two chemotherapy cycles, there was a significant improvement in motor weakness and the fecal and urinary function impairment. After a total of 6 cycles, spinal MRI and FDG-PET CT showed complete disappearance of the lesion. The patient remains in remission, at 1-year follow-up.

Conclusion: This report presents a case of primary spinal MALT lymphoma, which is extremely rare. Lymphoma should be considered in the differential diagnosis of patients who present with a spinal mass and the subtype of the lymphoma must be identified. The management of MALT lymphomas is quite heterogenous and there exist no universally-accepted therapeutic guidelines for this rare condition. A treatment option must be selected in consideration of the disease subtype, stage, and the clinical characteristics of the patient. In spinal MALT lymphoma, both local and systemic treatment options are available. Local treatments such as surgical resection or radiotherapy can achieve complete remission in patients with MALT lymphomas confined to a single site or at early stages. Systemic treatment is an option for patients who are not suitable for local treatment and appropriate patients may be administered systemic chemotherapy regimens that include anti-CD20 monoclonal antibodies.

https://doi.org/10.1016/j.htct.2020.09.083

PP 22

Ir2 leading to complete remission in r/r richter syndrome – a case report

Emin Abdullayev*, Christoph Buhl, Judith Niederland, Herrad Baurmann, Bertram Glass

Helios Clinic Berlin Buch: Department of Hematology and of Stem Cell Transplantation, Berlin, Germany

Introduction: Relapsed and refractory diffuse large B Non-Hodgkin lymphoma (r/r DLBCL) is a severe condition with fatal outcome for the majority of the patients. (1) Richter Syndrome is defined as a transformation of chronic lymphatic leukemia in a highly aggressive B-Non-Hodgkin lymphoma, mainly DLBCL. 20% of Richters Syndromes are de novo DLBCL, implying comparable prognosis to other aggressive Non-Hodgkin Lymphoma, whereas 80% are clonally related to the CLL cells and imply a poor prognosis of one-year median overall survival. (2) Despite huge efforts that have been achieved recently by implementing CAR-T Cells for r/r DLBCL and transformed Follicular Lymphoma, treatment of r/r Richter syndrome remains desperate with poor outcome. Allogenic stem cell transplantation is recommended for eligible patients. The combination of Anti CD 20 Antibody Rituximab with IMiD Lenalidomide and Bruton-kinase inhibitor Ibrutinib iR2 has shown safety and efficacy in a breaking phase II study. (2)

We present the rare case of a patient with refractory DLBCL after CLL (Richter Transformation) who achieved complete remission with iR2 and was successfully transplanted.

Case report: Our by now 74-year old patient was first diagnosed with CLL in 08/2014. He showed ubiquitous lymph nodes and evidence of p53 mutation, Binet stage B & RAI I.

He was treated with Ofatumumab + Bendamustine in the first line, Rituximab + Idelalisib in first relapse and Ibrutinib in second relapse before evolving to highly aggressive B-NHL in 10/2019. Richters Syndrome was first treated with Standard Immunochemotherapy (R-CHOP), before switching to Rituximab + Ifosphamid + Etoposid + Carboplatin (R-ICE) for refractory disease. There was further progress (clearly progressive lymph nodes cervical) after first cycle R-ICE chemotherapy, we decided to treat with a combination of immunotherapy with the Anti CD 79a-Antibody Polatuzumab in combination with Rituximab. Unfortunately, we saw again progressive disease after three cycles, that lead to the decision of experimental application of Ibrutinib in combination with Rituximab and Lenalidomid.

We saw an immediate effect as Lactat-dehydrogenase normalized very soon and lymph nodes disappeared completely.

https://doi.org/10.1016/j.htct.2020.09.084

PP 23

Primary spinal extramedullary diffuse large B-cell lymphoma presenting with initial spinal cord compression: a case report

O. Ekinci[1,*], A. Dogan[2], M. Aslan[1], I. Aras[3], C. Demir[2]

[1] *Department of Hematology, Faculty of Medicine, Fırat University, Elazığ, Turkey*
[2] *Department of Hematology, Faculty of Medicine, Yüzüncü Yıl University, Van, Turkey*
[3] *Department of Pathology, Faculty of Medicine, Yüzüncü Yıl University, Van, Turkey*

Objective: Extranodal lymphomas, by definition, can involve any organ or tissue. Brain parenchyma, spinal cord, eyes, cranial nerves, and meninx are extranodal regions that show involvement at much lower rates. It is quite rare for lymphoma patients to present to the hospital with symptoms and findings associated with spinal cord compression as the initial presentation. This condition can lead to irreversible autonomic dysfunction, and motor and sensory loss. Here, we present a rare primary spinal intradural extramedullary diffuse large B-cell lymphoma (DLBCL) case who presented with acute neurological symptoms and no findings of cerebral involvement or involvement at any other site.

Case report: A 41-year-old male patient presented to our hospital with thoracic back pain and progressive complaints of weakness, numbness and difficulty in ambulation in bilateral lower extremities. On spinal MRI examination, a well-circumscribed intradural extramedullary mass with a craniocaudal extension of 6 cm and an AP diameter of 1 cm that was isointense to the spinal cord on T1-weighted sequences and slightly hyperintense on T2-weighted series, and showed diffuse homogenous contrast enhancement after intravenous contrast agent injection was determined between the vertebral levels T6 and T8. In the surgical operation, the mass showed partial invasion of the vertebral bone and the surrounding muscle. The mass invading the dura was resected and laminectomy was performed at T6-T9. On histopathological examination of the mass, there was diffuse malignant