

rates were more favorable ( $p=0.01$ ). Especially for BC with a high Ki-67. Disease progression was observed in 1/3 of BC patients with low levels of B1 cells. CD38 expression on B-cells was a prognostically favorable factor: the role is realized during 5–10-years of follow-up after surgery. Level CD38+ B-cells more than 10% correlated with high OS ( $p=0.02$ ). The presence of CD10+CD19+ B-lineage precursors was associated with a more favorable prognosis (OS, the threshold level 12%,  $p=0.04$ ). The prognostic role of the CD10 antigen was realized when patients were observed for more than 5-years. **Conclusion:** Total relative number of (more than 10%) of BM CD19+ cells were significantly related to OS in BC. B-cell precursors and CD38+ B-cells were associated with favorable prognosis. Prognostic role of B-lineage precursors and CD38- positive cells was in the periods of 5–10 years after surgery.

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#### OP 06\_Case report

##### NEURON SPECIFIC ENOLASE POSITIVE OVARIAN INTERMEDIATE GRADE SERTOLI LEYDIG CELL TUMOR: A RARE CASE REPORT

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**Objective:** Ovarian Sertoli-Leydig Cell Tumors (SLCTs) are rare sex cord-stromal tumors, accounting for less than 0.5% of all primary ovarian tumors. They are most commonly diagnosed in adolescents and young women and can present with a variety of symptoms, including abdominal pain, a palpable mass, and, in some cases, signs of hormonal imbalance. While tumor markers such as Cancer Antigen-125 (CA-125) may be elevated, Neuron-Specific Enolase (NSE) is not typically associated with these tumors. **Results:** A 14-year-old girl presented with diffuse abdominal pain and sudden abdominal distension. Laboratory tests revealed elevated CA-125 (65.3 U/mL, normal: 0–35 U/mL) and NSE (13.7  $\mu\text{g/L}$ , normal: 0–12.4  $\mu\text{g/L}$ ). Imaging studies, including transabdominal pelvic ultrasound and abdominal Computed Tomography (CT), demonstrated a large, 23 cm right ovarian mass with predominantly solid but focal cystic components, raising suspicion for malignancy. Given the tumor's size and characteristics, a fertility-sparing right salpingo-oophorectomy and paravertebral retroperitoneal lymph node biopsies were performed. Histopathological examination confirmed an intermediate-grade Sertoli-Leydig cell tumor with frequent mitotic figures but no necrosis. **Conclusion:** This case is notable as the first reported instance of an SLCT associated with elevated serum NSE levels. While NSE is primarily considered a marker for neuroendocrine tumors and small cell lung carcinoma, its elevation in this case raises questions about its potential role in SLCTs. This finding suggests a need for further research to determine whether NSE could serve as a useful biomarker in the diagnosis or monitoring of SLCTs. Given the rarity of these tumors and the limited data on

their tumor marker profiles, additional studies are needed to explore the clinical significance of NSE elevation in SLCTs.

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#### OP 07\_Case report

##### POLYRADICULOPATHY FOLLOWING CAR T- CELL THERAPY FOR LYMPHOID MALIGNANCIES, DIAGNOSTIC CHALLENGES: A REPORT OF 3 CASES

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**Objective:** Neurotoxicity is a serious but incompletely understood complication of CAR T-cell therapy. here we highlight presentation and diagnostic challenges of non-CNS CAR T-cell therapy complication. **Case series:** Case 1: A 43-year-old female with relapsed DLBCL stage IVB without CNS involvement underwent Axi-Cel CAR T-cell therapy, developing grade I CRS responded to tocilizumab. On day +15, developed diplopia and 6<sup>th</sup> nerve palsy MRI suggestive CNS lymphomatous infiltration, managed with dexamethasone and intrathecal MTX with a PET scan on day 30 showing CMR. Subsequently, she had limbs weakness with EMG/NCS confirming polyradiculopathy CSF showing high protein but negative for infection, malignant cells and autoimmune. Treatment included methylprednisolone, plasmapheresis, and IVIG, leading to slight improvement. Day 60 PET-CT revealed cervical and lumbar nerve roots neuritis, and by day 90, biopsy-confirmed disease relapse. She had partial response to glofitamab, unfortunately, she passed away four months post-CAR T-cell therapy. Case 2: A 38-year-old male with primary refractory stage III DLBCL received Axi-Cel after lymphodepletion with Flu/Cy. On day +1, grade I CRS developed and was treated with tocilizumab and dexamethasone. By day +4, he exhibited ICANS grade IV with confusion and seizures, managed with methylprednisolone, anakinra, and lorazepam. CSF showed high protein but no infection or malignant cells. MRI suggested viral encephalitis, and acyclovir was started. Extubated on day +8, but showed lower limb weakness (0/5 power) and urinary retention. Spinal MRI showed intramedullary T2 changes. IVIG was given on day +11, and physical therapy started. By day +16, he could stand; MRI normalized by day +29. PET-CT on day +32 showed a very good partial response. The patient was able to walk and discharged on day +39 with ongoing recovery. Case 3: A 36-year-old male with CML transformed to B-cell ALL with CNS involvement refractory to triple IT chemotherapy received IT thiotepea, complicating with lower limb weakness and sphincter loss. NCS confirmed L5 radiculopathy; MRI and CSF were negative for blasts or CNS disease. Post-Brexu-cel infusion (day +5 to +7), he developed CRS grade I, treated with