



# Gastric Cancer Factsheet: Insights & Key Developments

Key Insights on Gastric Cancer Care and Infrastructure

# Core Pillars:

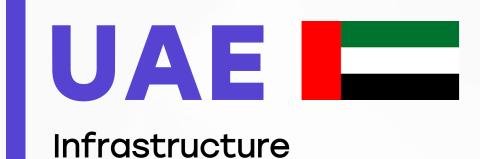
- 1. Infrastructure
- 2. Treatment Access, Research Funding and Awareness Campaigns
- 3. Survival Rates, Early Detection and Palliative Care
- 4. Utilization of Biomarkers
- 5. Clinical Guidelines
- 6. Reimbursement
- 7. Gastric Cancer Screening

Gastric cancer remains one of the most prevalent cancers worldwide, affecting millions of individuals each year. Despite advancements in diagnostics, treatment, and awareness, disparities in access to care, molecular testing, and specialized centers persist.

This factsheet provides a comprehensive overview of key pillars shaping Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer is not in the top male cancers.
- Incidence rate: Around 3 per 100,000 men per year.
- Total new cases (2022): Approximately 200-300 men.
- Daily diagnoses: About 1 man per day.
- Deaths (2022): Estimated ~200 men.
- 5-year survival rate: Estimated 40-50%.
- Most affected age group: Mostly men aged 65+.
- Screening participation: No organized screening; relies on clinical referral after symptoms.





- The UAE has grown from one cancer center (Al Ain) in 1981 to 30+ cancer centers, including four comprehensive facilities (e.g., Burjeel Cancer Institute, Tawam)
- Advanced diagnostics from major centers include endoscopic ultrasound, PET-CT, CT scan, and biopsy services integrated with multidisciplinary oncology teams

0

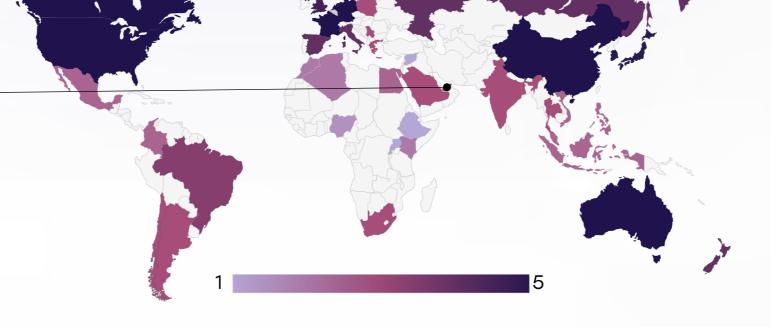
# Opportunity

- Expand telepathology and teleoncology linkages to support screening and decision-making in underserved emirates.
- Use mobile diagnostic clinics and strengthen regional centers under national cancer control plans.

#### Weakness

- Regional disparities exist: peripheral emirates and public clinics have limited endoscopy and molecular pathology capacity.
- Referral backlogs and access delays persist despite rich infrastructure in urban hubs

- Continuing strain on urban cancer centers could lead to waiting delays.
- Workforce limitations especially in oncology, pathology, and endoscopy—risk compromising timely care.



- 5. Advanced nationwide infrastructure, widespread availability in public and private sectors, integration with clinical practice.
- 4. Strong infrastructure in major hospitals and cancer centers, some regional disparities.
- 3. Moderate infrastructure, primarily in private settings or research institutions.
- 2. Limited infrastructure, available only in select centers or for high-cost private testing.
- 1. Minimal or no infrastructure, testing mostly unavailable or sent abroad.

Country	Specialized Centers	Genetic & Molecular Testing Infrastructure
South Africa	<u> </u>	<u> </u>
Kenya		
Nigeria		
Egypt	0	0
Morocco		
Algeria		
Ethiopia		
India	<u> </u>	
Japan		
South Korea		
China	0	0
Thailand	<u> </u>	0
Singapore		
United Kingdom		
Germany		0
France		
Netherlands		
Sweden		
Italy		
Spain		
Poland		
Mexico		
Brazil		
Argentina		
Chile		
Colombia		
United States		
Canada		
Australia		
New Zealand		
Greece		
Rwanda		
Uganda		
Serbia	<u> </u>	<u> </u>
Saudi Arabia		
UAE	0	
Syria		
Indonesia		
Vietnam		
Philippines		
Russia		
Malaysia		



# UAE

Treatment Access, Research Funding and Awareness Campaigns

0

# Weakness

 Universal health coverage (Daman, SEHA, private insurance) generally ensures access to surgery, chemotherapy, targeted therapies, and immunotherapy in public or private systems.

Strengths

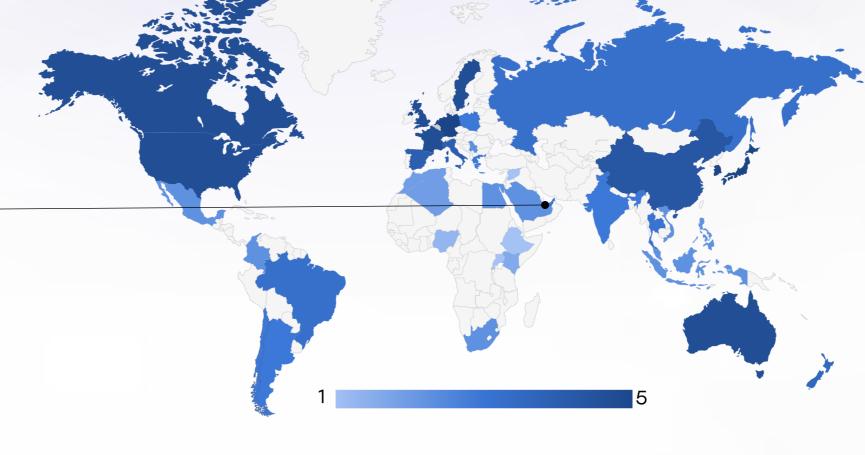
 UAE hospitals participate in regional and global research and clinical trials, supporting targeted treatments (e.g., HER2, PD-L1)

# Opportunity

- Leverage existing campaigns (e.g., Pink Caravan model) to integrate gastric cancer education via community outreach.
- Engage NGOs (like Friends of Cancer Patients, Emirates Cancer Society) to support subsidized biomarker and treatment access

- Public awareness of gastric cancer risk factors (H. pylori, diet, early symptoms) remains low compared to focus on breast/colon cancers.
- Access to high-cost therapies and biomarker testing is inconsistent and often limited to well-insured or private patients

- High costs and coverage limitations may create inequity in access between emirates, insurance tiers, or expatriates.
- Low patient advocacy and stigma around cancer disclosure can undermine prevention and screening uptake.



- 5. Strong healthcare infrastructure with comprehensive treatment access, high research funding, and nationwide awareness campaigns. Patients have access to advanced therapies, clinical trials, and widespread early detection programs.
- 4. Well-developed system with good treatment availability, strong research funding, and effective but regionally focused awareness campaigns. Some disparities may exist in rural areas or between public and private sectors.
- 3. Moderate development, with specialized treatments available in major hospitals, research funding concentrated on specific cancers, and occasional but limited awareness efforts. Healthcare access may be restricted by cost or geography.
- Limited system where cancer treatment is available only in select urban centers, research funding is minimal or sporadic, and awareness campaigns are rare or underfunded. Patients often face long wait times or financial barriers.
- 1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

Country	Treatment Access	Research Funding	Awareness Campaigns
South Africa	<u> </u>		
Kenya			
Nigeria			
Egypt	<u> </u>		
Morocco			
Algeria			0
Ethiopia			
India	<u> </u>	<u> </u>	<u> </u>
Japan			
South Korea			
China			
Thailand			
Singapore			
United Kingdom			
Germany			
France			
Netherlands			
Sweden			
Italy			
Spain			
Poland	<u> </u>	<u> </u>	<u> </u>
Mexico	<u> </u>		
Brazil	0	$\bigcirc$	<u> </u>
Argentina	<u> </u>	<u> </u>	<u> </u>
Chile	<u> </u>	<u> </u>	<u> </u>
Colombia	<u> </u>		
United States			0
Canada			0
Australia			0
New Zealand	0		0
Greece	0	0	<u> </u>
Rwanda			
Uganda			
Serbia	<u> </u>		
Saudi Arabia	<u> </u>		
UAE	<u> </u>		
Syria			
Indonesia	0	0	0
Vietnam	<u> </u>		
Philippines		0	0
Russia	0	0	0
Malaysia			



# UAE

Survival Rates, Early **Detection and** Palliative Care

#### Strengths Weakness

0

W

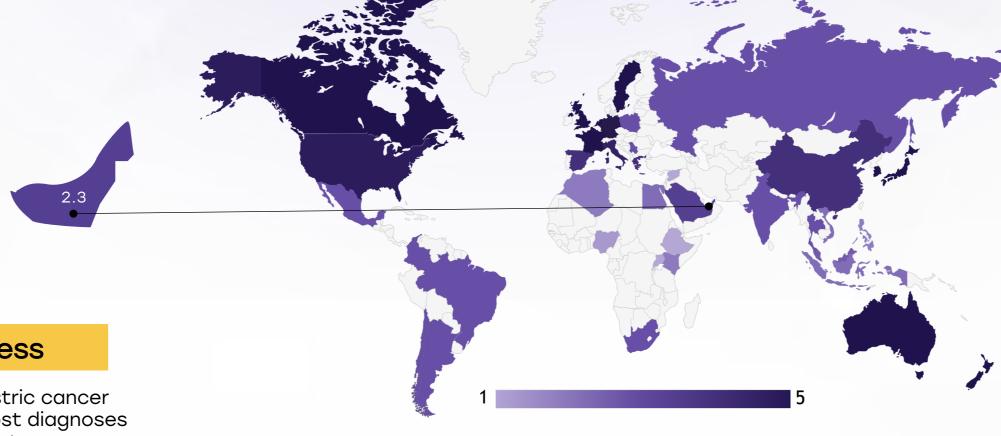
- Early-stage patients treated at major centers achieve more favorable outcomes due to integrated care; palliative care is now available at Tawam (since 2007), Burjeel (2020), American Hospital Dubai, and Mediclinic Dubai
- Cancer survivorship and psychosocial services are emerging at select centers
- like Burjeel and Tawam

# Opportunity

- Train general practitioners and primary care teams to recognize alarm signs and fast-track referrals.
- Expand palliative and survivorship programs through national cancer control plans and professional training.

- No formal gastric cancer screening; most diagnoses occur at late stage, resulting in low overall survival (likely <20%).
- Palliative care availability is concentrated in major cities-service gaps remain in Sharjah, Ajman, and remote areas

- · Late presentation and fragmented follow-up reduce efficacy and continuity of care.
- Cultural stigma and reluctance to seek help early may further delay interventions.



- 5. High survival rates, strong early detection programs, and well-established palliative care services. Patients have access to timely diagnosis, advanced treatments, and comprehensive end-oflife care.
  - 4. Good survival rates, effective early detection efforts, and accessible but regionally limited palliative care. Some disparities may exist in rural areas or for specific cancer types.
  - 3. Moderate survival rates, early detection available but not widespread, and palliative care services mainly in urban centers. Some patients experience delays in diagnosis or limited end-of-life care.
  - 2. Low survival rates, early detection efforts are inconsistent or underfunded, and palliative care is minimal or only available in select hospitals. Cancer patients face significant access barriers.
  - 1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

Country	Survival Rates	Early Detection	Palliative Care
South Africa	<u> </u>	$\bigcirc$	<u> </u>
Kenya	0		0
Nigeria	0		
Egypt	0		
Morocco	0		
Algeria			
Ethiopia			
India	<u> </u>	<u> </u>	<u> </u>
Japan			
South Korea			
China			
Thailand			
Singapore			
United Kingdom			
Germany			
France			
Netherlands			
Sweden			
Italy			
Spain			
Poland			
Mexico			
Brazil			
Argentina			<u> </u>
Chile			
Colombia			
United States			
Canada			
Australia			
New Zealand			
Greece	0		0
Rwanda			
Uganda			
Serbia	<u> </u>	<u> </u>	<u> </u>
Saudi Arabia	<u> </u>	<u> </u>	<u> </u>
UAE	<u> </u>	<u> </u>	<u> </u>
Syria			
Indonesia	<u> </u>		•
Vietnam	<u> </u>		<u> </u>
Philippines			
Russia	$\bigcirc$	<u> </u>	<u> </u>
Malaysia	<u> </u>		<u> </u>





- HER2 testing and trastuzumab use are available in tertiary centers (e.g., Burjeel, Tawam) for advanced gastric cancer management
- PD-L1 (CPS ≥ 1) testing and MSI-H/dMMR profiling are increasingly incorporated to guide immunotherapy decisions.

# Opportunity

- Expand molecular diagnostics infrastructure via partnerships between governmental and private labs.
- Incorporate HER2, MSI, and PD-L1 testing into national clinical protocols and insurance reimbursement schedules.

#### Weakness

- Testing for advanced targets (CLDN18.2, FGFR2b) is typically unavailable or limited to clinical trial settings.
- Public sector pathology services lack capacity for standardized biomarker panels, and results may involve out-of-pocket costs.

W

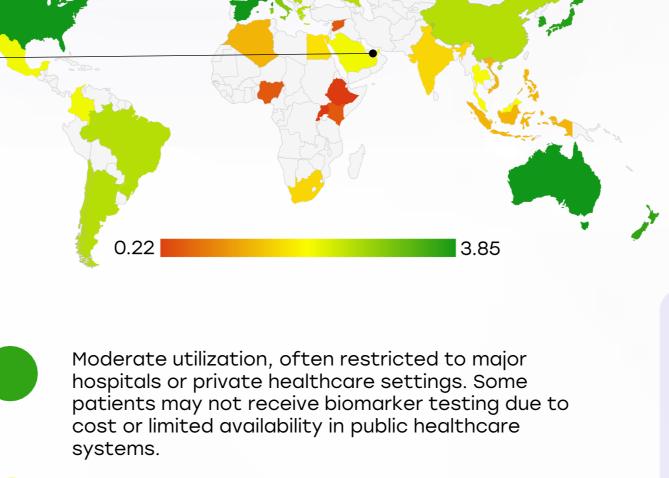
0

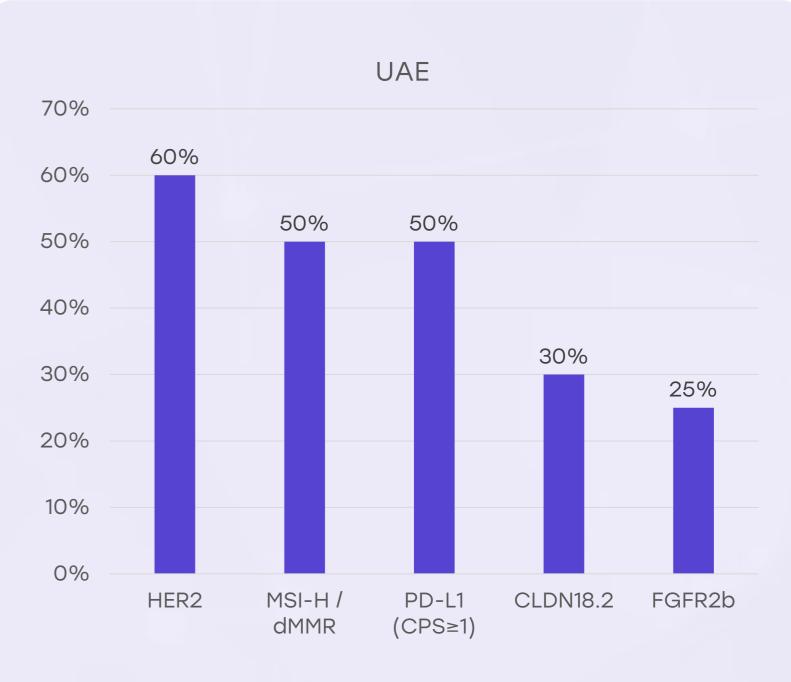
#### Threats

- High testing and treatment costs, plus limited insurance coverage, may discourage clinicians from ordering biomarkers.
- Inequitable access across regions and income levels may widen treatment disparities.

Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.

Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.









 The Ministry of Health (MoHAP) has launched updated scientific cancer guidelines aligned with latest global standards-currently for breast, cervical, and colon cancers but potentially extendable to gastric cancer.

S

0

W

 Major hospitals follow international guidelines adapted locally, with multidisciplinary tumor boards standard at centers like Burjeel, Tawam, SKMC, Cleveland Clinic Abu Dhabi.

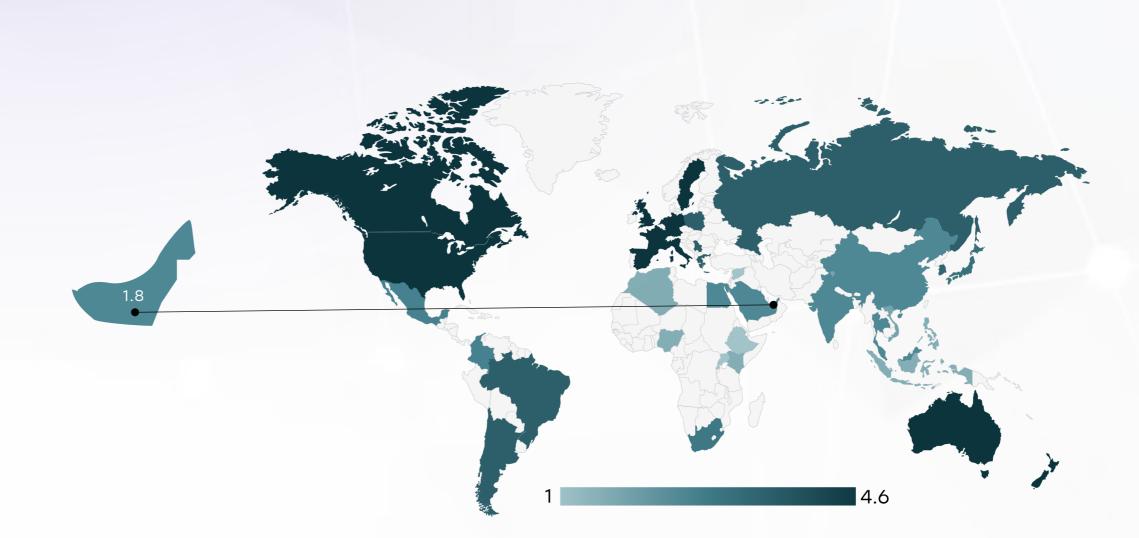
# Opportunity

- Expand MoHAP guideline framework to include gastric cancer, with biomarkerinformed decision pathways.
- Roll out virtual CME training and guideline summaries to all emirates to improve uptake.

#### Weakness

- Morocco cancer clinical guidelines currently exclude gastric cancer-specific biomarker integration and national standardization is lacking.
- Primary care providers and regional hospitals may not consistently adhere to the latest protocols or referral pathways.

- Delays or fragmentation in guideline updates may result in inconsistent adoption across public and private sectors.
- Institutional inertia could slow implementation of biomarker-driven protocols.



	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	×	*	*	0	*
Feasibility of Integration	*	*	*	0	*
Adoption of International Guidelines	*	*	*	0	*
Engagement with Updates	*	*	*	*	0
ESMO Guidelines Implementation	×	*	*	×	0





 Universal coverage under UAE insurance schemes (private and government plans) includes chemotherapy, radiotherapy, surgery, trastuzumab, and immunotherapy in many cases

S

0

W

 Charity and aid programs via DHA/SEHA (Abu Dhabi), FoCP and Al Jalila Foundation provide support for the uninsured or underinsured

# Opportunity

- Advocate for inclusion of core biomarker diagnostics and targeted therapies in national insurance benefits.
- Pilot outcome-based reimbursement models tied to effectiveness of biomarker-matched therapies.

#### Weakness

- MSI, PD-L1 testing and emerging treatments (e.g., CLDN18.2 therapeutics) may not be uniformly reimbursed, leading to outof-pocket payment burdens.
- Social insurance may not cover onco-fertility or survivorship services; expat coverage may vary greatly.

- Cost pressures on insurers may limit expansion of coverage to emerging diagnostics or treatments.
- Differential access between emirates or by visa status may perpetuate inequities.



- A structured reimbursement system exists, ensuring biomarker testing is covered through national healthcare systems, insurance, or public-private partnerships. Patients face no direct financial burden.
- A reimbursement framework is in place, but patients may still have out-of-pocket expenses such as co-pays, limited coverage, or financial caps on testing.
- No formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

Country	Reimbursement Framework	No-cost Access
United States	0	0
United Kingdom		
Canada		
Australia		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain	0	0
Poland	0	0
Japan		
South Korea		
China	0	0
India	0	0
Singapore		
Thailand		0
South Africa	0	0
Kenya	0	0
Nigeria	0	0
Egypt	0	0
Morocco	0	0
Algeria		
Ethiopia	0	0
Mexico		
Brazil		
Argentina		
Chile		
Colombia	0	0
New Zealand	0	0
Greece	0	0
Rwanda	0	0
Uganda	0	0
Serbia		
Saudi Arabia	0	0
UAE		
Syria	O	O
Indonesia		O
Vietnam		O
Philippines	O	O
Russia		
Malaysia		





- Although no formal gastric screening exists, endoscopy is available widely for symptomatic individuals in hospitalbased GI units.
- Active public awareness and screening campaigns (e.g., Pink Caravan) demonstrate mobilization capacity for preventive outreach

# Opportunity

- Introduce pilot risk-based screening campaigns using non-invasive H. pylori serology or breath tests in high-risk older adults.
- Leverage established colorectal/breast screening infrastructure to embed opportunistic upper GI detection.

#### Weakness

W

S

0

- The UAE currently DOES NOT implement gastric or H. pylori screening at the population level.
- Low public and primary-care awareness of gastric cancer risk leads to underreferral and minimal early detection.

- Competing resource allocation to breast, cervix, and colorectal screening may delay gastric cancer-focused initiatives.
- Cultural reluctance toward endoscopy and misconceptions may reduce screening uptake.

Country	Castria Cancer Corcening
Country	Gastric Cancer Screening
United States	Annual LDCT (50-80 years, high-risk smokers)
United Kingdom	LDCT for high-risk individuals (55-74 years)
Canada	LDCT for high-risk individuals (55-74 years)
Australia	No national program, high-risk groups advised LDCT
Germany	No national program, under evaluation
France	No national LDCT screening
Netherlands	Participating in European screening studies
Sweden	No national LDCT screening
Italy	Regional pilot LDCT screening
Spain	No national LDCT program
Poland	No national program
Japan	No national LDCT program
South Korea	LDCT for high-risk individuals (50-74 years)
China	No national LDCT program
India	No national LDCT program
Singapore	No national LDCT program
Saudi Arabia	No national LDCT program; some hospital-based opportunistic screening
UAE	No national LDCT program; early-stage pilot studies ongoing in select hospitals
Syria	No national LDCT program; screening not prioritized due to conflict
Malaysia	No program; high-risk CT pilots

Country	Gastric Cancer Screening
Thailand	No national LDCT program
South Africa	No national LDCT program
Kenya	No national LDCT program
Nigeria	No national LDCT program
Egypt	No national LDCT program
Morocco	No national LDCT program
Algeria	No national LDCT program
Ethiopia	No national LDCT program
Mexico	No national LDCT program
Brazil	No national LDCT program
Argentina	No national LDCT program
Chile	No national LDCT program
Colombia	No national LDCT program
New Zealand	No national LDCT program
Greece	No national LDCT program
Rwanda	No national LDCT program
Uganda	No national LDCT program
Serbia	No national LDCT program
Indonesia	No national LDCT program; opportunistic screening in private sector
Vietnam	No national LDCT program; early pilot screening studies in Hanoi and Ho Chi Minh
Philippines	No national LDCT program; feasibility and awareness programs under discussion
Russia	No formal national LDCT program; regional pilot screening programs in large cities