International Cancer Patient Coalition

Argentina

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 among the most common male cancers; it is within the top 10 in men.
- Incidence rate: Approximately 10 per 100,000 men per year.
- Total new cases (2022): Estimated around 4,460 cases in men (~8,900 both sexes).
- Daily diagnoses: Roughly 25 men per day.
- Deaths (2022): Around ~2,500 deaths.
- 5-year survival rate: Estimated ≈ 50–60%.
- Most affected age group: Peaks around 60–70 years.
- Screening participation: Minimal; detection often at symptomatic stages.

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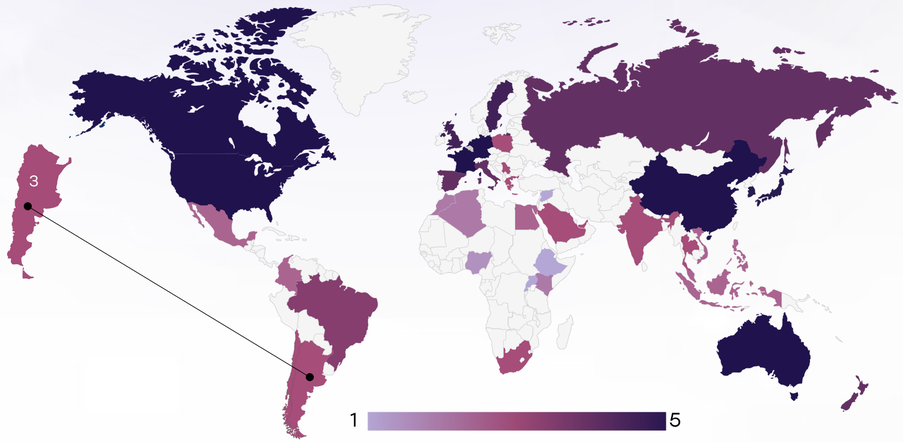
Infrastructure



Strengths

- Advanced public and private cancer hospitals like Instituto Ángel H. Roffo and Hospital de Clínicas in Buenos Aires provide gastric cancer surgeries, chemotherapy, and diagnostic services.
- Universal healthcare model offers access to oncology services to a majority of the population.

Weakness

- Unequal distribution of oncology resources between urban and rural provinces (e.g., Patagonian and northern regions).
- High reliance on centralized pathology services delays biomarker testing and diagnosis.

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Opportunity

- Expansion of cancer care networks (Red Nacional de Cáncer) to improve access in under-served regions.
- Investment in regional cancer diagnostic hubs to decentralize services.

Threats

- Economic instability can impact medical imports (e.g., imaging devices and reagents) and delay upgrades.
- Brain drain of oncology professionals to private sector or abroad.

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	3	3
Kenya	2	2
Nigeria	2	2
Egypt	2	3
Morocco	2	2
Algeria	2	2
Ethiopia	1	1
India	3	4
Japan	4	4
South Korea	4	4
China	4	4
Thailand	3	3
Singapore	4	4
United Kingdom	4	4
Germany	5	4
France	4	4
Netherlands	5	4
Sweden	5	4
Italy	4	4
Spain	4	4
Poland	4	3
Mexico	2	3
Brazil	3	3
Argentina	3	3
Chile	3	3
Colombia	2	3
United States	5	5
Canada	5	4
Australia	4	4
New Zealand	4	4
Greece	4	3
Rwanda	1	1
Uganda	1	1
Serbia	3	3
Saudi Arabia	4	4
UAE	4	4
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	4	3
Malaysia	4	4

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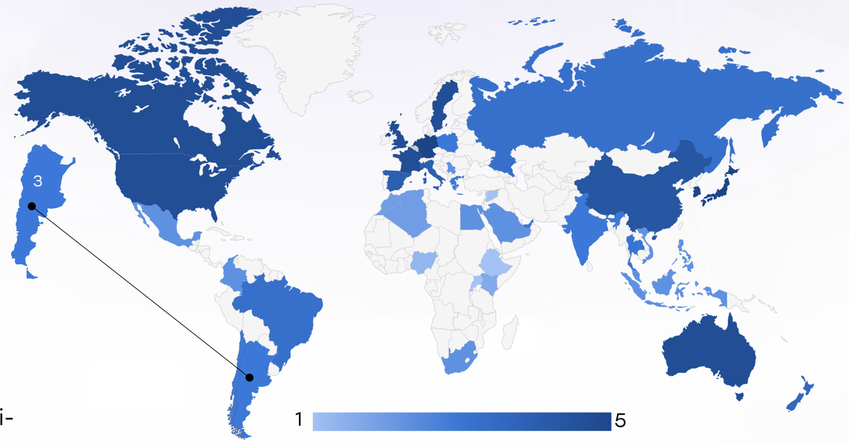
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Targeted therapy (trastuzumab) is accessible for eligible HER2+ GC cases in both private and some public centers.
- Argentina participates in international clinical trials, contributing to innovation and therapy access.

Weakness

- Novel therapies like anti-PD-L1 immunotherapies and FGFR2b inhibitors are expensive and not uniformly covered.
- Public awareness of gastric cancer is low, especially among at-risk rural and elderly populations.

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Opportunity

- Argentina's strong academic ecosystem (e.g., CONICET and UBA) can boost gastric cancer research and biomarker validation.
- Government-led prevention and cancer awareness campaigns can integrate GC risk factors (H. pylori, diet).

Threats

- Budget constraints and inflation limit sustained public funding for awareness and research programs.
- Competing focus on more prevalent cancers (breast, prostate) reduces GC visibility.

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.

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.

Country	Treatment Access	Research Funding	Awareness Campaigns
South Africa	3	4	4
Kenya	4	1	1
Nigeria	4	1	1
Egypt	3	4	4
Morocco	4	4	4
Algeria	4	4	4
Ethiopia	1	1	1
India	3	3	3
Japan	5	5	5
South Korea	5	5	5
China	4	5	4
Thailand	3	3	3
Singapore	5	4	4
United Kingdom	5	5	4
Germany	5	5	5
France	5	4	4
Netherlands	5	5	4
Sweden	5	5	4
Italy	5	4	4
Spain	5	4	4
Poland	3	3	3
Mexico	3	4	4
Brazil	4	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	4	4
United States	5	5	4
Canada	5	5	4
Australia	5	5	4
New Zealand	4	4	4
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	3	4	4
Saudi Arabia	3	4	4
UAE	3	3	3
Syria	1	1	1
Indonesia	3	4	4
Vietnam	3	4	4
Philippines	4	4	4
Russia	4	3	3
Malaysia	3	4	4

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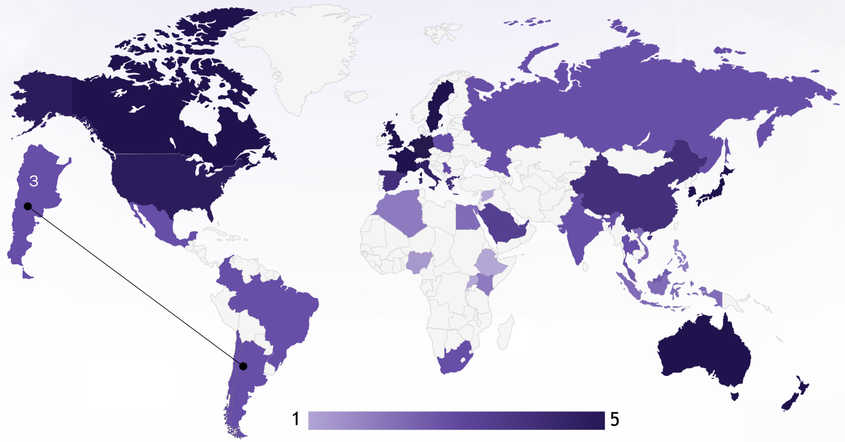
Survival Rates, Early Detection and Palliative Care



Strengths

- Major cities offer high-quality surgical treatment, with 5-year survival rates approaching global averages when detected early.
- Some centers offer integrated palliative care and pain management for advanced GC cases.

Weakness

- Late-stage presentation is common—more than 60% of patients are diagnosed at stage III or IV.
- Early detection through surveillance endoscopy is limited to symptomatic individuals.

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Opportunity

- Risk stratification screening models based on family history and H. pylori status can improve early detection.
- Expansion of community-based palliative and supportive care programs in the provinces.

Threats

- Rural populations often receive a diagnosis too late due to lack of GI specialists and endoscopy access.
- Cultural stigmas around cancer hinder early care-seeking behavior.

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-of-life 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	3	3	3
Kenya	2	2	2
Nigeria	2	1	1
Egypt	3	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	5	5	5
South Korea	5	5	5
China	4	4	4
Thailand	3	3	3
Singapore	5	5	5
United Kingdom	5	5	5
Germany	5	5	5
France	5	5	5
Netherlands	5	5	5
Sweden	5	5	5
Italy	4	4	4
Spain	4	4	4
Poland	3	3	3
Mexico	3	3	3
Brazil	3	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	3	3
United States	5	5	4
Canada	5	5	5
Australia	5	5	5
New Zealand	5	5	5
Greece	4	4	4
Rwanda	1	1	1
Uganda	1	1	1
Serbia	3	3	3
Saudi Arabia	3	3	3
UAE	3	3	3
Syria	1	1	1
Indonesia	3	2	2
Vietnam	3	2	2
Philippines	3	2	2
Russia	3	3	3
Malaysia	3	2	3

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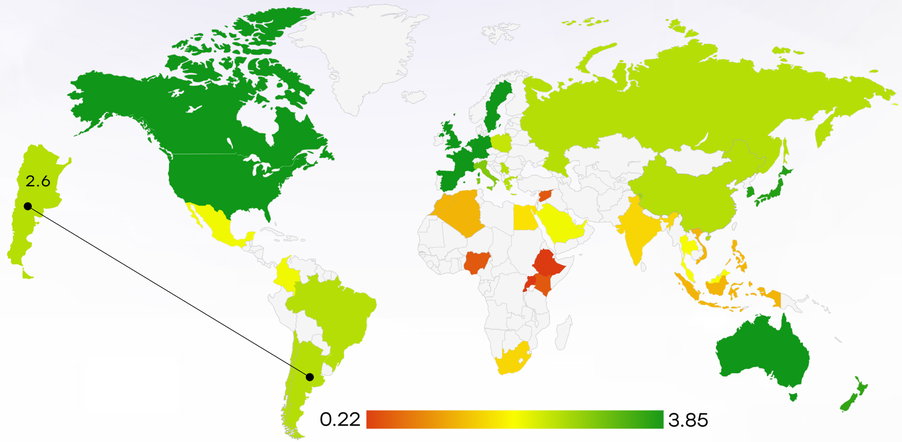
Utilization of Biomarkers



Strengths

- HER2 testing is widely available and reimbursed in most urban oncology centers.
- Selected academic hospitals conduct PD-L1 CPS testing for advanced-stage treatment planning.

Weakness

- MSI-H/dMMR, CLDN18.2, and FGFR2b testing is largely limited to research or private institutions.
- No standardized biomarker testing protocol across the country.

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Opportunity

- Public-private collaborations can fund national biomarker testing programs for gastric cancer.
- Establishing centralized biobanks to support molecular profiling of GC.

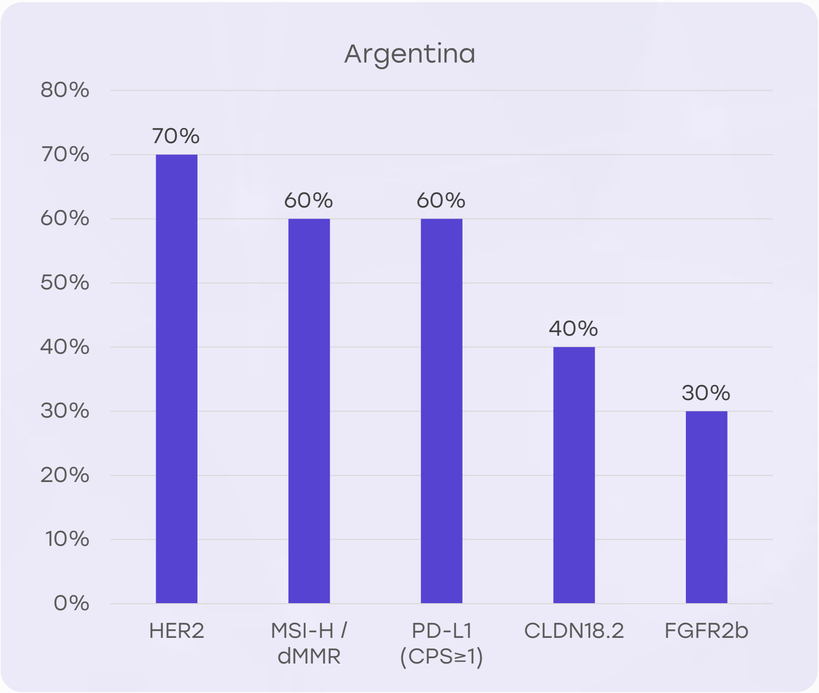
Threats

- Inconsistent reimbursement leads to financial toxicity for patients requiring personalized therapies.
- Delays in IHC/NGS results affect timely treatment initiation in advanced cases.

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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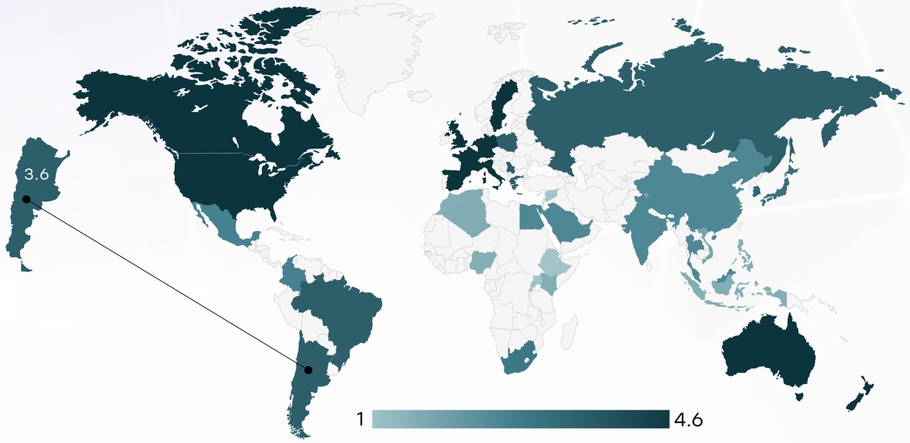
Clinical Guidelines



Strengths

- National guidelines (INCA) are aligned with global standards for surgery, chemotherapy, and HER2 testing.
- Argentine Society of Clinical Oncology (AAOC) promotes continuing education for oncologists.

Weakness

- Guidelines are not always updated with the latest biomarker-driven treatment protocols.
- Local adaptation is limited in low-resource or regional hospitals.

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Opportunity

- Establishment of region-specific treatment algorithms integrating local epidemiological trends.
- Use of telemedicine to train rural physicians on guideline adherence.

Threats

- Clinical inertia in smaller cities due to outdated practices or lack of exposure to latest updates.
- Lack of uniform metrics to track adherence to national protocols.

	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	✖	O	✖	✖	✖
Feasibility of Integration	✖	O	✖	✖	✖
Adoption of International Guidelines	✖	O	✖	✖	✖
Engagement with Updates	✖	✖	✖	O	✖
ESMO Guidelines Implementation	✖	O	✖	✖	✖

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Reimbursement

Strengths

- Universal coverage of basic cancer treatment under public health system (Plan SUMAR, INSSJP for seniors).
- Trastuzumab and chemotherapy are partially or fully reimbursed for eligible patients.

Weakness

- Immunotherapies (e.g., nivolumab) and advanced diagnostics are not fully reimbursed in public system.
- Private health plans vary widely in coverage and co-pay requirements.

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Opportunity

- Value-based health policies can support outcome-linked reimbursement for targeted therapies.
- Expanding national health registries can help advocate for more inclusive coverage policies.

Threats

- Ongoing inflation and budget reallocations threaten sustainability of reimbursement for high-cost therapies.
- Fragmentation of public-private coverage creates equity gaps in treatment access.

● 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	●	●
Poland	●	●
Japan	●	●
South Korea	●	●
China	●	●
India	○	○
Singapore	●	●
Thailand	●	●
South Africa	○	○
Kenya	○	○
Nigeria	○	○
Egypt	○	○
Morocco	○	○
Algeria	●	●
Ethiopia	○	○
Mexico	●	●
Brazil	●	●
Argentina	●	●
Chile	●	●
Colombia	●	●
New Zealand	●	●
Greece	●	●
Rwanda	○	○
Uganda	○	○
Serbia	●	●
Saudi Arabia	●	●
UAE	●	●
Syria	○	○
Indonesia	●	○
Vietnam	●	○
Philippines	○	○
Russia	●	●
Malaysia	●	●

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Colorectal Cancer Screening

Strengths

- Endoscopic diagnosis is standard in symptomatic cases and for patients with familial GC history.
- H. pylori testing and eradication are integrated in GI practices.

Weakness

- No nationwide screening program for GC despite moderate incidence.
- Limited public awareness of risk factors like diet, tobacco, and H. pylori.

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Opportunity

- Targeted screening in high-risk populations (e.g., indigenous communities, family history).
- School-based nutrition programs to reduce salt-preserved food consumption linked to GC risk.

Threats

- Absence of routine screening may lead to underdiagnosis in early stages.
- Economic and geographic barriers reduce participation in opportunistic diagnostic testing.

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