

54.5% indicated the gynecologist. Almost all the patients had clear that the procedure would've been performed by a radiologist. The most requested patients' medical professional as first choice to share the biopsy result was the trusted doctor (44%), one patient out of three preferred to meet with the radiologist, in both cases the radiologist was indicated to be the first or second choice from 30 and 31 women respectively. 70% of the patients preferred to meet the doctor in person, 26% preferred a phone call and 3% preferred to be notified via email. The majority of women indicated their preferences to receive the result on time, on top of making questions and trusting the doctor to communicate the result.

Conclusions: All patients knew that a radiologist would perform the upcoming invasive procedure. A limited number of patients in a single site has been involved. Male patient preferences were not included, due to the lack of patients in the observational period. The radiologist is the medical professional chosen to give the biopsy result from 1/3 to half patients, even if in previous questions it wasn't acknowledged to be a trusted doctor, at the level of a family doctor or a gynecologist. Patients still prefer to meet the doctor in person, even if they would receive the result as soon as possible.

No conflict of interest.

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Poster

Cost-effectiveness of digital mammography screening in the Netherlands: An extensive evaluation of 920 strategies

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Background: The benefits and harms of breast cancer screening programmes have been debated. Recent improvements in treatment as well as changes in screening performance may shift the balance between benefits and harms and might imply that current strategies may not be the most optimal. In addition, some countries are facing capacity issues. Therefore, this cost-effectiveness study evaluates optimal screening intervals in the Netherlands.

Material and Methods: Using a microsimulation model, the cost effectiveness of 920 breast cancer screening strategies with varying starting age (between 40 and 60), stopping age (between 64 and 84), and interval (annual, biennial, triennial and quadrennial) were simulated. The number of quality adjusted life years (QALYs) and net costs (in €) per 1,000 women were predicted (3.5% discounted) and incremental cost-effectiveness ratios (ICERs) were calculated to compare screening scenarios.

Table 1 QALYs gained and net costs per 1,000 women (3.5% discounted) and ICERs of strategies on the efficiency frontier

Strategy	QALYs gained (per 1,000 women)	Additional costs (per 1,000 women, 3.5% discounted)	ICER
Biennial 50-74	72.0	268,473	Dominated
Quadrennial 60-64	16.7	34,083	2,044
Quadrennial 56-64	27.1	56,351	2,129
Quadrennial 53-65	37.2	80,558	2,394
Quadrennial 52-64	38.8	84,762	2,730
Quadrennial 52-68	43.4	99,496	3,200
Quadrennial 50-70	50.1	56,351	3,674
Triennial 48-69	63.1	186,821	4,805
Triennial 48-72	65.7	200,340	5,365
Triennial 47-71	67.7	210,851	5,726
Triennial 46-73	71.5	236,265	6,388
Triennial 44-71	75.2	261,981	6,947
Triennial 44-74	77.0	275,095	7,073
Biennial 44-72	92.1	397,337	8,112
Biennial 43-73	96.0	431,623	8,754
Biennial 42-74	99.3	467,115	10,728
Biennial 41-75	102.4	503,798	12,008
Biennial 40-76	105.3	542,016	13,285
Annual 41-75	131.8	1029,897	18,403
Annual 40-75	135.1	1093,597	18,864
Annual 40-76	135.7	1105,482	19,944
Annual 40-78	136.6	1127,665	27,199
Annual 40-79	136.8	1137,974	44,491
Annual 40-81	137.2	1157,036	46,438
Annual 40-82	137.3	1165,691	93,080
Annual 40-83	137.4	1173,771	93,433
Annual 40-84	137.5	1181,296	95,626

Results: In total, 26 strategies covering all four intervals were on the efficiency frontier. For a willingness-to-pay threshold of €20,000/QALY gained, the annual 40-76 screening strategy would be optimal (Table 1). However, this strategy resulted in more overdiagnoses and required a high screening capacity. The current strategy in the Netherlands, biennial 50-74, was estimated to cost €268,473 and gained 72.0 QALYs per 1,000 women and was dominated. The triennial 46-73 strategy resulted in a similar amount of QALYs gained (71.5), while the costs were lower (€236,265), the amount of overdiagnoses was comparable, and the required screening capacity was lower.

Conclusions: Screening for breast cancer triennially between ages 46 and 73 can reduce costs without decreasing benefits or increasing harms compared to the current strategy.

No conflict of interest.

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Poster

Organisational characteristics of informed decision-making implementation in mammography screening programmes in 28 European countries

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¹University of Antwerp, Epidemiology, Antwerp, Belgium; ²Université catholique de Louvain, Faculté de Psychologie et des Sciences de l'Education, Louvain La Neuve, Belgium **Background:** Although much research has been published on interventions designed to facilitate informed decision-making in mammography screening few comparable data is available regarding the approaches taken by screening programmes towards real-world implementation. Therefore, this study aimed to provide a comprehensive overview of the situation by exploring the characteristics of how mammography screening programmes in Europe address informed decision-making.

Material and Methods: Data was collected via an online survey distributed to screening programme coordinators in Europe. Responses provided to the survey questions addressing the official policy of the programmes towards informed decision making, plus the strategy for implementation and evaluation were used to compute using a Multiple Correspondence Analysis to facilitate a Hierarchical Cluster Analysis of the mammography screening programmes into comparable groups.

Results: 35 responses were received representing independent mammography screening programmes from 28 different European countries. 27 respondents reported that the programme provides information to women on the benefits and harms of mammography screening and that a policy is in place for facilitating informed decision-making for women offered screening. Heterogeneity was reported towards the modalities used to implement the policy with 10 programmes stating that decision aids are used in practice to support informed choice. Only one programme reported an attempt to measure the proportion of women who have made an informed decision. The cluster analysis identified three emerging categories of programmes: established programmes distinguished by either reporting a policy specific to mammography screening and resources directed to implementation; established programmes with a general policy, applicable to other screening programmes, and the lack of administrative support to monitor implementation; and emerging programmes without a defined policy and few information provided to women regarding the benefits and harms of mammography screening. No statistically significant differences in participation rates amongst the two categories with a policy.

Conclusions: The data indicates a broad adoption by mammography screening programmes in Europe of the principle of supporting informed decision-making defined by either a specific or general policy directive. Validated best practices of how to develop, implement and evaluate a specific policy to promote informed decision-making, with culturally appropriate and responsive tools for measurement of informed choice, would provide much needed support cancer screening programmes to ensure that they help women make an informed choice.

No conflict of interest.

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Poster

Breast incidentalomas. How often do they are? – A 5-year Greek hospital experience

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Background: Aim of the study is to evaluate the rate of referrals to the breast unit due to incidental breast findings on thoracic CT.