Young age seems to be a negative prognostic factor, with an increased risk of local recurrence and reduced overall survival.

**Methodology** We carried out a retrospective study, based on files from the Medical Oncology department of the CHU Tlemcen, including patients aged ≤35 years old, treated for breast cancer during the year 2020 and 2021. Our objective is to determine the epidemiological, clinical, histological and molecular characteristics.

**Results** Eighteen patients were included, represent 6% of all cases treated during this period. They were between 30 and 35 years old (94.44%). The majority of patients (12) had a family history of neoplasia including 3 first degree, 11 second degree and beyond and 2 had a history of first degree breast cancer. The diagnosis was mainly made at a localized stage in 15 patients (T1: 4, T2: 12, T3: 2) and only 3 (16.7%) at a metastatic stage. Surgical treatment was performed in 17 patients (11: radical, 5: conservative, 1: palliative). The anatomicopathological study revealed mostly invasive ductal carcinoma in 15 patients (83.3%), grade (II: 9 and III: 9), with lymph node invasion in 11 patients (N2: 8, N1: 3, N0: 6). The immunohistochemical study found positive hormone receptors in 13 patients (72.2%) and a HER2 score 3 in 3 patients (16.7%), a luminal B status in 8 patients (44.4%) and triple negative in 4 patients (22.2%). The majority of patients are still alive (16 patients).

**Conclusion** Breast cancer in young women is a separate entity due to the frequency of neoplastic family history, diagnostic stage and specific molecular profile.

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**GYNAECOLOGIC ONCOLOGY MEETS HEPATOBILLIARY SURGERY; UNEXPECTED FINDINGS DURING SURGICAL EXPLORATION**

**Introduction/Background** Peritoneal carcinomatosis with/without lymph node involvement is a particularly common clinical scenario in gynaecological oncology. However, unexpected diagnoses may occur following an exploratory laparotomy. We present three exceptional cases of patients that were finally diagnosed with cancer of hepatobiliary origin.

**Methodology** The first patient, age 55, had a history of high grade endometrial cancer stage I that had been managed with surgery and brachytherapy. Three years post surgery, she presented with extensive paraaortic nodal disease, which was surgically resected. The second patient, age 66, had a history of gallbladder cancer, that had been managed with cholecystectomy. She presented with an adrenal mass and omental metastases; she underwent exploratory laparotomy. The third patient, age 75, presented with tension ascites and peritoneal carcinomatosis; she also underwent exploratory laparotomy.

**Results** The first patient’s pathology report revealed a poorly differentiated carcinoma with Hepar-1 expression; differential diagnosis had to be made between hepatocellular carcinoma and clear cell carcinoma (Hepar-1 expression is a very distant possibility in clear cell endometrial carcinomas). She has been receiving multiple regimens of adjuvant chemotherapy during the last four years. She had been in remission for the first two years; she has recently progressed with newly found metastases in the anterior abdominal wall. The second patient was diagnosed with metastatic adenocarcinoma of biliary origin and synchronous early stage primary ovarian carcinoma. She received adjuvant chemotherapy and remains in remission 1 year post surgery. The third patient was diagnosed with metastatic cholangiocarcinoma. She was eventually referred to palliative care due to poor performance status. She eventually died one month postoperatively.

**Conclusion** Gynaecological oncologists should be suspicious of non gynaecological diagnoses when tackling extensive abdominopelvic disease. Multidisciplinary approaches and consultations are crucial for decision making, diagnosis and improvement of patient outcomes.