



Colorectal Cancer Factsheet: Insights & Key Developments

Key Insights on Colorectal 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. Colorectal Cancer Screening

Colorectal 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 colorectal cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Among the top 3 cancers in Brazilian men.
- Incidence rate: Approximately 20 per 100,000 men per year.
- Total new cases (2022): Around 19,300 men.
- Daily diagnoses (2022): About 53 men per day.
- Deaths (2022): Roughly 11,500 men.
- 5-year survival rate: Estimated around 48-50%.
- Most affected age group: Men aged 55-75 years.
- Screening participation: Limited coverage, with programs expanding in urban areas; rural uptake is low.





- Brazil has well-equipped cancer centers in major cities (e.g. INCA in Rio, Sírio-Libanês in São Paulo) offering advanced diagnostics and treatments.
- Urban hospitals have access to colonoscopy, CT/MRI, pathology, and specialized surgery.

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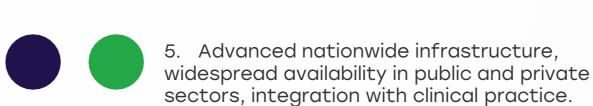
Opportunity

- Invest in regional cancer diagnostic hubs and modernize public hospital labs.
- Use telemedicine and mobile screening units to reach underserved areas.

Weakness

- Significant disparities
 between urban centers
 and rural or northern
 regions, leading to
 inequitable access.
- Many public hospitals lack modern molecular diagnostic labs capable of high-volume testing.

- Budget constraints and administrative delays limit infrastructure expansion.
- Brain drain of oncology specialists to private or international institutions.



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





Treatment Access, Research Funding and Awareness Campaigns

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Strengths

- Public healthcare system (SUS) ensures free CRC treatment, including surgery, chemo, and radiotherapy.
- Brazil participates in international CRC trials and has growing genomic research at leading institutions.

Opportunity

- Launch nationwide awareness campaigns, especially for populations over 50 and in rural areas.
- Promote public-private partnerships for biomarker-driven clinical trials.

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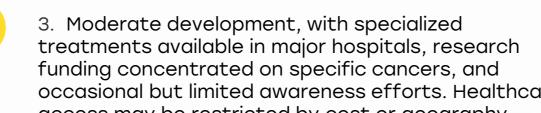
- Targeted tl availability (e inhibitors, immunotherapy) is uneven across the public system.
- Awareness campaigns for CRC are less widespread than for breast or prostate cancer.

- Economic instability can slow access to innovative therapies.
- Disparities in care quality between public and private sectors.

- 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.
- 2. 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.

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5. Strong healthcare infrastructure with comprehensive treatment access, high research funding, and nationwide awareness campaigns. Patients have access to advanced therapies, clinic
trials, and widespread early detection programs.



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





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

Strengths

- CRC survival in Brazil is improving with more early-stage diagnoses due to better access to screening.
- Palliative care services are expanding in urban centers and through NGO-run hospice systems.

Opportunity

- Train primary care physicians and community health agents to detect early CRC symptoms.
- Integrate communitybased palliative care models, focusing on underserved areas.

Weak

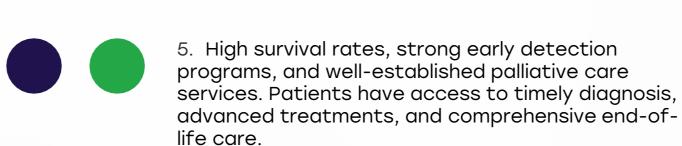
- Late-sta diagnoses remain frequent, especially in poorer regions.
- Palliative services and pain management remain underdeveloped in many public settings.

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Threats

- Limited follow-up capacity leads to higher rates of recurrence and latestage mortality.
- Cultural resistance or low awareness can slow early treatmentseeking.



- 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.

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





- KRAS and BRAF testing are routinely ordered for metastatic CRC in major urban centers.
- MSI/dMMR testing is increasingly used to identify patients eligible for immunotherapy.

Opportunity

- Incorporate expanded molecular panels (including NRAS/PIK3CA) into public cancer pathways.
- Develop public sector lab capacity via federal funding or partnerships.

Weakness

- testing are not widely available and are often limited to private labs.
- Biomarker testing incurs high costs and is not consistently integrated in public protocols.

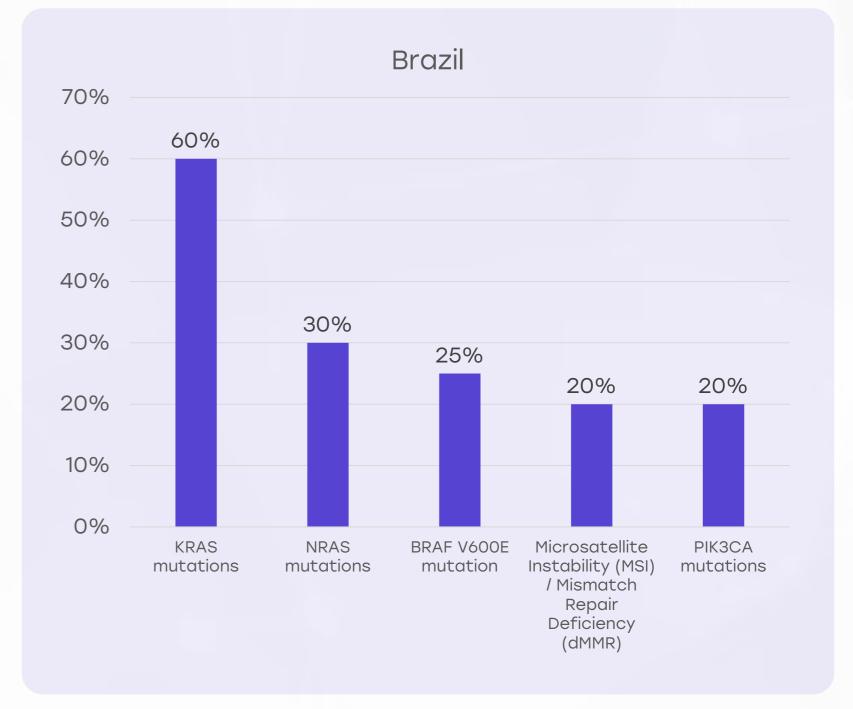
Threats

- High out-of-pocket costs may exclude lower-income patients from precision diagnostics.
- Slow adoption of biomarkers into standard practice can delay targeted therapy uptake.

Moderate utilization, often restricted to major hospitals or private healthcare settings. Some patients may not receive biomarker testing due to cost or limited availability in public healthcare systems.

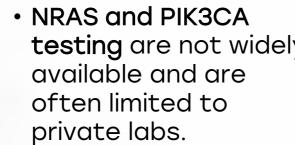
> Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.

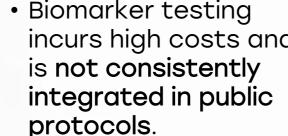
Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.





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- CRC treatment in Brazil follows international standards (e.g. ESMO, NCCN) with adaptations by national oncology groups.
- Some centers have local protocols supporting biomarker testing for treatment decisions.

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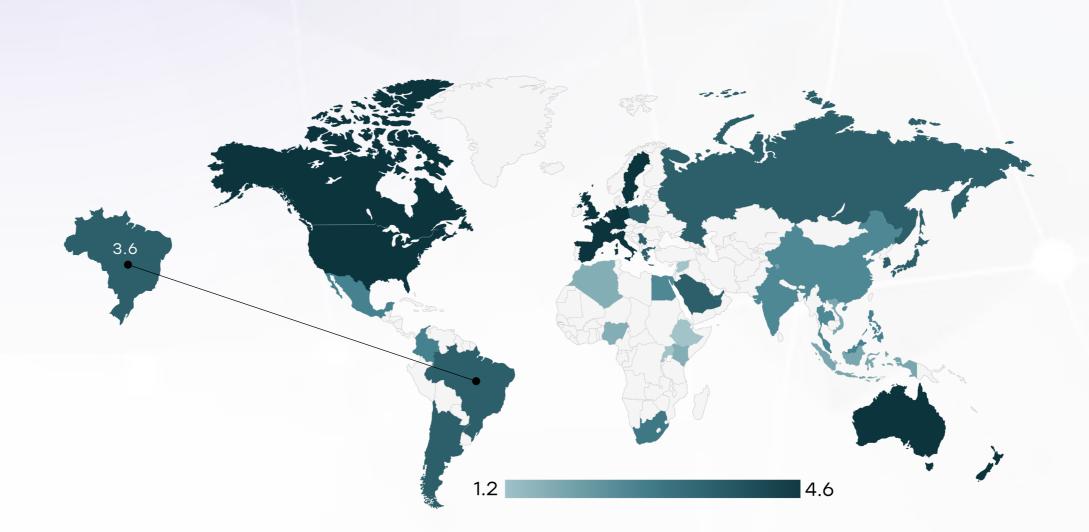
Opportunity

- Develop Brazil-specific CRC guidelines that explicitly embed biomarker thresholds and pathways.
- Provide training and support to ensure consistent guideline adoption across Brazil's states.

Weakness

- Lack of a uniform national guideline integrating molecular testing across all regions.
- Variable compliance between public hospitals and private institutions.

- Regional health system fragmentation complicates unified implementation.
- Economic or political shifts could disrupt guideline updates and training efforts.



	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	*	×	*





- SUS covers core
 CRC treatments for
 all patients at no
 direct cost.
- KRAS/BRAF/MSI testing may be covered in some high-resource hospital networks.

Opportunity

- Advocate for inclusion of essential biomarkers (e.g. MSI, KRAS) in the national reimbursement list.
- Introduce valuebased payment models linking genomic testing to treatment outcomes.

Weakness

 No formal reimbursement framework for NRAS or PIK3CA testing and newer targeted therapies under SUS.

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 Private health plans offer uneven coverage, leading to inequity for patients without private insurance.

- Fiscal constraints within SUS could delay reimbursement expansions.
- High diagnostic costs create inequities and delay decisions in public hospitals.



- 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		
United Kingdom		
Canada		
Australia		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain	0	
Poland		
Japan		
South Korea		
China		
India		0
Singapore		
Thailand		
South Africa	0	0
Kenya	0	0
Nigeria	0	0
Egypt	0	0
Morocco	0	0
Algeria		
Ethiopia	0	0
Mexico	0	
Brazil		
Argentina	0	
Chile		
Colombia		
New Zealand		
Greece		
Rwanda	0	0
Uganda	0	0
Serbia		
Saudi Arabia		
UAE		
Syria	0	0
Indonesia		0
Vietnam		O
Philippines	0	0
Russia		
Malaysia	0	
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- Some Brazilian states have implemented FIT-based CRC screening pilots for ages 50-75.
- National awareness of CRC as a public health priority has increased.

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Opportunity

- Scale up FIT-based screening nationwide, integrated into primary care networks.
- Use regional successes to advocate for national roll-out and tracking systems.

Weakness

- No national CRC screening program yet; participation remains inconsistent.
- Follow-up colonoscopy availability is limited, leading to missed diagnoses after positive FIT.

- Capacity backlogs in colonoscopy services may hinder effective screening.
- Fear or lack of knowledge about CRC screening could suppress uptake.

Country	Colorectal 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	Colorectal 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