Fondo Colombiano de
Enfermedades de Alto Costo

A brief of cancer situation within the framework of health insurance in Colombia, 2022

CUENTA DE ALTO COSTO
Fondo Colombiano de Enfermedades de Alto Costo

A brief of cancer situation within the framework of health insurance in Colombia, 2022

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

Annual periodicity

Bogotá, C. D., Colombia, november 2023

© All rights reserved

Suggested citation: Fondo Colombiano de Enfermedades de Alto Costo, Cuenta de Alto Costo (CAC). A brief of cancer situation within the framework of health insurance in Colombia 2022; Bogotá, C. D. 2023.

The total or partial reproduction of this book is prohibited without written authorization

The full textbook in spanish of the situation of cancer in Colombia is available at this link

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: tumor (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

Chapter 1

Cancer overview

Period analyzed: January 2nd, 2021 to January 1st, 2022.

General characterization of cases

The cancer registry increased up to 462,857 cases; 438,120 were invasive.

44,870 cases were diagnosed during the period analyzed, from those the 94.7% were invasive.

52.5% of new cancer cases were women.

Median age of new cancer cases was 63 years (IQR: 51 - 73).

64.3% were insured by the third payer, and most new cases (31.5%) lived in the Central region.

Most frequent types of cancer

among new cases in women were breast (29.2%), cervical (9.4%) and, colon and rectum (7.6%).

In men, prostate cancer (21.6%), colon and rectum (9.5%), and stomach cancer (7.4%) **were the most frequent among new cases.**

In people with invasive cancer, 31,964 deaths, from all causes, were notified.

Morbidity and mortality of invasive cancer

Crude prevalence increased by 9.6% compared to 2021.

The highest age-standardized PNCR were observed in breast, prostate, and colon and rectum cancer with 27, 16 and 7 new cases per 100,000 people, respectively.

Age-standardized prevalence was 825 cases (95% CI: 822.5 - 827.4) per 100,000 people.

Bogotá, D. C., as a region, had the highest age-standardized PNCR, prevalence and mortality.

Crude PNCR

increased by **16.1%** compared to 2021.

In women, most deaths were observed in those with breast (25.5%), cervical (9.4%), and colon and rectum (8.7%) cancer.

In men, the highest proportion of deaths was observed in prostate (23.5%), stomach (10.4%), and colon y rectum cancer (9.5%).

Breast, prostate and cervical cancer had the highest age-standardized general mortality with 16, 13 and 6 deaths per 100,000 people.

Age-standardized PNCR was 84 new cases (95% CI: 83.2 - 84.8) per 100,000 people.

Age-standardized general mortality was 59 deaths (95% CI: 58.3 - 59.6) per 100,000 people.

Clinical characterization of new cases

91.8% of new cases were solid tumors, 4.3% were lymphomas and 1.8% were leukemia.

60.9% of solid tumors and **65.8%** of lymphomas reported correctly the stage at diagnosis with the TNM system.

25.8% of solid tumors staged at diagnosis were at stage II.

Risk classification was reported in 63.7% of people with leukemia and 54.0% of lymphomas.

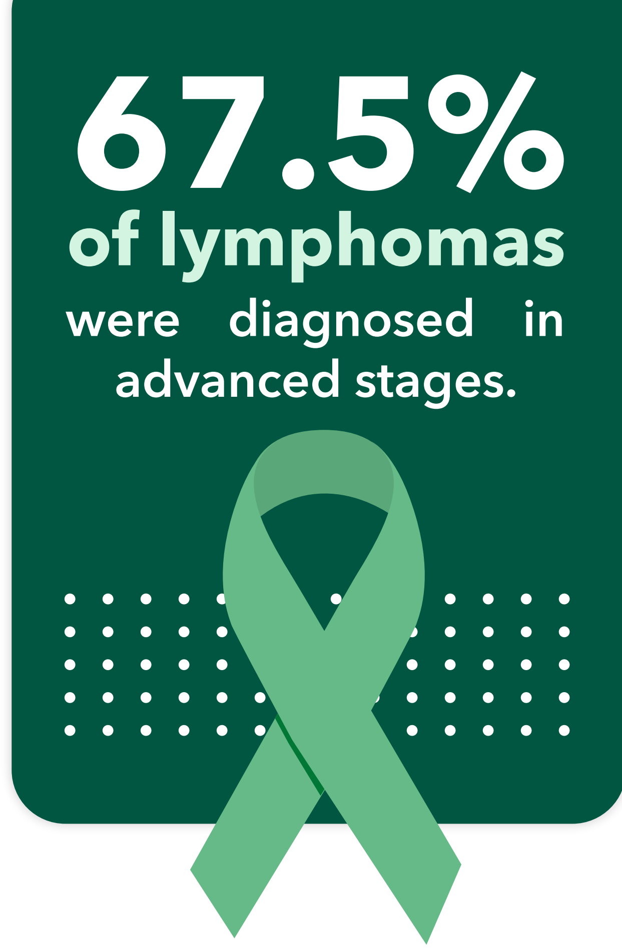
Surgery was the most frequent treatment (38.7%), followed by systemic therapy (37.5%).

At the national level,

median waiting time to diagnosis was

30 days

and to the first treatment was 52 days, representing an 8.3% and 20.0% increase, respectively.



Diagnosis was shortly provided in adults with ALL and AML, with a median time of 6 days.

For treatment initiation, the shortest median waiting time was registered in cases with ALL (2 days).

Prostate cancer had the longest median waiting time to diagnosis with 44 days (IQR: 27 - 79).

The longest median waiting time to treatment was 65 days for cases with melanoma (IQR: 44 - 104) and prostate cancer (IQR: 32 - 107).

Breast cancer

Chapter 2

Breast cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

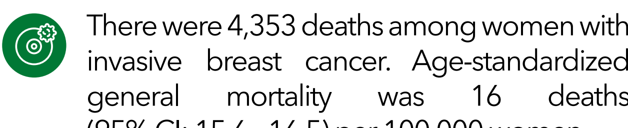
Morbidity and mortality of breast cancer

It was the most frequent among the 11 prioritized cancer types and continues to be the most common in women (29.2% of total new cases).

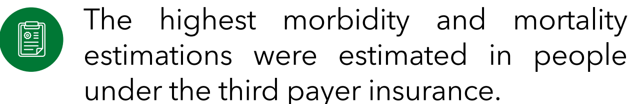
There were 8,018 new cases, 93,949 prevalent cases and 4,449 deaths during the period analyzed.

7,346 new invasive cases were notified

Age-standardized PNCR was **28 new cases** (95% CI: 26.9 - 28.1) per 100,000 women.



There were 4,353 deaths among women with invasive breast cancer. Age-standardized general mortality was 16 deaths (95% CI: 15.6 - 16.5) per 100,000 women.



The highest morbidity and mortality estimations were estimated in people under the third payer insurance.

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

The general mortality increased by 10.2% in 2022.

From prevalent cases, 88,842 were invasive. Age-standardized prevalence was 329 cases (95% CI: 327.0 - 331.3) per 100,000 women.

Characterization of new cases of breast cancer

65.0% of new cases were under the third payer insurance and the majority (32.0%) lived in the Central region.

91.6% were invasive cases. This proportion was higher in women with state insurance (95.2%).

Nationally, in 89.6% of the cases the stage at diagnosis was reported correctly, being higher in women with third payer insurance.

83.2% of new cases had the HER2 test, from which 73.7% had a negative result.

Hormone receptors were tested in 89.1% of new cases, from which, 65.3% were positive for both estrogen and progesterone receptors.

At the national level, median waiting time to diagnosis was

27 days

(IQR: 14 - 52) and to the first treatment was 52 days **(IQR: 31 - 83).**

Median age was

59 years

(IQR: 49-68).

40.3% of new cases were diagnosed at stage II. This proportion was similar in women with state (40.9%) and third payer insurance (39.1%).

From women with equivocal or undetermined HER2 result, only 42.7% received the FISH test in compliance with the diagnostic algorithm.

Systemic therapy was the most frequent treatment (63.3%), followed by surgery (40.6%).

Diagnosis and treatment were shortly provided in people with special insurance with medians of 17 days and 39 days, respectively.

The longest median waiting time to the first treatment was estimated in women under state insurance (66 days).

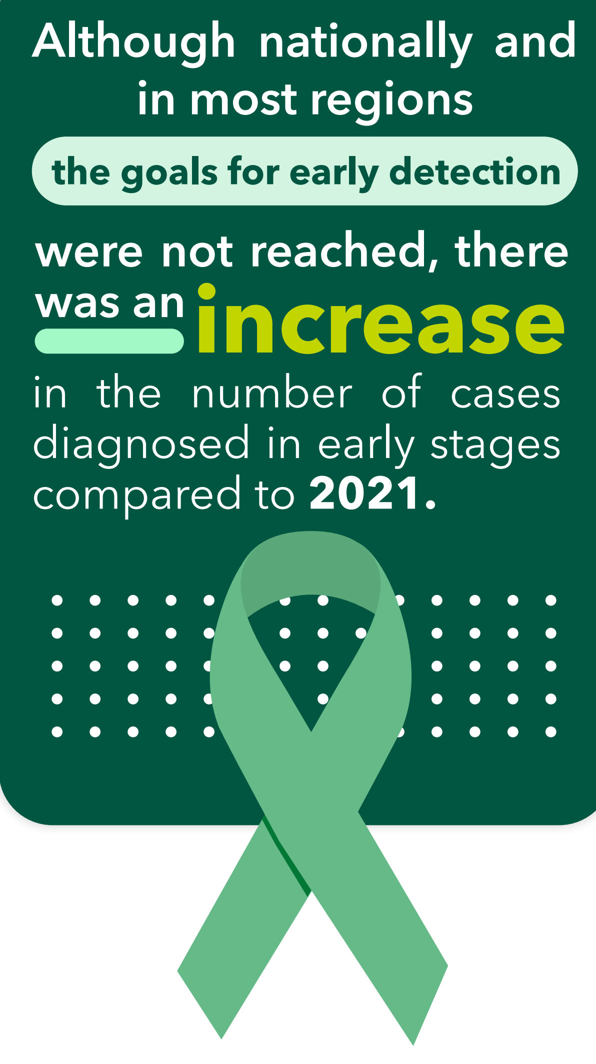
Women diagnosed at stage IV were shortly diagnosed and treated compared with those in early stages.

Quality measures in breast cancer

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

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

None of the indicators related with timely access to care reached the established goals, nationally and among most of the demographic regions.



Prostate cancer

Chapter 3

Prostate cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of prostate cancer

It was the second most frequent

among the 11 prioritized cancer types

and continues to be the most common in men

(21.6% of total new cases).

There were 4,196 new cases, 52,281 prevalent cases, and 3,720 deaths during the period analyzed.

There were 4,191 new invasive cases notified.

Age-standardized PNCR was 16 cases (95% CI: 15.3 - 16.2) per 100,000 men.

Among prevalent cases, 51,786 were invasive. Age-standardized prevalence was 187 cases (95% CI: 185.6 - 188.8) per 100,000 men.

All morbidity and mortality estimations were higher in Bogotá, D. C., and the Central region.

Compared to 2021, the mortality increased by 7.2% and the PNCR by 54.6%.

There were 3,681 deaths in men with invasive cancer. Age-standardized general mortality was 13 deaths (95% CI: 12.2 - 14.0) per 100,000 men.

Characterization of new cases of prostate cancer

67.4% were under the third payer insurance and most new cases (25.6%) lived in the Central region.

99.9% of new cases were invasive, with a similar trend among insurance groups.

At the national level,
73.9%
reported the stage at diagnosis.
This proportion was higher in the third payer insurance.

37.4% of the cases were diagnosed at stage II. In men with state insurance, the majority were diagnosed in stage IV (43.9%).

Nationally, the median waiting time to diagnosis was
44 days
(IQR: 27 - 79) and to the first treatment was 65 days **(IQR: 32 - 107).**

Median age was
69 years
(IQR: 64-75).

91.6% had a report of the Gleason score; this proportion was higher in the exception insurance (94.8%) and third payer insurance (92.6%).

28.1% of all new cases were at group number 1 of the Gleason score.

At the national level, 90.6% of the cases had PSA at diagnosis and 62.5% had it after the treatment.

Systemic therapy was the most frequent treatment (43.4%), followed by surgery (28.3%).

The especial insurance reported the shortest time to diagnosis (median: 34 days) and to the first treatment (median: 42 days).

Men under exception and state insurance groups had the longest time to confirm the diagnosis (median: 48 days), while in the third payer insurance the longest time to treatment was estimated (median: 68 days).

Cases diagnosed in stage IV had the shortest time to the diagnosis and treatment compared with early stages.

Quality measures in breast cancer

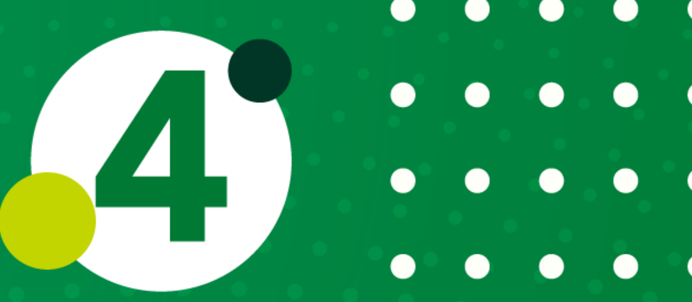
TNM staging and early detection was higher in the third payer insurance (78.1% and 64.1%, respectively) than in the state insurance (69.5% and 41.0%, respectively).

None of the indicators regarding access to diagnosis and treatment reached the proposed goal neither in the country, nor in any of the insurance groups.

Nationally, the early detection indicator had a

low performance,

nevertheless, the indicador related to the Gleason score report reached the established goal.



Cervical cancer

Chapter 4

Cervical cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

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.

There were 2,587 new cases (*in situ* and invasive), 27,304 prevalent cases, and 1,543 deaths during the period analyzed.

There were 1,848 new invasive cases notified.

Age-standardized PNCR was 7 new cases (95% CI: 6.7 - 7.3) per 100,000 women.

From all prevalent cases, 20,570 were invasive. The age-standardized prevalence was 77 cases (95% CI: 76.4 - 78.5) per 100,000 women.

Age-standardized prevalence and mortality of invasive cancer cases were higher in the regions of Amazonía-Orinoquía and Caribe, and in women under the state insurance.

The age-standardized PNCR of invasive cancer was higher in the Caribe and Pacific regions.

In comparison to 2021, the PNCR increased by 16.7% and the mortality decreased by 1.2%.

There were 1,543 deaths in women with invasive cancer. Age-standardized general mortality was 6 deaths (95% CI: 5.5 - 6.1) per 100,000 women.

Characterization of new cases of cervical cancer

49.6% of the cases were under the third payer insurance, and most cases (2.1%) were residents of the Caribe region.

According to the ICD-10, 71.4% were invasive cases; this proportion was higher in women with state insurance (76.1%).

31.0%
were staged as *in situ* neoplasms.

Stage III was the most frequent among invasive cases according to the TNM/FIGO staging (23.2%).

Nationally, the median time to diagnosis was
30 days
(IQR: 18 - 56) and to the first treatment was 63 days **(IQR: 40 - 97).**

The median age was
46 years
(IQR: 37-59).

At the national level, 92.0% had a report of TNM/FIGO staging; this proportion was higher in women under the third payer insurance.

In women under state insurance, the majority (28.2%) were diagnosed at stage III, while in the third payer insurance group, 35.4% of new cases were staged as *in situ* neoplasms.

Surgery was the most frequent treatment (36.2%), followed by systemic therapy (34.2%).

Among insurance groups, there was a general tendency to the reduction of waiting times to diagnosis in 2022, mainly in the state and the exception insurance. Moreover, the third payer insurance delivered the initial treatment shortly.

Women diagnosed with carcinoma *in situ* and stage I had shorter waiting times to diagnosis. On the contrary, the longest waiting times to the initial treatment were observed in cases diagnosed in stage III and IV.

Quality measures in cervical cancer

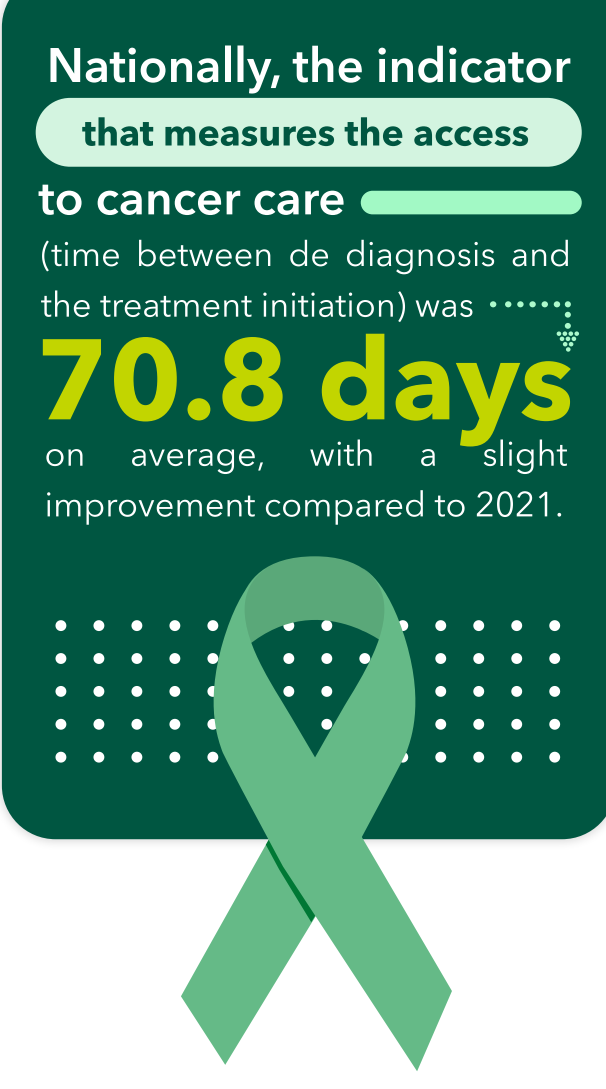
In the country the indicator related to the

TNM/FIGO

staging of new cases

did not reached the established goal (87.9%). Similar results were observed in most insurance groups.

Indicators that evaluate the access to care reached the goals at the national level, with a similar tendency among most insurance groups and geographical regions.



Colon and rectum cancer

Chapter 5

Colon and rectum cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of colon and rectum cancer

It was the third most frequent among the 11 prioritized cancer types accounting for the 8.3% of new cases reported.

There were 3,910 new cases, 29,941 prevalent cases and 3,036 deaths during the period analyzed.

There were 3,851 new invasive cases notified.

Age-standardized PNCR was 7 new cases (95% CI: 7.0 - 7.5) per 100,000 people.

Among prevalent cases, 29,368 were invasive. Age-standardized prevalence was 55 cases (95% CI: 54.2 - 55.5) per 100,000 people.

There were 3,001 deaths among people with invasive cancer. Age-standardized general mortality was 6 deaths (95% CI: 5.3 - 5.7) per 100,000 people.

The highest morbidity and mortality estimations were observed in Bogotá, D.C., (as a region), and in people under the third payer insurance.

The general mortality decreased by 2.5% and the PNCR increased by 17.8% compared to 2021.

Characterization of new cases of colon and rectum cancer

53.0% were women.

65.9% had the third payer insurance and most cases (31.3%) lived in the Central region.

Most new cases were diagnosed at stage III (38.8%).

A similar distribution was observed in the state and the third payer insurance.

The median age was 66 years (IQR: 56-74).

98.5% were invasive, with a similar proportion among insurance groups.

In the country, 72.9% of the cases had a report of the stage at diagnosis. This proportion was higher in the especial insurance (87.5%).

Systemic therapy was the most frequent treatment (50.4%), followed by surgery (46.9%).

Diagnosis was shortly provided in people with the exception insurance (median: 16 days; IQR: 6 - 40).

The shortest waiting time to treatment initiation was registered in people with the especial insurance (median: 25 days; IQR: 20 - 42).

The waiting times to diagnosis and initial treatment were shorter in people diagnosed at stage IV compared to those in early stages.

At the national level, median waiting time to diagnosis was 20 days (IQR: 8 - 40) and to the first treatment was 50 days **(IQR: 25 - 84).**

Quality measures in colon and rectum cancer

Regarding the indicator that evaluates the waiting times to diagnosis, the performance was high in most geographical regions. At the national level the goal was also reached, with an average time of 28.1 days.

The remaining measures related to timely access to care did not reach the goals neither nationally, nor in most regions and insurance groups.

In the country and among all insurance groups the early detection of cases reached the goal established (27.7%).

This was also accomplished in al insurance groups, however it was higher in the third payer group (29.7%) compared to the state insurance (22.1%).

Stomach cancer

Chapter 6

Stomach cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of stomach cancer

It was the fifth most frequent among the 11 prioritized cancer types accounting for the 5.0% of new cases reported.

There were 2,364 new cases, 13,645 prevalent cases, and 2,673 deaths during the period analyzed.

There were 2,353 new invasive cases notified.

Age-standardized PNCR was 4 new cases (95% CI: 4.3 - 4.6) per 100,000 people.

Among prevalent cases, 13,485 were invasive. The age-standardized prevalence was 25 cases (95% CI: 24.9 - 25.7) per 100,000 people.

The highest mortality and prevalence were observed in Bogotá, D. C., as a region, and the PNCR in the Pacific region. All estimations were higher in the third payer insurance.

Compared to 2021, the mortality decreased by 3.6% and the PNCR increased by 9.9%.

There were 2,656 deaths in those with invasive cancer. Age-standardized general mortality was five deaths (95% CI: 5 - 6) per 100,000 people.

Characterization of new cases of stomach cancer

60.7% were men.

58.0% were affiliated to the third payer insurance; most new cases (30.3%) were residents of the Central region.

52.2% of new cases were diagnosed at stage IV with a similar distribution among insurance groups.

Systemic therapy was the most frequent treatment (46.4%) followed by surgery (32.7%).

Nationally, the median waiting time to diagnosis was 17 days (IQR: 8 - 33) and to the initial treatment was 43 days **(IQR: 21 - 76).**

The median age was 64 years (IQR: 54-74).

99.5% were invasive, with similar proportions registered in all insurance groups.

At the national level, in 67.6% of the cases the staged at diagnosis was reported. This proportion was higher in people under the third payer insurance (71.4%).

Diagnosis was shortly provided in people with especial insurance, with a median of 7 days. Likewise the shortest waiting time to treatment initiation was registered in the third payer insurance group.

People diagnosed at stage IV had shorter waiting times to diagnosis and treatment compared to those in early stages.

Quality measures in stomach cancer

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 proportion of cases that had a nutrition evaluation presented a low performance, in the country, among regions and insurance groups.

Lung cancer

Chapter 7

Lung cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of lung cancer

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

There were 1,245 new cases, 4,954 prevalent cases and 1,417 deaths during the period analyzed.

Among prevalent cases, 4,921 were invasive. Age-standardized prevalence was 9 cases (95% CI: 8.9 - 9.4) per 100,000 people.

There were 1,412 deaths among people with invasive lung cancer. Age-standardized general mortality was 3 deaths (95% CI: 2.5 - 2.8) per 100,000 people.

The highest morbidity and mortality estimations were observed in the Central region and in the third payer insurance group.

Compared to 2021, the mortality and the PNCR decreased by 18.2% and 2.7%, respectively.

1,243 new cases of invasive cancer were notified. Age-standardized PNCR was 2 new cases (95% CI: 2.2 - 2.5) per 100,000 people.

Characterization of new cases of lung cancer

51.4% were men.

61.1% had the third payer insurance and most cases (43.9%) lived in the Central region.

74.2% of new cases were diagnosed at stage IV.

Most people under the state insurance (79.0%) were also diagnosed at that stage.

Despite timely access to diagnosis, most cases were diagnosed on advanced stages.

At the national level, the media waiting time to diagnosis was 27 days (IQR: 13 - 47) and to the first treatment was 39 days **(IQR: 19 - 68).**

The median age was 69 years (IQR: 62-76).

99.8% were invasive. This proportion was higher in people with exception (100.0%) and third payer insurance (99.9%).

At the national level, 83.6% were staged at diagnosis. This proportion was higher in people under the third payer and the exception insurance.

Systemic therapy was the most frequent treatment (45.5%), followed by radiotherapy (22.3%).

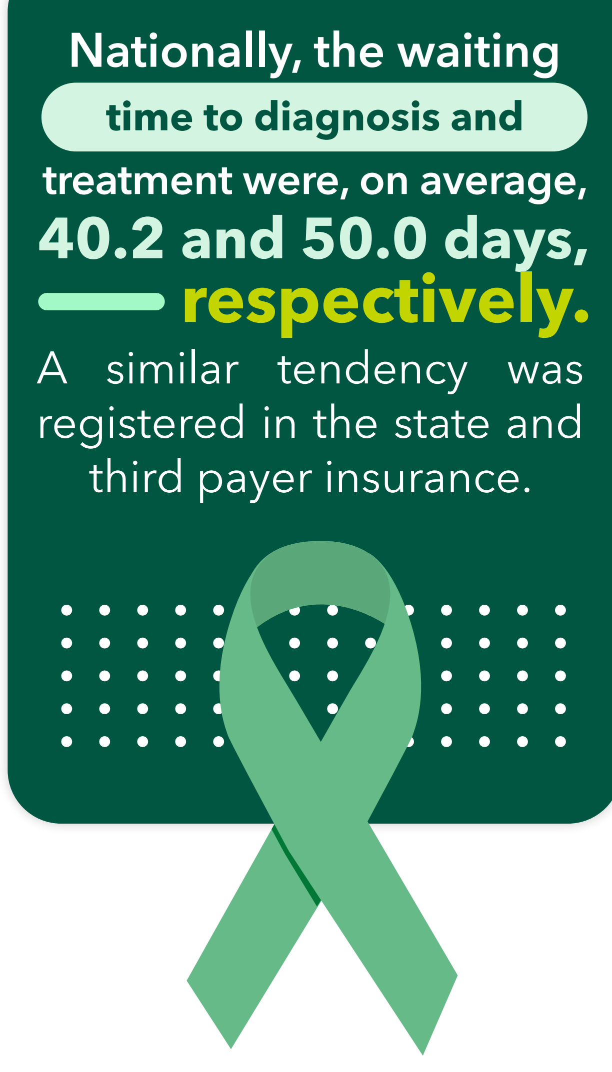
Waiting time to diagnosis and treatment initiation were shorter in people diagnosed at stage III and IV compared to those at early stages.

Quality measures in lung cancer

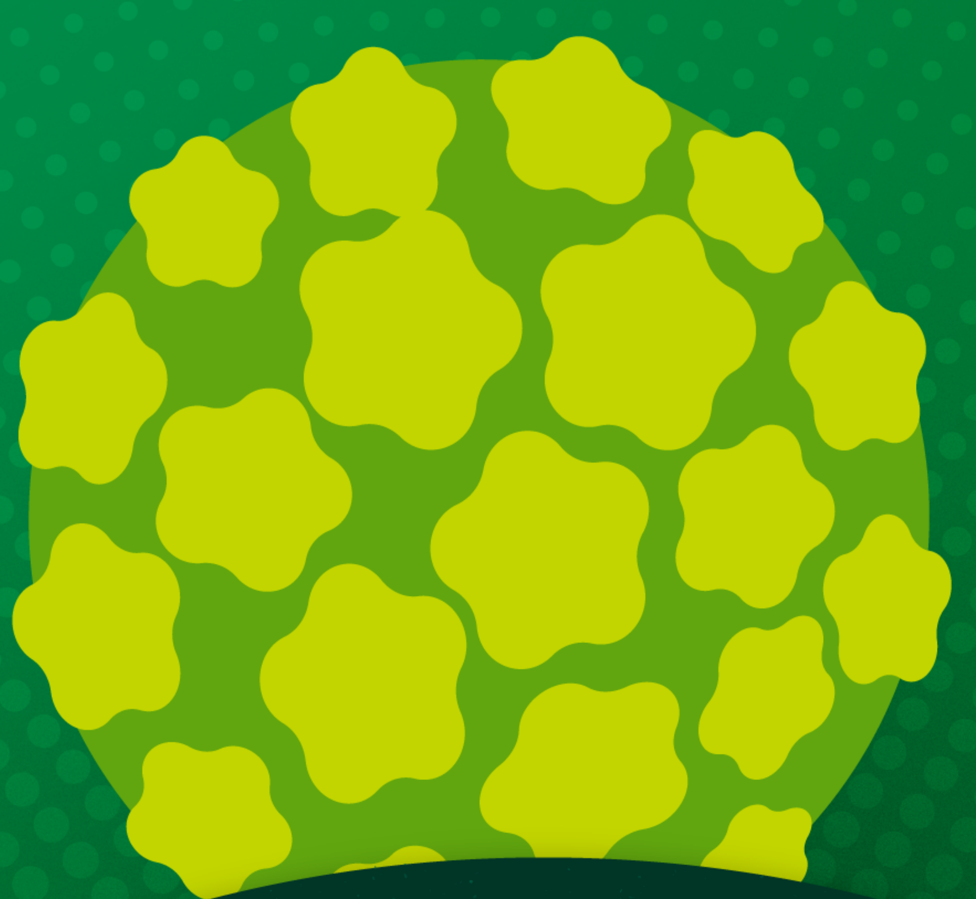
Nationally, and in most geographical regions the goals for early detection and TNM staging of new cases were not achieved.

TNM staging of new cases is a particularly critical aspect due to its low performance in most regions. This tendency was also observed in the third payer and exception insurance groups.

The proportion of new cases diagnosed at early stages was higher in the especial insurance (42.9%) among insurance groups.



Melanoma



Chapter 8

Melanoma

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of melanoma

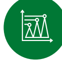
It was the eighth most frequent among the 11 types of prioritized cancer.

There were 717 new cases, 6,695 prevalent cases and 409 deaths during the period analyzed.

508 new invasive cancer cases were notified.

Age-standardized PNCR was 1 new case (95% CI: 0.9 - 1.1) per 100,000 people.

There were 370 deaths among people with invasive melanoma. Age-standardized mortality was 0.7 deaths (95% CI: 0.6 - 0.8) per 100,000 people.



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

The PNCR increased by 31.6% and the general mortality decreased by 8.9% compared to 2021.

Among prevalent cases, 4,978 were invasive. Age-standardized prevalence was 9 cases (95% CI: 9.1 - 9.6) per 100,000 people.

Characterization of new cases of melanoma

53.8% were women.

72.5% were affiliated to the third payer insurance and most cases (40.3%) lived in the Central region.

70.9% were invasive.

This proportion was higher in people under state insurance (85.8%).

According to the TNM staging, 41.0% of new cases were diagnosed *in situ*. All regimens but the state insurance (with most cases diagnosed in stage III: 26.0%) presented the same trend.

At the national level, the media waiting time to diagnosis was

33 days

(IQR: 22 - 55) and to the first treatment was 65 days **(IQR: 44 - 112),** registering a big gap between the two stages of cancer care.

The median age was

63 years

(IQR: 51-73).

At the national level, 70.4% were staged at diagnosis, with a higher proportion in the third payer (73.5%).

Surgery was the most frequent treatment in new cases (52.7%), followed by systemic therapy (13.8%).

39.8% of the new cases did not receive any treatment during the period.

Diagnosis was shortly provided in people from the exception insurance (median: 25 days), while the longest waiting time was observed in the state insurance (median: 34 days) and especial insurance (median 37 days).

The shortest time to treatment initiation was reported in people under the third payer insurance (median: 64 days) contrary to the state insurance (median: 75 days).

According to the TNM staging, the diagnosis was provided shortly in cases in stage II. Meanwhile, the shortest time to treatment was registered in cases diagnosed *in situ*.

Quality measures in melanoma

The goal for the report of TNM staging of new cases was not reached

and it continues to be a challenge nationally and in most geographic regions.

The indicator related to the early detection of melanoma cases presented a high performance in the country, as well as in the third payer insurance and the special regimen.

Regarding the time between the remission due to the presence of a lesion and performing the biopsy, there was a high performance of the indicator nationally, in most regions and insurance groups.

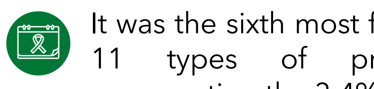
Adult Non-Hodgkin Lymphoma (NHL)

Chapter 9

Adult non-Hodgkin lymphoma (NHL)

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of NHL



It was the sixth most frequent among the 11 types of prioritized cancers, representing the 3.4% of new cases.

There were 1,524 new cases, 16,358 prevalent cases, and 1,331 deaths during the period analyzed.

The highest PNCR, prevalence and general mortality were observed in Bogotá, D. C., as a region, and in people under the third payer insurance.

The age-adjusted PNCR was

4 new cases

(95% CI: 3.9 - 4.3)

per 100,000 people aged ≥18 years.

The age-adjusted prevalence was 43 cases (95% CI: 42.6 - 44.0) per 100,000 people aged ≥18 years.

The age-adjusted general mortality was 3 deaths (95% CI: 3.3 - 3.7) per 100,000 people aged ≥18 years.

Compared to 2021, the general mortality decreased by 12.4%.

Characterization of new cases of NHL

51.8% were men.

67.7% were under the third payer insurance and most cases (30.3%) lived in the Central region.

Globally,

risk classification was documented in

48.5% of the cases.

37.5% were classified as high risk; this proportion was higher in people from the exception (42.9%) and the state insurance (40.4%).

At the national level,

63.3%

had the Lugano staging classification; this proportion was higher in people under third payer insurance **(66.6%).**

The median age was

61 years

(IQR: 48-72).

In all insurance groups, most cases were diagnosed at stage IV, as well as in the national scenario (45.1%).

Systemic therapy was the most frequent treatment (72.8%).

Nationally, the median waiting time to diagnosis was 30 days (IQR: 15 - 50) and to the first treatment was 24 days (IQR: 9 - 55).

The shortest time to diagnosis was observed in people affiliated to the special insurance (median: 19 days).

The treatment initiation was shortly delivered in people under third payer insurance (median: 21 days).

The waiting times to diagnosis and treatment were shorter in cases diagnosed at stage IV compared to those in early stages.

Quality measures in NHL

All insurance groups had a high performance in the indicators related to clinical staging, risk classification and early detection.

Timely access to the biopsy performance and the treatment initiation register a medium performance in most regions and in the country.

Adult Hodgkin Lymphoma (HL)

Chapter 10

Adult Hodgkin lymphoma (HL)

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of HL

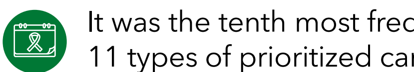
It was the tenth most frequent among the 11 types of prioritized cancers.

There were 347 new cases, 4,431 prevalent cases, and 193 deaths during the period analyzed.

The highest prevalence and general mortality estimations were observed in Bogotá, D. C., as a region; while the PNCR was higher in the Central region. The highest estimations were registered in people under the third payer insurance.

The age-adjusted PNCR was

1 new case



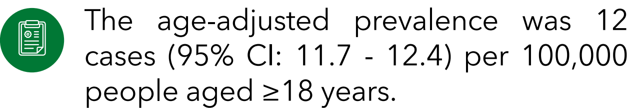
(95% CI: 0.8 - 1.0)

per 100,000 people aged ≥18 years.

The age-adjusted prevalence was 12 cases (95% CI: 11.7 - 12.4) per 100,000 people aged ≥18 years.

The age-adjusted general mortality was 0.5 deaths (95% CI: 0.4 - 0.6) per 100,000 people aged ≥18 years.

Compared to 2021,



all morbidity and mortality estimations

increased.

This was more significant in the case of the general mortality (23.3%).

Characterization of new cases of HL

54.5% were men.

68.6% were affiliated to the third payer insurance and most cases (34.0%) lived in the Central region.

At the national level,

70.6%

had risk classification;

this proportion was higher in people from the third payer insurance (73.1%)".

In 72.6% of the cases the clinical staging was reported. Most of them were diagnosed at stage II, with a similar trend in the state and the third payer insurance.

At the national level, the media waiting time to diagnosis was

30 days

(IQR: 14 - 64) and to the first treatment was 25 days **(IQR: 11 - 56).**

The median age was

43 years

(IQR: 30-60).

67.8% were classified as high-risk cases; this proportion was higher in people from the exception insurance (88.9%).

Systemic therapy was the most frequent treatment (76.1%).

The shortest times to diagnosis were registered in people from the exception regimen (median: 11 and 22 days, respectively).

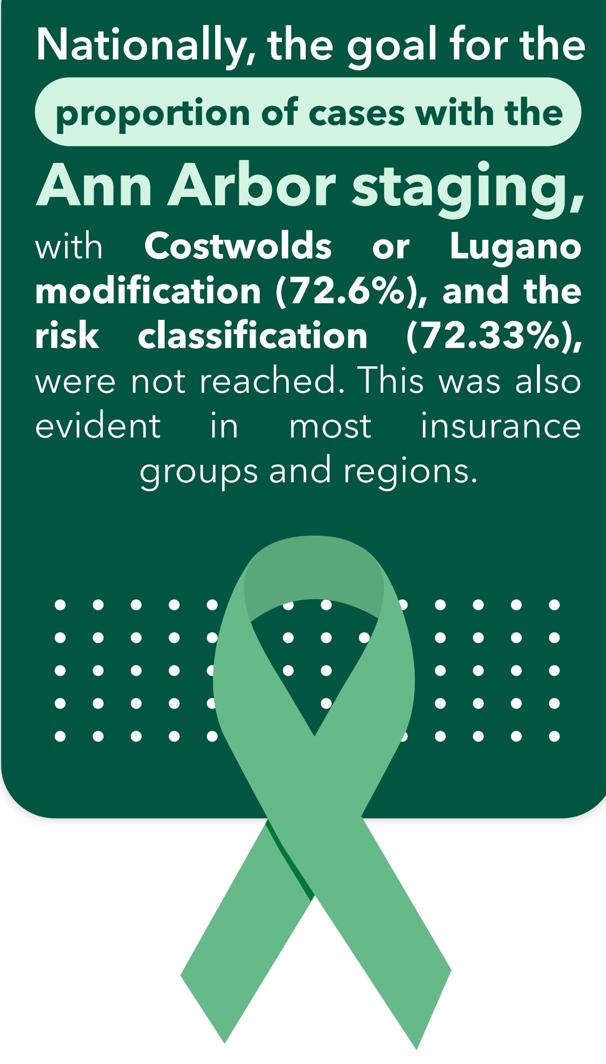
The waiting time for diagnosis was shorter in cases at stage IV, while those at stage III had the shortest time to the initial treatment.

Quality measures in HL

In the country, there was a low performance of most indicators. The opposite was observed for the indicator related to the waiting time to diagnosis, that met the proposed goal.

The waiting time between the biopsy and the diagnostic confirmation, was the only indicator that had a high compliance at the national level.

On average, the waiting times were 24.3 days for the biopsy, 11.8 days to the diagnostic confirmation and 38.3 days for the treatment initiation.



Adult acute lymphoblastic leukemia (ALL)

Chapter 11

Adult acute lymphoblastic leukemia (ALL)

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of ALL

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

There were 183 new cases, 1,836 prevalent cases and 232 deaths during the period analyzed.

The highest morbidity and mortality estimations were observed in Bogotá, D. C., as a region. Among regimens the higher rates were registered in the third payer insurance.

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

Age-standardized prevalence was 5 cases (95% CI: 4.8 - 5.2) per 100,000 people aged ≥18 years.

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

The prevalence increased by 11.0% while the general mortality decreased by 2.0% in comparison to 2021.

Characterization of new cases of ALL

51.1% were men.

58.2% were affiliated to the third payer insurance and most cases (22.8%) lived in the Central region.

Among risk groups, the waiting times to have access to **cancer care** were lower in people with intermediate risk.

Diagnosis and treatment were shortly provided in people from the exception regimen, while for the treatment initiation, this was evident in the third payer insurance.

At the national level, 55.4% had risk classification at diagnosis; this proportion was higher in people under the third payer insurance **(58.2%).**

The median age was 38 years (IQR: 27-52).

72.6% of new cases were classified with high or unfavorable risk, being higher in the state insurance (83.7%).

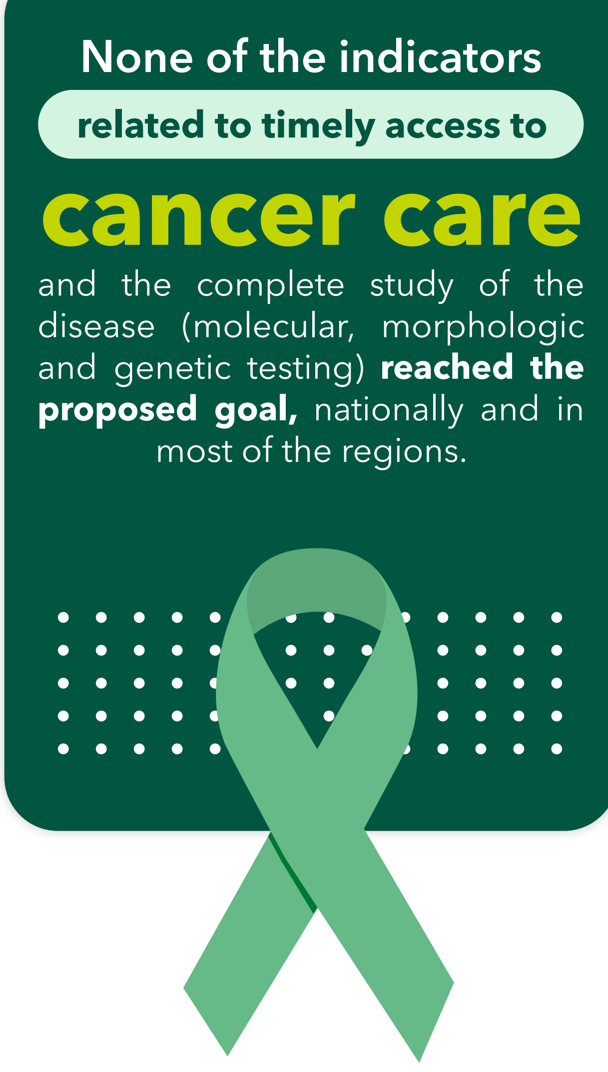
Systemic therapy was the most frequent treatment (79.9%), followed by radiotherapy and hematopoietic stem cell transplantation (2.2% each).

At the national level, the median waiting time to diagnosis was 8 days (IQR: 4 - 17) and to the first treatment was 5 days (IQR: 1 - 13).

Quality measures in ALL

At the national level, the goal for risk classification of new and prevalent cases was not reached, with similar results registered in all regions and insurance groups.

The indicator related to the quality of the bone marrow biopsy varied among regions with a high performance in the Amazonía-Orinoquía and an intermediate compliance in the Caribe and the Pacific regions.



12

Adult acute myeloid leukemia (AML)

Chapter 12

Adult acute mieloyd leukemia (AML)

Period analyzed: January 2nd, 2021 to January 1st, 2022.

Morbidity and mortality of AML

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

There were 249 new cases, 1,525 prevalent cases and 251 deaths during the period analyzed.

Age-standardized PNCR was

0.7 new cases

(95% CI: 0.6 - 0.8)

per 100,000 people aged ≥18 years.

Age-standardized prevalence was 4 cases (95% CI: 3.9 - 4.3) per 100,000 people aged ≥18 years.

Age-standardized general mortality was 0.6 deaths (95% CI 0.6 - 0.8) per 100,000 people aged ≥18 years.

PNCR and general mortality decreased by

5.6% and 8.1%

respectively compared to 2021.

The highest PNCR and prevalence were observed in Bogotá, D. C., as a region; the general mortality was higher in the Amazonía-Orinoquía. All morbidity and mortality estimations were higher in the third payer insurance.

Characterization of new cases of AML

56.2% were men.

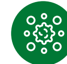
73.1% were under the third payer insurance and most cases (32.9%) lived in the Central region.

At the national level,
45.4%
had risk classification at diagnosis;
this proportion was higher in people under the state insurance (52.4%).

The shortest waiting times to diagnosis and treatment initiation was observed in people with low risk stratification.

Nationally, median waiting times to diagnosis was
7 days
(IQR: 3 - 20) and to the first treatment was 4 days **(IQR: 1 - 18).**

The median age was
61 years
(IQR: 43-72).


64.6% of new cases were classified at high or unfavorable risk, with a higher proportion presented in the state insurance (72.7%).

Systemic therapy was the most frequent treatment (74.3%), followed by hematopoietic stem cell transplantation (2.4%) and radiotherapy (0.8%).

Diagnosis was shortly provided in people under the exception insurance (median: 3 days); the shortest treatment initiation waiting time were registered in the third payer and the exception insurance (median: 3 days).

Quality measures in AML

The risk classification indicator did not reach the proposed goal in new or prevalent cases. This was observed in the country, all regions and most insurance groups.

The proportion of AML cases that accomplished the standards for the quality of bone marrow biopsy varied among regions, with a high performance in the Amazonía-Orinoquía, and an intermediate level in the Oriental and Pacific regions.

Other types of **cancer**

Chapter 13

Other types of cancer

Period analyzed: January 2nd, 2021 to January 1st, 2022.

General characterization of cases

There were

202,861

non-prioritized cancer cases,

20,385 were new cases and 13,218 died.

The highest number of

new cases were, in descending order,

skin tumors (non-melanoma), thyroid and endocrine gland tumors, and female genital organs neoplasms.

55.1% of the new cases were female.

65.9% of new cases were in the third payer insurance.

Median age of the new cases was

64 years

(IQR: 52-75).

Clinical characterization of new cases

Skin cancer (non-melanoma):

Histology report was notified in 91.9% of new cases. This proportion was higher in people under the exception and especial insurance.

Basal cell carcinoma was the most frequent (72.1%), with similar results observed among insurance groups.

Tumors of the thyroid and endocrine glands:

The subgroup with the highest representation was the thyroid gland tumor, including carcinoma *in situ* (83.9%).

In 42.8% of new cases, the clinical staging was notified; this proportion was higher in the people under the exception and the state insurance.

24.6% of new cases were classified in stages I. Similar results were obtained among insurance groups.

Tumors of other female genital organs:

72.8% of new cases were staged, being higher in people affiliated to the state and third payer insurance.

Among new cases with staging report, most were diagnosed at stage I, nationally (30.9%) and in all insurance groups.

44.1% and 44.6% of new cases were diagnosed with malignant ovarian and uterine body tumors, respectively.

Tumors of other digestive organs:

Malignant tumors of the pancreas were the most common subgroup

(35.9%), followed by **liver tumors**, including *in situ* cases (19.7%).

58.5% of cases had staging information reported; 32.6% were diagnosed at stage IV.

Tumors of the kidney and other urinary organs:

Malignant kidney and urinary bladder tumors were the most frequent subgroups

(54.3% and 41.9%, respectively).

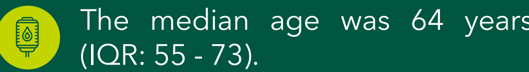
58.9% of new cases were staged; this proportion was higher in the third payer and the exception insurance.

21.0% of cases were classified as stage I.

Other hematologic malignancies:

The median age was 64 years (IQR: 55 - 73).

53.5% of new cases were male.



Multiple myeloma and other plasmacytic neoplasms

was the most frequent subgroup, accounting for 48.4% of new cases.

17.3% of the cases had a report of the risk classification.

Fondo Colombiano de
Enfermedades de Alto Costo

Follow us in our social networks

www.cuentadealtocosto.org