survival, particularly through its interaction with Estrogen Receptors (ER). The study by Ladikou et al.[1] highlights that estrogen receptors are expressed in B-cell malignancies, including CLL, and predominantly involve the ERβ isoform, which has antiproliferative effects when selectively activated. Importantly, the disruption of estrogen-mediated pathways may lead to reduced proliferation and enhanced apoptosis of malignant B-cells. To the best of our knowledge, this is the second case of SR of CLL after letrozole treatment in the literature.[2] Future studies need to focus on the genetic causes of SR of CLL.

Keywords: Chronic lymphocytic leukemia, Letrozole, Spontaneous regression.

References:

1. Ladikou EE, Kassi E. The emerging role of estrogen in B cell malignancies. Leuk Lymphoma. 2016;58:528-39.
2. Paydas S. Regression of chronic lymphocytic leukemia with aromatase inhibitor-letrozole? Leuk Res. 2008;33: 566-7.

Table 1 Peripheral lymphocyte counts of the patient.

Date	Lymphocyte Count	Letrozole
September 2018	7.02	-
January 2020	8.58	-
August 2022	10.45	-
December 2023	8.11	-
February 2024	1.49	+*
July 2024	2.37	+
November 2024	2.8	+
January 2025	3.37	+

*Letrozole 2.5 mg/day was initiated in January 2024.

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Adult Hematology Abstract Categories

Chronic Myeloid Leukemia

PP 14_Case report

ANALYSIS OF RESPONSE TO FIRST-LINE THERAPY WITH IMATINIB IN AZERBAIJANI CML PATIENTS

Aypara Hasanova [a], Chingiz Asadov [a], Aytan Shirinova [a], Gunay Aliyeva [b], Zohra Alimirzoyeva [a]

[a] *National Hematology and Transfusiology Center, Azerbaijan*
[b] *National Centre of Oncology, Azerbaijan*

Objective: Imatinib mesylate is a selective tyrosine kinase inhibitor that has become the prototype for targeted therapy in hematologic malignancies. The introduction of Imatinib (IM) for the treatment of Chronic Myeloid Leukemia (CML) has significantly altered the natural course of the disease. The drug is specifically designed to inhibit the expansion of cells expressing the BCR/ABL1 fusion gene and receptors for stem cell factor, c-kit tyrosine kinases, and platelet-derived growth factors. To evaluate the response of Azerbaijani patients in the chronic phase of Chronic Myeloid Leukemia (CML) to treatment with imatinib mesylate (400 mg/day), monitored via Real-Time Quantitative Polymerase Chain Reaction (RT-qPCR). **Methodology:** This study spans from January 2015 to December 2019 and includes 242 patients in the chronic phase of CML. A total of 1,187 samples were collected from these patients at specific intervals: 3–5 months, 6–11 months, 12–17 months, 18–23 months, and ≥24-months after the initiation of IM therapy. Among them, 69 patients had samples analyzed at all time points. The quantification of BCR/ABL1 was performed using RT-qPCR, with ABL1 serving as the control gene. The BCR/ABL1 ratio results were expressed as a percentage according to the International Scale (IS). **Results:** The molecular response profile of patients with samples from all time intervals (n = 69) showed that during the first interval (3–5 months), 73.9% (51/69) of patients exhibited a 1-log reduction in BCR-ABL1IS transcript levels. At 12–17 months, monitoring indicated that 92.7% (64/69) of patients achieved at least a 1-log reduction, while 72.4% (50/69) attained at least a 2-log reduction. This observation did not apply to the second group, as initial molecular testing for some patients was only performed at 12–18 months or later after starting IM therapy. **Conclusion:** Unsatisfactory responses can be attributed to improper drug use due to side effects, non-adherence to therapy, delayed monitoring, or secondary resistance to the drug. Proper adherence to treatment and consistent monitoring play crucial roles in therapeutic outcomes. These findings reaffirm the necessity of regular monitoring every three or six months. This study demonstrates that the response to IM in Azerbaijani CML patients in the chronic phase aligns with the responses reported in randomized international studies.

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Adult Hematology Abstract Categories

Aggressive B-cell lymphoma

PP 15_ Case report

OUTCOMES OF DIFFUSE LARGE B-CELL LYMPHOMA IN OLDER ADULTS TREATED IN RESOURCE-CONSTRAINED SETTINGS

Natasha Ali [a], Raheel Iftikhar [b], Zeeshan Khan [c], Usman Ahmed [d], Humera Mahmood [e], Zeba Aziz [c]

[a] *Aga Khan University Karachi, Pakistan*
[b] *Armed Forces Bone Marrow Transplant Centre Rawalpindi, Pakistan*
[c] *Hameed Latif Hospital Lahore, Pakistan*
[d] *Shaukat Khanum Memorial Cancer Hospital & Research Center Lahore, Pakistan*
[e] *Nuclear Medicine, Oncology and Radiotherapy Institute Islamabad, Pakistan*

Objective: Treating Diffuse Large B-Cell Lymphoma (DLBCL) in elderly patients is challenging. There is limited data available from Low- and Middle-Income Countries (LMICs) on elderly DLBCL. We analyzed the presentations and survival outcomes of patients with DLBCL according to their socioeconomic status. **Methodology:** This was a multicenter retrospective study conducted from 2015 to 2023. We included 176 patients aged 60 years or older. The variables examined were age, gender, subtype, resource environment and treatment received. Kaplan-Meier curve was created for the entire patient cohort; t-test was utilized to compare means, Disease-Free Survival (DFS) and Overall Survival (OS), with a significance level of $p < 0.05$. Analysis was performed using SPSS version 29. **Results:** The median age was 66 years (range: 60–89 years). Ninety-three (57%) patients were treated in limited resource settings, while 43% had enhanced resources. ECOG performance scores between 2 and 3 were present in 71%. Median IPI score was 3. RCHOP regimen was administered to 51% (n = 81) patients, and CHOP regimen to 20% (n = 32) patients. In 21% (n = 38) salvage treatment was given due to relapsed/refractory disease. None of the patients in this group received consolidation with autologous stem cell transplant. The entire cohort's OS was 12-months, while DFS was 8-months. OS (33.9% vs. 8.2%; $p = 0.00$) and DFS (29% vs. 5.9%; $p = 0.00$) were better in patients with enhanced resources. The median DFS of patients treated in enhanced settings was 1.3-years versus 0.4-years in limited resource settings ($p < 0.0001$) **Conclusion:** Survival rates were lower for patients receiving treatment in resource-limited settings. Outcomes can be improved with early referral and inclusion of Rituximab. Enhanced geriatric assessments along with better supportive care is essential.

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PP 16_ Case report

METHOTREXATE-ASSOCIATED STEVENS-JOHNSON SYNDROME AND TOXIC EPIDERMAL NECROLYSIS: TWO CASE REPORTS

Yakup Unsal [a], Muhammed Murati [a], Guler Delibalta [b], Serdar Bedii Omay [a], Vildan Yazici [c], Nedim Polat [d]

[a] *Emsey Hospital Bone Marrow Transplantation Center, Turkey*
[b] *Emsey Hospital Infectious Diseases, Turkey*
[c] *Emsey Hospital Dermatology Department, Turkey*
[d] *Private Polat Pathology Laboratory, Turkey*

Objective: Stevens-Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN) are rare but severe mucocutaneous diseases. These conditions are mostly drug-induced and have high mortality rates. They are primarily characterized by skin and mucosal involvement. In addition to supportive treatments, plasmapheresis and immunosuppressive drugs are used in treatment. We present our experience with 2 cases of SJS/TEN that developed after high-dose Methotrexate use in the treatment of two different hematological malignancies. **Case report 1:** A 58-year-old male was diagnosed with Primary Central Nervous System (CNS) Lymphoma in August 2024. The patient started on MATRIX (Methotrexate 3000 mg/m^2/day, Cytarabine 1000 mg/m^2/day, Rituximab 375 mg/m^2/day) therapy. On September 2, 2024, the first cycle of treatment was administered. On the 8th day, erythematous rashes appeared on the palms and soles. The patient was consulted with dermatology and received local treatment for a suspected drug reaction. The lesions resolved. During the second cycle of MATRIX therapy on September 30, 2024, the patient received four doses of intrathecal Methotrexate 12 mg and Cytarabine 100 mg by October 3, 2024. On the fourth day of treatment, the creatinine level rose to 3.05 mg/dL (baseline 0.9 mg/dL). Suspecting toxic nephropathy, hydration therapy was initiated under nephrology consultation. On the 10th day of treatment, the patient developed a fever above 38°C, accompanied by erythematous lesions on the skin, particularly in the oral mucosa. Following the recommendation of the Infectious Diseases Department, treatment with Cefoperazone/Sulbactam and Micafungin was initiated. During the same period, the patient developed diarrhea (6–8 times per day) and was given symptomatic treatment. On the 13th day of treatment, as skin rashes increased, Prednisolone (1 mg/kg) was initiated. However, the skin lesions continued to progress. On the 15th day of treatment, with a creatinine level of 1.8 mg/dL, the patient developed absolute neutropenia. Filgrastim (G-CSF) therapy was started. The patient was consulted with the Dermatology Department due to the skin lesions. Pale erythema on the skin and erythematous patches with targetoid vesicles on the extremities were observed. The body surface area involvement was estimated to be approximately 10%–30%. A skin biopsy was performed, and the findings were reported as Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis (SJS/TEN). Based on the current findings, the patient was diagnosed with SJS/TEN Overlap Syndrome, and pulse Prednisolone 500 mg was initiated for 3 days. Due to elevated acute phase reactants and absolute neutropenia, the Infectious Diseases Department recommended discontinuing Cefoperazone & Sulbactam treatment. The patient was then started on Meropenem and Daptomycin. On the 23rd day of treatment, as the skin lesions continued to progress, Cyclosporine A therapy was considered. However, due to ongoing Acute Renal Failure, Tacrolimus infusion was initiated instead. Concurrently, plasmapheresis (1:1) was performed. On the 25th day of treatment, the patient remained in absolute neutropenia (neutrophil count: 0), and IVIG (0.4 g/kg/day) was started. On the 26th day, the patient developed desaturation and was transferred to the intensive care unit, where elective intubation was performed. The patient was connected to a mechanical ventilator, but unfortunately, on the 27th day of treatment, the patient died due to multiorgan failure. **Case report 2:** A 34-year-old female patient was diagnosed with Acute Lymphoblastic Leukemia (B-ALL) in December 2024. The patient, who was Philadelphia chromosome-negative, received the first cycle of Hyper-CVAD therapy (Cyclophosphamide 2×300 mg/m^2/day for 3 days, Vincristine 2 mg/day, Adriamycin 50 mg/m^2/day, Decort 40 mg/day for 4 days). Remission was achieved, and a total of 3 doses of intrathecal Methotrexate 12 mg and Cytarabine 100 mg were administered. On January 6, 2025,