (9.3%), 94 had stage III disease (72.9%), and 12 had stage IV (9.3%) disease. At a threshold of 25% change in serum biomarker level indicating progressive disease, HE4 had an overall accuracy for change in disease status of 81.8% (95% CI, 79.7% to 83.7%) with a specificity of 90.5% (95% CI, 88.7% to 92.1%), sensitivity of 45.2% (95% CI, 39.2% to 51.2%), PPV of 53.2% (95% CI, 46.6% to 59.7%) and a NPV of 87.4% (95% CI, 85.4% to 89.2%). The concordance comparison of HE4 accuracy (81.8%)/CA 125 accuracy (82.6%) was 0.990, indicating HE4 was not inferior to CA 125 (McNemar's test p-value=.522).

Table 2. Summary of Observational Study Characteristics

Study	Study Type	Country	Dates	Participants N	Treatment 1 n	Treatment 2 n
Vallius et al (2017)[9]	Observational cohort	Finland	2009-2014	FIGO Stage III-IV EOC 49	PDS + platinum-based chemotherapy 22	NACT + IDS 27

EOC: epithelial ovarian cancer; FIGO: Federation of International Gynecology and Obstetrics; IDS: interval debulking surgery; NACT: neoadjuvant chemotherapy; PDS: primary debulking surgery.

Table 3. Summary of Observational Study Results

Study	Treatment 1	Treatment 2
Vallius et al (2017)[9]		
	Median (range)	Median (range)
HE4 (pmol/L)		
At diagnosis	573 (59 to 1391)	1070 (156 to 12,128)
Pre-IDS	N/A	104 (35 to 477)
Postoperative	96 (34 to 856)	99 (39 to 384)
Nadir	48 (25 to 204)	69 (31 to 257)
Post-primary therapy	48 (25 to 431)	61 (31 to 175)
CA 125 (U/mL)		
At diagnosis	1094 (17 to 17,992) N/A	1078 (156 to 20,897)
Pre-IDS	181 (32 to 2023)	43 (7 to 464)
Postoperative	12 (4 to 162)	42 (6 to 589)
Nadir	12 (4 to 127)	15 (4 to 447)
Post-primary therapy		15 (4 to 37)

CA 125: cancer antigen 125; HE4: human epididymis protein 4; IDS: interval debulking surgery; NACT: neoadjuvant chemotherapy; PDS: primary debulking surgery; (pmol/L): picomole per liter; Treatment 1: PDS + platinum-based chemotherapy; Treatment 2: NACT +IDS; (U/mL): units per milliliter.

Study relevance and study design and conduct limitations are reported in Tables 4 and 5.

Table 4. Study Relevance Limitations

Study	Population	Intervention	Comparator	Outcomes	Duration of Follow-Up
Vallius et al (2017) [9]	1. Study population is mixed regarding risk factors 2. Clinical context for primary debulking surgery + chemotherapy differs from neoadjuvant chemotherapy + interval debulking surgery				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.
a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of
intended use.
b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4.Not the intervention of interest.
c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3.Delivery not similar intensity as intervention; 4. Not delivered effectively.
d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not
establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 5. Study Design and Conduct Limitations

Study	Selection[a]	Blinding[b]	Delivery of Test[c]	Selective Reporting[d]	Completeness of Follow-Up[e]	Statistical[f]
Vallius et al (2017)[9]			2. Broad date range for obtaining samples	2. Assessment of residual disease solely on based on surgeon evaluation		1.Not uniformly reported

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.
a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3.Evidence of selective publication.
d Follow-Up key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of
crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
f Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple
observations per patient; 3. Confidence intervals and/or p values not reported; 4.Comparative treatment effects not calculated.

Clinically Useful

The available observational studies have used HE4 alone or in combination with CA 125 to predict residual tumor mass and association with recurrence after primary chemotherapy. In addition, HE4 alone or in combination with CA 125 has been assessed for its association with residual disease and tumor progression during the course of primary chemotherapy after tumor debulking as well during neoadjuvant chemotherapy followed by interval debulking surgery. Improvement in health outcomes would depend on demonstrating that further assessment and management decisions or individuals with ovarian cancer were initiated that would improve health outcomes. There is no clear chain of evidence demonstrating that incremental changes in ovarian cancer detection would lead to improved health outcomes. No prospective studies were identified that compared health outcomes in individuals who had ovarian cancer managed with and without HE4 testing, alone or in combination with CA 125 or other disease markers.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for individuals managed with and without the test. Because these are intervention studies, the preferred evidence would be from (RCTs).

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Section Summary: Biomarker Human Epididymis Protein 4 Testing in Individuals With Ovarian Cancer

For individuals who have ovarian cancer who receive a measurement of serum biomarker HE4, the evidence includes 7 nonrandomized prospective and retrospective studies comparing the diagnostic accuracy of HE4 with CA 125 for predicting disease progression and/or recurrence. Data submitted to the FDA for approval of commercial HE4 tests found that HE4 was not inferior to CA 125 for detecting ovarian cancer recurrence. Although a single

prospective observational study found elevated levels of HE4, but not CA 125, at the time of cancer progression was significantly associated with reduced overall survival, a direct comparison between biomarkers was not provided. Overall, the superiority of HE4 to CA125 (alone or in combination), the key question in the evidence review, was not demonstrated in the available literature. In addition, there is no established cutoff in HE4 levels for monitoring disease progression, and cutoffs in studies varied. There is no direct evidence from prospective controlled studies on the impact of HE4 testing on health outcomes, and no clear chain of evidence that changes in management based on HE4 would lead to an improved health outcome.

BIOMARKER HUMAN EPIDIDYMIS PROTEIN 4 TESTING in Individuals with ADNEXAL MASSES

Clinical Context and Test Purpose
The purpose of testing serum biomarker HE4 levels is to provide an alternative to or an improvement on existing testing in individuals with adnexal masses.

The following PICO was used to select literature to inform this review.

Populations
The relevant populations of interest are individuals with adnexal masses.

Interventions
The test being considered is testing serum biomarker HE4 levels. These levels are used to evaluate women with adnexal masses who are undergoing diagnostic workup for ovarian cancer.

Comparators
Comparators of interest include measurement of CA 125 and measurement of the combination CA 125 plus HE4.

Outcomes
The general outcomes of interest are OS, disease-specific survival, test accuracy, test validity, and other test performance measures.

Evaluation of an adnexal mass would be determined by whether or not the indivdual has surgical management, and typical clinical follow-up in the absence of a pathological diagnosis would be every 6 months.

Study Selection Criteria
See information under the first indication.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Review of Evidence

Systematic Reviews and Meta-Analyses

A number of meta-analyses have accessed studies on the accuracy of HE4 for diagnosing ovarian cancer. Table 6 presents the pooled sensitivities and specificities of HE4 from meta-analyses that conducted quality assessments of individual studies and that limited their reviews to studies using pathologic findings as to the reference standard for ovarian cancer diagnosis.[14,15,16,17,18,19,20,21,22,23]

Table 6. Meta-Analyses of Human Epididymis Protein 4 for Diagnosing Ovarian Cancer

Meta-Analyses (Year)	No. of Studies	Pooled Sensitivity (95% CI), %	Pooled Specificity (95% CI), %
Olson et al (2021)[14]	7	79.4 (74.1 to 83.8)	84.1 (79.6 to 87.8)
Suri et al (2021)[15]	25	73 (71 to 75)	90 (89 to 91)
Huang et al (2018)[16]	18	81 (77 to 85)	91 (86 to 93)
Dayyani et al (2016)[17]	5	82 (68 to 90)	85 (72 to 93)
Macedo et al (2014)[18]	45	78 (77 to 79)	86 (85 to 87)
Wang et al (2014)[19]	28	76 (72 to 80)	93 (90 to 96)
Zhen et al (2014)[20]	25	74 (72 to 76)	90 (89 to 91)
Yang et al (2013)[21]	31	73 (71 to 75)	89 (88 to 90)
Ferraro et al (2013)[22]	14	79 (76 to 81)	93 (92 to 94)
Yu et al (2012)[23]	12	80 (77 to 83)	92 (90 to 93)

CI: confidence interval; HE4: human epididymis protein 4

Meta-analyses differed somewhat in their study inclusion criteria, search dates and other factors but, as shown in Table 6, had similar results in terms of diagnostic value of HE4; pooled sensitivities ranged from 73% to 82%, and pooled specificities ranged from 84.1% to 93%.

Several of the previous meta-analyses also pooled data from studies on the diagnostic accuracy of CA 125, alone and/or in combination with HE4 and findings are shown in Table 7.

Table 7. Meta-Analyses of CA 125 Alone or Combined with HE4 for Diagnosing Ovarian Cancer

Meta-Analyses (Year)	No. of Studies	Pooled Sensitivity (95% CI), %	Pooled Specificity (95% CI), %
CA 125 alone			
Olson et al (2021)[14]	8	81.4 (74.6 to 86.2)	56.8 (47.9 to 65.4)

Suri et al (2021)[15.]	26	84 (82 to 85)	73 (72 to 74)
Dayyani et al (2016)[17.]	5	80 (66 to 89)	83 (66 to 92)
Wang et al (2014)[19.]	28	79 (74 to 84)	82 (77 to 87)
Zhen et al (2014)[20.]	25	74 (72 to 76)	83 (81 to 84)
Ferraro et al (2013)[22.]	13	79 (77 to 82)	78 (76 to 80)
Yu et al (2012)[23.]	10	66 (62 to 70)	87 (85 to 89)
HE4 and CA 125			
Zhen et al (2014)[20.]	9	90 (87 to 92)	85 (82 to 87)
Ferraro et al (2013)[22.]	4	82 (78 to 86)	76 (72 to 80)

CA 125: cancer antigen 125; CI: confidence interval; HE4: human epididymis protein 4

All meta-analyses included in Table 7, except Dayyani et al (2016), Olson et al (2021), and Suri et al (2021) reported statistical comparisons between the diagnostic performance of HE4 and CA 125. None found that the performance (combination of sensitivity and specificity) of HE4 and CA 125 differed significantly. However, both Wang et al (2014)[19] and Zhen et al (2014)[20] found that the specificity (but not sensitivity) of HE4 was significantly higher than CA 125.

Findings differed in the 2 meta-analyses that compared the diagnostic performance of HE4 and CA 125 versus CA 125 alone. Ferrero et al (2013) did not find that the sensitivity and specificity of HE4 in combination with CA 125 differed significantly from that of CA 125 alone.[22] Zhen et al (2014) found that both the sensitivity and specificity of HE4 combined with CA 125 were significantly better than CA 125 alone.[20] In the subgroup of nine studies that made direct comparisons in the Zhen et al (2014) meta-analysis, the sensitivity of HE4 plus CA 125 was 90% (95% CI, 87% to 92%) and for CA 125 alone was 74% (95% CI, 69% to 78%) , and the specificity of HE4 plus CA 125 was 85% (95% CI, 82% to 87%) and for CA 125 alone was73% (95% CI, 69% to 76%) for CA 125 alone. In addition, in the Zhen et al (2014) meta-analysis, the overall diagnostic accuracy (measured by the diagnostic odds ratio) was significantly higher for the combination of HE4 and CA 125 than for HE4 alone. Pooled diagnostic odds ratio were 10.31 (95% CI, 6.18 to 17.21) for CA 125 and 53.92 (95% CI, 26.07 to 111.54) for HE4 plus CA 125. Zhen et al (2014) noted several limitations to their meta-analysis, including substantial publication bias for HE4, heterogeneity among studies, and a lack of consideration given to clinical factors such as menopausal status.

Nonrandomized Observational Studies
Several studies have evaluated the diagnostic performance of HE4 as a second-line test after the subjective assessment of transvaginal ultrasound. The final histologic diagnosis was used as the reference standard.

Kaijser et al (2014) enrolled 389 patients with a suspicious pelvic mass who were scheduled for surgery.[24] Data on 360 (93%) patients were available for analysis. Experienced

ultrasonographers categorized each mass as benign, borderline, or invasive malignant. Serum samples were obtained before surgery and HE4 levels were measured, using a cutoff of at least 70 pmol/L to indicate malignancy. Overall, subjective ultrasound evaluation by an experienced examiner had higher sensitivity and specificity than serum HE4. Sensitivity was 97% with subjective assessment ultrasound and 74% with HE4, and specificity was 90% and 85%, respectively. The additional consideration of HE4 levels after sonographers categorized a mass as benign resulted in a slight increase in sensitivity and a large increase in the number of false positives. Moreover, the sequential use of serum HE4 after sonographers categorized a mass as malignant resulted in lower sensitivity and an increase in specificity.

Moszynski et al (2013)[25] retrospectively reviewed records on 253 women with adnexal masses. Women were examined with transvaginal ultrasound by an experienced examiner before surgery. The sonographer categorized masses as certainly benign, probably benign, uncertain, probably malignant, and certainly malignant. Tumors in the certainly benign and certainly malignant categories were excluded from further analysis, and the remainder (n=145) were considered suspicious tumors. HE4 and CA 125 levels were measured in serum, and a cutoff of 65 pmol/L was used for HE4. The sensitivity and specificity of ultrasound evaluation for diagnosing the suspicious tumors were 93.3% and 90.6%, respectively. Neither HE4 nor CA 125 improved diagnostic accuracy for suspicious tumors. The sensitivity and specificity of HE4 were 80.0% and 91.7%, respectively, and the sensitivity and specificity of CA 125 were 85.8% and 74.7%, respectively. A logistic regression analysis confirmed that neither HE4 nor CA 125 improved diagnostic accuracy beyond that of subjective assessment of ultrasonography.

Nikolova et al (2017)[26] conducted a study to measure the effectiveness of HE4 compared with CA125 for differentiating ovarian endometriosis from EOC in premenopausal women. In the observational study, 164 patients were divided into three study groups: ovarian endometriosis (n=37), other benign pelvic masses (n=57), and EOCs (n=11); and a control group (n=59). Analysis of biomarkers in blood samples from all four groups determined that HE4 performed the best at differentiating endometriosis from EOC (specificity=100%, accuracy=95.83%), while CPH-I also performed well (specificity=97.30%, accuracy=93.75%). CA125 was found to have significantly lower specificity and accuracy. Limitations of the study include the relatively small cohort.

Gentry-Maharaj et al (2020)[27] performed a cohort study nested within the screening population of a larger multicenter RCT to assess the ability of HE4 and CA 125 to diagnose ovarian cancer in postmenopausal women with adnexal masses. The initial trial (United Kingdom Collaborative Trial of Ovarian Cancer Screening; UKCTOCS) randomized 202,638 postmenopausal women to be screened for ovarian cancer to multimodal screening with CA 125 levels, transvaginal ultrasound, or no screening. Women who were randomized to 1 of the screening groups who had an abnormality received a repeat of the initial screening test that they received, and those with persistent abnormalities were further assessed by a clinical team subsequently managed with surgery or conservative management, and had serum CA 125 and HE4 levels taken within 6 months of the scan. A total of 1590 women met these criteria and were found to have adnexal masses. Follow-up occurred for a median of 10.9 years. Clinical validity results for ultrasound plus CA 125, ultrasound plus HE4, and a combination of ultrasound plus CA 125 plus HE4 are described in Tables 8 and 9 below. In addition, reported area under the curve (AUC) values at a specificity of 90% were as follows:0.896 (95% CI,

0.847 to 0.935) for ultrasound plus CA 125 pls HE4, 0.893 (95% CI, 0.844 to 0.933) for ultrasound plus CA125, and 0.854 (95% CI, 0.802 to 0.9). Reported AUC values were significantly lower for the ultrasound plus HE4 group compared to the ultrasound plus CA 125 plus HE4 group (p=0.0554and 0.033, respectively); AUC values were not significantly different when comparing the ultrasound plus CA 125 plus HE4 group to the ultrasound plus CA 125 group (p=0.4527). These 2 groups were also reported to have a similar sensitivity at 90% specificity (p=0.564); comparison of sensitivity among other groups was not provided.

Carreras-Dieguez (2022)[28] retrospectively evaluated the performance of several serum biomarkers, including CA 125 and HE4, to preoperatively identify EOC or metastatic ovarian cancer in women with a diagnosis of an adnexal mass based on pelvic imaging (N=1071). In this study, the AUC for HE4 was higher than for CA 125 (0.91 vs. 0.87). Subgroup analysis showed that in premenopausal women (n=629), HE4 performed better than CA 125 (AUC, 0.86 vs 0.76, respectively; p<.05). Conversely, in postmenopausal women (n=442), HE4 and CA 125 AUCs did not significantly differ (0.91 and 0.93, respectively). In a subgroup of patients with inconclusive diagnosis (n=348), the AUC for HE4 and CA 125 was 0.84 and 0.810, respectively. Lastly, in a subgroup of patients with stage 1 EOC (n=58), the AUC for HE4 and CA 125 was 0.86 and 0.81, respectively.

Lof et al (2022)[29] evaluated the role of HE4 in discriminating benign from malignant tumors in patients who presented with a pelvic mass on ultrasound that was suspected of ovarian origin. A total of 316 patients were included, of which 195 had a benign, 39 had a borderline and 82 had a malignant ovarian mass. HE4 performed better when age-based cut-offs were applied (sensitivity, 65%; specificity, 79%) instead of one cut-off at 70 pmol/L (sensitivity, 68%; specificity, 65%) or 150 pmol/L (sensitivity, 38%; specificity, 96%). CA 125 performed slightly better when menopausal-based cut-offs were applied (sensitivity, 72%; specificity, 53%) compared with one cut-off at 35 kU/L (sensitivity, 71%; specificity, 50%).

Table 8. Characteristics of Diagnostic Studies Evaluation HE4 as a Test for Ovarian Cancer

Study	Country	Participants	Evaluated Tests
Kaijser et al (2014)[24]	EU	Women with adnexal masses scheduled for surgery (N=289)	HE4
Moszynski et al (2013)[25]	EU	Women with adnexal masses (N=253)	HE4, CA 125, individually and combined in ROMA score
Nikolova et al (2017)[26]	Macedonia, Serbia	Women with ovarian endometriosis, benign pelvic masses, EOCs (N=164)	HE4, CA 125, individually and combined in ROMA score and CPH-I
Gentry-Maharaj et al (2020)[27]	England, Wales, Ireland	Postmenopausal women with adnexal masses (N=1590)	HE4, CA 125, individually and combined
Carreras-Dieguez (2022)[28]	Spain	Pre- and post-menopausal women with a diagnosis of an adnexal mass based on pelvic imaging (N=1071)	HE4, CA 125, individually and combined in ROMA score and CPH-I

Lof et al (2022)[29]	Netherlands	Pre- and post-menopausal women with a pelvic mass that was suspected of ovarian origin on ultrasound (N=316)	HE4, CA 125, individually and combined in ROMA score

CA 125: cancer antigen 125; CPH-I: Copenhagen Index;
CI: confidence interval; HE4: human epididymis protein 4 ROMA: Risk of Ovarian Malignancy Algorithm.

Table 9. Clinical Validity of HE4 as a Test for Ovarian Cancer

Study	Initial N	Final N	Excluded Samples	Prevalence of Condition	Clinical Validity (95% Confidence Interval)			
					Sensitivity	Specificity	PPV	NPV
Kaijser (2014)[24]	389	360	29	40%				
HE4 (≥70 pmol/L)					74%	85%		
SA					97%	90%		
Moszynski (2013)[25]		253		41.4%				
HE4 (≥65 pmol/L)					80.0%	91.7%	87.3%	86.7%
SA					93.3%	90.6%	87.5%	95.1%
Nikolova (2017)[26]		164						
CA 125(≥35 U/mL)					81.8% (48.2-97.7)	48.7% (31.9-65.6)	32.1% (15.9-52.4)	90.0% (68.3-98.8)
HE4(≥70 pmol/L)					81.8% (48.2-97.7)	100% (90.5-100)	100% (66.4-100)	94.87% (82.7-99.4)
Gentry-Maharaj (2020)[28]		1590						
CA 125[a]					74.4% (63.8-83.3)		27.8% (21.8-34.3)	98.6% (97.8-99.1)
HE4[a]					67.9% (57.5-78.4)		26% (20.1-32.6)	98.2% (97.3-98.8)
CA 125 plus HE4[a]					75.6% (65.4-84.3)		28.1% (22.1-34.7)	98.6% (97.9-99.2)
Carreras-Dieguez (2022)[28]		1071						
CA 125 (≥100 U/mL)					61.86 (55.21 to 68.09)	92.71% (90.73 to 94.29)	68.91% (62.07 to 75.02)	90.30% (88.11 to 92.11)
HE4 (≥70 pmol/L)					83.25% (77.31 to 87.88)	86.11% (83.40 to 88.43)	61.15% (55.11 to 66.87)	95.14% (93.22 to 96.53)
HE4 (≥120 pmol/L)					69.11 %(62.23 to 75.23)	96.29% (94.65 to 97.44)	83.02% (76.42 to 88.06)	92.23% (90.10 to 93.93)
Lof et al (2022)[29]		316						
CA 125 (≥35 kU/L)					71%	50%	34%	83%
HE4 (≥70 pmol/L)					68%	65%	41%	86%

HE4 (≥150 pmol/L)				38%	96%	76%	81%

CA 125: cancer antigen 125; HE4: human epididymis protein 4; NPV: negative predictive value; PPV: positive predictive value; SA: subjective assessment. [a]All Clinical validity measures reported at a fixed 90% specificity

Study relevance and study design and conduct gaps are reported in Tables 10 and 11.

Table 10. Study Relevance Limitations

Study	Population	Intervention	Comparator	Outcomes	Duration of Follow-Up
Kaijser et al (2014)[24]	1. 7% of data unavailable from population				
Moszynski et al (2013)[25]					
Nikolova et al (2017)[26]					
Gentry-Maharaj (2020)[27]					
Carreras-Dieguez (2022)[28.]					
Lof et al (2022)[29.]	1. General hospital population. Also, the final histological diagnosis was missing for 30 patients (~9%)				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

[b] Intervention key: 1. Classification thresholds not defined; 2. Version used unclear; 3. Not intervention of interest.

[c] Comparator key: 1. Classification thresholds not defined; 2. Not compared to credible reference standard; 3. Not compared to other tests in use for same purpose

[d] Outcomes key: 1. Study does not directly assess a key health outcome; 2. Evidence chain or decision model not explicated; 3. Key clinical validity outcomes not reported (sensitivity, specificity and predictive values); 4. Reclassification of diagnostic or risk categories not reported; 5. Adverse events of the test not described (excluding minor discomforts and inconvenience of venipuncture or noninvasive tests)

[e] Follow-Up key: 1. Follow-up duration not sufficient with respect to natural history of disease (true positives, true negatives, false positives, false negatives cannot be determined).

Table 11. Study Design and Conduct Limitations

Study	Selection[a]	Blinding[b]	Delivery of Test[c]	Selective Reporting[d]	Completeness of Follow-Up[e]	Statistical[f]
Kaijser et al (2014)[24]	2. Selection retrospective and not randomized	1. Results were not blinded				1. p-values/ CI not reported
Moszynski et al (2013)[25]	2. Selection retrospective and not randomized	1. Results were not blinded				1. p-values/ CI not reported
Nikolova et al (2017)[26]	2. Selection not randomized; small cohort	1. Results were not blinded				1. p-values not reported

Gentry-Maharaj (2020)[27]						1. p-values not reported for all comparisons
Carreras-Dieguez (2022)[28.]	2. Selection retrospective and not randomized	1. Results were not blinded				1. p-values not reported for all comparisons
Lof et al (2022)[29.]	2. Selection not randomized	1. Results were not blinded				1. pP-values not reported

CI: confidence interval

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

[a] Selection key: 1. Selection not described; 2. Selection not random or consecutive (ie, convenience).

[b] Blinding key: 1. Not blinded to results of reference or other comparator tests.

[c] Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.

[d] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

[e] Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to followup or missing data.

[f] Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison to other tests not reported.

Clinically Useful

Although HE4 levels are associated with presence of ovarian cancer, the test does not have high sensitivity or specificity. Thus, it cannot be used to rule in or rule out ovarian cancer before surgery. No prospective studies were identified that compared health outcomes in individuals with adnexal masses managed with and without HE4 testing, alone or in combination with CA 125 or other disease markers. There is no strong chain of evidence demonstrating that clinical decisions based on HE4 testing would improve individual outcomes.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for individuals managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Section Summary: Biomarker Human Epididymis Protein 4 Testing in Individuals With Adnexal Masses

For individuals who have adnexal masses who receive a measurement of serum biomarker HE4, the evidence includes diagnostic accuracy studies and meta-analyses. Meta-analyses have generally found that HE4 and CA 125 have a similar overall diagnostic accuracy (ie, sensitivity, specificity) and several found that HE4 has significantly higher specificity than CA 125 but not sensitivity. Two meta-analyses had mixed findings on whether the combination of HE4 and CA 125 is superior to CA 125 alone for the initial diagnosis of ovarian cancer. The number of studies evaluating the combined test is relatively low, and publication bias in studies of HE4 has been identified. In addition, studies have not found that HE4improves diagnostic accuracy beyond that of subjective assessment of transvaginal ultrasound. There is no direct

evidence from prospective controlled studies on the impact of HE4 testing on health outcomes, and no clear chain of evidence that changes in management based on HE4 would lead to an improved health outcome.

BIOMARKER HUMAN EPIDIDYMIS PROTEIN 4 SCREENING In ASYMPTOMATIC INDIVIDUALS NOT AT HIGH RISK OF OVARIAN CANCER

Clinical Context and Test Purpose
The purpose of testing serum biomarker HE4 levels is for diagnosis in individuals who are asymptomatic and not at high-risk of ovarian cancer.

The following PICO was used to select literature to inform this review.

Populations
The relevant populations of interest are asymptomatic individuals not at high-risk of ovarian cancer.

Interventions
The test being considered is testing serum biomarker HE4 levels. These levels are used for screening in asymptomatic individuals.

Comparators
Comparators of interest include no ovarian cancer screening (asymptomatic individuals).

Outcomes
The general outcomes of interest are OS, disease-specific survival, test accuracy, test validity, and other test performance measures.

Though not completely standardized, follow-up for individuals who are asymptomatic and not at high-risk of ovarian cancer would typically occur in the years before diagnosis.

Study Selection Criteria
See information under the first indication.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Review of Evidence

Observational Studies
Several retrospective studies aimed at determining the potential value of using HE4 and other biomarkers in early identification of ovarian cancer in asymptomatic women. Anderson et al (2010) published data on 34 women with ovarian cancer and 70 matched controls, all of whom were participating in an unrelated RCT on smokers at increased risk of lung cancer.[30] Blood samples were available for the women between 0 and 18 years before ovarian cancer diagnosis. In descriptive analyses, individual serum markers, including HE4, CA 125, and mesothelin, showed increasing accuracy over time approaching the diagnosis of ovarian

cancer. Mean concentrations of these markers, which were measured by visually read immunoassays, began to increase approximately three years before diagnosis but attained detectable levels only within the final year before diagnosis. The study had a small sample size, limiting the ability to conduct quantitative analysis, and included only heavy smokers and therefore may not be representative of the population of women at risk of ovarian cancer.

Urban et al (2011) retrospectively reviewed preclinical serum samples to evaluate the potential utility of HE4 and other markers as a secondary screening test in women found to have epithelial ovarian cancer.[31] There were samples from 112 ovarian cancer patients and 706 matched controls. Individuals participated in the Prostate, Lung, Colorectal and Ovarian (PLCO) trial and had been screened annually for six years with CA 125. Serum samples to evaluate potential markers were taken from the year proximate to that in which women were diagnosed with ovarian cancer. (Serum samples were not available for the fourth screen, so they were taken from the third year for the women diagnosed with ovarian cancer between the third and fourth screens.) Investigators evaluated the associations between CA 125, HE4, and levels of 5 other markers with malignancy, accounting for increasing CA 125 levels and adjusting for demographic characteristics. Increase in CA 125 levels was associated with statistically significant increases in all of the markers. Levels of HE4 were most elevated, compared to controls, ie, the highest average HE4 level was 4.26 standard deviations above the mean HE4 level in control samples.

Terry et al (2016) retrospectively analyzed prospectively collected data from the European Prospective Investigation into Cancer and Nutrition (EPIC) study, a multicenter cohort study investigating the relation between diet and cancer.[32] The analysis used a nested case-control design. A total of 197 women who developed invasive ovarian cancer were matched with 725 randomly selected ovarian-cancer free controls. Baseline and follow-up blood samples were analyzed for levels of several biomarkers (ie, CA 125, HE4, cancer antigen 15.3, cancer antigen 72.4) and the sensitivity, specificity, and area under the receiver operating characteristic curve were calculated. CA 125 was best able to discriminate between cases and controls within 6 months of ovarian cancer diagnosis (C statistic, 0.92), followed by HE4 (C statistic, 0.84). The ability of the markers to discriminate between cases and controls decreased with longer intervals between blood draws and cancer diagnosis. For example, with a 1- to 2-year time lag, C statistic values were 0.72 for CA 125 and 0.65 for HE4; for a 3- to 6-year time lag, the C statistic was 0.55 for CA 125. (Data on HE4 were not available for the 3- to 6-year time-lag analysis.)

Clinically Useful

No RCTs or nonrandomized comparative studies evaluating the clinical utility of screening asymptomatic women with HE4 were identified. The studies have not estimated the sensitivity and specificity of HE4 in the screening setting, and thus the chain of evidence supporting screening is incomplete.

Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for individuals managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Section Summary: Biomarker Human Epididymis Protein 4
Screening In Asymptomatic Individuals Not at High Risk of Ovarian Cancer
For individuals who are asymptomatic and not at high-risk of ovarian cancer who receive screening with a serum biomarker HE4 test, the evidence includes several retrospective comparative studies and no prospective studies comparing health outcomes in asymptomatic women managed with and without HE4 screening. The retrospective studies found that HE4 levels increased over time in women ultimately diagnosed with ovarian cancer. Prospective comparative studies are needed to determine definitively whether HE4 testing is a useful screening tool.

SUMMARY OF EVIDENCE
For individuals who have ovarian cancer who receive measurement of serum biomarker HE4, the evidence includes 4 nonrandomized prospective and retrospective studies comparing the diagnostic accuracy of HE4 and CA 125 for predicting disease progression and/or recurrence. Relevant outcomes are overall survival (OS), disease-specific survival, test accuracy and validity, other test performance measures, and change in disease status. Data submitted to the U.S.Food and Drug Administration (FDA) for approval of commercial HE4 tests found that HE4 was not inferior to CA 125 for detecting ovarian cancer recurrence. Although a single prospective observational study found elevated levels of HE4, but not CA 125, at the time of cancer progression was significantly associated with reduced overall survival OS, a direct comparison between biomarkers was not provided. Overall, the superiority of HE4 to CA 125 (alone or in combination), the key question in the evidence review, was not demonstrated in the available literature. In addition, there is no established cutoff in HE4 levels for monitoring disease progression, and cutoffs in studies varied. There is no direct evidence from prospective controlled studies on the impact of HE4 testing on health outcomes, and no clear chain of evidence that changes in management based on HE4 would lead to an improved health outcome. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have adnexal masses who receive measurement of serum biomarker HE4, the evidence includes diagnostic accuracy studies and meta-analyses. Relevant outcomes are OS, disease-specific survival, test accuracy and validity, and other test performance measures. Meta-analyses have generally found that HE4 and CA 125 have similar overall diagnostic accuracy (ie, sensitivity, specificity) and several found that HE4 has significantly higher specificity than CA 125 but not sensitivity. Two meta-analyses had mixed findings on whether the combination of HE4 and CA 125 is superior to CA 125 alone for the initial diagnosis of ovarian cancer. The number of studies evaluating the combined test is relatively low and publication bias in studies of HE4 has been identified. In addition, studies have not found that HE4 improves diagnostic accuracy beyond that of subjective assessment of transvaginal ultrasound. There is no direct evidence from prospective controlled studies on the impact of HE4 testing on health outcomes, and no clear chain of evidence that changes in management based on HE4 would lead to improved health outcome. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are asymptomatic and not at high risk of ovarian cancer who receive screening with serum biomarker HE4, the evidence includes several retrospective comparative studies and no prospective studies comparing health outcomes in asymptomatic women managed with and without HE4 screening. Relevant outcomes are OS, disease-specific survival, test validity, and other test performance measures. The retrospective studies found that HE4 levels increased over time in women ultimately diagnosed with ovarian cancer. Prospective comparative studies are needed to determine definitively whether HE4 is a useful screening tool. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Obstetricians and Gynecologists

Guidelines from the American College of Obstetricians and Gynecologists on evaluation and management of adnexal masses (2016, reaffirmed 2021) state that measurement of cancer antigen 125 (CA 125) is the most extensively studied serum marker to be used in combination with imaging to determine the likelihood of malignancy.[33] The authors also suggest that measurement of CA 125 is most useful for identification of nonmucinous epithelial cancer in postmenopausal women. Although the guideline mentions that human epididymis protein 4 (HE4) has recently been identified as a biomarker that may be useful for distinguishing between benign and malignant masses, no further recommendations regarding HE4 are provided.

In 2017 (reaffirmed 2024), a committee opinion document from ACOG and the Society of Gynecologic Oncology stated that tumor markers such as CA 125 and transvaginal ultrasound, alone or in combination, have not improved early detection or survival in women with average risk for ovarian cancer.[34] There is also a potential for harm if surgery is performed in response to a positive test result.

National Comprehensive Cancer Network

The National Comprehensive Cancer Network ovarian cancer guidelines (v.3.2024) state that, for monitoring and follow-up of patients with stage I to IV ovarian cancer with a complete response to initial treatment, "If the CA-125 level was initially elevated, then measurement of a CA-125 level or other tumor markers is recommended."[35] The guidelines do not specify any marker other than CA-125 for monitoring patients after treatment. The guidelines also recommend "CA-125 or other tumor markers as clinically indicated" for patients referred with newly diagnosed ovarian cancer after recent surgical procedure.

The NCCN guideline provides the following comment about screening using HE4: "Some evidence suggests that HE4 [human epididymis protein 4] may be a useful prognostic marker in patients with ovarian cancer, decreases during response to treatment, and may improve early detection of recurrence relative to CA-125 alone. The NCCN guidelines currently do not recommend routine HE4 as part of preoperative workup because results vary across studies.

Several biomarker combination tests have received Food and Drug Administration approval for estimating the risk of ovarian cancer in patients with adnexal masses and planned surgery. The Risk of Ovarian Malignancy Algorithm (ROMA) test includes HE4 plus and CA-125 plus menopausal status the OVA1 test includes 5 markers including CA-125 (but not HE4), and the OVERA test includes 5 markers including both CA-125 and HE4. The NCCN guidelines state the following about using these biomarker tests: "Currently, the NCCN Panel does not recommend the use of these biomarker tests for determining the status of an undiagnosed adnexal/pelvic mass."

The NCCN guidelines state the following on screening for ovarian cancer:
"Very few biomarkers have been tested prospectively to determine whether they can detect ovarian cancer or predict development of ovarian cancer in women who have no other signs or symptoms of cancer. Data show that several markers (including CA-125, HE4, mesothelin, B7-H4, decoy receptor 3 [DcR3], and spondin-2) do not increase early enough to be useful in detecting early-stage ovarian cancer."

National Institute for Health and Care Excellence
In 2011, NICE recommended using CA 125 to test for ovarian cancer in patients presenting to primary care providers with symptoms of ovarian cancer.[36] No other biomarker tests are mentioned in the NICE guidance.

U.S. Preventive Services Task Force Recommendations
The U.S. Preventive Services Task Force updated its recommendations for screening for ovarian cancer in February 2018.[37] The Task Force recommended against screening for ovarian cancer in asymptomatic women (D recommendation). HE4 was not specifically discussed.

ONGOING AND UNPUBLISHED CLINICAL TRIALS
Some currently ongoing and unpublished trials that might influence this review are listed in Table 12.

Table 12. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
Unpublished			
NCT01768156	Determination of the Prognostic and Predictive Value of the New Marker HE4 in Metastatic Ovarian Cancer Monitoring	101	Nov 2016 (no results posted)

NCT03982914	The Use of a New Biomarker, HE4, in Combination With Simple Ultrasound Rules in the Prediction of Malignancy in a Pelvic Mass Detected on Ultrasound	814	Aug 2021
NCT02595281	Determination of the Interest of HE4 as a Relapse Biomarker in Ovarian Cancers Stages IIIb, IIIc and IV After Neo-adjuvant Chemotherapy and Surgery	90	July 2022

NCT: national clinical trial

Government Regulations
National/Local:

There is no national or local coverage determination for Human Epididymis Protein (HE4).

There is a fee for 86305 on the 2025 Clinical Laboratory Fee Schedule. An assigned fee is not a guarantee of coverage.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- CA 125 Testing (Retired)
- Multimarker Serum Testing Related to Ovarian Cancer (e.g., OVA1®, Overa™,OvaWatch and ROMA™ testing)
- Germline Genetic Testing for BRCA1, BRCA2, and PALB2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 1/6/25, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
7/1/10	5/12/10	5/18/10	Joint policy established
1/1/14	6/18/13	6/26/13	Policy updated to mirror BCBSA; policy position changed from established to experimental/ investigational.
5/1/15	2/17/15	2/27/15	Routine maintenance • References updated: 5-12,16 and 18 added • Updated Medical Policy Statement – No status change
7/1/16	4/19/16	4/19/16	Routine maintenance
5/1/17	2/21/17	2/21/17	Routine maintenance
5/1/18	2/20/18	2/20/18	Routine maintenance
5/1/19	2/19/19		Routine maintenance
5/1/20	2/18/20		Routine maintenance. References 10 and 11 added.
5/1/21	2/16/21		Routine maintenance. Ref 10, 22 added.
5/1/22	2/15/22		Routine maintenance Ref 10,12,13,14,15,16,33,35 added
5/1/23	2/21/23		Routine maintenance (jf) Ref removed 6,8,12,14, added 3, 8, 13, 28 and 29 Vendor Managed: Avalon policy G2124 reviewed Serum Tumor Markers for Malignancies. However, this biomarker was not supported or adopted in their review. Avalon's 2022 policy didn't support HE4. Aligned with BCBMS policy.
5/1/24	2/20/24		Routine maintenance (jf) Vendor Managed: NA
5/1/25	2/18/25		Routine maintenance (jf) Vendor Managed: NA

Next Review Date: 1st Qtr, 2026

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: SERUM BIOMARKER HUMAN EPIDIDYMIS PROTEIN 4 (HE4)

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
BCNA (Medicare Advantage)	See the Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.