Adult Hematology Abstract Categories, Lymphoma

OP 06

AUTOLOGOUS PERIPHERAL BLOOD STEM CELL TRANSPLANTATION IN PATIENTS WITH HIV-ASSOCIATED LYMPHOPROLYPHERATIVE DISORDER

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Objective: Autologous transplantation of bone marrow/peripheral blood stem cells in patients with HIV-associated lymphopoliferative disorder is a feasible and relatively safe therapeutic option. However, at the moment there are a number of unsolved problems, including optimal risk/benefit pre-transplant conditioning, taking into account drug-drug interactions and indications for hematopoietic stem cell transplantation. **Methodology:** Since 2020 PBSCT has been performed in 15 patients with HIV in our center. The 12 (80%), had diagnosis of HIV-associated plasmablastic lymphoma (HIV-PBL), 3 patients (20%) were with HIV-associated Hodgkin' lymphoma (HIV-HL). All of the patients with HIV-PBL were transplanted after completion of a first-line treatment and achievement of at least a partial response. The pre-transplant conditioning was performed using BEAM-like regimens. **Results:** Toxicity from organs and systems did not exceed grade 2 (moderate) mainly from the gastrointestinal tract, no need antiretroviral therapy in all of the cases. Median time to neutrophil engraftment was +12 days, while to platelet engraftment was +13 days. At the time of submitting the abstract all of the transplanted patients described above except one (lethal case due to progression of concomitants hepatitis C virus (HCV) infection) are in the state of remission. **Conclusion:** Autologous transplantation of peripheral blood stem cells in patients with HIV is a feasible and relatively safe option with clear planning of the patient's treatment strategy from the first day of therapy and accompanying consideration of drug-drug interactions which is confirmed both by world literature and our Center's own experience.

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Adult Hematology Abstract Categories, Platelet Diseases

OP 07

MAINTENANCE LOW-DOSE CORTICOSTEROID THERAPY IN PATIENTS WITH CHRONIC ITP: SINGLE CENTER RESULTS

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Objective: Immune thrombocytopenia (ITP) is an acquired, autoimmune disease affecting 2 to 4 individuals per 100,000 annually. ITP is characterized by an isolated platelet count of $<100 \times 10^3/\mu$L. The diagnosis of primary ITP relies on excluding non-immune causes of thrombocytopenia (myelodysplastic syndrome, inherited thrombocytopenia) and secondary immune thrombocytopenia caused by other conditions such as autoimmune diseases (systemic lupus erythematosus), malignancies (chronic lymphocytic leukemia), infections (hepatitis C virus and HIV), and medications. The clinical manifestations of ITP range from entirely asymptomatic patients to increased petechiae-ecchymosis and rarely major or life-threatening bleeding. Corticosteroids are the first-line treatment. Initial treatment for ITP consists of methylprednisolone at a dose of 1mg/kg/day or dexamethasone administered at 40mg/day for 4 days, repeated every 14-28 days. While >75% of adult patients respond to corticosteroids, only 20-30% remain in continuous remission after cessation." **Methodology:** We have 114 registered patients with immune thrombocytopenia (ITP) in our clinic over the past 5 years. Among these patients, a subgroup of 45 who received high-dose corticosteroid treatment as first-line therapy, responded to corticosteroids, but subsequently experienced loss of response, was identified as corticosteroid-sensitive. This group was selected for follow-up with maintenance low-dose steroid (LDS) therapy for 1 year. Patients were treated with 4 mg of methylprednisolone for 4 days per month and followed up for 12 months. Among our patients, 18 achieved response with platelet levels $>30 \times 10^3 / \mu$ L without signs of bleeding (see Table 1), while in 27 patients, additional corticosteroid doses were added or second-line treatment modalities such as splenectomy or eltrombopag were initiated due to platelet levels dropping below $30 \times 10^3 / \mu$ L " **Results: Conclusion:** The goal of treatment in a patient with ITP is not only to normalize platelet counts but also to achieve a level of platelets that can prevent clinically significant bleeding. Based on this premise, we have demonstrated that maintenance corticosteroid therapy at an acceptable cumulative dose can reliably maintain platelet levels within a safe range. We believe that this should be further supported by larger multicenter studies."

Table 1: Demographic characteristics of patients responsive to low-dose steroid treatment"

Female/Male	12/6
Median age	52
1.month median trombocyte	$32 \times 10^3 / \mu$ L
3. month median trombocyte	$55 \times 10^3 / \mu$ L
12. month median trombocyte	$87 \times 10^3 / \mu$ L

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