



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 ranks around the top 7-8 cancers in Indian men.
- Incidence rate: Approximately 6-7 per 100,000 men per year.
- Total new cases (2022): Around 57,700 men.
- Daily diagnoses: Approximately 158 men per day.
- Deaths (2022): About 66,400 men.
- 5-year survival rate: Likely under 40%, reflecting late diagnosis and later-stage presentation.
- Most affected age group: Men aged 60 and older.
- Screening participation: Virtually none; most diagnoses occur symptomatically.





- Presence of high-volume tertiary cancer centers like Tata Memorial Hospital, AIIMS, and Kidwai Institute with advanced surgical, diagnostic, and radiotherapy infrastructure.
- National Cancer Grid connects over 300 institutions to standardize cancer care delivery across the country.

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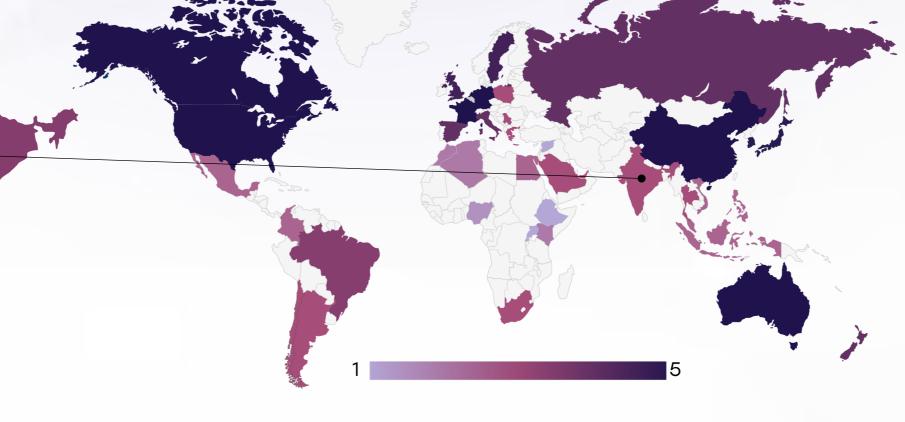
Opportunity

- Increasing private sector investment in oncology infrastructure across tier-2 cities.
- Public-Private Partnerships (PPP) to improve accessibility in underserved regions.

Weakness

- Significant disparity in cancer care infrastructure between urban and rural areas.
- Shortage of specialized gastro-oncology departments in tier 2 and 3 cities.

- Infrastructure overwhelmed by the burden of multiple cancers, including gastric, especially in the northeast and coastal belts.
- Fragmentation of services leads to delayed diagnosis and treatment initiation.



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





Treatment Access, Research Funding and Awareness Campaigns

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Strengths

- Public schemes like
 Ayushman Bharat and
 state-funded cancer
 programs reduce
 treatment costs for the
 poor.
- Select research institutions participate in clinical trials for novel gastric cancer therapies.

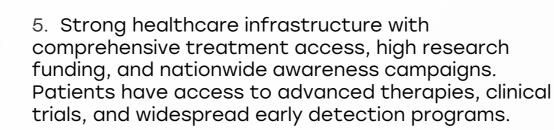
Opportunity

- Government and nonprofits can launch campaigns focusing on early warning signs, dietary risk factors, and H. pylori screening.
- International research collaboration to bring more trials and newer treatments to India.

Weakness

- Limited public funding specifically allocated for gastric cancer research.
- Public awareness about gastric cancer symptoms and risk factors (like H. pylori) remains very low.

- Lack of culturally tailored communication around cancer symptoms reduces early help-seeking behavior.
- Misinformation and stigma around cancer treatment, especially chemotherapy and surgery.



- 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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Survival Rates, Early Detection and Palliative Care

Strengths

- Early-stage gastric cancer patients treated at tertiary centers have relatively good surgical outcomes.
- Integration of palliative care in many comprehensive cancer centers.

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Opportunity

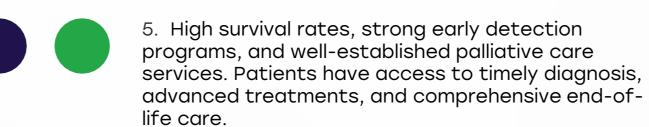
- Train primary care physicians to detect early symptoms like dyspepsia, unintended weight loss, and anemia.
- Expand mobile palliative units and home-based services using telehealth.

Weakness

- Most patients present at Stage III or IV, with 5-year survival below 20%.
- Limited availability of community-based palliative services outside metros.

Threats

- Fragmented referral system causes delays in diagnosis and loss to follow-up.
- Urban-rural divide impacts access to timely pain management and supportive 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.

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

Survival

Rates

Country

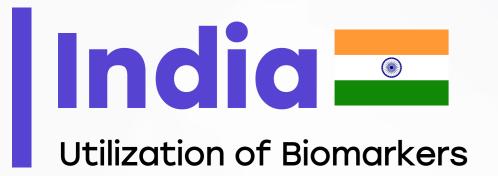
Palliative

Care

Early

Detection





- available and used in major centers for advanced gastric cancers.
- increasingly offered for clinical decisionmaking.

Opportunity

- Subsidized testing through government oncology labs or publicprivate partnerships.
- Scale biomarker use by integrating them into standard treatment protocols.

Weakness

- Access to advanced biomarkers like CLDN18.2 and FGFR2b is restricted to research settings or top-tier hospitals.
- Low awareness among general oncologists about emerging biomarkers in gastric cancer.

Threats

- Cost and lack of insurance coverage for advanced biomarker testing.
- Inconsistent quality and validation across diagnostic labs.

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.





HER2 testing is

MSI and PD-L1 testing

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- Indian Council of Medical Research (ICMR) has issued guidelines for gastrointestinal cancers.
- Major hospitals follow ESMO/NCCN protocols adapted to Indian patient profiles.

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Opportunity

- Dissemination of simplified guidelines via the National Cancer Grid and digital platforms.
- Mandatory Continuing Medical Education (CME) for gastroenterologists and GPs.

Weakness

- Variability in adherence to guidelines across public and private sectors.
- Primary care doctors often unaware of the latest diagnostic and referral pathways.

- Rapidly evolving global treatment standards may be hard to implement uniformly in resourceconstrained areas.
- Gaps in documentation and registry limit feedback on guideline effectiveness.



	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	*





- Central government schemes like Ayushman Bharat cover surgical, radiotherapy, and chemotherapy costs for economically weaker sections.
- Some state cancer programs reimburse biomarker-based therapy partially.

Opportunity

- Inclusion of newgeneration targeted therapies under essential drug lists.
- Expansion of public insurance to cover diagnostics like HER2, PD-L1.



- Limited reimbursement for high-cost targeted therapies or advanced diagnostics.
- Insurance caps often do not match the realworld cost of longterm cancer care.

- Out-of-pocket expenditure still forms ~60% of cancer treatment costs for middle-income families.
- Risk of financial toxicity leading to treatment abandonment.



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





- Opportunistic endoscopy available in gastroenterology OPDs for high-risk patients.
- Northeast India and coastal regions are being studied for high-prevalence mapping.

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Opportunity

- Regional pilot screening programs for highprevalence areas using endoscopy or noninvasive markers.
- Combine H. pylori testing with gastric cancer risk education campaigns.

Weakness

- No national screening program or guideline for gastric cancer.
- H. pylori infection rarely tested or treated proactively in primary care.

- Competing priorities like breast and cervical cancer dominate public screening funds.
- Endoscopy is perceived as invasive and expensive by general population.

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	Castrio Cancor Corponing
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