International Cancer Patient Coalition

Saudi Arabia

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 leading male cancers.
- Incidence rate: Around 4 per 100,000 men per year.
- Total new cases (2022): About 800–1,000 men.
- Daily diagnoses: Around 2–3 men per day.
- Deaths (2022): Estimated 600–700 men.
- 5-year survival rate: Estimated 35–45%.
- Most affected age group: Mostly men aged 60 and above.
- Screening participation: No national screening; detection is primarily symptom-based.

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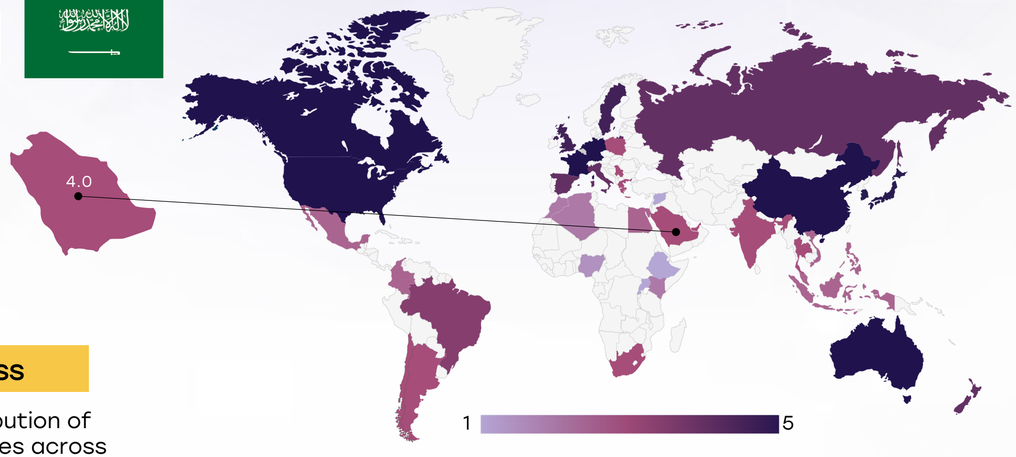
Infrastructure



Strengths

- Modern cancer treatment centers such as King Faisal Specialist Hospital and King Abdulaziz Medical City are well-equipped.
- Rapidly expanding digital health infrastructure and investment in healthcare digitization under Vision 2030.

Weakness

- Uneven distribution of cancer facilities across regions; rural and peripheral areas lack adequate oncology infrastructure.
- Shortage of trained endoscopists and oncology nurses, particularly outside major urban areas.

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Opportunity

- Government commitment to expanding specialized healthcare centers in all provinces.
- Public-private partnerships can fast-track infrastructure development for early diagnosis and treatment.

Threats

- Overreliance on a few tertiary hospitals may cause referral bottlenecks.
- Maintenance and staffing challenges in remote regions may slow expansion.

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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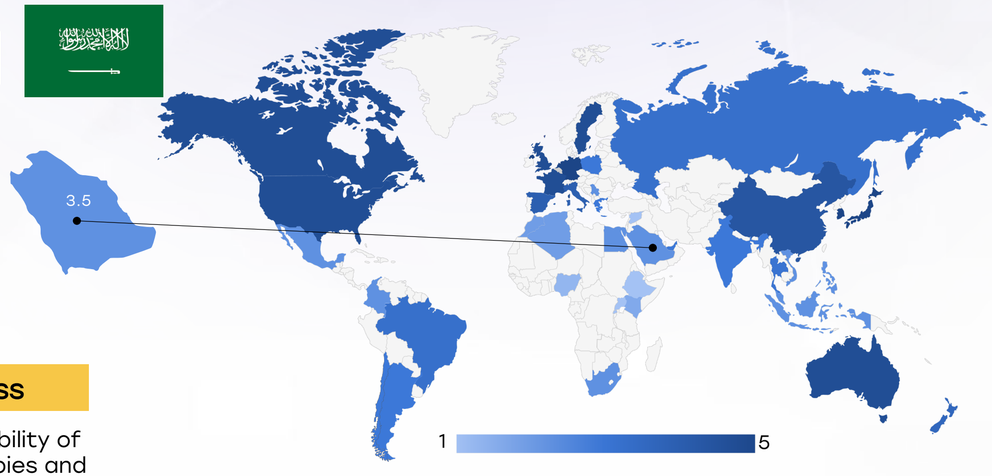
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Cancer treatment, including surgery and chemotherapy, is provided free to citizens through public healthcare.
- Government has invested in national cancer registries and clinical research frameworks in leading hospitals.

Weakness

- Limited availability of immunotherapies and targeted treatments for advanced gastric cancer.
- Public awareness of gastric cancer symptoms remains low compared to breast or colorectal cancer.

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Opportunity

- Increase gastric cancer research funding via Vision 2030 health research priorities.
- National-level awareness campaigns can integrate lifestyle risk factors like diet and **H. pylori** infection.

Threats

- Low prioritization of gastric cancer due to its declining incidence and overshadowing by more prevalent cancers.
- Lack of patient advocacy in rare cancers reduces public health momentum.

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	2	2
Kenya	2	1	1
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	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	2	2
Brazil	4	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	2	2
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	2	2
Saudi Arabia	3	2	2
UAE	3	3	3
Syria	1	1	1
Indonesia	3	2	2
Vietnam	3	2	2
Philippines	2	2	2
Russia	4	3	3
Malaysia	3	2	2

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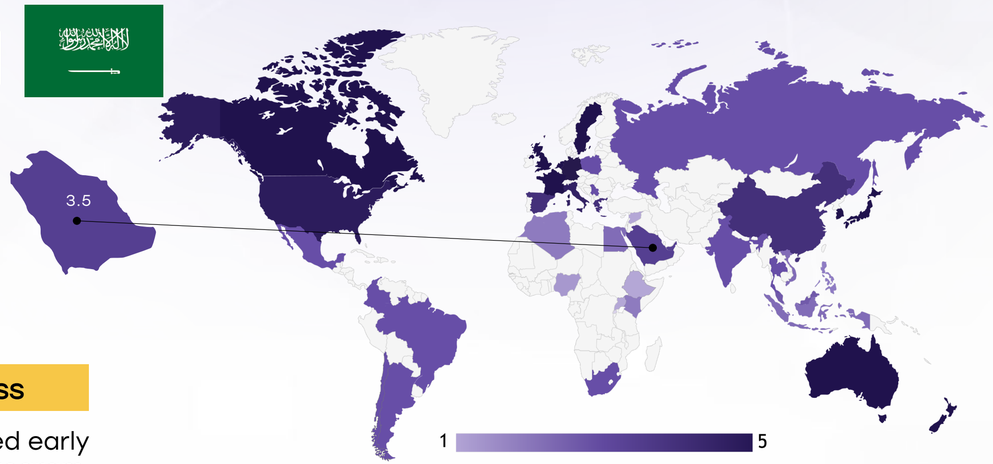
Survival Rates, Early Detection and Palliative Care



Strengths

- Improvements in surgical techniques and perioperative care in major hospitals have improved survival in operable cases.
- Dedicated palliative care programs exist in some tertiary centers.

Weakness

- No structured early detection program; most cases are detected in advanced stages.
- Limited integration of palliative care at the primary care level.

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Opportunity

- National screening strategies for high-risk patients (family history, ulcers, **H. pylori**) can improve stage at diagnosis.
- Expansion of home-based and community-supported palliative care services aligned with cultural preferences.

Threats

- Social stigma and fatalistic attitudes may delay help-seeking and reduce survival.
- Growing burden of comorbidities (diabetes, obesity) complicates cancer treatment and recovery.

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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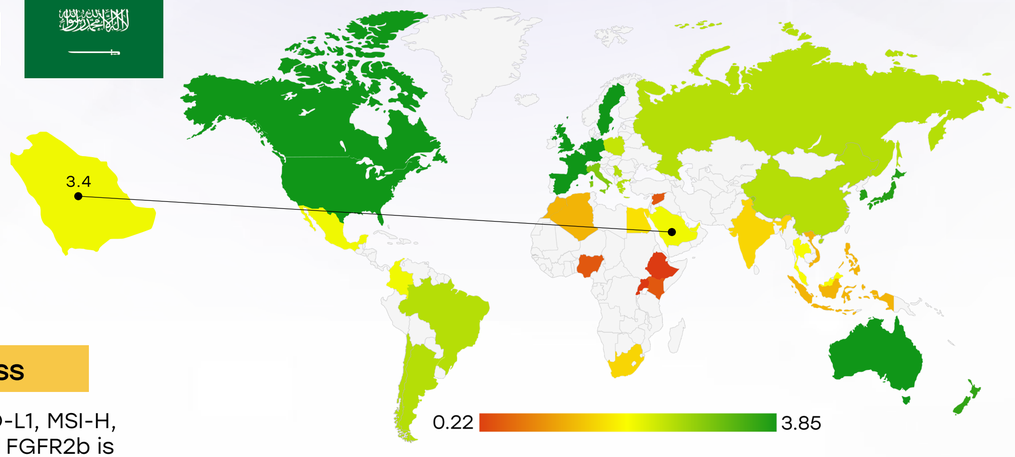
Utilization of Biomarkers



Strengths

- HER2 testing is available in most tertiary hospitals; Trastuzumab is used in HER2-positive advanced gastric cancer.
- Larger centers like King Abdulaziz City and King Faisal Hospital have molecular pathology labs capable of biomarker testing.

Weakness

- Testing for PD-L1, MSI-H, CLDN18.2, and FGFR2b is inconsistent and largely absent outside clinical trials.
- Lack of national guidelines or mandates on molecular profiling for gastric cancer

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Opportunity

- Collaborations with international institutions can build capacity for biomarker adoption.
- Incorporating biomarker testing into national cancer guidelines will expand access and treatment personalization.

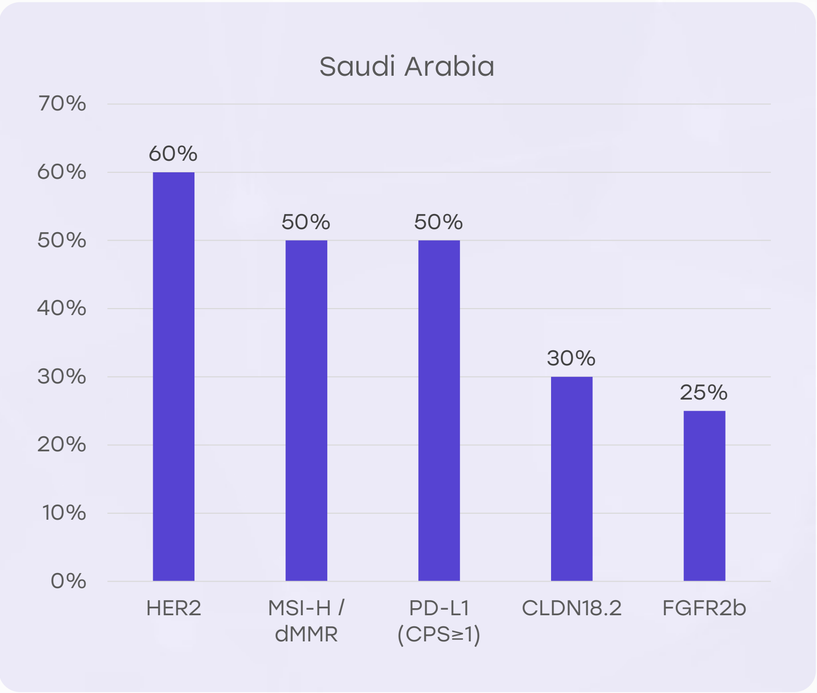
Threats

- High cost of biomarker testing without reimbursement limits its widespread use.
- Lack of clinician training and awareness about novel biomarker applications.

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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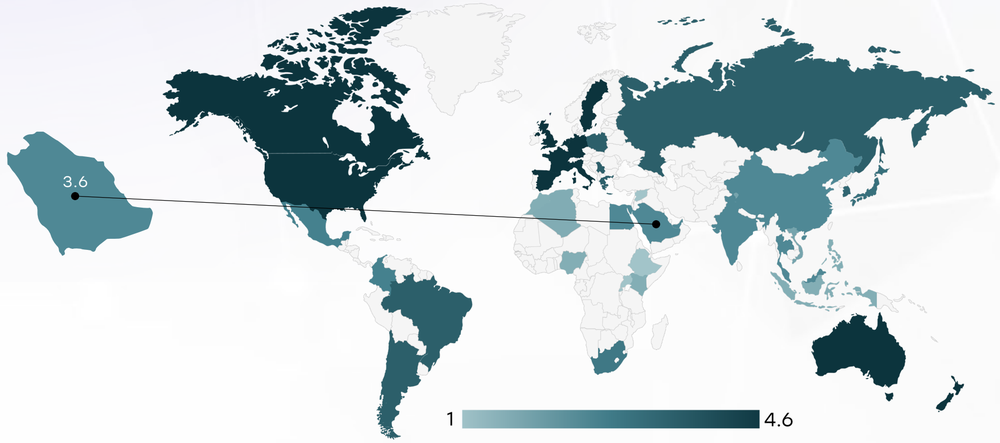
Clinical Guidelines



Strengths

- Saudi Oncology Society (SOS) has adopted ESMO- and NCCN-based treatment protocols for GI cancers.
- Leading hospitals follow standardized diagnostic and treatment algorithms.

Weakness

- National clinical guidelines for gastric cancer are not publicly available or uniformly enforced.
- Variability in care standards between private and public sector hospitals.

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Opportunity

- Development and dissemination of national gastric cancer guidelines would standardize care across the Kingdom.
- Continuous medical education (CME) programs can ensure oncologists stay updated with international advances.

Threats

- Rapid expansion of the private health sector may lead to inconsistent adherence to unified guidelines.
- Language and resource limitations may hinder adoption of international recommendations in rural hospitals.

	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

- Comprehensive healthcare coverage for Saudi citizens, including cancer care.
- Major treatments including surgery and first-line chemotherapy are covered under public funding.

Weakness

- Newer targeted therapies (e.g., for PD-L1 or FGFR2b) are not always covered or approved for gastric cancer.
- Expatriate residents often face challenges accessing full-spectrum cancer care due to limited private insurance coverage.

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Opportunity

- Aligning reimbursement with international standards can increase access to innovative therapies.
- Policy reforms under Vision 2030 could broaden coverage of personalized medicine tools.

Threats

- Budget constraints due to fluctuating oil revenues may limit future expansion of coverage.
- Rising treatment costs from novel therapies may strain public systems.

● 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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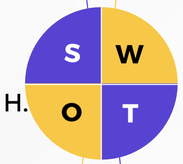
Gastric Cancer Screening

Strengths

- Diagnostic gastroscopy is available in major hospitals; patients with symptoms or alarm signs are prioritized.
- Health awareness of **H. pylori** and gastric ulcers is improving, encouraging diagnostic follow-up.

Weakness

- No national or population-level gastric cancer screening program.
- Low participation in preventive checkups, especially among older adults.



Opportunity

- Targeted screening in high-risk populations (gastritis, **H. pylori** positive, smokers) can detect cancers earlier.
- Integration of screening efforts with primary care and digital health portals under Vision 2030.

Threats

- Low public awareness and lack of health literacy may undermine uptake of any screening efforts.
- Cultural factors and fear of endoscopy may reduce patient participation rates.

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