infiltration of soft tissue. MS may present at any time of disease process and any localization. It should be kept in mind that hematological malignancies may be seen all over the body and may be present atypically because early diagnosis and treatment are very important cause of MS's aggressive clinical course.

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PP 04

Postdural puncture superior sagittal sinus thrombosis during remission induction therapy for acute lymphoblastic leukemia

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Objective: Superior sagittal sinus thrombosis (SSST) during the course of acute lymphoblastic leukemia (ALL) may arise during or even after treatment. Majority of the cases are either directly attributed to ALL or considered as a consequence of using chemotherapy agents including prednisone, vincristine, cytarabine and especially L-Asparaginase. Post-lumbar puncture intracranial hypotension is a rarely encountered cause of SSST in ALL.

Case report: A 27-year-old man was admitted with fatigue and following bone marrow aspiration and biopsy, he was diagnosed as having B-ALL. He received HyperCVAD regimen as remission induction therapy, which included doxorubicine, vincristine and cyclophosphamide, dexamethasone and intrathecal administration of methotrexate. Cranial computerized tomography (CT) prior to intrathecal methotrexate was normal. Cerebrospinal fluid analysis was acellular and showed no ALL infiltration. He complained of mild postural headache intrathecal treatment. Eight days after intrathecal administration of methotrexate on day 13 of HyperCVAD, he complained of newly developing non-postural headache and vomiting.

Methodology: At the time of symptoms, complete blood count showed the following: WBC: 5480/uL, Hgb: 12.3 g/dL and PLT: 148,000/uL. Coagulation profile studies showed prothrombin time of 13 s, partial thromboplastin time (PTT) of 30.9 s, and normal concentrations of fibrinogen. Neurologic examination including evaluation of his mental status, sensory, motor, and reflex functions of his extremities. Coronal plane contrast enhanced T1-weighted MRİ demonstrated a nonenhancing superior sagittal sinus with the empty delta sign, compatible with a diagnosis of SSVT. Enoxaparin 2×1 mg/kg was initiated. Platelet transfusions were given to keep platelet count over 50,000/uL during the course of anticoagulant therapy.

Results: SSST in the context of ALL has been ascribed to lymphoblastic infiltration of the superior sagittal sinus wall or to the chemotherapeutic agents used. L-Asparaginase decreases plasma antithrombin, plasminogen, and fibrinogen concentrations while prednisone may increase the levels of factor VIII. These hemostatic changes may predispose to thrombosis, especially in the setting of the turbulent flow in the superior sagittal sinus. Our patient harbored none of the aforementioned risk factors except for the use of corticosteroids. Any cause of intracranial hypotension, which induces a downward shift and traction of the brain, may disrupt the veins/sinus and hence may lead to venous dilatation and thrombosis.

Conclusion: Our patient most probably developed intracranial hypotension due to lumbar puncture, which resulted in SSST. The possibility of a dural venous thrombosis should be suspected in patients with ALL who had treatment with L-asparaginase and prednisone. However, SSST thrombosis should also be an important consideration in patients with dural puncture who report a changing pattern of their headache (postural headache becoming nonpostural in character) and severe nausea and vomiting.

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PP 05

Retrospective analysis of all patients single center experience

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Objective: The aim of study was to evaluate the demographic, clinical, laboratory, genetic and pathological features of the patients followed with the diagnosis of adult ALL in our center and to evaluate their contribution to the prognosis, treatment responses and overall survival rates of the patients and to contribute to the literature.

Methodology: A total of 116 patients diagnosed with ALL in our center between 2006–2018 were included in the study. Patients under 18 years of age and patients with active solid organ malignancies were not included in our study. The data of the patients were obtained by scanning the hospital computer automation system and patient files.

Results: Sixty-two of our patients are male and 54 are female. The mean age of the patients was 43.1 years. Twenty patients were T-ALL and 96 patients were B-ALL. In a quarter of patients, the Philedelphia chromosome was positive. 22 of our patients had standard risk and 94 had high risk class. Total survival rate was 52.6%. The mean total survival time was 41,4 months. 83.6% of the patients were in remission with induction therapy. Forty patients underwent allogeneic stem cell transplantation. There was no statistically significant difference between B-ALL, T-ALL and Ph+ ALL patients in terms of remission induction and survival. Tyrosine kinase inhibitors improved the prognosis of Ph+ ALL patients. In patients who received TKI treatment, the decrease in PCR values at the 3rd month was found to be a good prognostic factor. PCR monitoring is important in predicting prognosis in patients receiving