TKI. The presence of severe fibrosis in the bone marrow (Grade 2–4) was found to be poor prognostic.

Conclusion: In our study, although the overall survival rate is consistent with the literature, it is evident that it is still insufficient. Therefore, more study and innovation are needed in the treatment of adult ALL.

https://doi.org/10.1016/j.htct.2020.09.067

PP 06

Case report: acute lymphoblastic leukemia with bone involvement

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Objective: ALL is the most common type of acute leukemia in children, after AML in adults. At the time of diagnosis, there may be weakness due to anemia, signs of bleeding due to thrombocytopenia, signs of infection related to neutropenia. There may be bone pain due to expansion of the medullary cavity by the leukemic process. However, low back pain due to vertebral body collapse is one of the rare symptoms at the time of diagnosis. We are reporting an adult male patient with acute lymphoblastic leukemia who presented with paraparesis and multiple osteolytic lesions in lomber and thoracal vertebra.

Case report: A 63-year-old male patient had a complaint of back pain for 4 months, spreading to the left leg, accompanied by numbness and loss of strength. The patient without incontinence and painful walking was operated by the neurosurgery department. The patient with pancytopenia was consulted to us. In physical examination peripheral LAP was not detected and spleen size was determined as 16.5 cm by ultrasound. In the laboratory examination was remarkable for Hb: 9 g/dL, MCV: 79 fL, plt: $13*10^3$/uL, sedim 76 mm/h LDH: 1092 u/L. Other biochemical tests are normal. The L2 corpus pathological fracture biopsy result was determined as CD45+, Cd19+, Cd10+, TDT+, PAX 5+, c myc 30%+, Kİ 67% 50+, and was compatible with B lymphoblastic lymphoma infiltration. In bone marrow biopsy, 98% cellularıty, 99% blastic infiltration was detected. Blasts were CD34+, CD19+, PAX 5+, 80% CD10+, 80% TDT+, 50% CD22+, 30% CD20+, CD123+, respectively. Cytogenetics and fluorescence in situ hybridization (FISH) panel for ALL were normal; Philadelphia chromosome was not present. HyperCVAD chemotherapy was started for the patient who was diagnosed with B-ALL+ bone involvement. Intrathecal chemotherapies were given. After Hyper CVAD 2B chemotherapy, the patient was clapped due to sepsis.

Conclusion: Skeletal lesions can occur in a variety of malignant hematological conditions. In diseases such as multiple myeloma and waldenstrom macroglobulinemia, bone involvement is a common finding in diagnosis. Acute lymphoblastic leukemia and lymphomas can rarely present with osteolytic lesions and neurological involvement. ALL is a chemosensitive tumor, so chemotherapy is the main treatment option. In patients with bone involvement, radiotherapy and surgical resection are the other treatment options that can be applied.

https://doi.org/10.1016/j.htct.2020.09.068

CHRONIC LEUKEMIAS

PP 07

Chronic lymphocytic leukemia presenting as pulmonary involvement in an elderly patient: a case report

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Objective: A significant part of chronic lymphocytic leukemia (CLL) cases receive a diagnosis during the examination of routinely detected lymphocytosis or the investigation of the causes of lymphadenopathy or hepatosplenomegaly. Apart from these, CLL cases may rarely manifest as pulmonary involvement, which can include broncho-pulmonary infiltration, pleural effusion, or an endobronchial lesion. In the literature, cases presenting with CLL-associated broncho-pulmonary infiltration are extremely rare. Here, we present an elderly case with CLL presenting as pulmonary involvement.

Case report: An 82-year-old male patient presented to our hospital with progressive dyspnea, non-productive cough, and weight loss, which had persisted for one month. Chest X-ray radiography revealed opacity in the lower zone of the right lung. Contrast computed tomography (CT) of the chest visualized a soft-tissue density measuring approximately 74 mm × 75 mm in maximal axial dimensions in the inferior segment of the right middle lobe with surrounding ground-glass density and some air bronchogram localized near the medial hilum. Laboratory test results were as follows: hemoglobin level, 13.4 g/dL; total leukocyte count, 174×10^9/L; lymphocyte count, 148×10^9/L; platelet count, 192×10^9/L. Peripheral blood smear showed diffuse mature small lymphocytes and smudge cells. Peripheral blood flow cytometry revealed strong positivity for the CD5, CD20, CD19, and CD23 markers, consistent with CLL. A bronchoscopy was performed for diagnostic purposes and a transbronchial biopsy was taken from the lung parenchyma, and bronchoalveolar lavage (BAL) was performed. BAL cytology and microbiological tests were not diagnostic. On immunohistochemical examination of the parenchymal biopsy, neoplastic cells showed a CD20(+), CD5(+), CD23(+), CK(−), CK7(−), CK20(−), CD56(−), synaptophysin(−), chromogranin-A(−), CD3(−), TTF-1(−), Napsin A(−), and P63(−) staining pattern. The Ki67 proliferation index was 10%. The pathology clinic reported the result to be consistent with a chronic lymphocytic leukemia/small lymphoma infiltration. Cervical and abdominopelvic CT results of the patient were also considered and the CLL stage was determined as RAI 2