

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.

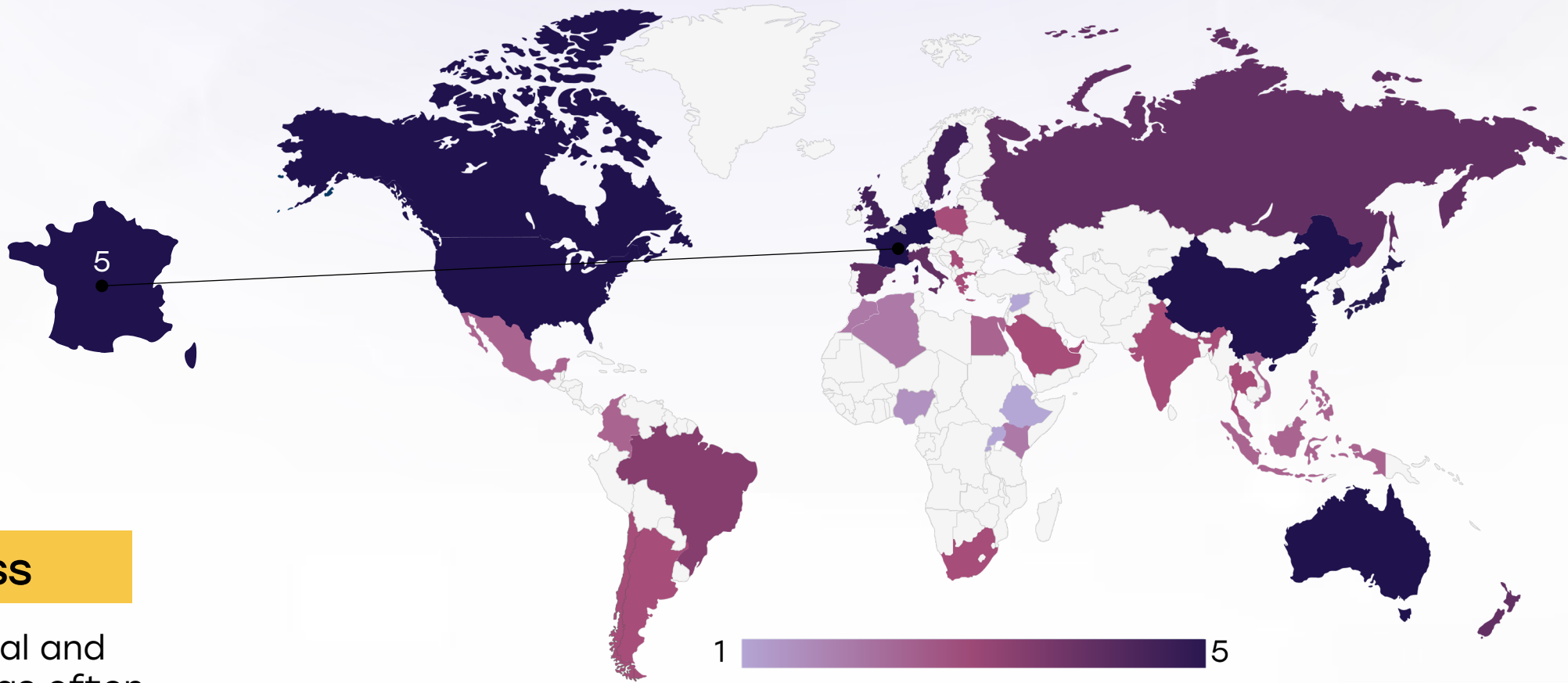
This factsheet provides a comprehensive overview of key pillars shaping Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer is not in the top 10 male cancers.
- Incidence rate: Approximately 7 per 100,000 men per year.
- Total new cases (2022): Around 4,000 men.
- Daily diagnoses (2022): About 11 men per day.
- Deaths (2022): Estimated ~6,000 men.
- 5-year survival rate: Around 25–30%.
- Most affected age group: Men aged 70 and older.
- Screening participation: No national program; detection usually occurs at symptomatic stages.

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Infrastructure



Strengths

- Integrated national public health system ensures widespread access to diagnostics (gastroscopy, imaging) and pathology across most regions.
- Specialized cancer centers in Paris, Lyon, and Marseille provide advanced molecular testing (e.g., HER2, MSI) and multidisciplinary care.

Weakness

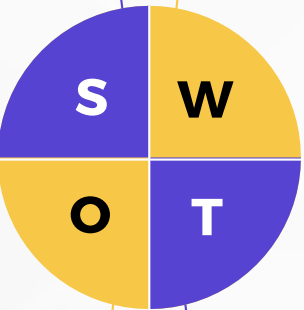
- Facilities in rural and peripheral areas often lack endoscopy units and molecular pathology for prompt diagnosis.
- Smaller hospitals face prolonged wait times and referral delays for GC evaluation and staging.

Opportunity

- Expand tele-health and mobile diagnostic units to underserved regions for earlier access to screening and biopsy.
- Strengthen regional pathology hubs that can serve multiple centers with rapid biomarker testing.

Threats

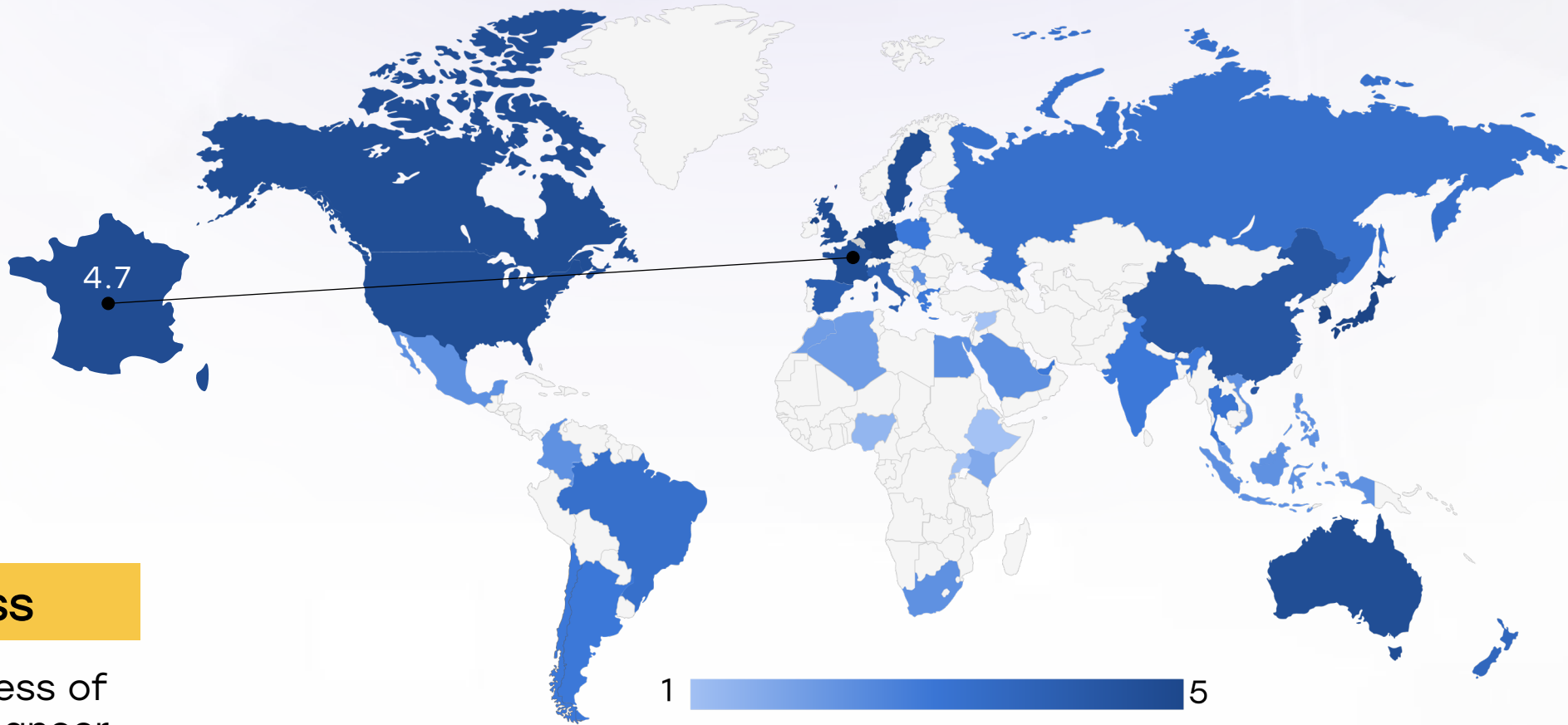
- Overcrowding of urban cancer centers may overwhelm resources during peak periods.
- Attrition of experienced healthcare professionals in public hospitals could degrade service quality.



Country	Specialized Centers	Genetic & Molecular Testing Infrastructure
South Africa		
Kenya		
Nigeria		
Egypt		
Morocco		
Algeria		
Ethiopia		
India		
Japan		
South Korea		
China		
Thailand		
Singapore		
United Kingdom		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain		
Poland		
Mexico		
Brazil		
Argentina		
Chile		
Colombia		
United States		
Canada		
Australia		
New Zealand		
Greece		
Rwanda		
Uganda		
Serbia		
Saudi Arabia		
UAE		
Syria		
Indonesia		
Vietnam		
Philippines		
Russia		
Malaysia		

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Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Universal healthcare guarantees access to standard GC treatments including surgery, chemotherapy, and trastuzumab for HER2+ cases.
- France actively participates in European biomarker-driven GC clinical trials (e.g., targeting PD-L1, CLDN18.2).

Weakness

- Public awareness of early gastric cancer symptoms and risk factors is low; educational campaigns are limited.
- Funding priorities favor more prevalent cancers, leading to underinvestment in GC-specific research.

Opportunity

- Launch national campaigns (TV, digital, GP outreach) to raise awareness about H. pylori, diet, and early gastric symptoms.
- Leverage EU research funds to support trials of new biomarkers (e.g., FGFR2b) and personalized therapies.

Threats

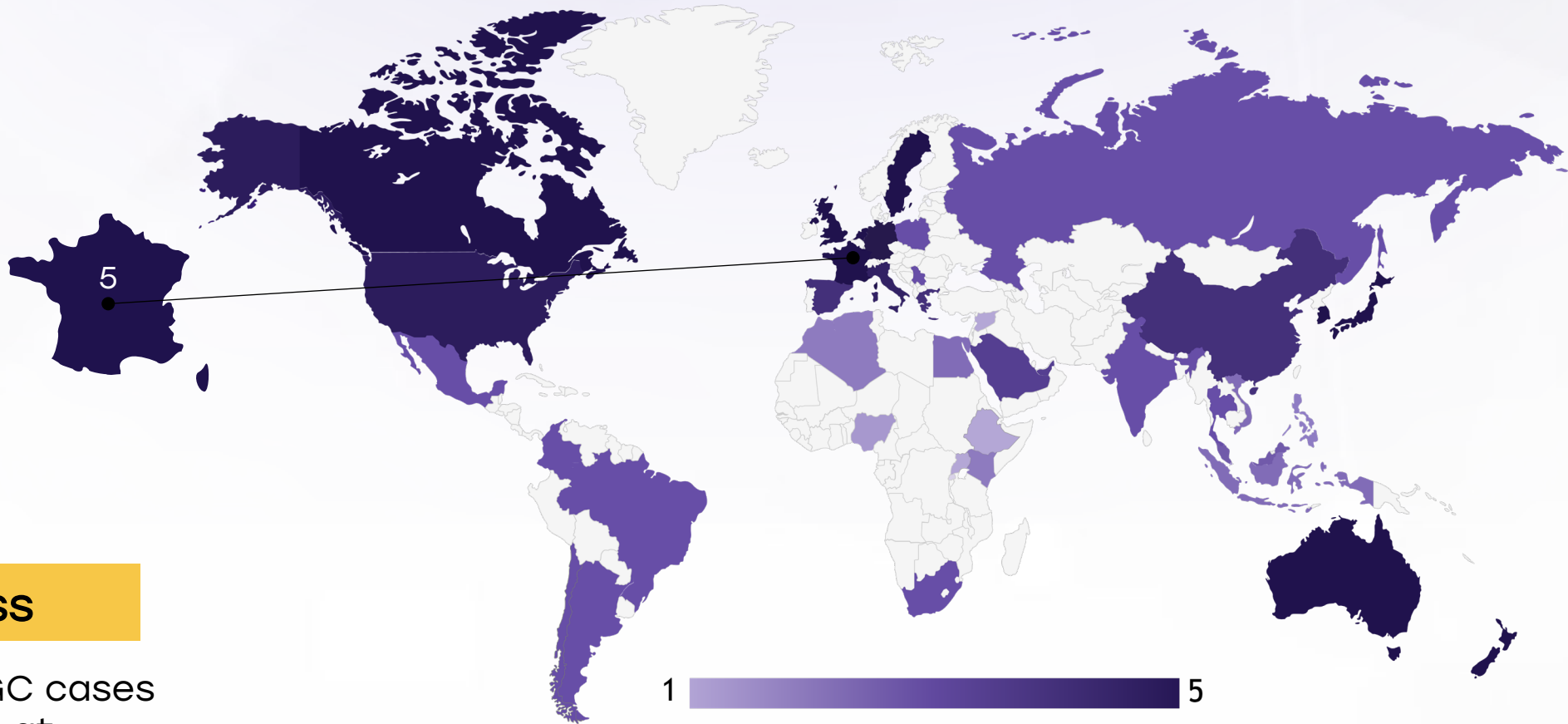
- Economic pressure on public health budgets may delay introduction of new GC therapeutics.
- Public mistrust or disengagement may limit the impact of awareness initiatives.

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

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Survival Rates, Early Detection and Palliative Care



Strengths

- High-quality palliative and supportive care systems are integrated into oncology services nationwide.
- Early-stage GC patients treated in top centers achieve outcomes comparable to international benchmarks.

Weakness

- Over 85% of GC cases are diagnosed at advanced stages; national 5-year survival remains under 15%.
- Lack of organized screening leads to acute-stage diagnoses; early detection is rare.

Opportunity

- Pilot early detection programs in high-risk populations (e.g., ≥60 years, family history) using non-invasive screening markers.
- Train GPs and community health nurses to identify alarm symptoms and fast-track referrals to specialists.

Threats

- Late-stage presentation remains common due to low symptom awareness and delayed diagnostics.
- Fragmented care coordination can undermine continuity of palliative and follow-up care.



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.

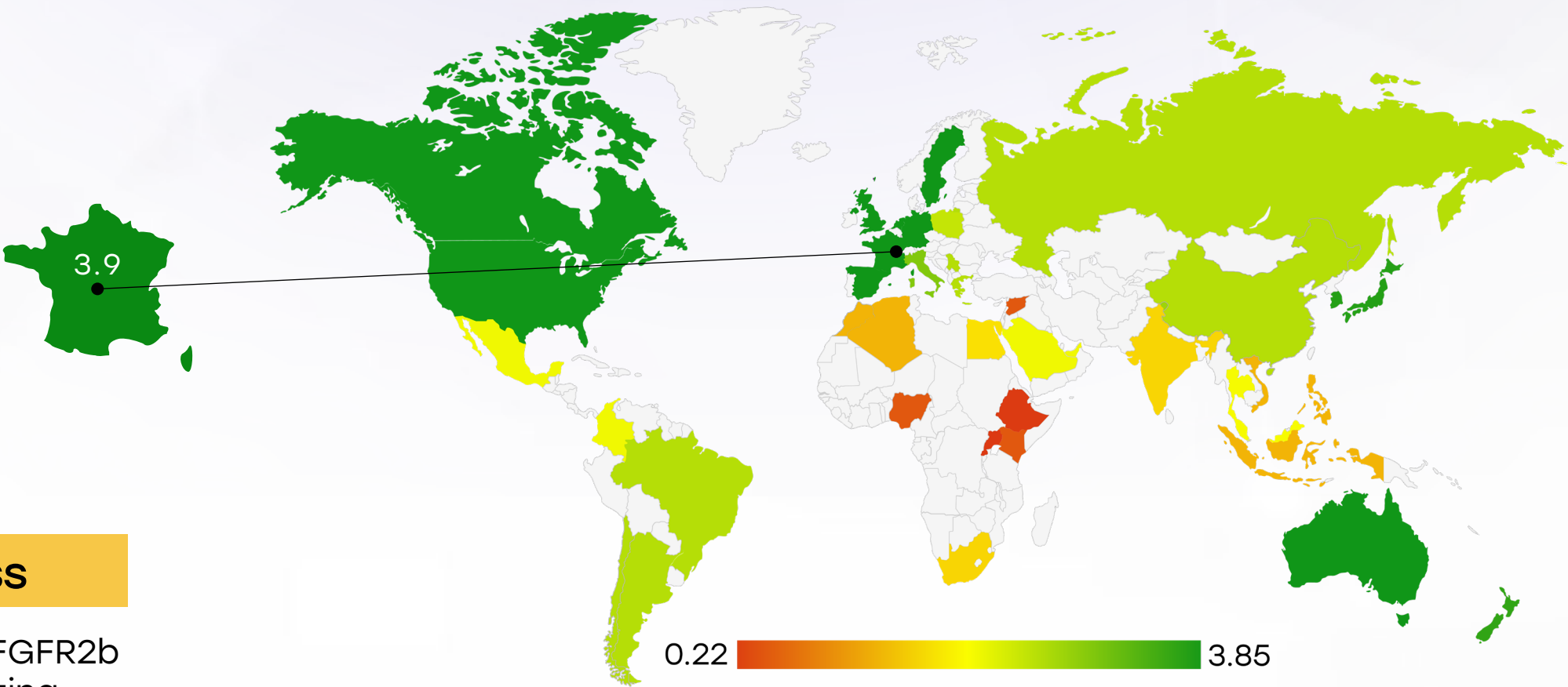


1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

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

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Utilization of Biomarkers



Strengths

- HER2 and MSI/dMMR testing are routinely performed in referral centers to guide trastuzumab and immunotherapy decisions.
- PD-L1 (CPS ≥ 1) assays are increasingly available for advanced GC patients eligible for checkpoint inhibitors.

Opportunity

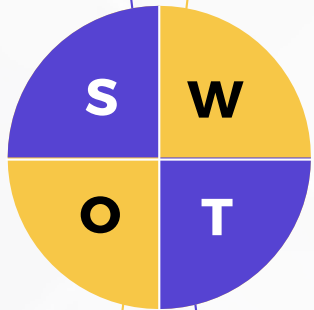
- Expand national biomarker testing standards and quality control through centralized laboratory networks.
- Encourage adoption of emerging biomarker-driven treatment algorithms—especially CLDN18.2 and FGFR2b—as evidence accrues.

Weakness

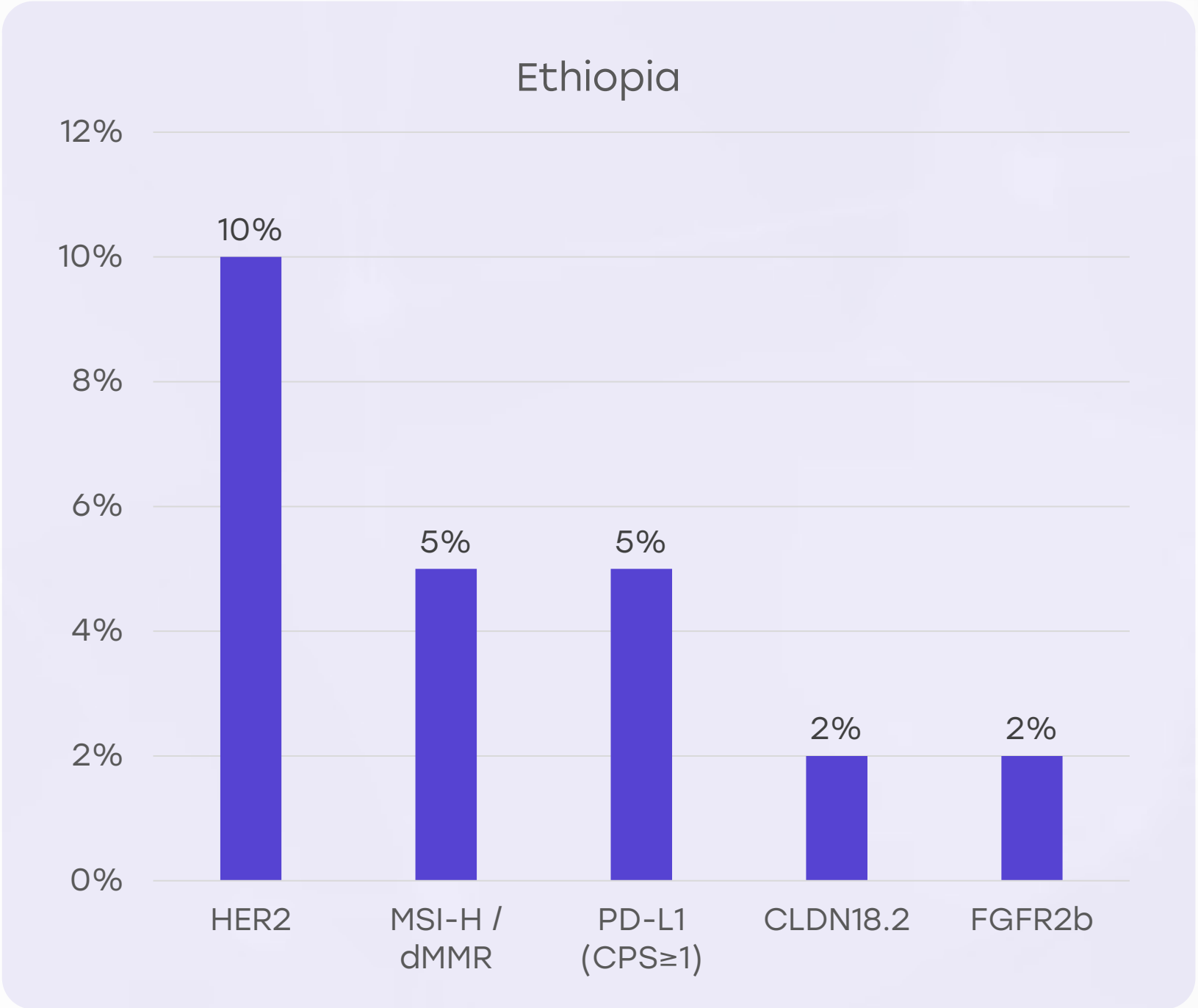
- CLDN18.2 and FGFR2b biomarker testing remains experimental and restricted to clinical research sites.
- Diagnostic capability varies regionally—many public hospitals lack consistent molecular testing infrastructure.

Threats

- High testing costs and lack of automated reimbursement delay adoption in routine clinical practice.
- Inconsistent access across regions may contribute to inequity in treatment decisions.



- 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.

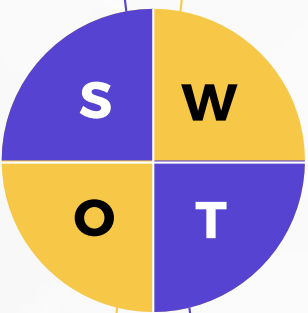


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Clinical Guidelines

Strengths

- National oncology guidelines by INCa/HAS align with ESMO/NCCN protocols, incorporating HER2 and MSI testing.
- Regular updates exist and are disseminated to teaching hospitals and major cancer networks.



Weakness

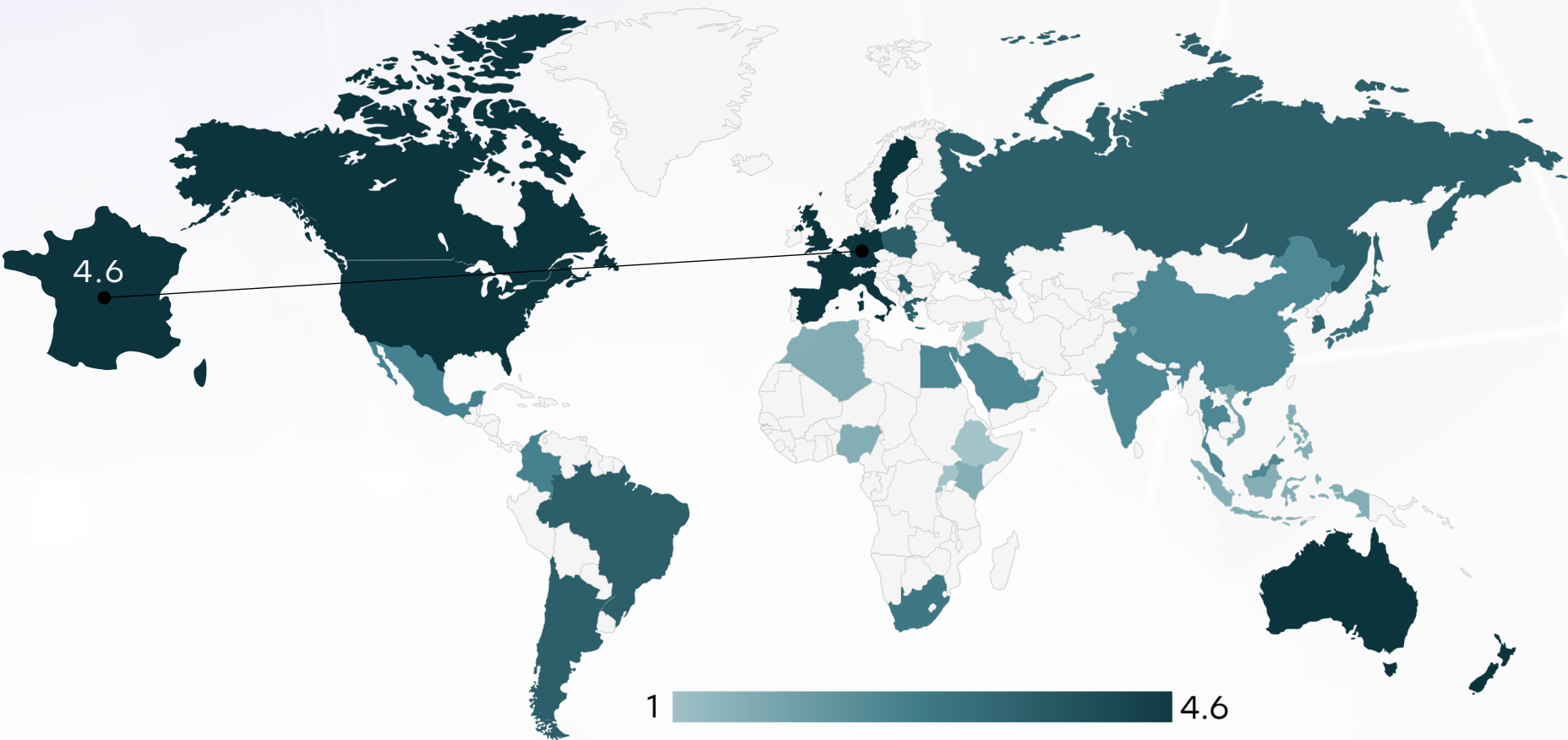
- Guidelines do not yet include therapies or testing for CLDN18.2 and FGFR2b—reflecting limited real-world integration.
- Smaller hospitals may not have access to updated guidelines or lack staff training in new standards

Opportunity

- Engage guideline committees to fast-track inclusion of novel biomarkers and therapies as clinical data matures.
- Use digital platforms and CME to improve awareness and adherence to guideline updates across all regions.

Threats

- Slow bureaucratic processes may delay guideline updates, affecting adoption of new treatments.
- Fragmented implementation between public/private sectors risks variability in care quality.



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

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Reimbursement



Strengths

- National health insurance system covers standard GC treatments and essential biomarker tests (HER2, MSI, PD-L1) when indicated.
- Pricing agreements ensure affordable access to trastuzumab and checkpoint inhibitor medications.

Weakness

- Biomarker-driven therapies for CLDN18.2 or FGFR2b are not yet reimbursed, limiting patient access to emerging treatments.
- Reimbursement policies may vary by hospital or region—leading to inconsistent coverage even within eligible populations.

Opportunity

- Advocate for expanded reimbursement of novel biomarker tests and related therapies using health-economic evidence.
- Pilot value-based reimbursement models tied to real-world outcomes in GC therapy.

Threats

- Rising drug costs may strain healthcare budgets—delaying listing of new therapies.
- Delays in regulatory approval and reimbursement pathways slow patient access to innovation.

- 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



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