as those based on high-doses of cytarabine (HDAC) remains controversial in the management of ASCT-eligible patients. Based on this premise, the current study aims to describe clinical and laboratory characteristics, assess outcomes, determine survival predictors, and compare responses between different primary therapeutic strategies, with focus on assessing the impact of HDAC-based regimens on outcomes in ASCT-eligible patients. **Methods:** This retrospective, observational, and single-center study involved 165 MCL patients, diagnosed and treated at the University of São Paulo, Brazil, from 2010 to 2022. Endpoints included overall OS, EFS, and POD-24 from up-front treatment. Survival curves were constructed using the Kaplan-Meier method and the Log-Rank test was used to assess the relationship between variables and outcomes. Univariate analysis was performed using the semi-parametric Cox test and multivariate analysis by Cox regression method or proportional ratios model. The results were presented in HR and 95% CI, and a p-value ≤ 0.05 was considered statistically significant. **Results:** The median age at diagnosis was 65 years and 73.9% were male. More than 90% of cases had a classic nodal variant (cnMCL), 76.4% had bone marrow infiltration, and 56.4% presented splenomegaly. Bulky ≥ 7 cm, B-symptoms, ECOG ≥ 2, and advanced-stage III/IV were observed in 32.7%, 64.8%, 32.1%, and 95.8%, respectively. Sixty-four percent of patients were categorized as high-risk according to MIPI score. With a median follow-up of 71.1 months (95% CI: 61.8-80.4) the estimated 2-year OS and EFS were 64.1% (95% CI: 56.2-71.9%) and 31.8% (95% CI: 23.0-40.6%), respectively. The ORR for the whole cohort was 64.7% (95% CI: 57.1-71.7%), with CR achieved in 41.5% (95% CI: 34.1-49.1%). POD-24 was observed in 46.7% (95% CI: 39.1-54.3%), and the overall mortality rate during all follow-up was 58.2% (95% CI: 50.6-65.5%), with disease progression being the main cause of death. Patients treated with R-HDAC-based regimens (43.4%-66/152) had higher ORR (85.9% vs 65.7%, p = 0.007) compared to those receiving R-CHOP (46.0%-70/152), as well as lower POD-24 rates (61.9% vs 80.4%, p = 0.043) and lower mortality (43.9% vs 68.6%, p = 0.004). However, intensified induction regimens using R-HDAC were not associated with a real OS benefit in MCL patients undergoing up-front consolidation with ASCT (2-year OS: 88.7% for R-HDAC plus ASCT vs 78.8% for R-CHOP plus ASCT, p = 0.289). Furthermore, up-front ASCT was independently associated with increased OS (p < 0.001), EFS (p = 0.005), and lower POD-24 rates (p < 0.001) in MCL. Additionally, CNS involvement (HR: 3.12, p = 0.004), tumor lysis syndrome (HR: 2.79, p = 0.026), albumin < 3.5 g/dL (HR: 2.69, p < 0.001), and failure to achieve remission after induction therapy (HR: 3.71, p < 0.001) were predictors of poor OS. **Conclusion:** In the largest Latin American cohort of MCL reported to date, we confirmed the OS benefit promoted by up-front consolidation with ASCT in young anf fit patients, regardless of the intensity of the immunochemotherapy regimen used in the pre-ASCT induction. Although HDAC-based regimens were not associated with an unequivocal increase in OS, it was associated with higher ORR and lower rates of early-relapses.

https://doi.org/10.1016/j.htct.2023.09.653

OUTCOMES, PROGNOSTIC FACTORS, PREDICTORS FOR TRANSFORMATION TO HIGH-GRADE B-CELL LYMPHOMA, AND THERAPEUTIC MANAGEMENT IN FOLLICULAR LYMPHOMA: REAL-WORLD EVIDENCE FROM A LARGE AND LONG-TERM LATIN-AMERICAN COHORT

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Introduction: FL is the most common low-grade B-cell NHL. Although indolent, it has heterogeneous biological behavior and variable clinical outcomes. Histologic transformation (HT) to high-grade B-cell NHL is associated with dismal survival. The therapeutic management of FL and its prognosis are highly dependent on its staging and tumor burden. Here we aimed to describe clinical characteristics, assess outcomes, determine predictors of survival and HT, and compare responses between different therapies applied in a large cohort of FL patients. **Methods:** This retrospective study involved 223 patients with FL G1-3A, diagnosed at USP, Brazil, from 2006 to 2022. FL patients were categorized into early-stage (I/II) (ES), advanced-stage (AS) (III/IV) with low tumor burden (LTV), and AS with high tumor burden (HTV) according to the GELF criteria. Endpoints were OS, PFS, early-relapse (< 24 months) and HT rates. Survival curves were constructed using the KM method and the Log-Rank test was used to assess the relationship between variables and outcomes. Univariate and multivariate analysis were performed. The results were presented in HR and 95% CI and p ≤ 0.05 was considered significant. **Results:** The median age at diagnosis was 60 years and 54.8% were female. 15% of cases had ES, 18.4% had AS-LTV, and 66.8% had AS-HTV. BM involvement, leukemic presentation, splenomegaly, and serous effusions occurred in 48.9%, 11.7%, 12.6%, and 21.1%, respectively. Bulky ≥ 7 cm, B-symptoms, ECOG ≥ 2, and involvement of ≥ 4 nodal areas were observed in 44.4%, 51.6%, 15.2%, and 56%, respectively. 49% of patients were categorized as high-risk according to the FLIPI score. With a median follow-up of 79.5 months (95% CI 67.0-92.0) the OS medians were 18 years (95% CI 14.9-21.1), 11 years (95% CI 9.2-12.9), and 10.5 years (95% CI 9.3-11.8) for ES, AS-LTV, and AS-HTV, respectively, p = 0.138. Similarly, the PFS medians were 6.7 years (95% CI 3.6-9.8), 8.4 years (95% CI 2.0-14.8), and 3.5 years (95 CI 1.8-5.3) for ES, AS-LTV, and AS-HTV, respectively, p = 0.171. Early-relapses occurred in 36.3% of cases, being 18.2%, 31.7%, and 41.0% for ES, AS-LTV, and AS-HTV, respectively, p = 0.032. The overall mortality rate was 29.1% for the whole cohort. HT was documented in 16.7% of cases, being 3.0%, 14.6% and 20.1% for ES, AS-LTV, and AS-HTV, respectively, p = 0.053. Among patients with AS-HTV, the R-CHOP regimen did not promote increased OS compared to the R-CVP regimen (p = 0.415), however it was associated with a substantial increase in PFS (p = 0.005). Age ≥ 60 years (HR 1.06, p < 0.001), ≥ 2 comorbidities (HR 3.85, p = 0.014), B-symptoms (HR 2.35, p = 0.015), HT (HR 2.77, p = 0.002) and thrombocytopenia (HR 2.96, p = 0.028) were predictors of poor

OS. Similarly, age ≥ 60 years (HR 1.08, p < 0.001), involvelment of ≥ 4 nodal areas (HR 1.27, p < 0.001), and high LDH (HR 1.65, p = 0.002) predicted decreased PFS. Serous effusions (HR 2.09, p = 0.05), albumin < 3.5 g/dL (HR 2.82, p = 0.05), B-symptoms (HR 2.00, p = 0.006), involvement of ≥ 4 nodal areas (HR 1.21, p = 0.014), and BM infiltration (HR 2.11, p = 0.05) were the main predictors for HT. **Conclusion:** Although it is characteristically an indolent disease, we demonstrated that a significant portion of FL patients have shortened survival. We confirmed this prognostic heterogeneity, particularly considering the clinical staging and tumor burden. Therefore, FL patients with AS-HTV had higher HT rates and early-relapses, both classic adverse prognostic markers, as well as a tendency to higher mortality. Additionally, we identified clinical and laboratory predictors for HT, which may in a near future direct adapted-risk therapeutic strategies.

https://doi.org/10.1016/j.htct.2023.09.654

CIRCULATING CELL-FREE DNA (CCFDNA) CONCENTRATIONS MEASURED BY CAPILLARY ELECTROPHORESIS: HIGH COST-EFFECTIVENESS IN DISCRIMINATING DLBCL PATIENTS AND ASSOCIATIONS WITH HIGH TUMOR BURDEN

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Introduction: DLBCL is a malignancy with marked clinical, biological and prognostic heterogeneity. Its different outcomes may be predicted by the identification of molecular biomarkers. Therefore, quantification of circulating cell-free DNA (ccfDNA) and circulating tumor DNA (ctDNA) have emerged as minimally invasive methods able to predict its prognosis. However, such measurements are based on the use of costly technologies and with restricted access in clinical practice. Here, we aimed to quantify ccfDNA in DLBCL using capillary electrophoresis (CEF), a low-cost and widely available methodology, in order to establish prognostic associations between its serum concentrations, clinical characteristics and outcomes. **Methods:** This prospective study involved 54 DLBCL patients, diagnosed at USP, from 2019 to 2020, and 23 healthy-controls. All cases were treated with 6-8 cycles of R-CHOP. Plasma samples were collected from DLBCL at three moments: at diagnosis, after the 4th CT cycle and at the end of treatment. ccfDNA was extracted using the *QIAamp MinElute ccfDNA* kit and quantified by CEF (*Agilent 2100 Bioanalyzer*). Comparison between two groups was performed using the Mann-Whitney test, and between three groups using the Kruskall-Wallis test. The cut-off for [ccfDNA] (1147 ng/μl) was determined by ROC methodology. Survival curves were constructed using the KM method and Log-Rank test was used to assess the relationship between variables and outcomes, and p≤0.05 was considered significant. **Results:** The median age at diagnosis was 57 years and 61.1% were female. Advanced-stage was observed in 59.3%, 29.6% had ECOG ≥ 2, 52.6% had IPI ≥ 3, and 44.4% had bulky ≥ 10 cm. BM infiltration and involvement of ≥ 2 EN sites occurred in 5.6% and 16.8%, respectively. With a median follow-up of 32 months, the medians OS and EFS were 32 months (95% CI 28-35) and 31 months (95% CI 28-34), respectively. The ORR was 76% (95% CI 63.5-86). The overall mortality rate was 20.4% (95% CI 11.1-32.3). ccfDNA concentrations were significantly higher in DLBCL compared to controls (p < 0.001), however, it did not differ significantly between samples from DLBCL collected at the 3 different time points (p = 0.602). We observed positive associations between ccfDNA [ ] in diagnostic DLBCL samples and biomarkers of high tumor burden, including higher LDH levels (p = 0.003), bulky (p = 0.011), ECOG ≥ 2 (p < 0.001), and IPI ≥ 3 (p = 0.069). However, ccfDNA[ ] at diagnosis were not statistically associated with ORR (p = 0.264), nor with clinical outcomes, including OS (1-year OS: 92% for [ccfDNA] < 1147 ng/μl vs 76% for [ccfDNA] ≥ 1147 ng/μl, p = 0.217) and EFS (1-year EFS: 92% for [ccfDNA] < 1147 ng/μl vs 69% for [ccfDNA] ≥ 1147 ng/μl, p = 0.270). We believe that the short follow-up time and sample number restriction may have contributed to the lack of statistically significant association between ccfDNA [ ] and responses/outcomes observed. In this sense, cohort expansion and NGS techniques for ctDNA identification are ongoing to assess its potential impact as a prognostic biomarker in our cohort. **Conclusion:** We demonstrated that ccfDNA [ ] measured by CEF were able to accurately discriminate healthy individuals from DLBCL, highlighting its potential role as a minimally invasive diagnostic biomarker. Furthermore, ccfDNA [ ] at diagnosis in DLBCL patients were positively associated with markers of high tumor burden and adverse prognosis. Our results suggest that measurement of ccfDNA by CEF may be a highly cost-effective methodology to identify high-grade B-cell NHLs and recognize DLBCL subgroups with adverse clinical-prognostic characteristics.

https://doi.org/10.1016/j.htct.2023.09.655

LESÃO RENAL AGUDA PÓS RENAL POR COMPRESSÃO DE LINFOMA DIFUSO DE GRANDES CÉLULAS B BULKY

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Introdução: A lesão renal aguda (LRA) é um quadro frequente dentro da clínica médica, havendo diversas etiologias, dentre elas a compressão extrínseca das vias urinárias. Esta compressão pode ser causada por tumores de origem local, como neoplasias ginecológicas, colorretal e, menos frequentemente, massas linfonodais de grandes dimensões. **Objetivo:** Relatar um caso de LRA pós renal devido compressão ureteral por linfoma difuso de grandes células B Bulky (LDGCB). **Relato de caso:** Paciente feminina, 45 anos, previamente hipertensa,