International Cancer Patient Coalition

Brazil

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 among top 10 cancers in both sexes, lower in men compared to prostate and lung.
- Incidence rate: Approximately 10.9 per 100,000 men per year.
- Total new cases (2022): Around 23,000 cases in men, ~46,000 both sexes.
- Daily diagnoses: ≈ 63 men per day.
- Deaths (2022): Likely around 13,600 deaths (both sexes).
- 5-year survival rate: Estimated 40–50%.
- Most affected age group: Primarily men 65 and older.
- Screening participation: No formal screening; late-stage detection common

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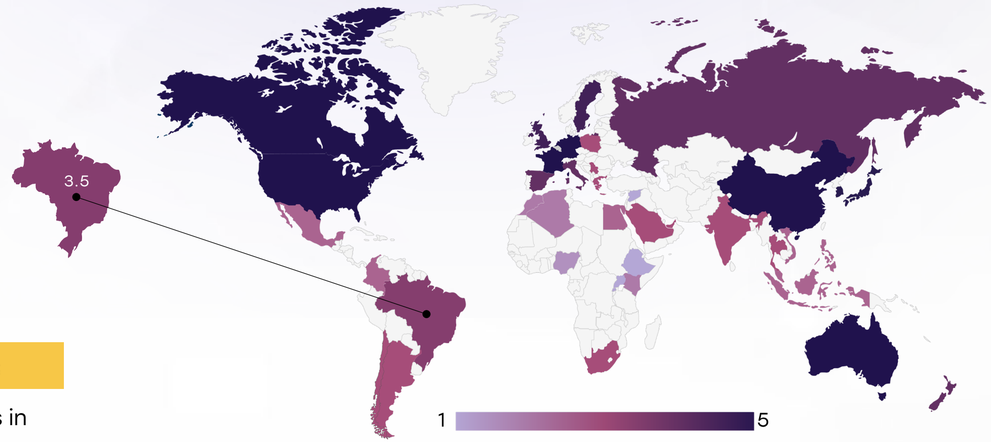
Infrastructure



Strengths

- Presence of leading cancer institutes like Instituto Nacional de Câncer (INCA) and AC Camargo Cancer Center, equipped for GC diagnosis, surgery, and biomarker testing.
- Advanced endoscopic facilities and gastric surgery services in major cities like São Paulo, Rio de Janeiro, and Brasília.

Weakness

- Major disparities in cancer care infrastructure between Southeast/South and North/Northeast regions.
- Rural and underserved regions often lack upper GI endoscopy services and oncology specialists.

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Opportunity

- Investment in regional cancer centres under Brazil's national oncology expansion plan (PNOCC).
- Mobile health units and telemedicine could enhance early diagnosis in remote areas.

Threats

- Overburdened public hospitals and long waiting times affect diagnostic and treatment timelines.
- Infrastructure gaps worsen health outcomes in low-income regions.

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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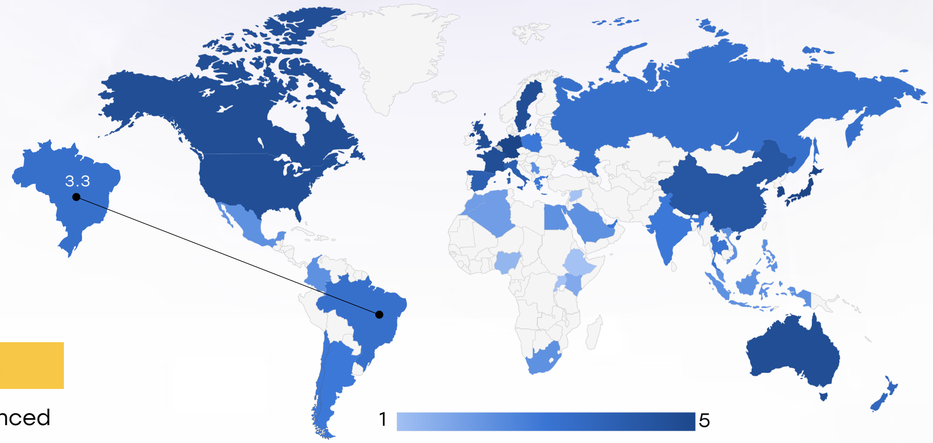
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Public health system (SUS) provides free cancer treatment, including surgery and chemotherapy for GC.
- Participation in global GC trials, including studies targeting HER2, FGFR2b, and PD-L1 biomarkers.

Weakness

- Access to advanced therapies (immunotherapy, targeted therapy) is limited in the public sector.
- Public funding and research for GC lags behind high-incidence cancers like prostate or breast.

S W O T

Opportunity

- Public-private partnerships could enhance access to targeted drugs and diagnostic testing.
- Regional and community-based awareness campaigns could improve symptom recognition and early presentation.

Threats

- Delayed incorporation of novel therapies into the SUS reimbursement list.
- Lack of awareness about gastric cancer, especially in lower socio-economic populations.

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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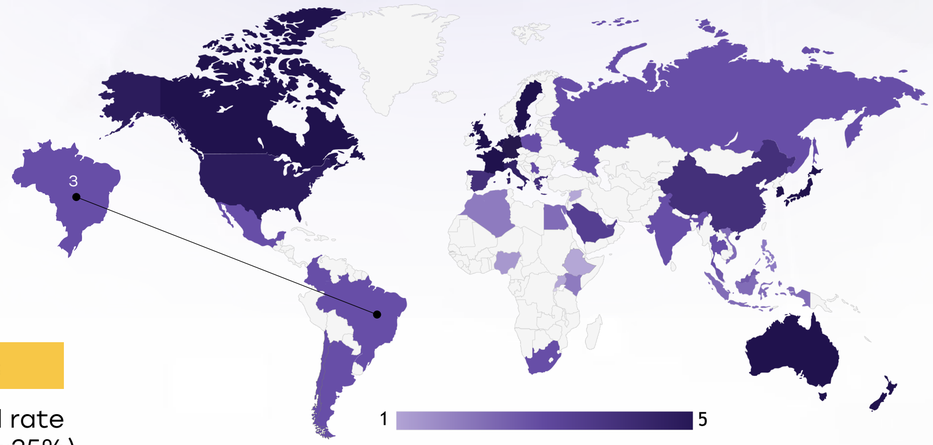
Survival Rates, Early Detection and Palliative Care



Strengths

- Availability of specialized cancer centres offering multidisciplinary care, including palliative and supportive services.
- Government-driven initiatives to improve early detection of GI cancers, especially H. pylori-related conditions.

Weakness

- 5-year survival rate for GC is low (~25%) due to late-stage diagnosis in over 60% of patients.
- Inequities in early detection and palliative access in rural and low-income communities.

S W O T

Opportunity

- Community-based primary health programs can help with symptom triage and referral.
- Expansion of palliative care networks through Brazil's national cancer control policy.

Threats

- Stigma and fear often delay symptom reporting and diagnosis.
- Fragmented care pathways contribute to delays in treatment initiation.

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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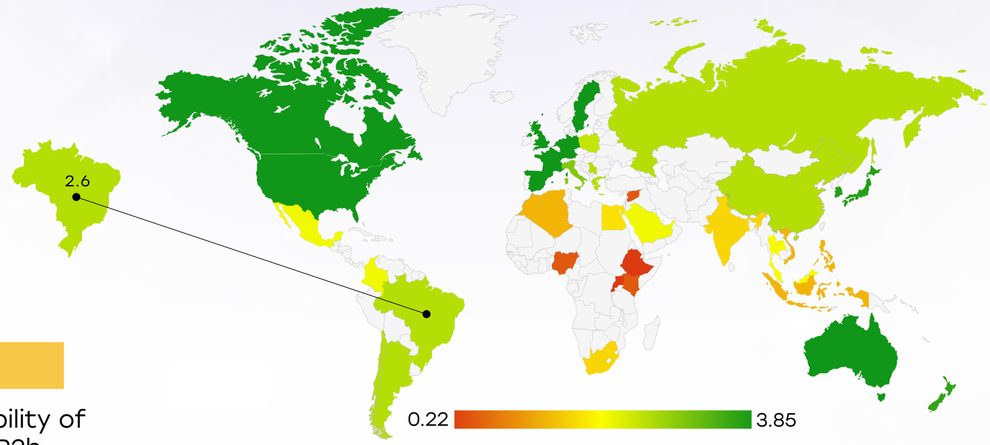
Utilization of Biomarkers



Strengths

- HER2 testing is established in private and some public tertiary centres for advanced GC cases.
- Growing uptake of PD-L1 testing in clinical trials and select private hospitals.

Weakness

- Limited availability of CLDN18.2, FGFR2b, and MSI-H/dMMR testing in public institutions.
- Inconsistent biomarker testing protocols and quality across the country.

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Opportunity

- Integration of biomarker testing into national GC treatment guidelines.
- Expansion of molecular pathology networks in collaboration with global pharma companies.

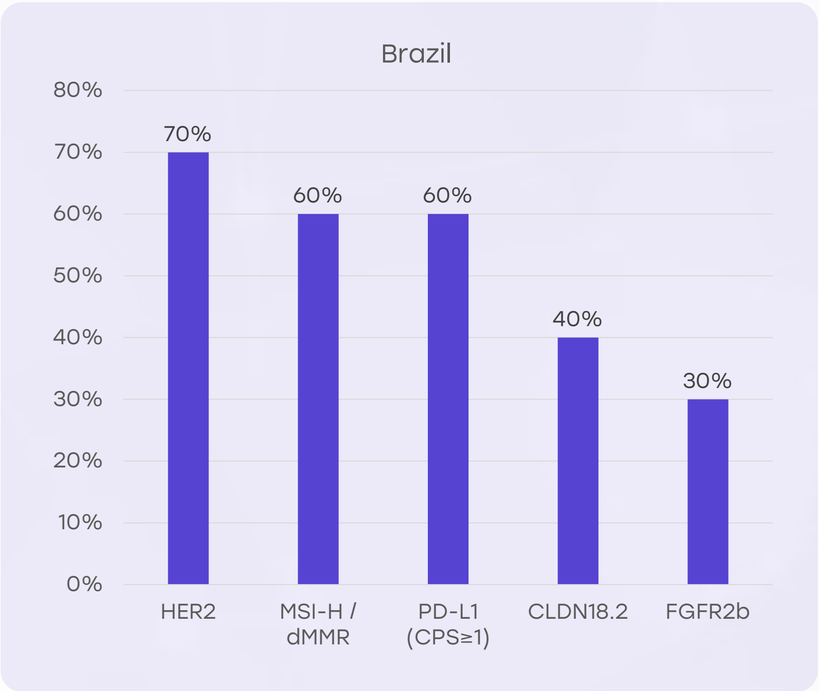
Threats

- Cost and availability barriers restrict biomarker testing, especially outside urban centres.
- Lack of reimbursement for biomarker diagnostics limits utilization in the SUS.

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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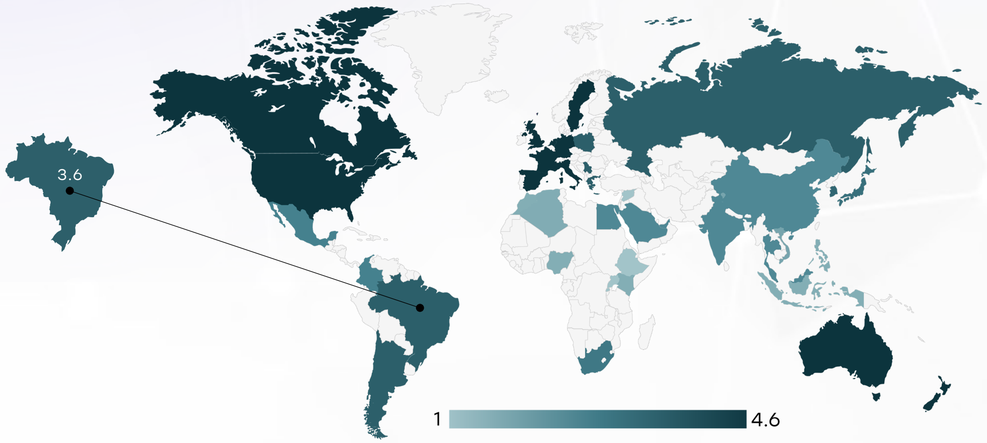
Clinical Guidelines



Strengths

- INCA provides national guidelines for GI cancers, including surgical, chemo, and radiotherapy protocols.
- Growing alignment with international best practices via Brazilian Society of Clinical Oncology (SBOC).

Weakness

- National guidelines lack detail on novel targeted therapies and biomarker-directed approaches.
- Regional implementation of guidelines remains inconsistent.

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Opportunity

- Update of guidelines to include HER2+, MSI-H/dMMR, and PD-L1 therapy indications.
- Greater engagement of multidisciplinary teams to standardize guideline implementation.

Threats

- Delays in regulatory approval of new drugs can stall updates to local guidelines.
- Differences in public vs. private sector protocols contribute to fragmented care.

	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

- SUS offers full reimbursement for standard GC treatments (gastrectomy, chemotherapy).
- Cancer treatment is prioritized in public funding policy under Brazil's constitutional right to health.

Weakness

- Lack of public reimbursement for targeted agents like trastuzumab, nivolumab, or zolbetuximab in GC.
- Advanced therapies are often accessible only in private sector or through compassionate use programs.

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Opportunity

- Introduction of Managed Access Agreements for high-cost biomarker-based therapies.
- Expanded reimbursement for diagnostics could boost early use of precision medicine.

Threats

- Economic constraints and regulatory delays limit adoption of new technologies.
- Fragmented insurance and public-private coverage systems lead to inequality in 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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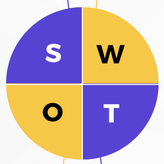
Colorectal Cancer Screening

Strengths

- H. pylori eradication strategies and endoscopy for symptomatic patients are included in primary healthcare pathways.
- National campaigns against stomach cancer in high-risk regions like the South and Southeast.

Weakness

- No national GC screening program, despite regional hotspots and high H. pylori prevalence.
- Limited endoscopic capacity in rural and underserved regions.



Opportunity

- Risk-based screening strategies for high-incidence areas (e.g., Japanese-Brazilian populations in Paraná).
- Integration of GC risk scoring in Family Health Strategy (Estratégia Saúde da Família) programs.

Threats

- Delayed diagnosis due to non-specific symptoms and lack of routine screening.
- Socioeconomic inequalities limit participation in opportunistic endoscopic screening.

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