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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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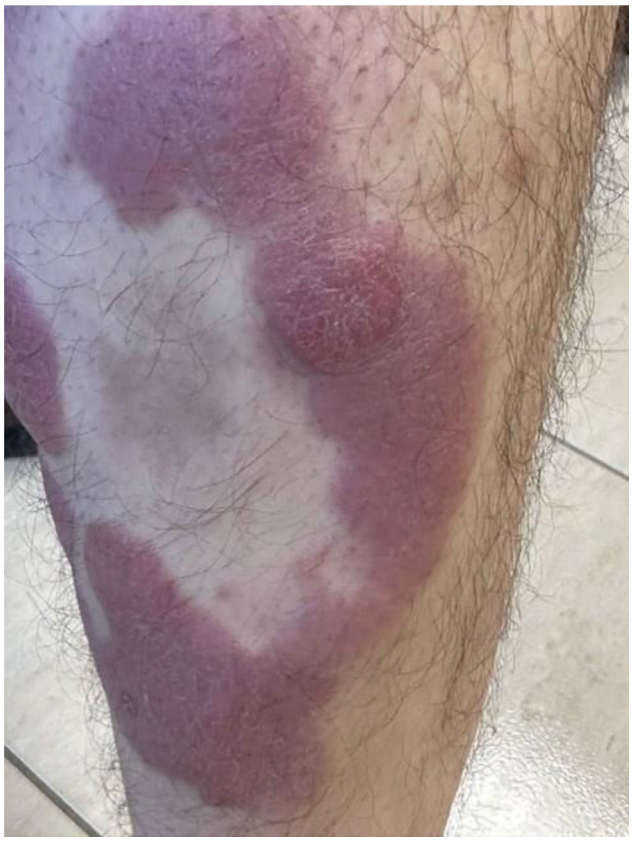
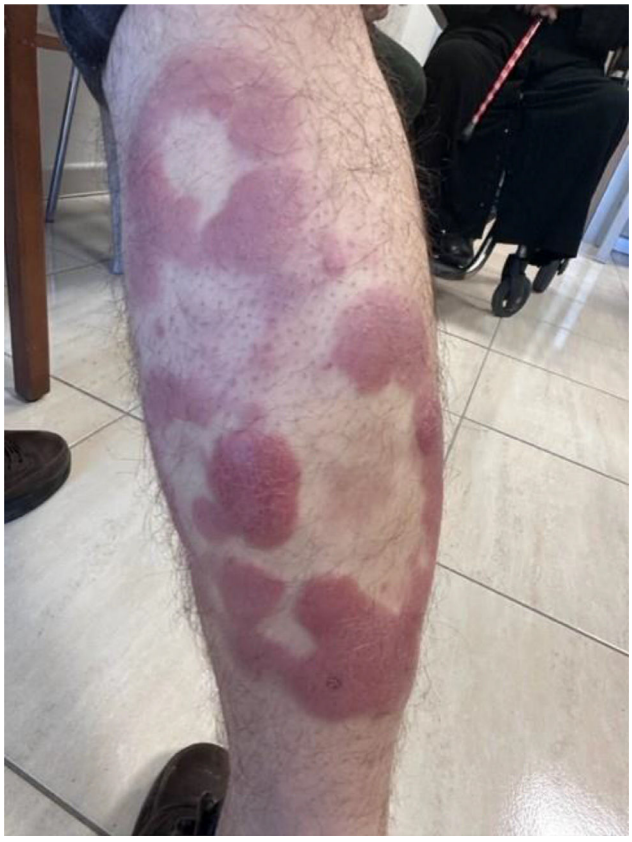
Objective: Mantle cell lymphoma (MCL) is a rare subtype of B-cell lymphoma characterized by clinical and biological heterogeneity. Lymph nodes are the most commonly involved sites. Other important regions affected by the disease are bone marrow and spleen. However, skin involvement is rare in MCL, and 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.





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PP 06

A CASE OF RECURRENT DIFFUSE LARGE B CELL NONHODGKIN LYMPHOMA WITH SKIN INVOLVEMENT

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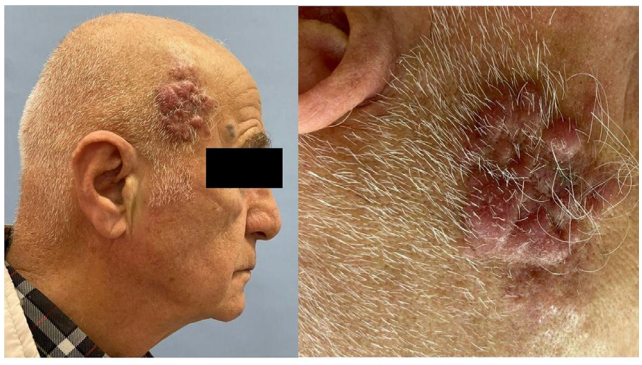
Objective: Diffuse large B-cell lymphoma (DLBCL) is the most common histological subtype of non-Hodgkin lymphoma (NHL). Extra nodal involvement of B-cell lymphoma is usually seen in the gastrointestinal system, followed by the skin. Skin involvement of B-cell lymphomas can be primary or secondary. In this article, we aimed to present a case of DLBCL which did not have skin involvement before but showed recurrence with skin involvement. **Case report:** A 77-year-old male patient presented with a diagnosis of DLBCL based on excisional LAP biopsy in the inguinal region conducted in November 2022. Laboratory tests revealed Hgb 14.3 g/dL, WBC 4.6 × 10^3/μL, plt 191 × 10^3/μL. Following 4 cycles of R-mini CHOP based on the stage 4 DLBCL diagnosis from PET-CT, interim PET-CT showed regression in existing lesions. Methodology: The R-miniCHOP regimen was completed with 8 cycles. In December 2023, a nodular lesion with raised erythematous ground and vascularity in the temporal region was identified (Figure 1). Dermatological evaluation and biopsy revealed infiltration consistent with high-grade B-cell lymphoma. PET-CT detected increased FDG uptake (SUVmax: 10.13) in a soft tissue-density lesion in the right parietal region. Due to age and performance status, the patient was planned for Rituximab-Lenalidomide protocol. Results: Starting from the 1st cycle, lesions showed regression, and by the 2nd week of the 1st cycle, complete disappearance of lesions was observed (Figure-2). Conclusion: In conclusion, while NHL usually recurs in the same sites of involvement, widespread secondary cutaneous involvement has also been reported in the literature. In our patient who did not have primary skin involvement, disease recurrence occurred in the cutaneous region.In cases like ours, the optimal treatment option is salvage chemotherapy followed by autologous stem cell transplantation.



Figüre-1: Infiltrating nodular lesion in the temporal region with vascularisation on a raised erythematous background