and significant regression was observed in skin lesions after treatment. However, our patient was excluded prior to BMT."

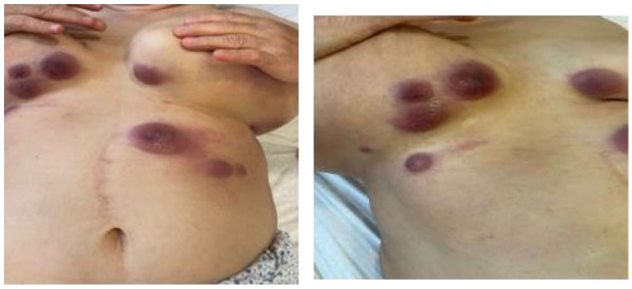

Figure 1: Palpable firm nodular lesions on the trunk and back

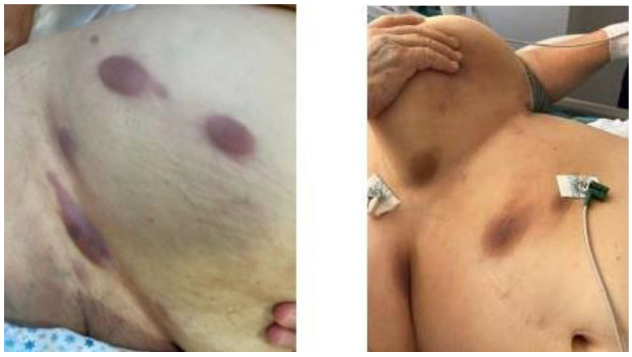

Figure 2: After treatment

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Adult Hematology Abstract Categories, Chronic Leukemias, PP 03

ADRENAL INSUFFICIENCY DETECTED BEFORE TREATMENT IN A PATIENT DIAGNOSED WITH BILATERALLY PRIMARY ADRENAL DIFFUSE LARGE B CELL LYMPHOMA:A CASE REPORT

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Case report: INTRODUCTION: Adrenal glands are one of the organs where malignancies frequently metastasize. However, primary malignancies of the adrenal glands are rare. Primary adrenal lymphomas (PAL) account for less than 1% of extranodal lymphomas. It is seen bilaterally in 75% of cases. The most common subtype is diffuse large B-cell lymphoma. **CASE:** A 57-year-old male patient with no known history of disease applied to an external center with complaints of weight loss (13 kg, more than 10% of body weight), tremors, loss of appetite and lower back pain. As a result of the evaluations made at an external center, thorax CT showed bilateral adrenal masses. PET CT was taken with the preliminary diagnosis of malignancy; In the right adrenal gland, approximately 11.6 × 8.1cm (SUVmax: 25.6) and in the left adrenal gland, approximately 10.1 × 7.2cm (SUVmax: 24.4) in size, heterogeneous dense hypermetabolic solid mass sections with necrotic areas were seen and left paraaortic (SUVmax: 11.7) lymph node with dimensions of 1.6 × 1.2 cm and a few mildly-intensely hypermetabolic lymph nodes were observed in the interaortocaval chain. Primary malignancy storage was evaluated in the foreground of dense hypermetabolic mass regions of heterogeneous structure defined in both adrenal glands. After pheochromocytoma was diagnosed, the patient was referred to our clinic after the tru-cut pathology performed on the mass lesions in the right adrenal gland revealed that the morphological and histochemical findings were consistent with diffuse large B-cell lymphoma. The patient's vital signs were stable upon admission. In the hemogram, Hgb: 9.7g/dL Hct: 31.2% MCV: 96 fL Platlet: 126.000 / mm3. In biochemistry, creatinine:1.83mg/dL urea:80 mg/dL Na:139 mmol/L K:4.36 mmol/L Ca:10.2mg/dL uric acid:9.4mg/dL LD:343U/L. There was no sign of adrenal insufficiency other than dehydration. The patient was started on hydration and allopurinol treatments. During follow-up, urea and creatinine levels decreased to normal limits. The patient's basal cortisol was 12.02 μg/dL and ACTH was 83.8ng/L. Low-dose (1μg) ACTH test was performed on the patient, for whom chemotherapy was planned for his primary disease, with the preliminary diagnosis of adrenal insufficiency. The patient's cortisol levels were detected as 8.23-10.35-8.93-9.75 μg/dL at 30-60-90 and 120 minutes, respectively, and hydrocortisone treatment was started with the diagnosis of adrenal insufficiency. During the follow-up of the patient, R-CHOP chemotherapy was started, and since the patient had prednisolone in the chemotherapy course, hydrocortisone was discontinued during chemotherapy and isolated prednisolone treatment was given. Central Nervous System involvement was detected in the cerebrospinal fluid during intrathecal (IT) chemotherapy (Mtx, Dexamethasone, Cytosine Arabinosine). Intrathecal therapy was initially administered 3 times a week and subsequently twice a week. Since no cells were detected in the cytocentrifuge, intrathecal chemotherapy was given 4 times. After 6 cycles of R-CHOP chemotherapy, the patient underwent Autologous peripheral stem cell transplantation because of high risk disease in December 2023. The patient, whose general condition is good during follow-up, is currently being followed in remission under replacement dose hydrocortisone treatment.

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PP 04

A FALSE POSITIVE PET-CT RESULT AFTER TREATMENT OF A PATIENT WITH DIFFUSE B-CELL LARGE CELL LYMPHOMA. A CLINICAL CASE.

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