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Familial Melanoma and Pancreatic Cancer: studies on genotype, phenotype and surveillance

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**Familial Melanoma and Pancreatic Cancer:
studies on genotype, phenotype and surveillance**

1. Cancers of the head and neck region are an important component of the clinical phenotype of *CDKN2A*-p16-*Leiden* mutation carriers. (*this thesis*)
2. Tobacco use is a significant modifier of cancer risk in *CDKN2A*-p16-*Leiden* mutation carriers. (*this thesis*)
3. Cystic precursor lesions of pancreatic cancer appear to have a higher malignant potential in *CDKN2A*-p16-*Leiden* mutation carriers than in individuals from FPC families. (*this thesis*)
4. A total pancreatectomy should be considered in *CDKN2A*-p16-*Leiden* mutation carriers diagnosed with an early-stage pancreatic cancer. (*this thesis*)
5. The diagnostic performance of the *CDKN2A*-p16-*Leiden* surveillance program for pancreatic cancer might be improved by the future implementation of a proteomic-based biomarker test. (*this thesis*)
6. Referral criteria for *CDKN2A* diagnostics should be based primarily on clinical prediction models such as *CM-Score*. (*this thesis*)
7. Mutations in genes involved in telomere integrity (*POT1*, *TERF2IP*, *ACD*, *TERT*) are minor contributors to the heritability of melanoma in the Dutch population. (*this thesis*)
8. A careful family history often tells us more about a patient's cancer risk than a genetic test result.
9. Improved survival is the most important, but certainly not the only parameter that determines whether a cancer surveillance program can be considered a success.
10. The advantages of multigene panel testing for hereditary cancer do not always outweigh the possible disadvantages.
11. Clinical guidelines should never replace clinical judgement.
12. Doing PhD research is 2% inspiration and 98% perspiration. (*adapted from Thomas A. Edison*)
13. Everything you can imagine is real. In science, however, what turns out to be real is not always easily imaginable beforehand. (*adapted from Pablo Picasso*)