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

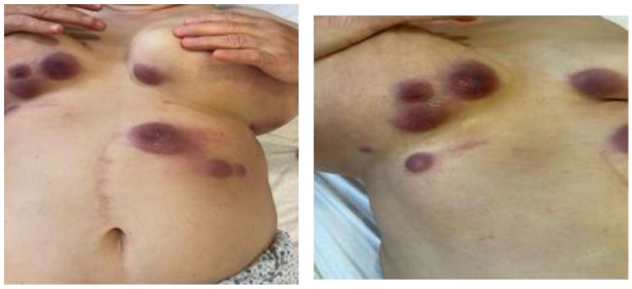

Figure 1: Palpable firm nodular lesions on the trunk and back

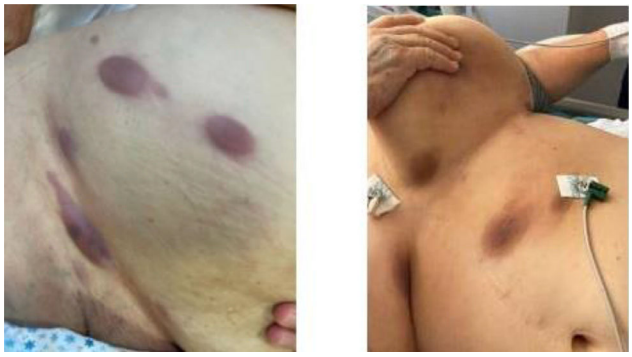

Figure 2: After treatment

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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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Objective: The use of 18F-fluorodeoxyglucose positron emission tomography (18F-FDG PET-CT) to determine the initial stage and assess the response to treatment for aggressive lymphomas is considered standard. Evaluation of bone marrow infiltration in PET-CT with 18F-FDG usually makes it possible to distinguish normal regenerating bone marrow after chemotherapy by the characteristic nature of absorption. **Case report:** A 54-year-old patient diagnosed with diffuse large B-cell lymphoma (DLBCL) with lesions of the lymph nodes and bone marrow of the focal form with osteodestruction of the lytic type. Therapy at the A.F. Tsyba MRRC – 6 cycles of R-CHOP, completed in December 2022. **Results:** The PET-CT - 2 cycles is completely normalized. The February 2023, PET-CT showed an increase in the level of metabolism in one of the foci of osteodestruction in the pelvic bones. The biopsy, March 2023, absence of signs of DLBCL. PET-CT, June 2023, the increase of contrast accumulation in previously identified foci. Trepan biopsy in July 2023 – a picture of hematopoiesis foci in the bone marrow, a statement of remission. PET-CT scan in December 2023 confirming the remission of the disease. **Conclusion:** False-positive PET-CT results in the era of rituximab began to be detected with greater frequency, therefore, their assessment and correct interpretation, as well as additional clarification using other available techniques, are necessary in modern clinical practice to choose tactics for further therapy.

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PP 05

A CASE OF RELAPSED REFRACTORY MANTLE CELL LYMPHOMA PRESENTING WITH SKIN LESIONS

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Objective: Mantle cell lymphoma (MCL) is a rare subtype of B-cell lymphoma characterized by clinical and biological heterogeneity. Lymph nodes are the most commonly involved sites. Other important regions affected by the disease are bone marrow and spleen. However, skin involvement is rare in MCL, and most cases occur due to secondary cutaneous spread of disseminated disease. In this report, a case of relapsed, refractory (R/R) MCL with skin lesions is discussed. **Case report:** A 43-year-old male patient was admitted to our clinic with the complaint of palpable cervical and axillary diffuse lymph nodes. The patient was diagnosed with MCL as a result of lymph node biopsy, and was evaluated as stage 4 and a high-risk disease according to the MIPI scoring system, After chemoimmunotherapy, autologous bone marrow transplantation was performed. The patient who was followed up as a complete response, macular lesions raised from the skin appeared on the lower extremities 4 years after the initial diagnosis (Figure 1), and a skin biopsy was performed; MCL was evaluated as R/R disease. In the immunohistochemical study, CD5, CyclinD1 were positive, Sox-11 was weakly positive, and Ki 67 were evaluated as 100%. The patient was delivered rituximab + ibrutinib (R+I) treatments. After treatment, skin lesions disappeared. After 3 cycles of treatment, the patient underwent an allogeneic bone marrow transplant from his fully compatible sibling. During this period, skin lesions appeared on the trunk, and a skin biopsy was performed; It was evaluated as GVHD (graft versus host disease) and prednol treatment was delivered. The patient, who was evaluated as prednol refractory during the follow-up, was delivered JAK-2 inhibitor and his complaints regressed. The patient was evaluated as a complete metabolic response at the 3rd month post-transplant follow-up. Figure-1 Lower extremity skin involvement Methodology **Conclusion:** MCL is a different type of non-Hodgkin lymphoma that usually affects extranodal sites. The most commonly affected areas are the bone marrow, gastrointestinal tract, and Waldeyer's ring, but the skin is rarely affected. The disease can present with a wide variety of lesions, ranging from petechial erythematous macules to subcutaneous nodules, and very atypical presentations, such as acneiform lesions, have also been reported. Since extremity and trunk involvement is more common, skin involvement can be seen anywhere in the body. Most often, skin lesions are accompanied by systemic symptoms, but a few cases of only cutaneous lesions without systemic involvement have been described. Skin lesions may develop before clinical symptoms appear. In one report describing five cases of MCL involving the skin; 3 patients initially presented with skin lesions but there was evidence of extensive disease at diagnosis. MCL can often involve the skin as a manifestation of disseminated disease and is often associated with blastoid cytological features. Our case also presented with erythematous macular lesions in R/R disease and showed significant improvement in skin lesions and lymphadenopathy with the combination of rituximab + ibrutinib. The poor outcomes seen in MCL patients with TP53 mutations receiving chemoimmunotherapy and second-line Bruton tyrosine kinase inhibitors suggest an urgent need for alternative approaches. There are a number of promising treatments for R/R MCL beyond covalent BTK inhibitors, including CAR T cell therapy and novel immunotherapeutics such as bispecific antibodies. Although most MCL patients have durable responses after chemoimmunotherapy, there is a need to prospectively identify high-risk patient subgroups for whom disease control with standard chemotherapy is poor. Because of the variability of its presentation, which includes nonspecific papules that appear benign, it is important to be aware of the skin manifestations of MCL.