anti-CD52 treatment, his general situation dete-riorated and pleural effusion and abdominal distension developed due to massive ascites. Small, mature lymphocytic cell infiltration was shown in ascites fluid on cytological examination. He died after six months of diagnosis. **Conclusion:** T-PLL is a very aggressive disease with a median survival of less than 1 year. Not all patients diagnosed with T-PLL require treatment immediately.Currently, IV alemtuzumab (anti-CD52) is the accepted best avaliable treatment with very high response rates when given as first-line treatment. However, treatment is notcurative and a minority of T-PLL patients experience long-term disease-free survival.

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PP 05

RETROSPECTIVE EVALUATION OF PATIENTS WITH ACUTE MYELOID LEUKEMIA RECEIVING VENATOCLAX-BASED TREATMENT

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Objective: Acute myeloid leukemia (AML) is the disease of elderly patients. Therefore, a significant number of patients are not suitable for intensive induction chemotherapy. In this study, it was aimed to retrospectively evaluate patients with AML who were treated Venatoclax-based regimens in our center. **Methodology:** The data of the patients who were treated Venatoclax-based regimens with the diagnosis of AML in the Bozyaka Training and Research Hospital Department of Hematology were scanned retrospectively from their files. **Results:** Data of 11 patients in total were reached. The mean age of the patients was 73.9. 8 of 11 patients were follow-up with diagnosis of AML , 3 patients with MDS RAEB II. Average follow-up time was 13.6 months. 5 patients died during follow-up. HMA +venatoclax was given to 6 patients as first-line, 4 patients second-line and 1 patient third-line therapy. Complete response was found in 3 patients, partial response in 1 patient, stable disease in 1 patient, and refractory disease in 1 patient. **Conclusion:** Venatoclax is a promising treatment option because it is an oral agent that can be tolerated by elderly patients and improves response rates and survival.

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PP 06

BONE MARROW NECROSIS IN ACUTE LYMPHOBLASTIC LEUKEMIA: A CASE REPORT

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Objective: Bone marrow necrosis (BMN) is an entity that necrotic cells are seen on amorphous eosinophilic ground with medullary infarctus but withouth cortical bone involvement. BMN is a postmortem diagnosis in most of the reports. Bone marrow biopsy and aspiration is essential for the diagnosis. The case we report here is a patient who is diagnosed BMN and ALL at the same time with the first bone marrow biopsy, which is showed extensive necrosis. **Case report:** A 42-year-old man applied to our E.R. with lumbal pain. The initial blood count showed leukocyte:5.13 × 109/l, neutrophil:2.68 × 109/l, Hgb:10.7 g/dl, Hct: %31.5, thrombocyte:127 × 109/l, LDH:539 u/l (N:0-250), ALP:185 u/l (N:40-150), Total Bilirubin:0.81 mg/dl, CRP:337mg/l (N<5)), ESH: 94mm/h, folic acide: 2.8ng/ml (N>5.4), Vitamin B12:398 pg/ml (N:210-900), ferritin: 5607 ug/l (N:22-320), fibrinogen:1304 mg/dl (N:200-400), D-Dimer:646 ug/l (N<243) and a normal range for PZ, aPTZ, INR. **Methodology:** Peripheral smear showed %38 PMN, %56 lymphocyte, %6 monocyte, normoblasts, rare tear drop cells and rare thrombocytes. Pathological evaluation revealed hypercellular bone marrow (%95), extensive necrosis, CD3(-) CD5(-) CD20(+), CD38(-), CD10 diffuse(+), BCL2(+) MPO(-) CD117(-), CD34(+) CD79a, Pax5 and TdT suboptimal (+). Flow cytometry showed no significant result because of the deficiency of material. PCR revealed no BCR-ABL transcript. **Results:** The patient diagnosed B precursor ALL. With the BFM IA protocol complete remission obtained. At the control BMB CD3, CD20, CD79a, Pax5, TdT, MPO, CD34 was applied but there was no neoplastic involvement. After the BFM IB protocol, complete remission has been pursued. The patient is currently receiving the BFM IC protocol. **Conclusion:** BMN is an uncommon pathology with poor prognosis. Primary etiology is malignancies, especially hematologic malignancies, at %90 of the cases. As we see at this case, while the clinical and laboratory findings are insignificant; when a patient shows fever with unknown origin, bone pain, newly developed cytopenias, we must keep in mind the diagnosis of BMN and if a patient is diagnosed BMN, necessary scaning must be done immediately for malignancies as the primary cause.

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PP 07

NEXT GENERATION SEQUENCING PRACTICES IN HEMATOLOGY: A RECENT EXPERIENCE OF A SINGLE CENTER

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Objective: Next-generation sequencing (NGS)-based technologies are novel methodologies for the diagnosis, prognostic assessment and decision of individualized treatment strategy in hematological neoplasia. NGS led to a more comprehensive understanding of the mutational landscape, especially in the myeloid neoplasms. Herein, we present the results of the patients who underwent NGS with the suspicion of myeloid neoplasia. **Methodology:** Retrospective data from a total of 13 patients were analyzed who were diagnosed between 01.10.2018 and 01.06.2021. There were four myeloid panels in the NGS. Panel 1 consists of ASXL1, CALR, CBL, CEBPA, CSF3R, and DNMT3A mutations. Panel 2 consists of EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, and MPL mutations. Panel 3 consists of NPM1, NRAS, RUNX1, SETBP1, and SF3B1 mutations. Panel 4 consists of SH2B3/LNK, SRSF2, TET2, TP53, U2AF1, ZRSR2 mutations. **Results:** Median age was 48. Diagnoses were AML (n=7), AA (n=1), MDS (n=2), DLBCL (n=1), MM (n=1), and Evans syndrome (n=1). Seven cases with malignant diagnoses were eligible for intensive therapy. There were no mutations detected by NGS in MM, AA, DLBCL, and Evans syndrome cases. Biallelic CEBPA mutation accompanied FLT3 mutation in 1 case. IDH1 and NPM mutation were detected in 1 APL case. MPL, SRSF2, ASXL1, CBL, U2AF1, SF2B1, and TET2 were mutations detected in cases with dysplasia. **Conclusion:** In our cohort, NGS did not add any significant information in the lymphoid malignancies and benign hematological cases. NGS helped to define the allelic ratio of FLT3+ mutations and helped to accurately define the ELN risk of AML. Mutations that were detected in the cases with dysplastic bone marrow findings were concordant that were reported in the literature. Larger case series are needed in order to define the therapeutic and prognostic implications.

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PP 08

INAPPROPRIATE ADH SYNDROME OCCURING DURING B-ALL TREATMENT

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Case report: Inappropriate ADH syndrome is a cause of hyponatremia with increased ADH secretion despite normal plasma osmolality and euvolemic state.There are many related drugs in its etiology.Inappropriate ADH syndrome occured in two B-ALL diagnosed patient during cyclophosphamide and vincristine treatment regimen.The detection of inappropriate ADH syndrome in both patients with euvolemic hyponatremia shows the importance of reviewing the drugs used by the patient in the etiology of hyponatremia.

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PP 09

T-ACUTE MYELOID LEUKEMIA CASE THOUGHT TO BE ASSOCIATED WITH RADIOIODINE (I^{131}) TREATMENT

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Case report: Ionizing radiation and chemotherapeutic agents can cause carcinogenic effects by causing DNA damage.A 40-year-old female patient diagnosed with thyroid papillary carcinoma in 2016 and subsequently administered 150 mCi radioiodine (I^{131}). Leukocytosis was detected in the examinations performed due to urinary system infection. She was diagnosed t(9:22) p210 positive AML M1-2. The patient had a history of Stargardt Syndrome.Development of t-AML after radioiodine treatment is very rare.

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PP 10

FLT3-ITD POSITIVITY IN AML; CASE SERIES

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Objective: Diagnosis of AML requires additional procedures, including pathological examination, immunophenotyping, cytogenetic examination, and molecular diagnosis. The determination of the specific cytogenetic abnormality is important for the selection of appropriate treatment and prognostic analysis.The 2 most common mutations of the FLT3 gene are FLT3-ITD and FLT3-D835. Here, we will present FLT3-ITD positive AML cases admitted to our clinic between 2019-2021. **Case report:** We have 5 cases of AML FLT3-ITD heterozygous. In all our cases, Midastaurin was given with 7+3 chemotherapy (CT) in the initial treatment. While 1 of our cases went into remission, the other 4 relapsed. All of the patients who relapsed were given FLAG CT, no remission was achieved and they were switched to ADE CT. Remission was achieved in 2 of 4 patients, 2 of them were refractory. One patient was given gilteritinib. HSCT was performed in 2 patients. While 2 of our