Introduction/Background Almost all types of cancers can appear at any age. They are very often related to the aging of tissues and lifestyle habits (smoking, alcohol consumption, UV exposure...). However, some types of cancers are diagnosed in young adults (under 25 years old), and their number has increased by 5 to 10% over the last 20 years. How many cancers are diagnosed each year in young adults? How can we explain their occurrence? Are the treatments the same? What are the chances of survival in this age group?

Methodology Our work consists of a retrospective study carried out at the Hassan 2 University Hospital of Fez, between January 2016 and December 2021, involving 8 cases of gynaecomammary cancer in young adults operated in our department aged between 15 and 25 years.

Results The average age was 22.37 years, with extremes between 17 and 25 years. These patients represented 10.95% of the total number of young adults operated on in our department during this period, 62.5% of these patients had breast cancer (invasive breast carcinoma), 12.5% had endometrial cancer (high-grade serous endometroid-like ADK of the ovary), 12.5% had cervical cancer (squamous cell carcinoma) and 12.5% had ovarian cancer (germ cell tumor).

Conclusion Early detection is the best way of the disease management, instead of proceeding to a systematic screening in a specific age group (mammmography, smear...), we should be able to adapt the screening according to the risk indicators and allow women with an increased risk, regardless of their age, to be screened earlier.
AGE LIMITS OF MAMMOGRAPHY SCREENING – A DECISION-ANALYTIC EVALUATION OF THE BENEFIT-HARM BALANCE TO INFORM DECISION MAKING FOR THE GERMAN SCREENING CONTEXT

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Introduction/Background Human papillomavirus (HPV) is the most common sexually transmitted infection leading to a significant number of benign, premalignant, and malignant lesions. The aim of the present study is to evaluate the existing knowledge of a portion of the Greek population about prevention, screening, and HPV vaccination.

Methodology The survey was designed in Google forms and distributed through social media between June 2021 and December 2021 in men and women aged >16 years old that were able to read and comprehend read language. The questionnaire was pre-tested in a group of 50 obstetrics and gynecology residents. Overall, the survey included 24 questions relevant to the prevalence and pathophysiology of HPV infection, 5 questions that aimed to evaluate knowledge related to the existence of HPV testing and 9 questions that evaluated knowledge related to the existence and efficacy of HPV vaccination. Logistic regression analysis was performed to evaluate the reliability and validity of the questionnaire.

Results Overall, 2,685 answers were received within a period of 6 months. Person reliability index was evaluated as high in both men (reliability 92.2%) and women (85.2%), indicating that both were able to correctly interpret questions and answer them. Several factors affected the rates of correct benefit ratio (IHBR). Comprehensive sensitivity analyses were conducted.

Results In the base-case analysis, the highest potential gain in LY was achieved with mammography at age 45–79 (annual, age 45–49 y; biennial, 50–79 y) with 10.0 LY gained (LYG) per 100 participating women compared with current screening. The highest gain in QALYs is expected by biennial mammography at ages 45–74 (3.5 QALYs gained/100 women vs. current screening). Considering potential burden associated with additional mammograms, lowering the start age to 45 years (biennial, age 45–69 y) has an IHBR of 47 additional mammograms/LYG (vs. current screening). Compared to this screening, biennial mammography at age 45–74 results in 96 additional mammograms/LYG. Extending biennial mammography to age 45–79 or additionally screen annually at age 45–49 results in substantially less favorable IHBRs. Overdiagnoses occurred mainly due to DCIS. Key results were robust in sensitivity analyses.

Conclusion Based on our results, extension of the starting and stopping age for mammography may prevent additional BC deaths and increase remaining life expectancy. Considering QoL, biennial screening from age 45 to 74 years may provide an acceptable benefit-harm balance.

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Awareness, knowledge and attitudes on primary and secondary prevention of cervical cancer: a survey study

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