How I Treat When I Don't Have the Resources

The OncoAlert Network:	"Dear Colleagues, A warm welcome to todays colloquium"
The OncoAlert Network:	We are wrapping up today with How I treat cancer series
The OncoAlert Network:	Please feel free to interact with our presenters
The OncoAlert Network:	"There is no certain Q&A time set, rather the questions will be during the presentation"
The OncoAlert Network:	Presenters will be available
The OncoAlert Network:	We start in 5 minutes
Rogelio Velasco Jr.:	Good evening from the Philippines. Great to see you all.
The OncoAlert Network:	A warm welcome to Dr. Velasco and our colleagues from the Philippines
The OncoAlert Network:	magandang gabi po
Gil Morgan:	"Hello Roger, hello Colleagues A warm hello!"
Rogelio Velasco Jr.:	"Thank you, Gil! Thank you for the opportunity. :)"
JOSÉ FERNANDO:	MORMING FOR EVERYONE
JOSÉ FERNANDO:	good morning
Gil Morgan:	We are honoured to have you here Roger!
Gil Morgan:	"Same to Jose Fernando, Good morning to Brazil!!"
Natalia Gandur Presenter:	Morning for Everyone!
Gil Morgan:	And ofcourse Natalia!!
Gil Morgan:	Such great start
The OncoAlert Network:	Just so you know that if you have a problem seeing the video (it has already started) Just refresh your screen
The OncoAlert Network:	Bom dia Brazil!
The OncoAlert Network:	Buenos Dias Argentina!
The OncoAlert Network:	We will start off today with Dr. Velasco
The OncoAlert Network:	"Dr. Velasco if you have any comments throughout, please feel free to make them in the chat"

Rogelio Velasco Jr.: Please feel free to key in your questions in the chatbox. Will be more than happy answer them.

Gil Morgan: Roger what is the top 3 reasons for lung cancer in the Philippines

Noha Rashad: "Hi everyone, happy to join"

The OncoAlert Network: "Hello Dr. Rashad, a warm welcome!"

JOSÉ FERNANDO: any data about hereditary lung cancer?

Rogelio Velasco Jr.: "Hi Gil, thank you for this question. Smoking is still the number one cause, followed by secondhand smoking exppusre, and occupational exposure. In the Philippines around 50% of patients with lung adenoCa harbor EGFR mutations, highlighting its genetic causality."

The OncoAlert Network: The POLLS ARE OPEN

Rogelio Velasco Jr.: "Jose, we still have no local data on the familial lung cancers. This, however, is a good topic to explore in the future."

The OncoAlert Network: you can vote on the right hand of you chat

JOSÉ FERNANDO: "great Velasco, maybe LMICs collaborations to investigate this data"

JOSÉ FERNANDO: any screening program in Philippines?

Rogelio Velasco Jr.: "Indeed. We have a screening program in our instutition. There is no national screening program using low-dose CT Scan. Unfortuantely, there is not national program. The majority is still opportunistic."

Rogelio Velasco Jr.: Yes Jose we can collaborate on some studies in the future!

Natalia Gandur Presenter: What was the magnitude of the benefit in terms of event-free survival (EFS) and overall survival (OS) with pembrolizumab compared to placebo in the KEYNOTE-671 study in operable NSCLC patients?

JOSÉ FERNANDO: "same here, my institution. have incidental noodle program associated to screening program"

Rogelio Velasco Jr.: Hi Natalia! Great question. For OS the hazard ratio 0.72 [95% CI 0.56–0.93] while for EFS the hazard ratio 0.59 [95% CI 0.48–0.72]) in KEYNOTE 671.

Natalia Gandur Presenter: Thank you Rogelio!

Natalia Gandur Presenter: "What are the challenges in accessing next-generation sequencing (NGS) for metastatic NSCLC patients with actionable mutations in the Philippines, and how do clinicians overcome these limitations?"

Rogelio Velasco Jr.: "Thanks for this question Natalia. It is mostly cost. Foundation one or guardant is out of pocket. We have some NGS panels sent to India or

	Taiwan (limited panels) but are much less expensive. Another strategy we employ is to test the for EGFR, ALK, ROS and PDL1 (since these are widely available)."
JOSÉ FERNANDO:	"Gil, congrats for the important polls"
Rogelio Velasco Jr.:	Thanks for your great questions!
Natalia Gandur Presenter:	Thank you Rogelio!
The OncoAlert Network:	Thank you Dr. Moura!
JOSÉ FERNANDO:	"here, in Brazil, pharmas program make the NGS test for free, but public patients hasnt access"
JOSÉ FERNANDO:	to therapies
Rogelio Velasco Jr.:	Thats great! We face major barriers in testing and treatment as well.
Natalia Gandur Presenter:	"Does the study suggest that lower doses of pembrolizumab could be a viable alternative in resource-limited settings, despite the lack of difference in OS or PFS? What other factors should be considered when evaluating dose reductions in immunotherapy?"
Rogelio Velasco Jr.:	"I think it still has to be proven in a prospective study. But some colleagues in the Phils, HK and India use the lower dose due to financial constraints. Thanks, Natalia!"
The OncoAlert Network:	We would like to add that Dr. Velasco is the recipient to an OncoAlert Catalyst award for his project in Lung Cancer in the Philippines
Gil Morgan:	Roger how much of a factor is environment and not just smoking in the Philippines in regards to Lung Cancer?
Gil Morgan:	air Pollution and such
Natalia Gandur Presenter:	"Given the challenges outlined in treating lung cancer in the Philippines—such as high out-of-pocket costs, lack of reimbursement for NGS, and limited clinical trial access—what strategies can be implemented to improve early detection and treatment accessibility for patients in resource-limited settings?"
The OncoAlert Network:	"A Great Presentation by Dr. Velasco, thank you!"
The OncoAlert Network:	A warm welcome to Dr. Jose Fernando Moura
Rogelio Velasco Jr.:	"Hi Gil, I agree. Ambient pollution can actually promote carcinogenesis in cells with EGFR and KRAS gene mutations. This was also presented in ESMO, a sample compound is PM2.5."

Rogelio Velasco Jr.: "Hi Natalia, hopefully we can turn ramp up our instituional screening program to a naitonal scale and have our insurance company reimburse the screening cost."

The OncoAlert Network: do you see a higher rate of EGFR or KRAS m lung cancer coming from regions with higher air pollution

Gil Morgan: "Jose Fernando, how is the screening for breast cancer in brazil"

Gil Morgan: do you feel its effective enough to detect the majority or is something missing

JOSÉ FERNANDO: institute of cancer recommends > 50 yo mammogram

Gil Morgan: "I know Brazil is a huge country, so it cant be the same uptake everywhere"

JOSÉ FERNANDO: medical society > 40

Gil Morgan: big discrepancy

JOSÉ FERNANDO: really big

Gil Morgan: what does the majority of the population do

Rogelio Velasco Jr.: "Hi Gil, though EGFR mutation rate in lung cancers from an air pollution region is higher than in affected individuals from less-polluted regions, this requires further validation."

JOSÉ FERNANDO: larger tumors

Gil Morgan: Thank you Rogelio

Rogelio Velasco Jr.: Is there access to neoadjuvant immuno for TNBC in Brazil?

JOSÉ FERNANDO: time to access diagnosis and access team is other program

JOSÉ FERNANDO: only private care has access to iO

Rogelio Velasco Jr.: Are there barriers in NGS testing in stage IV breast?

JOSÉ FERNANDO: "same Pharma has a program, but public patients hasn't access to therapies"

JOSÉ FERNANDO: "like capivasertib, olaparib"

JOSÉ FERNANDO: etc

The OncoAlert Network: and what is the percentage of people that have private insurance in Brazil as oppose to going though the national system

Natalia Gandur Presenter: "How does the disparity between public and private healthcare access in Brazil impact breast cancer outcomes, and what measures could be

	taken to bridge the gap in services such as genetic testing, SBRT, and reconstructive surgery?"
Rogelio Velasco Jr.:	Are these early phase trials available?
JOSÉ FERNANDO:	Great question Natalia.
JOSÉ FERNANDO:	really the gaps are larger and survival is affected in this context
JOSÉ FERNANDO:	amazona study show a poor survival in public healthcare
The OncoAlert Network:	A Great Presentation Dr. Moura! Thank you very much!
JOSÉ FERNANDO:	sorry for the English kkk
Natalia Gandur Presenter:	Thank you José!!
JOSÉ FERNANDO:	lol 😂
The OncoAlert Network:	We now welcome Dr. Rashad to present on GI Cancers in Egypt
Gil Morgan:	"Absolutely nothing Wrong with your English Jose Fernando, thank you for a wonderful Presentation!"
Rogelio Velasco Jr.:	Great presentation Jose!
Rogelio Velasco Jr.:	What is the most common cause of CRC and HCC in Egypt?
The OncoAlert Network:	We would like to add that Dr. Rashad is also an OncoAlert Catalyst Fellowship Recipient for her work in GI Cancers
Noha Rashad:	Thank you Gil.... honored to be with you today
Gil Morgan:	Such a pleasure to have you here Noha
Rogelio Velasco Jr.:	"Great lecture, Noha!"
Gil Morgan:	"Noha, what percent of the Egyptian population has access to the Big institutions for treatment?"
Noha Rashad:	Around 70%
The OncoAlert Network:	POLLS ARE OPEN
Rogelio Velasco Jr.:	How do you choose between Atezo Bev VS Durva and Trem for HCC?
The OncoAlert Network:	you can vote on your chat window right had side
The OncoAlert Network:	20 seconds and we close poll
Gil Morgan:	"Wow, 70% is a very good number"
Natalia Gandur Presenter:	"How do the real-world outcomes of sorafenib in the Egyptian population compare to global clinical trial data, and what factors might

	contribute to any observed differences in survival and disease control rates?"
Noha Rashad:	According to the esophageal varices severity as well as the aim of treatment..the STRIDE protocol usually offers a rapid tumor shrinkage..we offer it to patients who need rapid symptoms relief
Rogelio Velasco Jr.:	Thank you very much!
Natalia Gandur Presenter:	"How does the limited availability of newer systemic therapies like Atezolizumab/Bevacizumab and Tremelimumab/Durvalumab (STRIDE) in Egypt impact treatment decisions for lung cancer patients, and what strategies could improve access to these therapies?"
The OncoAlert Network:	The Correct answer to the poll is Chonic HCV infection
Rogelio Velasco Jr.:	How do you choose between Bev or Cetiximab plus chemo in metastatic CRC?
Noha Rashad:	"Compared to other real-world data as GIDEON study, we know that response to sorafenib is variable in different ethnic groups and highly affected by underlying pathogenesis"
Natalia Gandur Presenter:	Thank you Noha!
Gil Morgan:	"Noha when it comes to the Radiochemo, how many radiation centres do you have in Egypt and is there good access"
Noha Rashad:	I will answer the question on choosing beva vs anti EFFR is coming during the presentation
Noha Rashad:	I think more than 50 radiation centers
Rogelio Velasco Jr.: colon?	Thanks Noha. Where can we access the guielines you presented for
The OncoAlert Network:	That is a great number
JOSÉ FERNANDO:	"în braziil Geographic access is another barrier to treat patients, majority sites in cancer therapy is located in few cities with longer distancies to treat and patients living in rural areas without access to emergencies"
Noha Rashad:	"I can send you the guidelines, just send me your email"
Gil Morgan:	This is also true in the US and Sweden
Rogelio Velasco Jr.:	Rogervelascojr@gmail.com Thanks so much!
JOSÉ FERNANDO:	"sometimes the better therapy is less toxic, so we need consider this topic when deciding therapy, such dose dense, polichemo etc"

Noha Rashad:	"Most welcome, Rogelio."
The OncoAlert Network:	Noha now that you are touching NETs which are a tumor group with a large involvement of patient advocates
The OncoAlert Network:	How active are patient advocates in Social Media or in the education of other patients or development of their own research
Noha Rashad:	"Unfortunately, not active in this group at all.. most patient advocates are focusing on breast cancer.."
Natalia Gandur Presenter:	"Given the low rates of biochemical and imaging evaluations (such as 5-HIAA testing, serum chromogranin A, and Gallium DOTATATE PET/CT) in this study on neuroendocrine neoplasms (NENs) in Egypt, what alternative strategies could be implemented to improve diagnostic accuracy and staging in resource-limited settings?"
Noha Rashad:	We go with conventional radiology more..or if the patient is willing he can pay...or supposed by NGO's
The OncoAlert Network:	A Great Presentation Dr. Rashad
The OncoAlert Network:	and a warm Welcome To Dr. Gandur
Noha Rashad:	Many thanks sir..
Natalia Gandur Presenter:	Thank you! Open to questions
Rogelio Velasco Jr.:	Do you use the PEACE 1 Trail Regimen for Stage IV Prostate?
Natalia Gandur Presenter:	"The PEACE-1 trial demonstrated that the addition of abiraterone + ADT + docetaxel significantly improves overall survival in de novo metastatic hormone-sensitive prostate cancer (mHSPC). In high-resource settings, this triplet therapy is a preferred option, particularly for patients with high-volume disease."
Natalia Gandur Presenter:	"However, in resource-limited settings, accessibility to abiraterone and docetaxel can be a challenge. When the full regimen is not available, treatment is adapted based on feasibility—for example, using ADT + docetaxel alone, or in some cases, prioritizing ADT + AR inhibitors (e.g., enzalutamide, apalutamide) when chemotherapy is not an option."
Natalia Gandur Presenter:	The goal is always to optimize available resources while maintaining oncological outcomes as close as possible to standard care.
Natalia Gandur Presenter:	Great question Rogelio. Thank you!
Gil Morgan:	"Natalia, How do you prioritize treatment options when essential drugs are unavailable?"
Rogelio Velasco Jr.:	Thanks Natalia!

JOSÉ FERNANDO:	"great presentation Natalia, multidisciplinary is a great gap in public healthcare"
Natalia Gandur Presenter:	Thanks Gil for the question!
Natalia Gandur Presenter:	"The first step is risk stratification to determine the most effective and feasible approach. Surgery remains a cornerstone, particularly in renal and prostate cancer. In bladder cancer, intravesical chemotherapy, such as mitomycin, can be used when BCG is scarce."
Natalia Gandur Presenter:	"For systemic disease, repurposing older, cost-effective drugs like cisplatin or using TKIs like pazopanib can help bridge treatment gaps. Adapted guidelines, such as the NCCN Harmonized Guidelines, are crucial for structuring care in resource-limited settings."
Natalia Gandur Presenter:	Thank you Fernando!
Gil Morgan:	"Thank you Natalia, What role does multidisciplinary collaboration play when resources are limited?"
Natalia Gandur Presenter:	Very important question Gil!
Natalia Gandur Presenter:	"A well-structured multidisciplinary team (oncologists, urologists, radiologists, pathologists) is essential to optimizing care. In LMICs, where access to systemic therapies is challenging, these teams ensure that surgical and radiotherapy options are maximized. Virtual tumor boards and telemedicine-based consultations, such as Project ECHO, also help bridge expertise gaps, particularly in rural areas."
JOSÉ FERNANDO:	"communication can turn time between diagnosis , therapies shorter in a multidisciplinary discussion"
Gil Morgan:	Indeed
Natalia Gandur Presenter:	Agree with you Jose
JOSÉ FERNANDO:	i see that time is shorter in multidisciplinary discussions
Gil Morgan:	A well functioning MDT can save time to treatment
Gil Morgan:	and often better outcomes
JOSÉ FERNANDO:	"time to radiation, surgery are longer in public healthcare"
Natalia Gandur Presenter:	"Yes, that's right, Fernando."
Carlos Veliz Silveira:	"I am a urologist, with practice in uro-oncology. It is difficult to keep up-to-date with treatment protocols and standardized recommendations, because there are no resources available: new drugs, therapies, diagnostic imaging, radiotherapy equipment. The resources are available in private clinics but they are not very expensive. The vast

majority of patients do not have health insurance coverage and depend on medicine in the public sector, which is very lacking in resources. It is worrying to see that, for"

Natalia Gandur Presenter: "I completely understand your concern. The disparity between private and public healthcare access is a major challenge, especially when treatment advances are rapidly evolving. In resource-limited settings, adapting treatment strategies is key—leveraging surgery, radiotherapy (when available), and cost-effective systemic therapies like generic TKIs or repurposed chemotherapies. Have you seen any local initiatives aimed at improving access, such as public-private collaborations or expanded insurance coverage"

Carlos Veliz Silveira: "I am a urologist, with practice in uro-oncology. It is difficult to keep up-to-date with treatment protocols and standardized recommendations, because there are no resources available: new drugs, therapies, diagnostic imaging, radiotherapy equipment. The resources are available in private clinics but they are not very expensive. The vast majority of patients do not have health insurance coverage and depend on medicine in the public sector, which is very lacking in resources. It is worrying to see that, for"

Gil Morgan: Carlos is there a big discrepancy in outcomes depending on geographic location in your country

Carlos Veliz Silveira: for example, they cannot comply with treatment with ARPI (Abiraterone, Enzalutamide, Darolutamide), SBRT, immune checkpoint inhibitors. WHAT TO DO IN THESE CASES, ESPECIALLY WHEN THE DISEASE PROGRESSES?

Natalia Gandur Presenter: "When patients cannot access ARPIs (abiraterone, enzalutamide, darolutamide), SBRT, or immune checkpoint inhibitors, treatment must be adapted based on availability and efficacy."

Natalia Gandur Presenter: "For mHSPC (metastatic hormone-sensitive prostate cancer): If ARPIs are unavailable, we prioritize ADT + docetaxel, which remains a standard and cost-effective option. If chemotherapy is also not accessible, ADT alone can still provide disease control, though with shorter progression-free survival."

Natalia Gandur Presenter: "For mCRPC (metastatic castration-resistant prostate cancer): If ARPIs and immunotherapy are unavailable, alternatives include chemotherapy with docetaxel and, when progression occurs, cabazitaxel if accessible. Radionuclide therapy (e.g., Lutetium-177), though not widely available, is another option when feasible. In the absence of all these treatments, best supportive care and symptom management become critical to maintain the patient’s quality of life."

Natalia Gandur Presenter:	"For localized disease where SBRT is not an option: Conventional radiotherapy with adjusted fractionation or surgery can still be effective alternatives, depending on the stage."
Rogelio Velasco Jr.:	do you give docetaxel for more than 6 cycles if they cannot afford ARPIs?
JOSÉ FERNANDO:	"this is a big challenge in all tumor types, cause in some places we are treating patients based in 20 y old therapies"
JOSÉ FERNANDO:	connecting with centers with clinical trials can help some patients
Gil Morgan:	"Natlia, Given the increasing use of immunotherapy, how do you manage patients when these treatments are unavailable?"
Natalia Gandur Presenter:	"Yes Rogelio, when ARPI therapy is not available, we extend docetaxel up to 9 cycles, provided the patient tolerates it well. If the disease progresses, we move to cabazitaxel as the next-line treatment whenever possible."
Carlos Veliz Silveira:	"Precisely this situation that I have just presented fits into the important topic that they are presenting: "how to treat GU cancer if I lack resources, for example the only antiadrogens offered in public hospitals are Bicalutamide and flutamide, which I understand are no longer recommended,"
Natalia Gandur Presenter:	"Gil, In cases where immunotherapy is inaccessible, we prioritize cytoreductive surgery, radiation therapy, and chemotherapy-based regimens. For urothelial carcinoma, maintenance strategies with agents like mitomycin can be employed. In renal cancer, targeted therapies such as TKIs (pazopanib, sunitinib) serve as alternatives to IO-based regimens. Additionally, strengthening clinical trial participation in LMICs is an important strategy to improve patient access to novel treatments."
Natalia Gandur Presenter:	"Carlos, You’re absolutely right—this is exactly the kind of challenge we face in resource-limited settings. While bicalutamide and flutamide are no longer standard due to their limited efficacy compared to newer ARPI therapies, they may still have a role when no other options exist. In mHSPC, ADT + docetaxel remains a key approach when ARPIs are unavailable. For mCRPC, we prioritize chemotherapy (docetaxel, then cabazitaxel if available) and consider best supportive care if progression occurs. The goal is a"
Gil Morgan:	How is the participation of clinical trials in LATAM
Natalia Gandur Presenter:	The goal is always to optimize what is available while advocating for better access to modern therapies.
Rogelio Velasco Jr.:	"Thanks Natalia, great lecture and comprehensive answers!"

Gil Morgan:	"Natalia, I am in awe at the amount of information you are covering in this masterclass of a presentation"
Gil Morgan:	Thank you
Natalia Gandur Presenter:	"Gil, Clinical trial participation in Latin America (LATAM) is increasing but remains highly variable across countries. While nations like Brazil, Mexico, and Argentina have growing trial networks, many regions still face regulatory barriers, lack of infrastructure, and limited patient access."
Natalia Gandur Presenter:	"Expanding participation is crucial for improving treatment options, especially in resource-limited settings. Initiatives such as regional collaborations, streamlined approval processes, and patient education programs are key to enhancing recruitment and ensuring broader access to innovative therapies in LATAM."
Carlos Veliz Silveira:	"The contents of the chat will be recorded, so that they can be accessed later. I find the issues discussed in the chat very interesting."
The OncoAlert Network:	Thank you so much Dr. Gandur
Gil Morgan:	Carlos yes they will
Gil Morgan:	they will be in the description of the videos
Natalia Gandur Presenter:	"Thank you all for your thoughtful comments. I deeply appreciate your engagement. I've put a great deal of research, dedication, and passion into sharing this knowledge, and it truly means a lot to connect with you all today."
Gil Morgan:	A newsletter comes out tomorrow with the complete colloquium