GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE

ESMO SUMMIT LATIN AMERICA 2019

Gynaecological Cancer in Latin America

Andréia Melo, MD, PhD
INCA, Grupo Oncoclínicas

CONFLICT OF INTEREST

Research Support: BMS, Roche, Novartis, MSD, Clovis, AstraZeneca, Amgen, Abbvie

Speaker Bureau: BMS, Roche, Novartis, MSD

Advisory board: Roche, MSD, Novartis

AGENDA

- Epidemiology

- Cervix Cancer Screening

- Treatment Access

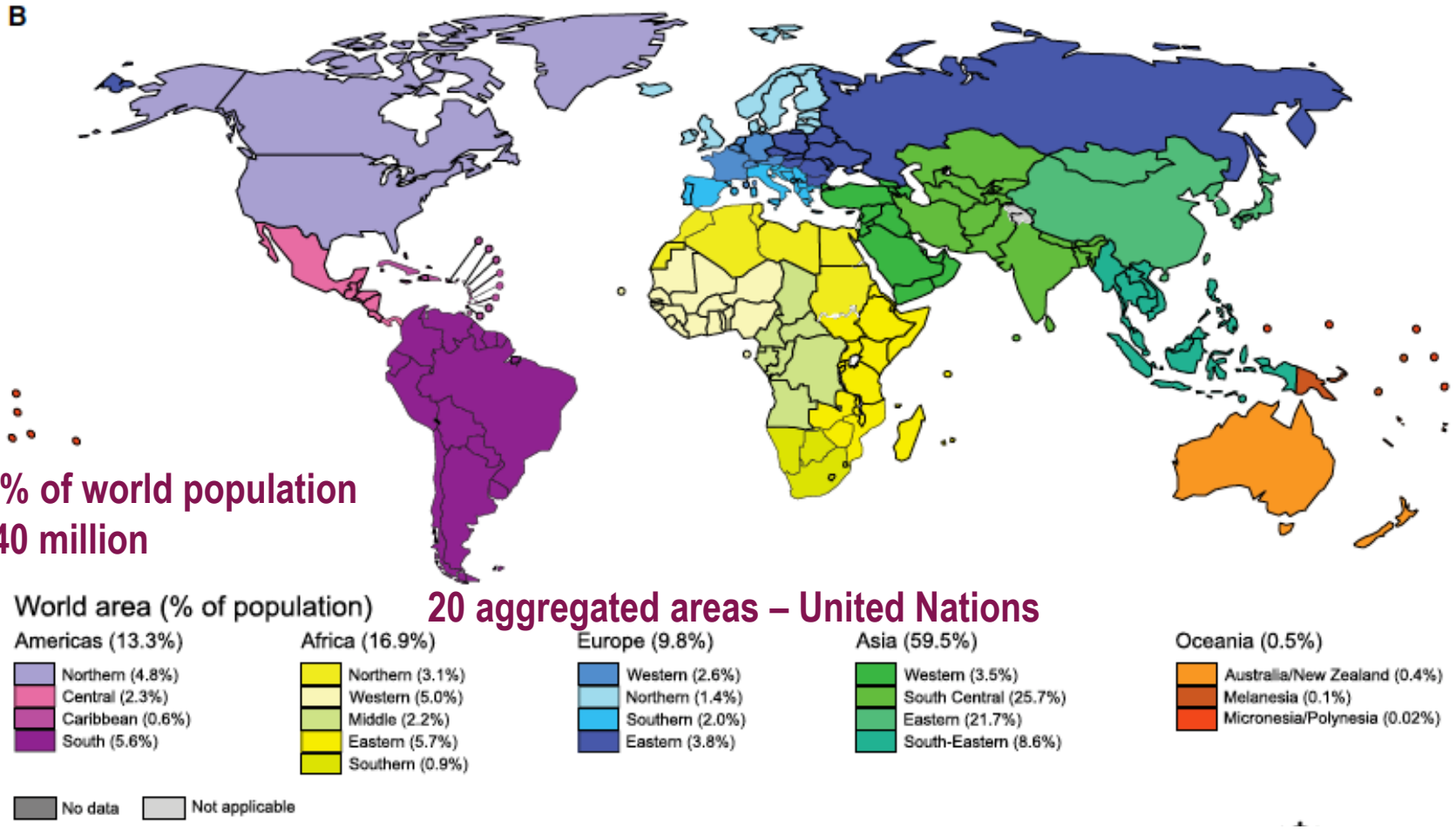
- HPV Vaccination

- Perspectives

Challenge #1

Gynecological cancer epidemiology in Latin America

POPULATION



8.5% of world population
~640 million

20 aggregated areas – United Nations

CA CANCER J CLIN 2018;68:394–424

World Health Organization

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LATIN AMERICA

- Demographic transition, ageing of populations

- Rapid industrialization and *westernization* of lifestyle

- A region marked by socioeconomic inequalities

CANCER REGISTRIES

IN LATIN AMERICA

- Necessary to enhance cancer registration
- Population-based cancer registries covering <10% of population
- Diversity of populations and risk factors between and within countries
- To better target populations at risk, with cancer control programs
- To evaluate public policies and cancer control activities

World Health Organization

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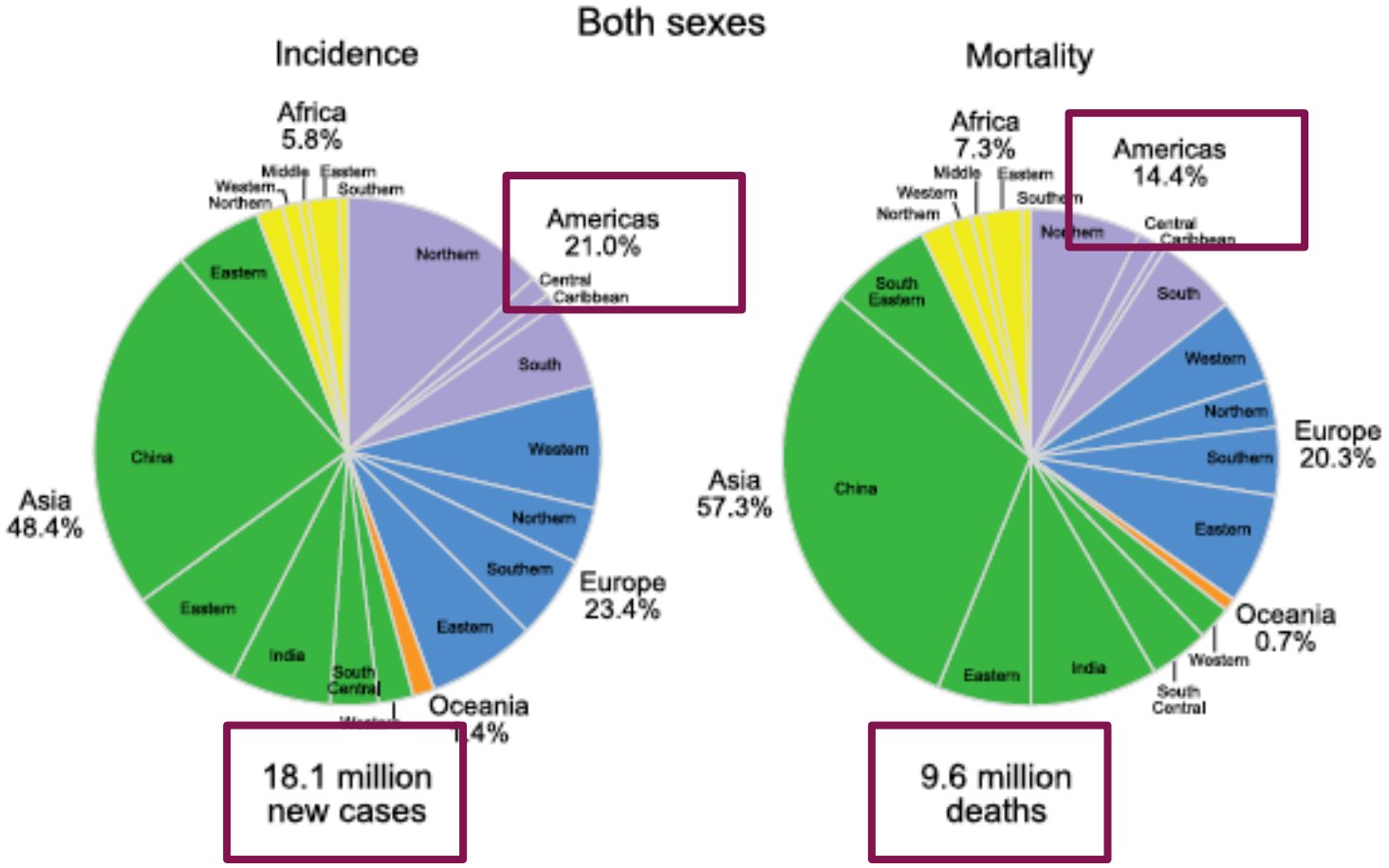
CANCER INCIDENCE

- Changes in life expectancy and age distribution of population structure
- Inequalities in economic development
- Socio-economic factors
- Demographic and epidemiological transition
- Changes in lifestyle and dietary patterns
- Infectious risk factors

CASES AND DEATHS IN 2018

BOTH SEXES

A

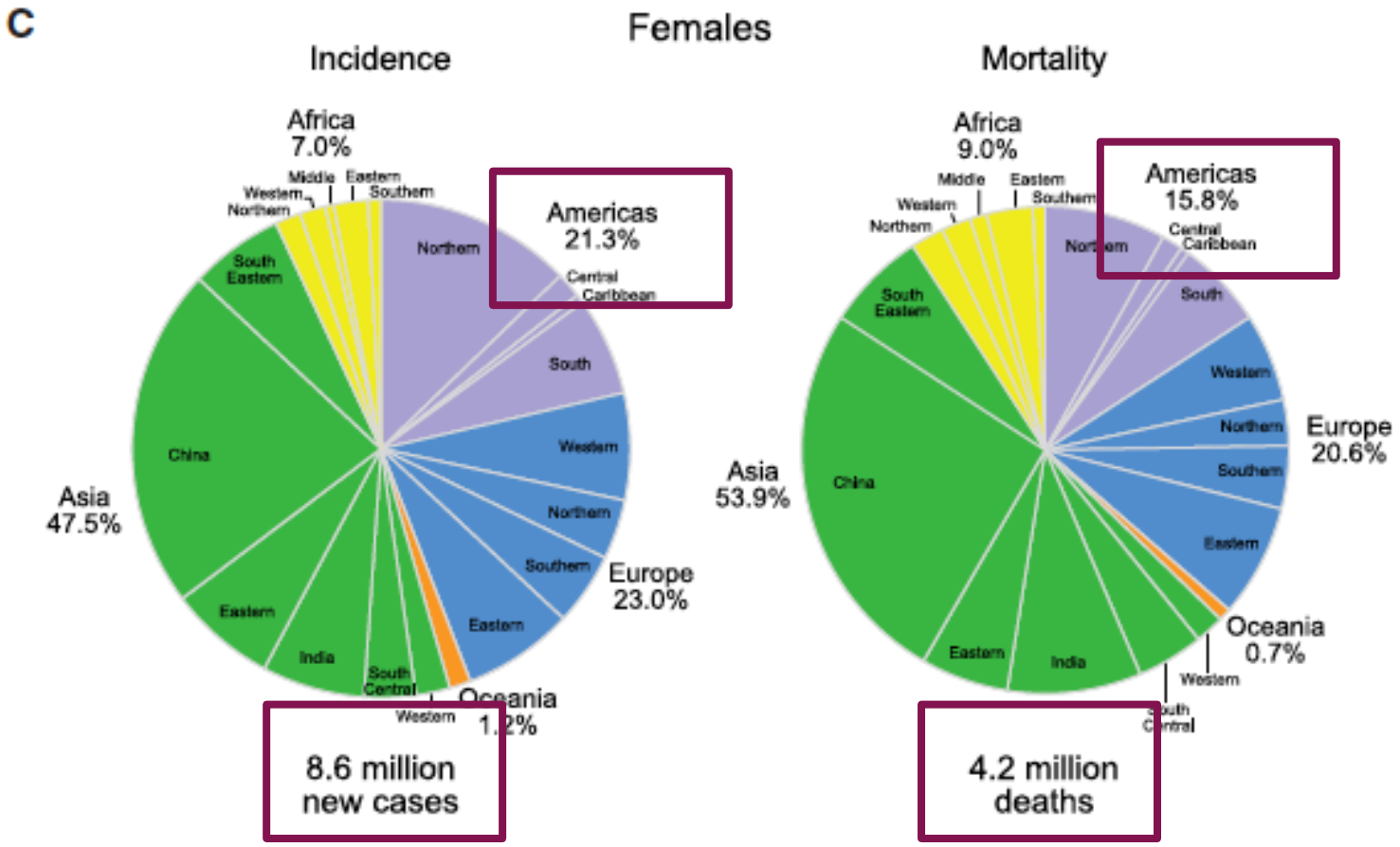


CA CANCER J CLIN 2018;68:394–424

17 M and 9.5 M excluding NMSC

CASES AND DEATHS IN 2018

FEMALES



CA CANCER J CLIN 2018;68:394–424

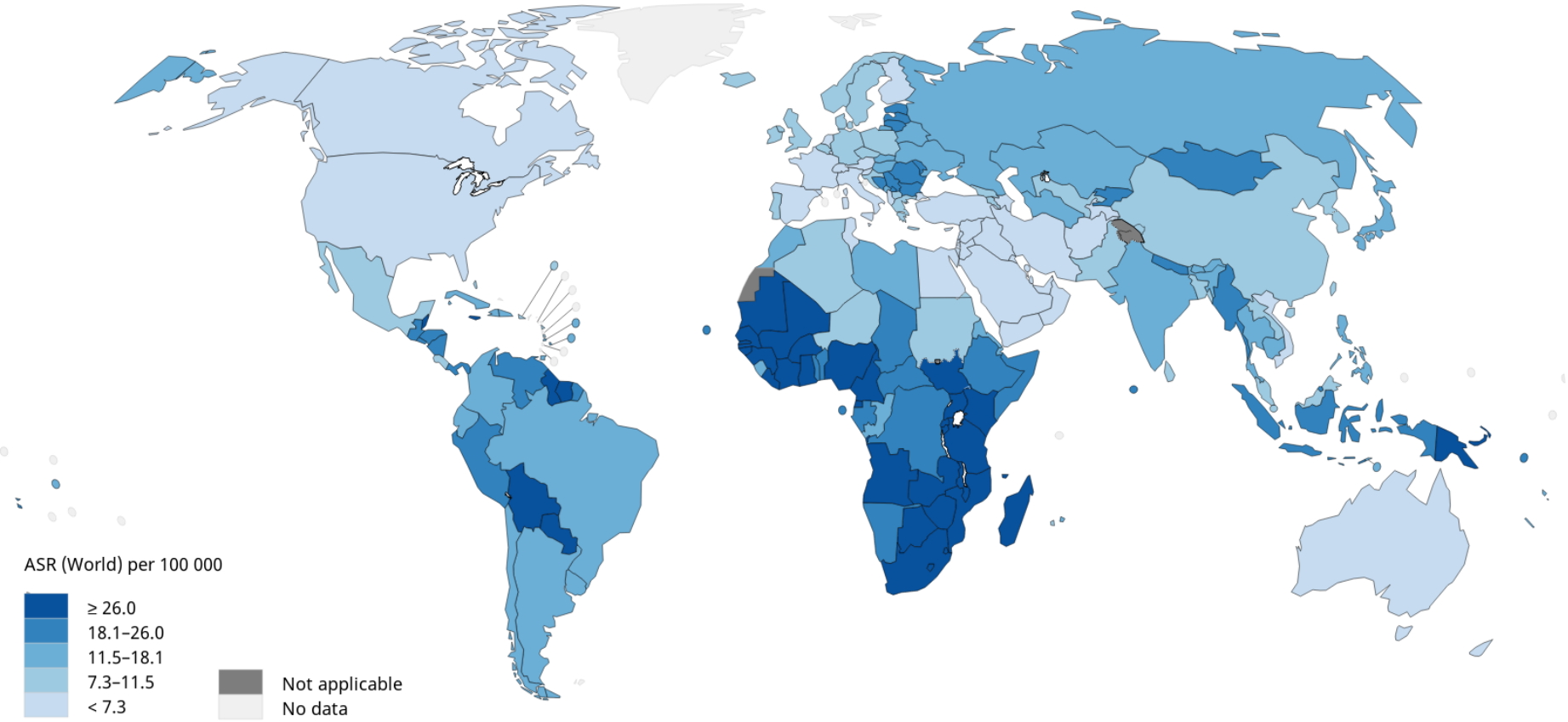
ESTIMATED NUMBER OF NEW CASES IN 2018

Latin America and the Caribbean

ICD	Cancer	Number
C00-97	All cancers	1412732
C53	Cervix uteri	56187
C54	Corpus uteri	29353
C56	Ovary	23285
C51	Vulva	3983
C52	Vagina	1925

http://gco.iarc.fr/

Estimated age-standardized incidence rates (World) in 2018, cervix uteri, all ages



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Data source: GLOBOCAN 2018
Graph production: IARC (http://gco.iarc.fr/today)
World Health Organization

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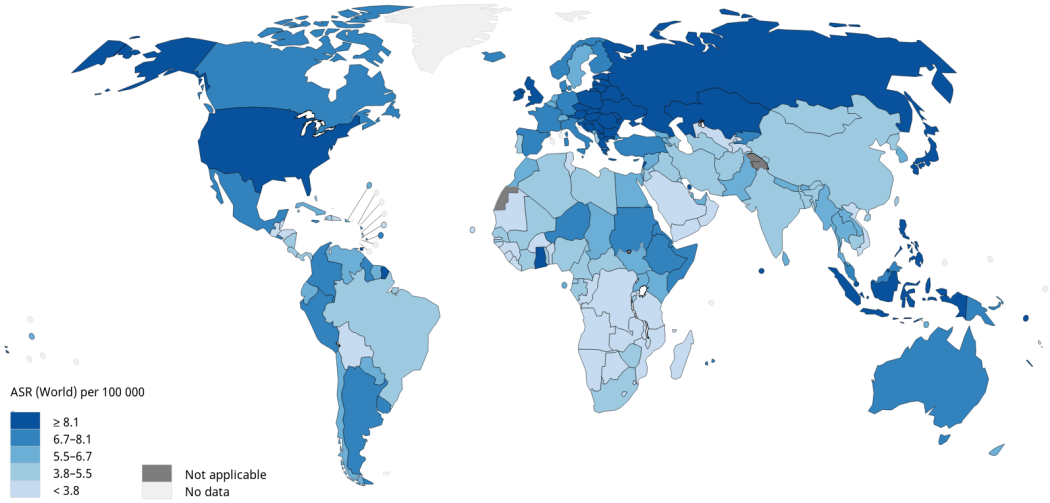
Estimated age-standardized incidence rates (World) in 2018, ovary, all ages



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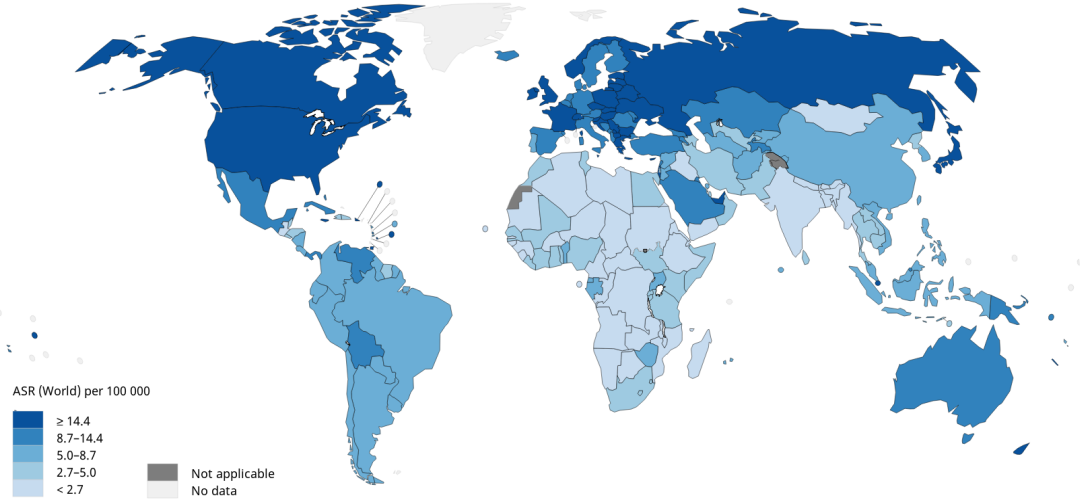
Estimated age-standardized incidence rates (World) in 2018, corpus uteri, all ages



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Data source: GLOBOCAN 2018
Graph production: IARC
(http://gco.iarc.fr/today)
World Health Organization

World Health Organization
© International Agency for Research on Cancer 2018

ESTIMATED NUMBER OF DEATHS IN 2018

Latin America and the Caribbean

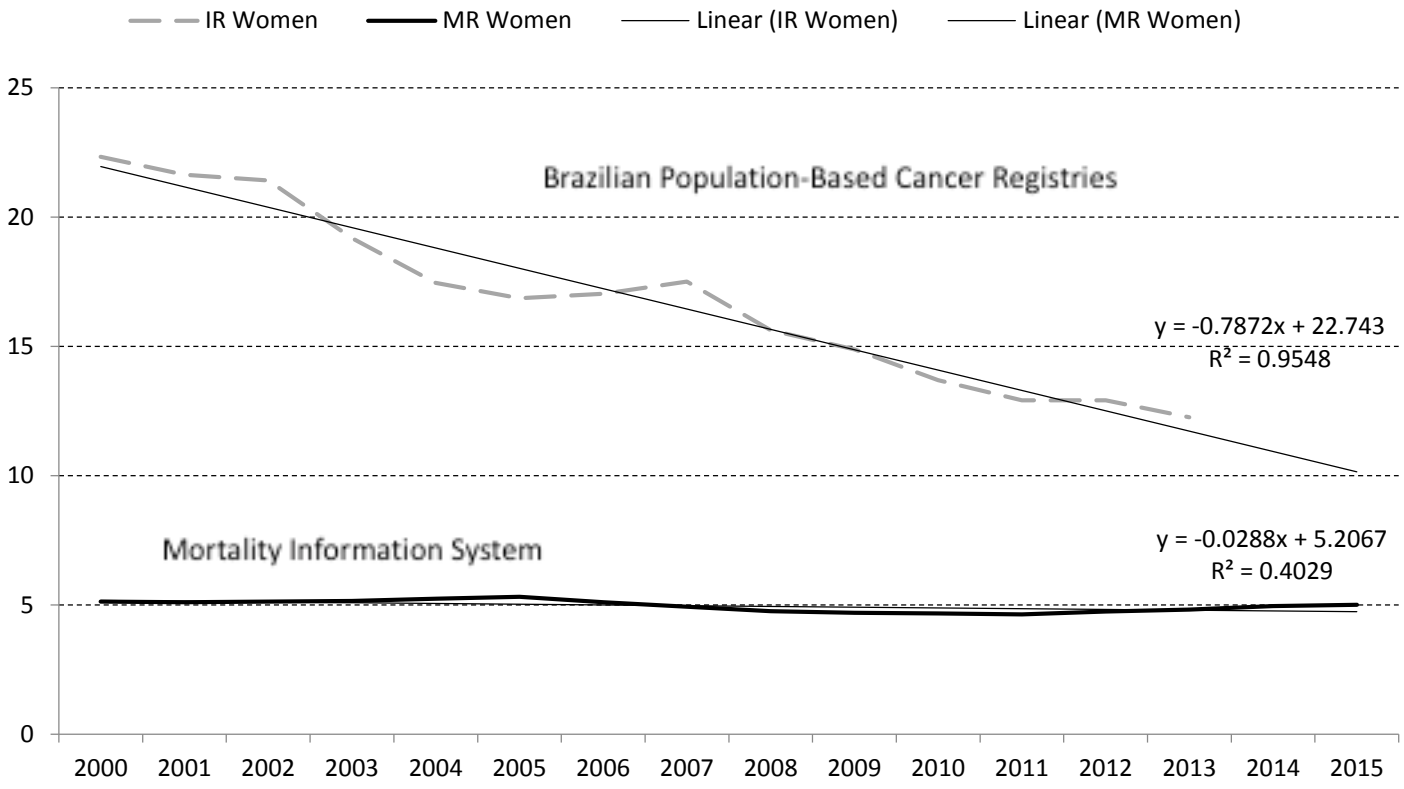
ICD	Cancer	Number
C00-97	All cancers	672758
C53	Cervix uteri	28318
C56	Ovary	13668
C54	Corpus uteri	7493
C51	Vulva	1265
C52	Vagina	582

http://gco.iarc.fr/

ESMO

ADJUSTED INCIDENCE AND MORTALITY RATE IN BRAZIL

CERVIX UTERI



Manuscript in preparation – unpublished data

Comparison of adenocarcinoma (ACA) and squamous cell carcinoma (SCC) of the uterine cervix in a sub-optimally screened cohort: A population-based epidemiologic study of 51,842 women in Brazil

Angélica Nogueira-Rodrigues [a,b,*], Carlos Gil Ferreira [b], Anke Bergmann [b,c], Suzana Sales de Aguiar [b], Luiz Claudio Santos Thuler [b,d]

- Retrospective cohort study was conducted using information from Brazilian hospital-based cancer registries
- 239 hospital units in 25 states of Brazil and the Federal District
- >70% locally advanced

Table 1
Patient and tumor characteristics (N = 51,842)*.

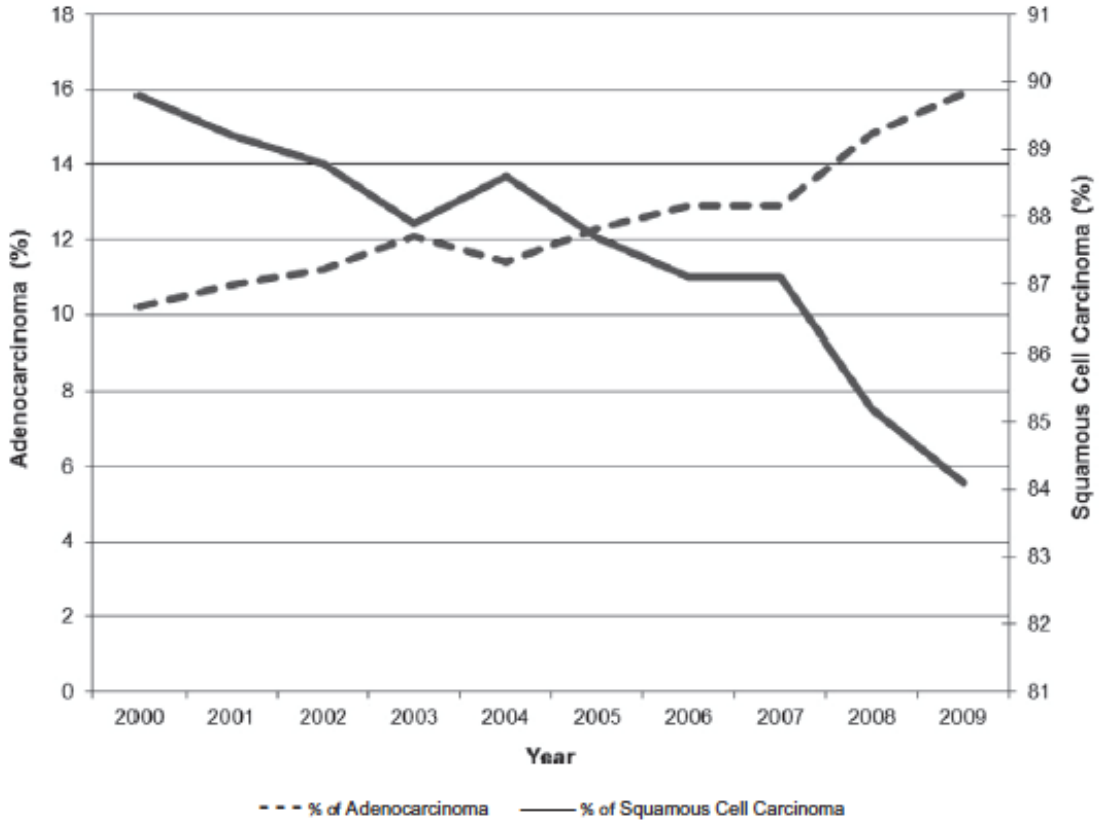
Characteristics	Adenocarcinoma (ACA) (N = 6302)	Squamous Cell Carcinoma (SCC) (N = 45540)	P-value
	N (%)	N (%)	
Age (years)			
15–24	61 (1.0)	725 (1.6)	<0.001
25–49	2966 (45.5)	21501 (47.2)	
50–64	2093 (33.2)	14419 (31.7)	
≥65	1282 (20.3)	8883 (19.5)	
Marital status			
Single	878 (22.1)	8747 (26.0)	<0.001
Married	2253 (56.6)	17482 (51.9)	
Widowed	607 (15.2)	5418 (16.1)	
Divorced	241 (6.1)	2011 (6.0)	
Ethnicity/skin color			
White	1928 (50.2)	12867 (41.5)	<0.001
Black/brown-skinned	1891 (49.2)	17940 (57.8)	
Yellow/indigenous	23 (0.6)	232 (0.7)	
Education level			
Illiterate	739 (16.4)	8244 (24.8)	<0.001
1 to 8 years	2986 (66.3)	21665 (65.1)	
>8 years	782 (17.4)	3361 (10.1)	
Alcohol habits			
Yes	218 (9.7)	2167 (12.9)	<0.001
No	2025 (90.3)	14665 (87.1)	
Smoking habits			
Yes	812 (31.0)	8674 (41.1)	<0.001
No	1806 (69.0)	12447 (58.9)	
Geographical area			
North	442 (7.0)	5794 (12.8)	<0.001
Northeast	1352 (21.5)	12864 (28.4)	
Middle-West	145 (2.3)	1537 (3.4)	
South	925 (14.7)	6729 (14.8)	
Southeast	3412 (54.4)	18428 (40.6)	
Year of diagnosis			
2000–2004	3392 (54.4)	26955 (59.7)	<0.001
2005–2009	2849 (45.6)	18219 (40.3)	
Stage of diagnosis (TNM)			
I	1629 (33.3)	6969 (21.3)	<0.001
II	1523 (31.2)	10746 (32.9)	
III	1381 (28.2)	12881 (39.5)	
IV	359 (7.3)	2048 (6.3)	

Gynecologic Oncology 135 (2014) 292–296

Comparison of adenocarcinoma (ACA) and squamous cell carcinoma (SCC) of the uterine cervix in a sub-optimally screened cohort: A population-based epidemiologic study of 51,842 women in Brazil

Angélica Nogueira-Rodrigues [a,b,*], Carlos Gil Ferreira [b], Anke Bergmann [b,c], Suzana Sales de Aguiar [b], Luiz Claudio Santos Thuler [b,d]

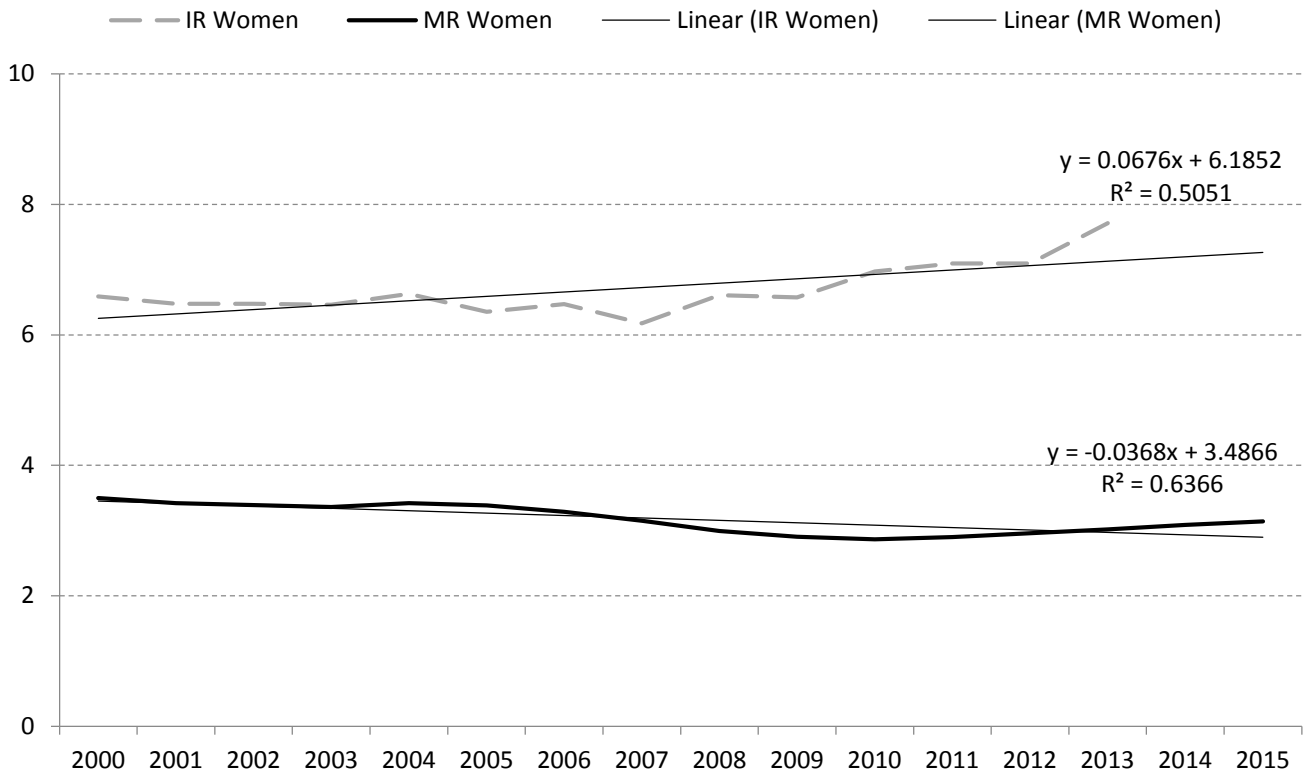
- An increase of 55.9% in adenocarcinoma was observed over 10 years



Gynecologic Oncology 135 (2014) 292–296

ADJUSTED INCIDENCE AND MORTALITY RATE IN BRAZIL

ENDOMETRIAL CANCER



Manuscript in preparation – unpublished data

Challenge # 2

Cervix cancer screening

Cervical Cancer Control in Latin America: A Call to Action

Brittany L. Bychkovsky, MD, MSc[1,2]; Mayra E. Ferreyra, MD[3]; Kathrin Strasser-Weippl, MD[4]; Christina I. Herold, MD[1,2]; Gilberto de Lima Lopes Jr, MD[5,6]; Don S. Dizon, MD[7]; Kathleen M. Schmeler, MD[8]; Marcela Del Carmen, MD[9]; Tom C. Randall, MD[10,11]; Angelica Nogueira-Rodrigues, MD, PhD[12]; Aknar Freire de Carvalho Calabrich, MD[13]; Jessica St. Louis, BA[14,15]; Caroline M. Vail, BS[14,15,16]; and Paul E. Goss, MD, PhD[2,14,15]

TABLE 1. Cervical Cancer Incidence, Mortality, Mortality to Incidence Ratio, and HPV Vaccination Status by Country in Latin America and the Caribbean[a]

				CC Screening		HPV Vaccination				
Country	Incidence per 100,000 Women	Mortality per 100,000 Women	Mortality to Incidence Ratio	Cytology Available in the Public/ Private Sector?	VIA Available in the Public/ Private Sector?	Presence of National Immunization Program (Year Initiated)	Sex/Age	Vaccine Type and Dosing Schedule	Estimated Coverage for First Dose (Year)[b]	Estimated Coverage for Completing the Series (Year)[b,c]
Argentina	20.8	8.3	0.40	Both	Both	Yes (2011)	Girls/11 y	Bivalent, 0-1-6 mo	80% (2011)	50% (2011)
Belize	32.7	14.9	0.46	Both	No	No				
Bolivia	47.7	21	0.44	Both	Private	No				
Brazil	16.3	7.3	0.45	Both	No	Yes (2014)	Girls/9-13 y	Bivalent, 0-6-60 mo	97% of girls aged 11-13 y (2014 overall)	53% received 2nd dose of girls aged 11-13 y (2014)*
Chile	12.8	6	0.47	Both	No	Yes (2014)	Girls/9-10 y	Quadrivalent, 0-12 mo	NA	NA
								Bivalent, 2-dose schedule		
Colombia	18.7	8	0.43	Both	Both	Yes (2012)	Girls/9-10 y	Quadrivalent, 0-2-6 mo	NA	NA
Costa Rica	11.4	4.4	0.39	Both	Both	No				
Cuba	17.1	6.7	0.39	Public	No	No				
Dominican Republic	30.7	12.3	0.40	Both	No	No				
Ecuador	29.0	14	0.48	Both	No	Yes (2014)	Girls/9-11 y	Bivalent, 2-dose schedule	NA	NA
El Salvador	24.8	11.9	0.48	Both	Both	No				
Guatemala	22.3	12.2	0.55	Private	Public	No				
Guyana	46.9	21.9	0.47	Public	Public	Yes (2012)	Girls/10-13 y	NA	NA	NA
Haiti	24.9	14.6	0.59	No	Public	No				
Honduras	29.4	14.1	0.48	Both	No	No				
Mexico	23.3	8	0.34	Both	NA	Yes (2008)	Girls/9-12 y	Both vaccines, 0-6-60 mo	98% (2010)	67% (2010)
Nicaragua	36.2	18.3	0.51	Both	Both	No				
Panama	18.7	7.1	0.38	Both	No	Yes (2008)	Girls/10 y	Bivalent, 0-1-6 mo	95% (2010)	67% (2010)
Paraguay	34.2	15.7	0.46	Both	No	Yes (2013)	Girls/10-11 y	NA	NA	NA
Peru	32.7	12	0.37	Both	No	Yes (2011)	Girls/10 y	Bivalent 0-1-6 mo	NA	NA
Suriname	38.0	15.7	0.41	Both	Both	Yes (2013)				
Trinidad and Tobago	24.5	12	0.49	Both	Both	Yes (2013)	Girls/11-12 y	NA	NA	NA
Uruguay	18.9	7.1	0.38	Both	Private	Yes (2013)	Girls/12 y	NA	NA	NA
Venezuela	32.8	12.3	0.38	Both	Both	No				
United States	6.6	2.7	0.41	Both	No	Yes (2006)	Girls and boys/11-12 y Girls and women/13-26 y if did not receive it previously. Boys and men/ 13-21 y if did not receive it previously	Both vaccines, 3-dose schedule	57.3% for girls aged 13-17 y (2013). 34.6% for boys aged 13-17 y (2013)	37.6% for girls aged 13-17 y (2013). 13.9% for boys aged 13-17 y (2013)
Canada	6.3	1.7	0.27	Both	No	Yes (2008)	Girls and women/9-26 y Boys and men/9-26 y	Both vaccines for girls and women, 3-dose schedule. Quadrivalent vaccine for boys and men, 3-dose schedule	NA	85% for girls in grade 6 (2013).[d] 79% for boys in grade 6 (2013)[d]

Cancer February 15, 2016

Cervical Cancer Control in Latin America: A Call to Action

Brittany L. Bychkovsky, MD, MSc[1,2]; Mayra E. Ferreyra, MD[3]; Kathrin Strasser-Weippl, MD[4]; Christina I. Herold, MD[1,2]; Gilberto de Lima Lopes Jr, MD[5,6]; Don S. Dizon, MD[7]; Kathleen M. Schmeler, MD[8]; Marcela Del Carmen, MD[9]; Tom C. Randall, MD[10,11]; Angelica Nogueira-Rodrigues, MD, PhD[12]; Aknar Freire de Carvalho Calabrich, MD[13]; Jessica St. Louis, BA[14,15]; Caroline M. Vail, BS[14,15,16]; and Paul E. Goss, MD, PhD[2,14,15]

- Data from health surveys in LA have demonstrated that <55% of eligible women received a recent Pap test
  - Especially for urban poor and rural population

- Poor infrastructure and staff
  - Poor-quality tests, suboptimal due to issues with sampling, preparation or interpretation
  - In Brazil: 10% of all samples were not interpretable

Cancer February 15, 2016

Challenge # 3

Treatment access

Published on: 21 August 2018

Brazilian health system: the turnaround goes beyond resilience

Andreia C de Melo, Medical Oncologist Oncoclinicas Institute for Research and Education - Brazil

Other Contributors:

Eduardo Paulino, Medical Oncologist

Pedro H Souza, Medical Oncologist

Carlos G Ferreira, Medical Oncologist

Massuda and colleagues have recently published at BMJ Global Health a paper entitled "The Brazilian health system at crossroads: progress, crisis and resilience" describing the Brazilian health system and its challenges in health system financing, coverage, resource allocation and the impact over the regional disparities in access to healthcare services and health outcomes.

Brazil is a large country with an estimated population of approximately 209 million inhabitants. The Universal Health Coverage provided by Brazilian Unified Health System (SUS) is a constitutional right of every citizen. According to the National Supplementary Health Agency (ANS) in May 2018 only 22.7% of Brazilians had private insurance plans, with a 12% decrease in relative numbers during the last 30 months due to the local political and economic crisis [1].

Every two years the Brazilian National Cancer Institute generates data on cancer. According to the last publication 600,000 new cases are expected for 2018 [2]. Currently cancer is the second most common cause of death in Brazil [2].

Since the middle of the last century, the scientific understanding of cancer began to rise. This enabled the development of novel therapeutic interventions, such as new surgical techniques, modern radiotherapy, cytotoxic agents and more recently, targeted therapy and immunotherapy, giving place to a growing number of oncological interventions to combat cancer, improving quality of life, overall survi...

https://gh.bmj.com/content/3/4/e000829.responses

Gynecologic cancer in Brazil and the law of sixty days

Eduardo Paulino,[1] Andréia Cristina de Melo,[1] Angélica Nogueira-Rodrigues,[2] Luiz Claudio Santos Thuler[1]

JOURNAL OF GYNECOLOGIC ONCOLOGY

In 2012 the Federal Government decreed the "Law of 60 days"
This law came into effect in 2013

Table 1. Time between diagnosis and first treatment comparing years 2009/2012 to 2013/2016

Time between diagnosis and first treatment (day)*	Years		Total†
	2009/2012	2013/2016	2009/2016
≤30	15,605 (35.8)	6,712 (34.9)	22,317 (35.5)
31–60	10,366 (23.8)	4,852 (25.3)	15,218 (24.2)
61–90	5,905 (13.5)	3,030 (15.8)	8,935 (14.2)
>90	11,738 (26.9)	4,618 (24.0)	16,356 (26.0)
Total	43,614 (100.0)	19,212 (100.0)	62,826 (100.0)

Values are presented as number (%).
*First treatment can be surgery, chemotherapy, or radiotherapy; †Data updated on August 7, 2017.

J Gynecol Oncol. 2018 May;29(3):e44

ESMO

Gynecologic cancer in Brazil and the law of sixty days

Eduardo Paulino,[1] Andréia Cristina de Melo,[1] Angélica Nogueira-Rodrigues,[2] Luiz Claudio Santos Thuler[1]

JOURNAL OF GYNECOLOGIC ONCOLOGY

- Delays in scheduling medical appointments and exams results
- Shortage in chemotherapy
- Shortage of radiotherapy
- Lack of equipped hospitals

J Gynecol Oncol. 2018 May;29(3):e44

Barriers to Primary Debulking Surgery for Advanced Ovarian Cancer in Latin America

Eduardo Paulino, MD,†‡ Angelica Nogueira Rodrigues, MD, PhD,‡§ Kathrin Strasser-Weippl, MD,‡|| Jessica St. Louis, BA,‡¶ Alexandra Bukowski, BA,‡¶ and Paul E. Goss, MD, PhD‡¶#*

- In Latin America physicians may overuse NACT for AOC

- Lack of expertise and infrastructure

Int J Gynecol Cancer 2017;27:1645

Endometrial Cancer in Brazil: Preparing for the Rising Incidence

Câncer de endométrio no Brasil: preparando-se para o aumento da incidência

Eduardo Paulino[1,2,3] Angélica Nogueira-Rodrigues[1,4] Paul E. Goss[1] Lilian Faroni[2,3]
Gustavo Guitmann[2] Kathrin Strasser-Weippl[5] Alexandra Bukowski[1]

- Overweight and obesity
  - IBGE in the past 5 decades the % of women >20 years old who are overweight or obese increased from 29 to 48% and 8 to 17%
  - 38.2% of Brazilian women will be obese by 2022
- Older age
  - Life expectancy increased from 73.9 in 2000 to 78.8 in 2014

Rev Bras Ginecol Obstet 2018;40:577–579

Endometrial Cancer in Brazil: Preparing for the Rising Incidence

Câncer de endométrio no Brasil: preparando-se para o aumento da incidência

Eduardo Paulino[1,2,3] Angélica Nogueira-Rodrigues[1,4] Paul E. Goss[1] Lilian Faroni[2,3]
Gustavo Guitmann[2] Kathrin Strasser-Weippl[5] Alexandra Bukowski[1]

- Training of gyneco-oncologists

- Preventive strategies

- Number or radiotherapy machines/sites

Rev Bras Ginecol Obstet 2018;40:577–579

A systematic review of radiotherapy capacity in low- and middle-income countries

Surbhi Grover[1], Melody J. Xu[1], Alyssa Yeager[1], Lori Rosman[2], Reinou S. Groen[3], Smita Chackungal[4], Danielle Rodin[5], Margaret Mangaali[1], Sommer Nurkic[2], Annemarie Fernandes[1], Lilie L. Lin[1], Gillian Thomas[5] and Ana I. Tergas[6]*

- Number of radiation machines in Latin America has increased over the past 30 years, especially in countries with greater population
- From 1989 to 2004 – Brazil 165 to 270 (64% increase), Venezuela 18 to 44 (144% increase)
- The distribution varies widely from country to country
- The capacity remains insufficient, older machines

Frontiers in Oncology, Volume 4, Article 380, 2015

ESMO

A systematic review of radiotherapy capacity in low- and middle-income countries

Surbhi Grover[1], Melody J. Xu[1], Alyssa Yeager[1], Lori Rosman[2], Reinou S. Groen[3], Smita Chackungal[4], Danielle Rodin[5], Margaret Mangaali[1], Sommer Nurkic[2], Annemarie Fernandes[1], Lilie L. Lin[1], Gillian Thomas[5] and Ana I. Tergas[6]*

- Insufficient number of full-time radiation oncologists and radiation technologists

- At the time of publication only Bolivia and Venezuela had > 1 radiation oncologist per 1000 cancer cases

- Formal training programs for radiation oncology are rising

Frontiers in Oncology, Volume 4, Article 380, 2015

ESMO

Challenge # 4

HPV vaccination

Efficacy, immunogenicity, and safety of a 9-valent human papillomavirus vaccine in Latin American girls, boys, and young women☆

Ángela María Ruiz-Sternberg[a,*], Edson D. Moreira Jr[b], Jaime A. Restrepo[c], Eduardo Lazcano-Ponce[d], Robinson Cabello[e], Arnaldo Silva[f], Rosires Andrade[g], Francisco Revollo[h], Santos Uscanga[i], Alejandro Victoria[j], Ana María Guevara[k], Joaquín Luna[l], Manuel Plata[m], Claudia Nossa Dominguez[n], Edison Fedrizzi[o], Eugenio Suarez[p], Julio C. Reina[q], Misoo C. Ellison[r], Erin Moeller[r], Michael Ritter[r], Christine Shields[r], Miguel Cashat[r], Gonzalo Perez[r], Alain Luxembourg[r]

Background: A 9-valent human papillomavirus (HPV6/11/16/18/31/33/45/52/58; 9vHPV) vaccine was developed to expand coverage of the previously developed quadrivalent (HPV6/11/16/18; qHPV) vaccine.

Methods: Efficacy, immunogenicity, and safety outcomes were assessed in Latin American participants enrolled in 2 international studies of the 9vHPV vaccine, including a randomized, double-blinded, controlled with qHPV vaccine, efficacy, immunogenicity, and safety study in young women aged 16–26 years, and an immunogenicity and safety study in girls and boys aged 9–15 years. Participants (N = 5312) received vaccination at Day 1, Month 2, and Month 6. Gynecological swabs were collected regularly in young women for cytological and HPV DNA testing. Serum was analyzed for HPV antibodies in all participants. Adverse events (AEs) were also monitored in all participants.

Results: The 9vHPV vaccine prevented HPV 31-, 33-, 45-, 52-, and 58-related high-grade cervical, vulvar, and vaginal dysplasia with 92.3% efficacy (95% confidence interval 54.4, 99.6). Anti-HPV6, 11, 16, and 18 geometric mean titers at Month 7 were similar in the 9vHPV and qHPV vaccination groups. Anti-HPV antibody responses following vaccination were higher among girls and boys than in young women. Most (> 99%) 9vHPV vaccine recipients seroconverted for all 9 HPV types at Month 7. Antibody responses to the 9 HPV types persisted over 5 years. The most common AEs were injection-site related, mostly of mild to moderate intensity.

Conclusions: The 9vHPV vaccine is efficacious, immunogenic, and well tolerated in Latin American young women, girls, and boys. These data support 9vHPV vaccination programs in Latin America, a region with substantial cervical cancer burden.

An Alert to Latin America: Current Human Papillomavirus Vaccination Trends Highlight Key Barriers to Successful Implementation

Angelica Nogueira-Rodrigues, MD, PhD[1,2,3,4]; Alexandra Bukowski, BA[1,2]; Eduardo Paulino, MD[1,2,4,5,6]; Jessica St. Louis, BA[1,2]; Adriana Barrichello, MD[1]; Cinthya Sternberg, PhD[7,8]; Markus A. C. Gifoni, MD[7]; Silvana Luciani, MHSc[9]; and Paul E. Goss, MD, PhD[1,2,10]

- Panama and Mexico were the first countries in Latin America to include HPV vaccination in their immunization programs (2008/2009)

- In Brazil the vaccine was introduced in 2014

- PAHO stated that immunization is available to >80% girls the Americas

Cancer June 15, 2017

An Alert to Latin America: Current Human Papillomavirus Vaccination Trends Highlight Key Barriers to Successful Implementation

Angelica Nogueira-Rodrigues, MD, PhD[1,2,3,4]; Alexandra Bukowski, BA[1,2]; Eduardo Paulino, MD[1,2,4,5,6]; Jessica St. Louis, BA[1,2]; Adriana Barrichello, MD[1]; Cinthya Sternberg, PhD[7,8]; Markus A. C. Gifoni, MD[7]; Silvana Luciani, MHSc[9]; and Paul E. Goss, MD, PhD[1,2,10]

Latin American countries with national recommendations for HPV vaccine

Figure 1. Latin American countries with national recommendations for the human papillomavirus vaccine. The countries not shown are Saba and St. Maarten.

Cancer June 15, 2017

An Alert to Latin America: Current Human Papillomavirus Vaccination Trends Highlight Key Barriers to Successful Implementation

Angelica Nogueira-Rodrigues, MD, PhD[1,2,3,4]; Alexandra Bukowski, BA[1,2]; Eduardo Paulino, MD[1,2,4,5,6]; Jessica St. Louis, BA[1,2]; Adriana Barrichello, MD[1]; Cinthya Sternberg, PhD[7,8]; Markus A. C. Gifoni, MD[7]; Silvana Luciani, MHSc[9]; and Paul E. Goss, MD, PhD[1,2,10]

- Reduction in vaccine uptake
  - Brazil: >=1 dose decreased from 92% of target population in 2014 to 69.5% in 2015
  - Similar trend in others Latin America countries

Cancer June 15, 2017

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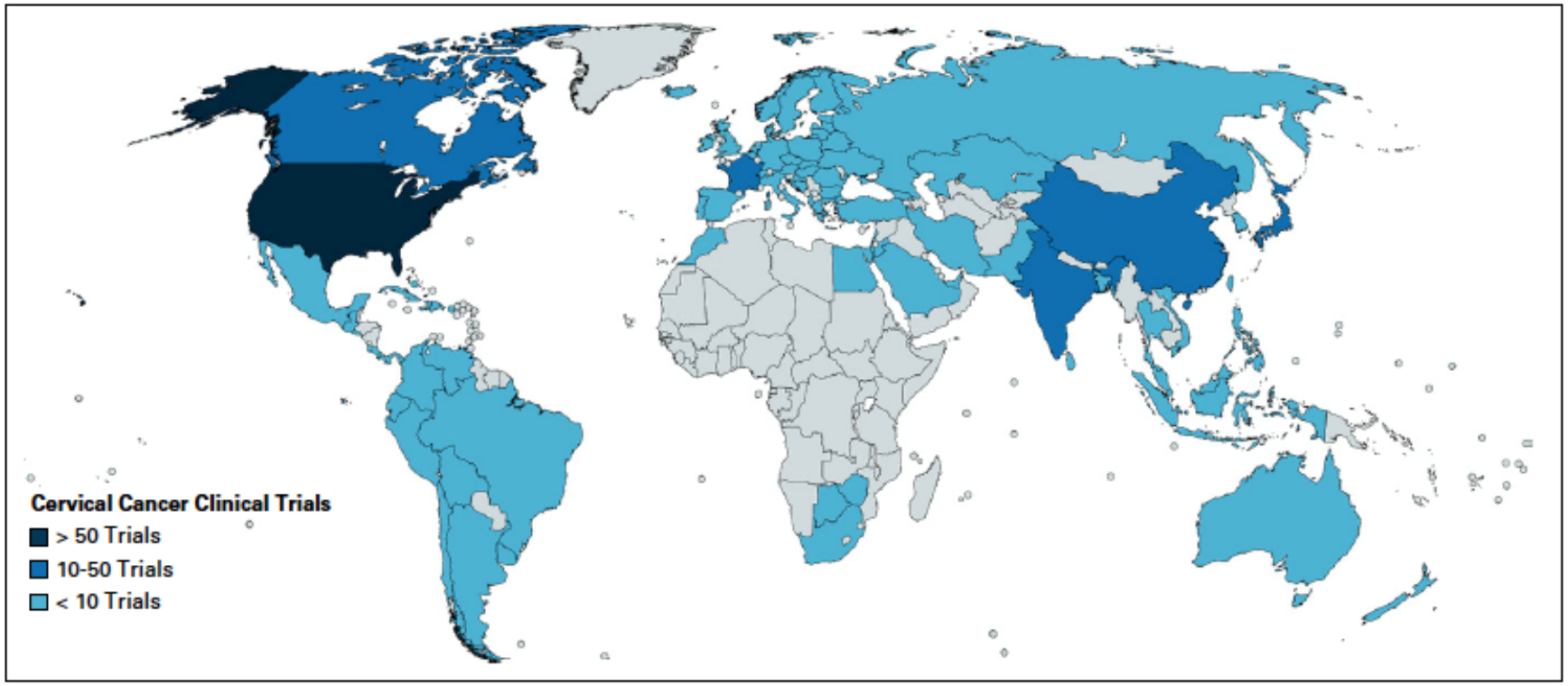
Perspectives

Disparities in Breast, Lung, and Cervical Cancer Trials Worldwide

Geographic distribution of clinical trials for cervical cancer ClinicalTrials.gov or the WHO International Clinical Trial Registry Platform between 2010 and 2017



jgo.org on April 11, 2018.

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AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Clinical Cancer Advances

Nine Research Priorities to Accelerate Progress Against Cancer

6 Increase Equitable Access to Cancer Clinical Trials

Certain patient populations are consistently under-represented in cancer clinical trials. These include patients from racial and ethnic minorities, rural areas, lower socioeconomic groups, and people older than 65 years as well as adolescents and young adults age 15–39 years. Decreased representation among these groups can limit access to the promising treatments offered through these trials and means that research findings may not fully account for the diversity of biological, social, and cultural factors that influence outcomes. Additional research is needed to ensure that every patient with cancer, regardless of race, ethnicity, age, geographic location, or socioeconomic status, benefits from research advances.

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TAKE HOME MESSAGES

- Geographic coverage by population-based cancer registries in Latin America remains low
- Cervical cancer incidence rates observed in Latin America are among the highest in the World
- Improve quality of cervical cancer screening and also the treatment access to gynecological cancer
- Improve the number of clinical trials in the field

Thank you!

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