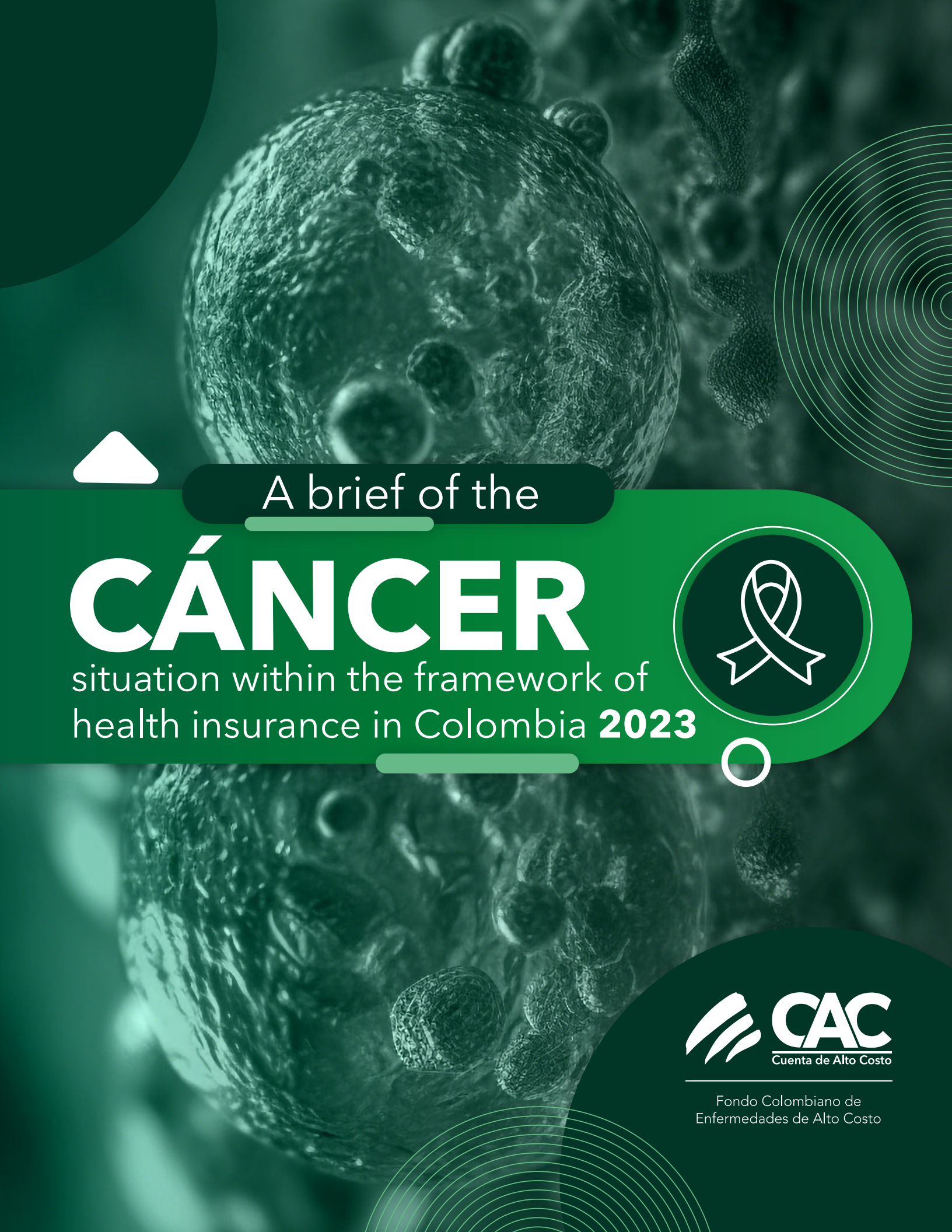

A brief of the

CÁNCER

situation within the framework of health insurance in Colombia **2023**

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Cuenta de Alto Costo

Fondo Colombiano de Enfermedades de Alto Costo

A brief of the cancer situation within the framework of health insurance in Colombia 2023

Cuenta de Alto Costo
Fondo Colombiano de Enfermedades de Alto Costo

A brief of the cancer situation within the framework of health insurance in Colombia 2023

Fondo Colombiano de Enfermedades de Alto Costo
Cuenta de Alto Costo (CAC)

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Change Tracking Table

Date	Version	Description of changes	Localization of changes
	1.0		

Abbreviations

PNCR: Proportion of New Cases Reported. For the purpose of this document and a better understanding, it can be interpreted as an equivalent of incidence.

IQR: Interquartile range.

CI: Confidence interval.

TNM: Internationally accepted standard classification for cancer staging. (T), nodes (N), and metastases (M).

FISH: Fluorescence *in situ* hybridation.

ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th revision.

NHL: Non-Hodgkin lymphoma.

HL: Hodgkin lymphoma.

ALL: Acute lymphoblastic leukemia.

AML: Acute myeloid leukemia.

1

Cancer
overview

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Infographic summary

Chapter **1** at a glance

Cancer overview

Period: January 2, 2022 to January 1, 2023

General characterization of cases

The cancer registry recorded **491,510** **invasive cases.**

During the analyzed period,

58,813 cases

were diagnosed, **94.4%** of which were invasive.

Among individuals with invasive cancer, 30,914 deaths from all causes were notified.

Of the new cases, 58.5% ocurred in women.

Median age of new cancer cases was 64 years (IQR: 52 - 73).

The most frequent cancer types among new cases in women were breast (27.6%), cervical (9.2%) and colorectal (7.1%).

In men, the most frequent cancer types among new cases were prostate (23.7%), colorectal (8.5%), and stomach cancer (6.2%).

66.8% were insured by the third payer,

and most new cases **(32.8%)** resided in the Central region.

Morbidity and mortality of invasive cancer

Crude PNCR
increased by 23.5%
compared to 2022.

- Age-standardized PNCR was 104 new cases (95% CI: 103.0 – 104.7) per 100,000 people.
- Crude prevalence increased by 10.8% compared to 2022.
- Age-standardized prevalence was 917 cases (95% CI: 914.4 - 919.5) per 100,000 people.
- Bogotá, D. C., as a region, had the highest age-standardized prevalence and mortality.
- Age-standardized general mortality was 57 deaths (95% CI: 56.0 - 57.2) per 100,000 people.

Breast,
prostate and colorectal cancers
had the highest age-standardized general mortality.

- In men, the highest proportion of deaths occurred in prostate (21.1%), stomach (10.8%), and colon and rectum cancer (10.4%).
- In women, most deaths were observed in those with breast (24.1%), colon and rectum (9.5%) and cervical (9.1%) cancers.

Clinical characterization of new cases

- Of the new cases, 92.1% were solid tumors, 4.0% were lymphomas and 1.6% were leukemia.
- The stage at diagnosis was accurately reported using the TNM system in 58.4% of solid tumors and 73.7% of lymphomas.
- Among staged solid tumors, 26.2% were diagnosed at stage II.

67.5% of lymphomas
were diagnosed in advanced stages.

- Risk classification was reported in 67.4% leukemia cases and 62.2% of lymphomas cases.
- Surgery was the most frequent treatment (40.4%), followed by systemic therapy (37.4%).
- Of those receiving systemic therapy, 33.6% were treated with neoadjuvant therapy and 27.5% with initial curative therapy (excluding surgery).
- The median wait time for diagnosis was 36 days, a 20.0% increase from the previous period. However, the median time to treatment initiation decreased by 7.7% (median: 48 days).

Breast cancer

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Infographic summary

Chapter **2** at a glance

Breast cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of breast cancer

There were **9,484** **new cases,**

103,240 prevalent cases, and 4,096 deaths during the analyzed period.

It was the most frequent among the 11 prioritized cancer types and remains the most common in women.

A total of

8,702 **new invasive cases**

were notified. Age-standardized PNCR was 32 new cases (95% CI: 31.5 - 32.8) per 100,000 women.

Of the prevalent cases, 97,136 were invasive. Age-standardized prevalence was 356 cases (95% CI: 353.9 - 358.3) per 100,000 women.

There were 4,009 deaths among women with invasive breast cancer. Age-standardized general mortality was 15 deaths (95% CI: 14.2 - 15.1) per 100,000 women.

The highest mortality rates were estimated in people covered by the third payer insurance.

The highest PNCR age-standardized rates were observed in the Central region; while, the prevalence was highest in Bogotá, D. C. (as a region).

General mortality decreased by 9.0% in 2023.

Characterization of new cases of breast cancer

The median age was
59 years
(IQR: 49 - 68).

Of the new cases, 66.0% were covered by the third payer insurance, and the majority (31.6%) resided in the Central region.

A total of 91.8% of cases were invasive, with a higher proportion among women with state insurance (94.8%).

Nationally, the stage at diagnosis was correctly reported in 88.2% of the cases, with better performance in special insurance.

41.5% of new cases were diagnosed at stage II. This proportion was similar in women with state (39.8%) and third payer insurance (42.5%).

The HER2 test was performed in 83.3%, and 75.2% of those tested had a negative result.

Hormone receptors were tested in
87.9% of new cases,
from which, and 66.4% were positive for both estrogen and progesterone receptors.

Of the women with an equivocal or undetermined HER2 result, only 30.2% received the FISH test, in line with the diagnostic algorithm.

Systemic therapy was the most common treatment (65.4%), followed by surgery (44.5%).

Quality measures in breast cancer

Nationally, the average waiting time to first treatment was 27 days.

Treatment was provided more quickly to individuals with special insurance, with an average waiting time of 23 days.

In 2023, the target for opportunity indicators were not reached, both nationally and in most demographic regions.

There was an
increase
in the number of
cases diagnosed
at early stages compared to 2022.

Regarding the management of hormonal blockade and anti-HER2 therapy, there is a need to prioritize strategies within the regions to achieve high performance.

Quality measures related to staging, early detection of new cases, as well as HER2 and hormonal receptors testing, showed higher performance in the special insurance group compared to the national results.

Prostate cancer

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Infographic summary

Chapter **3** at a glance

Prostate cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of prostate cancer

There were **5,793 new cases,** 57,551 prevalent cases, and 3,282 deaths during the analyzed period.

It was the second most frequent among the 11 prioritized cancer types, and remains the most common in men (23.7% of total new cases).

A total of 5,788 new invasive cases notified. Age-standardized PNCR was 22 cases (95% CI: 21.0 - 22.1) per 100,000 men.

Among the prevalent cases, 57,093 were invasive.

Age-standardized prevalence was 206 cases (95% CI: 204.2 - 207.6) per 100,000 men.

There were 3,254 deaths among men with invasive cancer. Age-standardized general mortality was 11 deaths (95% CI: 10.7 - 11.5) per 100,000 men.

All morbidity and mortality estimates were higher in Bogotá, D. C.

Compared to 2022, the PCNR increased by 36.4%, while the mortality rate decreased by 12.7%.

Characterization of new cases of prostate cancer

The median age was

70 years

(IQR: 64 - 75).

69.6% were covered by third payer insurance, and most new cases (26.4%) resided in the Caribbean region.

Nearly all new cases (99.9%) were invasive, with a similar trend across insurance groups.

At the national level, the reporting of stage at diagnosis decreased by 20.7%, compared to 2022.

A total of 46.3% of cases were diagnosed at stage II.

The Gleason score was reported in 93.6% of cases, with a similar trend across insurance groups.

Of all new cases,

26.9% were in Gleason score group 1.

At the national level, 90.8% of cases had PSA test at diagnosis, and 68.7% had it post-treatment.

Systemic therapy was the most frequent treatment (47.8%), followed by surgery (27.4%).

Quality measures in prostate cancer

Nationally, the average waiting time to diagnosis and treatment was 76 days.

The special insurance reported the shortest time to diagnosis.

Men under state insurance had the longest time to confirm the diagnosis, while those under third payer insurance had the longest time to treatment.

TNM staging was higher in the third payer insurance (74.2%).

At the national level,

the goal for TNM staging

of new cases were not met.

The same tendency was observed among demographic regions.

Nationally, the early detection indicator had a low performance, nevertheless, the indicador related to the Gleason score report reached the established goal.

None of the indicators regarding access to diagnosis and treatment reached the proposed goal, either nationally or within insurance group.

Cervical cancer

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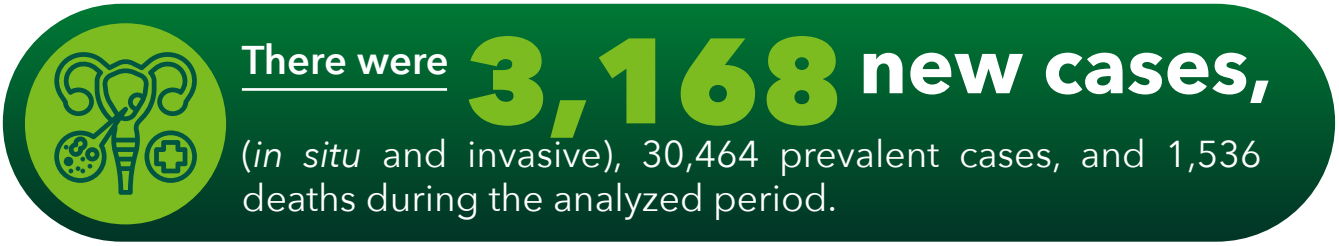
Infographic summary

Chapter **4** at a glance

Cervical cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of cervical cancer



It was the fourth most frequent among the 11 prioritized cancer types and the second most common in women.

A total of

2,144 new invasive cancer cases

were notified. Age-standardized PNCR was 8 new cases (95% CI: 7.7 - 8.4) per 100,000 women.

Of all prevalent cases, 22,400 were invasive. The age-standardized prevalence was 83 cases (95% CI: 82.2 - 84.4) per 100,000 women.

There were 1,475 deaths among women with invasive cancer. Age-standardized general mortality was 6 deaths (95% CI: 5.2 - 5.7) per 100,000 women.

Age-standardized prevalence, PCNR, and mortality of invasive cancer cases were higher in the regions of Amazonía-Orinoquía and Caribbean.

Compared to 2022,

the PCNR increased and the mortality decreased.

Characterization of new cases of cervical cancer

The median age was

46 years

(IQR: 36 - 58).

A total of 56.5% of cases were covered by third payer insurance, with most cases (27.8%) resided in the Caribbean region.

According to the entity, 1.7% of the new cases were Native people, and 1.2% were Black community.

A total of 67.7% of new cases were invasive.

At the national level, 89.1% had a TNM/FIGO staging report; with higher proportion among women under third payer insurance (90.2%).

A total of 35.8% were staged as *in situ* neoplasms. Stage III was the most frequent among invasive cases according to TNM/FIGO staging (23.0%).

Surgery

was the most

frequent treatment

(41.9%), followed by systemic therapy (31.1%).

In women under state insurance, the majority (29.7%) were diagnosed at stage III, while in the third payer insurance group, 43.2% of new cases were staged as *in situ* neoplasms.

Quality measures in cervical cancer

Nationally, the average waiting time to the first treatment was 28 days.

There was a general trend to reduced waiting times to treatment in 2022, particularly in the state and third payer insurance group.

In the country the indicator related to TNM/FIGO staging of new cases did not reached the established goal.

Indicators assessing

access to care did not reach the targets nationally, with a similar trends observed in most geographical regions.

Nationwide, the average time from cancer diagnosis to first treatment was 63 days, showing a modest improvement over 2022.

Colon and rectum cancer

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Infographic summary

Chapter **5** at a glance

Colon and rectum cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of colon and rectum cancer

There were **4,538 new cases,** 33,215 prevalent cases, and 3,235 deaths during the analyzed period.

It was the third most frequent among the 11 types of prioritized cancer, accounting for 7.7% of new cases reported.

A total of **4,466 new invasive cases** were notified. Age-standardized PNCR was 8 new cases (95% CI: 8.1 - 8.6) per 100,000 people.

Of the prevalent cases, 32,576 were invasive. Age-standardized prevalence was 60 cases (95% CI: 59.7 - 61.0) per 100,000 people.

There were 3,196 deaths among people with invasive cancer. Age-standardized general mortality was 6 deaths (95% CI: 5.7 - 6.1) per 100,000 people.

The highest morbidity and mortality estimations were observed in Bogotá, D. C. (as a region).

Compared to 2022, both **morbidity and mortality estimates increased.**

Characterization of new cases of colon and rectum cancer

The median age was

66 years

(IQR: 57- 75).

A total of 54.1% were women.

69.1% of cases had third payer insurance, and most cases (31.8%) resided in the Central region.

98.4% of cases were invasive, with similar proportion among insurance groups.

Nationwide, 72.8% of cases had a reported stage at diagnosis. This proportion was higher in the special insurance (76.5%).

Most new cases were

diagnosed at stage III

(38.4%). A similar distribution was observed in the state and the third payer insurance.

Systemic therapy was the most common treatment (49.1%), followed by surgery (45.8%).

Quality measures in colon and rectum cancer

On a national scale, the average waiting time to diagnosis was 40 days and to the first treatment was 57 days.

Diagnosis and treatment were promptly provided to individuals with special insurance.

In the country, early detection met the established goal (32.4%). This was also accomplished across all insurance groups, with the highest rate observed in the special insurance group (36.8%).

Regarding the indicator that

evaluates the waiting times to diagnosis,

the goals were not met in most geographical regions.

The remaining measures related to timely access to care did not reach the goals either nationally or in most regions and insurance groups.

Stomach cancer

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Infographic summary

Chapter **6** at a glance

Stomach cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of stomach cancer

During the period analyzed, there were 2,455 new cases,

14,027 prevalent cases, and 2,765 deaths.

It was the fifth most frequent among the 11 prioritized types of cancers, accounting for 4.2% of new cases reported.

There were

2,447 new cases of invasive cancer.

Age-standardized PNCR was 5 new cases (95% CI: 4.4 - 4.8) per 100,000 people.

Among the prevalent cases, 13,872 were invasive. The age-standardized prevalence was 26 cases (95% CI: 25.3 - 26.2) per 100,000 people.

There were 2,755 deaths among those with invasive cancer. Age-standardized general mortality of 5 deaths (95% CI: 4.9 - 5.3) per 100,000 people.

The highest morbidity and mortality estimations were observed in Bogotá, D. C. (as a region). These estimations were also higher in the third payer and special insurance.

Compared to 2022,

the PCNR increased by 2.6%.

Characterization of new cases of stomach cancer

The median age was
65 years
(IQR: 55 - 74).

61.5% of the cases were men.

60.4% were affiliated to the third payer insurance, and the majority of new cases (30.4%) were residents of the Central region.

99.7% were invasive, with similar proportions registered across all insurance groups.

At the national level, the stage at diagnosis was reported in 66.3% of the cases. This proportion was higher among those covered by exception insurance (69.6%).

51.3%
of new cases were diagnosed at
stage IV,
with a similar distribution among insurance groups.

Systemic therapy was the most frequent treatment (46.5%) followed by surgery (32.7%).

Quality measures in stomach cancer

Nationally, the average waiting time to diagnosis increased to 30 days and to the initial treatment decreased to 52 days, compared to 2022.

Treatment was promptly provided to individuals with exception insurance.

At the national level and in most regions, the indicators related to the access to diagnosis and the waiting time between surgery and the administration of adjuvant therapy reached the established goals.

The early detection of
stomach cancer
met the goals,
both nationally and within the state and third payer insurance groups.

The proportion of cases that underwent a nutrition evaluation showed a poor performance, at the country, among regions and insurance groups.

Lung cancer

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Infographic summary

Chapter **7** at a glance

Lung cancer

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of lung cancer

There were **1,518 new cases**

5,402 prevalent cases and 1,509 deaths during the analyzed period.

It was the seventh most frequent among the 11 types of prioritized cancer.

1,513 new cases of invasive cancer were notified. Age-standardized PNCR was 3 new cases (95% CI: 2.6 - 2.9) per 100,000 people.

Among prevalent cases,

5,366 were invasive.

Age-standardized prevalence was 10 cases (95% CI: 9.6 - 10.2) per 100,000 people.

There were 1,504 deaths among people with invasive lung cancer. Age-standardized general mortality was 3 deaths (95% CI: 2.6 - 2.9) per 100,000 people.

The highest morbidity and mortality estimations were observed in the Central region.

Compared to 2022,

the prevalence increased by 7.7%.

Additionally, the PCNR and the mortality increased by 19.8% and 5.8%, respectively.

Characterization of new cases of lung cancer

The median age was

69 years

(IQR: 62 - 76).

53.1% of the cases were men.

64.8% were covered by third payer insurance, and the majority of cases (42.2%) were residents of the Central region.

99.7% were invasive. This proportion was higher among individuals with exception (100.0%) and under state insurance (100.0%).

At the national level,

75.8% **were staged at diagnosis,**

with a higher proportion among those with

third payer insurance

(78.8%).

Systemic therapy was the most frequent treatment (43.6%), followed by radiotherapy (19.4%).

Quality measures in lung cancer

At the national level, the average waiting time to diagnosis was longer compared to 2022.

Nationally, and in most geographical regions, the goals for TNM staging of new cases were not achieved.

At both the national level and in most regions, the

indicators for access to care partially met the goals.

The proportion of cases that underwent a nutrition evaluation showed a poor performance, at the country, among regions and insurance groups.

Melanoma

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Infographic summary

Chapter **8** at a glance

Melanoma

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of melanoma

There were **927 new cases,**

7,765 prevalent cases and 476 deaths during the analyzed period.

It was the eighth most frequent among the 11 prioritized types of cancer.

A total of 657 new invasive cancer cases were notified. Age-standardized PNCR was 1 new case (95% CI: 1.1 - 1.3) per 100,000 people.

Among prevalent cases,

5,666 were invasive.

Age-standardized prevalence was 11 cases (95% CI: 10.3 - 10.8) per 100,000 people.

There were 435 deaths among people with invasive melanoma. Age-standardized mortality was 1 death (95% CI: 0.7 - 0.9) per 100,000 people.

The highest morbidity and mortality estimations were observed in the Central region and among those with special insurance.

The PNCR increased by 27.0%

compared to 2022.

Characterization of new cases of melanoma

The median age was
64 years
(IQR: 52 - 74).

54.3% of the cases were women.

75.2% were covered by the third payer insurance, and the majority of cases (46.2%) resided in the Central region.

70.9% were invasive. This proportion was higher in people under state insurance (81.1%).

At the national level, 68.9% were staged at diagnosis, with a higher proportion among those with third payer (70.6%).

According to the
TNM staging,
35.2% of new cases
were diagnosed at stage I and II.

Surgery was the most common treatment for new cases (56.3%), followed by systemic therapy (14.5%).

Quality measures in melanoma

Nationwide, the average waiting time to diagnosis was 18 days.

The longest time to treatment initiation was reported among individuals with state insurance (88 average day), in contrast to those with special insurance (40 average days).

The goal for reporting TNM staging of new cases was not achieved and remains a challenge both nationally and in most geographic regions.

Early detection of
melanoma cases showed strong performance in the country,
as well as in most geographic regions, except for the Caribbean region.

The average time to confirm a melanoma diagnosis achieved moderate compliance at the national level.

Adult non-Hodgkin lymphoma (NHL)

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Infographic summary

Chapter **9** at a glance Adult non-Hodgkin lymphoma (NHL)

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of NHL

There were **1,869 new cases,**

18,022 prevalent cases, and 1,252 deaths during the analyzed period.

It was the sixth most frequent among the 11 prioritized types of cancers, representing 3.2% of new cases.

The age-adjusted PNCR was 5 new cases (95% CI: 4.6 - 5.1) per 100,000 people aged ≥ 18 years.

The age-adjusted prevalence was

47 cases

(95% CI: 46.3 - 47.6) per 100,000 people aged ≥ 18 years.

The age-adjusted general mortality was 3 deaths (95% CI: 3.0 - 3.4) per 100,000 people aged ≥ 18 years.

The highest PNCR, prevalence and general mortality were observed in Bogotá, D. C. (as a region).

Compared to 2022,

the prevalence and PCNR increased by 7.7% and 19.8%, respectively.

Characterization of new cases of NHL

The median age was

62 years

(IQR: 50 - 72).

52.1% of the cases were men.

70.6% were covered by third payer insurance, with most cases (32.5%) residing in the Central region.

At the national level, 71.9% of cases had the Lugano staging classification; this proportion was higher among those with third payer insurance (74.9%).

In all insurance groups, as well as nationally, most cases were diagnosed at stage IV (31.6%).

Overall, risk classification was

documented in 59.0%

of the cases.

24.2% were classified as high risk; this proportion was higher among those with third-payer insurance (24.6%).

Systemic therapy was the most common treatment (76.3%).

Quality measures in NHL

Nationally, the average waiting time to access a biopsy and diagnosis confirmation increased by 3.4% compared to 2022.

The shortest time to diagnosis was observed among individuals affiliated with third-payer insurance (an average of 14 days).

In the third-payer and state insurance groups, the waiting time for diagnosis confirmation and initial treatment decreased compared to 2022. Nevertheless, these groups did not meet the established goals.

Timely access to

biopsy and treatment initiation

showed poor performance in most regions and at the national level.

Adult Hodgkin lymphoma (HL)

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Infographic summary

Chapter **10** at a glance

Adult Hodgkin lymphoma (HL)

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of HL

There were **350** new cases,

4,976 prevalent cases, and 156 deaths during the analyzed period.

It was the eleventh most frequent among the 11 prioritized types of cancers.

The age-adjusted PNCR was 1 new case (95% CI: 0.8 - 1.0) per 100,000 people aged ≥ 18 years.

The age-adjusted prevalence was

13 cases

(95% CI: 12.8 - 13.6) per 100,000 people aged ≥ 18 years.

The age-adjusted general mortality was 0.4 deaths (95% CI: 0.3 - 0.5) per 100,000 people aged ≥ 18 years.

The highest PNCR and general mortality estimations were observed in Central region; while the prevalence was higher in Bogotá, D. C.

Compared to 2022, both the

PCNR and mortality decreased,

with a more significant reduction in general mortality (22.6%).

Characterization of new cases of HL

The median age was

40 years
(IQR: 29 - 60).

55.7% of the cases were men.

65.4% were affiliated to the third payer insurance, and the majority of cases (31.1%) resided in the Central region.

Clinical staging was reported in 80.9% of the cases. Most of them were diagnosed at stage IV (28.6%), showing a similar trend in both state and third payer insurance.

Systemic therapy

was the most frequent treatment (85.8%).

Quality measures in HL

At the national level, the average waiting time to access the biopsy was 40 days, to diagnosis was 17 days and to the first treatment was 35 days.

The waiting time for diagnosis was shorter compared to 2022. However, this indicator did not meet the established goals.

The waiting time between the

biopsy and diagnostic confirmation

was longer during this period.

Nationally, the goal for the proportion of cases with the Ann Arbor staging, using Costwolds or Lugano modification (80.9%), and for risk classification (74.9%), were not reached. This was also evident in most regions.

Adult acute lymphoblastic leukemia (ALL)

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Infographic summary

Chapter **11** at a glance

Adult acute lymphoblastic leukemia (ALL)

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of ALL

There were 193 new cases,

2,098 prevalent cases and 239 deaths during the analyzed period.

It was the ninth most frequent among the 11 prioritized types of cancer.

The age-standardized PNCR was 0.5 new cases (95% CI: 0.4 - 0.6) per 100,000 people aged ≥ 18 years.

The age-adjusted prevalence was

6 cases

(95% CI: 5.3 - 5.8) per 100,000 people aged ≥ 18 years.

The age-standardized mortality was 0.6 deaths (95% CI: 0.6 - 0.7) per 100,000 people aged ≥ 18 years.

The highest morbidity and mortality estimations were observed in Bogotá, D. C. as a region. Among insurance regimens, the highest rates of PNCR and prevalence were registered in the special insurance.

The prevalence increased,

by 11.8% compared to 2022.

Characterization of new cases of ALL

The median age was

36 years

(IQR: 23 - 58).

59.6% of the cases were men.

57.0% were affiliated with the third payer insurance, and the majority of cases (26.4%) resided in the Central region.

At the national level, 65.8% of cases had risk classification at diagnosis; with a higher among those with exception insurance (83.3%).

76.4% of new cases

were classified as high or unfavorable risk, being higher percentage in the state third payer insurance (78.1%).

Systemic therapy was the most common treatment (87.6%), followed by radiotherapy (1.6%) and hematopoietic stem cell transplantation (4.7%).

Quality measures in ALL

Nationally, the average waiting time to access to diagnosis and to the first treatment decreased compared to 2022.

At the national level, the goal for risk classification of new and prevalent cases was not reached, with similar results observed across all regions.

None of the indicators related to timely

access to cancer care

and the complete study of the disease (molecular, morphologic and genetic testing) reached the proposed goal, either nationally or in most regions.

The indicator related to the quality of bone marrow biopsy varied across regions, showing a high performance in the Amazonía-Orinoquía and the Pacific regions, while other regions demonstrated partial performance.

12

Adult acute myeloid leukemia (AML)

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Infographic summary

Chapter **12** at a glance

Adult acute myeloid leukemia (AML)

Period: January 2, 2022 to January 1, 2023

Morbidity and mortality of AML

There were **362** new cases,

1,784 prevalent cases and 307 deaths during the period analyzed.

It was the tenth most frequent among the 11 prioritized types of cancer.

The age-standardized PNCR was 1 new cases (95% CI: 0.9 - 1.0) per 100,000 people aged ≥ 18 years.

The age-standardized prevalence was

5 cases

(95% CI: 4.5 - 4.9) per 100,000 people aged ≥ 18 years.

The age-standardized general mortality was 1 death (95% CI 0.7 - 0.9) per 100,000 people aged ≥ 18 years.

The highest PNCR were observed in Caribbean region, while prevalence and general mortality was higher in the Bogotá, D. C. (as a region).

The PCNR and general mortality rates were higher among individuals with third payer insurance.

Compared to 2022,

the PCNR and mortality

increased by 41.2% and 20.6%, respectively.

Characterization of new cases of AML

The median age was
62 years
(IQR: 45 - 74).

57.2% of the cases were women.

64.9% were covered by third payer insurance and most cases (31.5%) lived in the Central region.

At the national level, 55.2% of cases had risk classification at diagnosis; with a higher proportion among those under state insurance (67.0%).

65.5% of new cases
were classified as high or unfavorable risk, with a higher proportion among those under third payer insurance (67.5%).

Systemic therapy was the most common treatment (82.3%), followed by hematopoietic stem cell transplantation (3.9%) and radiotherapy (1.7%).

Quality measures in AML

Nationally, the average waiting times to diagnosis was 19 days and to the first treatment was 16 days.

The shortest time to diagnosis was observed among individuals with special insurance.

The risk classification
indicator
did not reach the proposed goal for either new or prevalent cases,
both nationally and across all regions.

The indicator related to the quality of bone marrow biopsy varied across regions, showing a low performance in the Caribbean and the Oriental regions.

13

Other types of cancer

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Infographic summary

Chapter **13** at a glance

Other types of cancer

Period: January 2, 2022 to January 1, 2023

General characterization of cases

There were **236,520** **non-prioritized cancer cases,**
27,545 were new cases and 13,080 died.

The highest number of new cases, in descending order, were skin tumors (non-melanoma), thyroid and endocrine gland tumors, and female genital organs neoplasms.

56.5% of the new cases were female.

The median age of the new cases was 65 years (IQR: 53 - 75).

68.0% of new cases were covered by third payer insurance.

Clinical characterization of new cases

Skin cancer (non-melanoma):

A histology report was provided for **98.1%** **of new cases.**

Basal cell carcinoma was the most frequent type (75.7%).

Tumors of the thyroid and endocrine glands:

The thyroid **gland tumor** **subgroup** accounted for 86.8% of cases, including carcinoma *in situ*.

Clinical staging was reported in 45.7% of new cases.

Tumors of other female genital organs:

45.8% of new cases

were diagnosed with uterine body tumors, and 41.3% with malignant ovarian tumors.

Staging was reported in 67.8% of new cases.

Among staged cases, most were diagnosed at stage I.

Tumors of the kidney and other urinary organs:

Malignant kidney tumors

were the most frequent subgroup (59.6%).

Staging was reported in 58.1% of new cases.

26.7% of cases were classified as stage I.

Tumors of other digestive organs:

Malignant tumors of the pancreas

were the most common subgroup (32.8%), followed by liver tumors (19.8%).

Staging information was reported in 57.3% of cases; with 31.9% were diagnosed at stage IV.

Other hematologic malignancies:

Multiple myeloma and other plasmacytic neoplasms was the most frequent subgroups, accounting for 46.1% of new cases.

15.9% of new cases

had a risk classification report.

CAC

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MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL

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