19.5, 14.9 and 17.7. In 2019 Hodgkin lymphoma was diagnosed in 9.4% of cases, non-Hodgkin lymphomas – in 36.4%, multiple myeloma and plasma cells neoplasms – in 8.6%, lymphoid leukemias – in 13.7%, myeloid leukemias – in 8.3%, monocytic leukemias – in 1.7%, and other leukemias – in 19.8%. The male's rate was 51.5%, the female's rate – 48.5%. The age of 50–79 years prevailed in both genders (males – 65%, females – 72.5%). The children constituted 4.0% of newly diagnosed cases and 4.8% of those under the follow-up at the end of the year. Regarding the chronic myeloproliferative neoplasms (CMN), prefibrotic stage of PMF was confirmed in 42.1% of cases, fibrotic stage – in 57.9%. The diagnosis of CML was asserted in chronic phase in 89.3% of patients and in accelerated phase in 10.7%. PV was diagnosed in erythremic stage in all cases: II A – in 87.1% of cases, IIB – in 12.9%. The age group of 60–69 years proved to be more numerous in PV (80.6%), as compared with CML (53.4%) and PMF (52.6%) cases. The disease span range from the onset to diagnosis was 1.4–7 months (median – 3.5 ± 0.63 months) in PMF, 1.5–12 months (median – 2.1 ± 0.37 months) in CML, and 1–8 months (median – 3.8 ± 0.54 months) in PV. The clinical onset and addressability of patients with CML and PMF did not significantly differ, the absolute majority (over 90%) being consulted by the family doctors because of the appearance of fatigue, left upper hemiabdomen heaviness and pain. The majority of PV patients (67.7%) addressed for the medical care by reason of a stable arterial hypertension and astheno-vegetative syndrome.

Conclusion: The incidence of malignant lymphomas and leukemias in Moldova emerged rather lower than in the majority of European countries mainly due to the migration of a workable population. Mostly the 50–79 years old males proved to be affected. PV yielded to be less frequently registered CMN, diagnosed more tardily due to the resemblance with cardiovascular disorders.

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PP 10

A rare case: coexistence of small cell lung cancer and chronic lymphocytic leukemia

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Objective: The most common type of leukemia in adults; chronic lymphocytic leukemia (CLL), which is detected in 25% of all leukemias. In epidemiological studies in western societies, its incidence was found to be 4/100,000. CLL is an advanced age disease and its incidence increases with age. While some of the patients are followed up asymptomatically and with lymphocytosis without any treatment indications, others may show aggressive clinical course, appear with cytopenia and cause chemotherapy indications. Suppression of immunity and B cell dysfunction in CLL can cause secondary malignancies. In a much rarer group of patients, the diagnosis of CLL and solid organ cancer is made simultaneously. In such cases, pathological or cytogenetic common mechanisms or common risk factors such as smoking and radiation may play a role in etiology. We also wanted to present the coexistence of small cell lung cancer (SCLC) and CLL, which are rarely diagnosed simultaneously, and may contribute to the literature.

Case report: In the examination of a 82-year-old male with a history of smoking 30 packs/year, who suffered from ongoing loss of balance for approximately 1 month, an irregular limited mass with a size of 3×2 cm was detected in the upper left lobe. The fine needle biopsy result from the mass was reported as SCLC and was considered Stage 3 in the evaluation. The patient was started on cisplatin 75 mg/m^2 + etoposide 100 mg/m^2 chemotherapy protocol treatment by department of pulmonary diseases. During the diagnosis process, the patient, who was found to have had long-standing lymphocytosis, was also asked for flow cytometry examination upon monitoring of mature lymphocyte infiltration and basket cells in the peripheral smear examination. In flow cytometric examination, CD5, CD19, CD20, CD23 were positive and CD10, CD103 were negative and these findings were reported as B-lymphoproliferative disease (CLL). The patient, who was evaluated as stage 1 CLL with detailed blood tests and imaging, was followed up without treatment. During follow-up, in the evaluation of the patient with deep anemia, the direct coombs test was positive (IgG) and the biochemical markers were compatible with hemolysis, 60 mg/day (1 mg/kg/day) methylprednisolone treatment was started for the patient who was diagnosed with autoimmune hemolytic anemia. With the initiation of corticosteroid therapy, a significant increase in both hemoglobin value and improvement in hemolysis parameters of the patient was observed and treatment was continued by decreasing the dose. The patient, whose steroid treatment is completed and hemogram parameters are monitored within normal limits, is followed up without treatment by the hematology department in terms of CLL. At the same time, the third cycle of chemotherapy has been completed with the diagnosis of SCLC and is followed by the department of pulmonary diseases.

Conclusion: CLL constitutes a high risk factor for many solid tumors such as lung, breast, colon and prostate cancer. In a study in which 4.869 CLL patients were screened for secondary malignancy, 33 lung cancers were detected and SCLC was 6% among all lung cancers.

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PP 11

Stevens–Johnson syndrome secondary to rituximab administration in a chronic lymphocytic leukemia patient

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Objective: Stevens–Johnson syndrome (SJS) is an acute hypersensitivity reaction that compromises the integrity of mucous membranes and cutaneous tissue. Chronic

lymphocytic leukemia(CLL) is a chronic B-lymphoproliferative neoplasm that is one of the most often appearances in daily hematological practice. The CD20 antigen is an attractive target in CLL as it is present on the surface of mature B-cells. Rituximab is a highly specific chimeric mouse/human anti-CD20 antibody that is widely used in the treatment of CLL and other B-lymphomas. The aim of this abstract is to describe the occurrence of Stevens-Johnson syndrome as a result of the administration of Rituximab to a patient with CLL

Case report: We report the case of a 49 years old caucasian male that four years previously was diagnosed with CLL stage A Binet. The "watch and wait" strategy was adopted at that time. But the patient disappeared from the current supervision of the hematologist and returned after 4 years with B symptoms, giant splenomegaly, hepatomegaly, peripheral lymphadenopathy, and bicytopenia (anemia and thrombocytopenia) that accompanied the lymphocytosis in peripheral blood. Stage C Binet was established, and for this patient was proposed the initiation of treatment with chemoimmunotherapy type FCR according to guidelines. But, the patient refused to administer any type of chemotherapy and in the absence of new targeted therapeutic alternatives, the most plausible solution was to initiate monotherapy with Rituximab 375 mg/m^2 weekly. On the 3rd day after the second administration of rituximab, he experienced a febrile episode 38.5 °C, fatigue, and weakness, moderate pain all over the skin, which were aggravated by a slight touch and a non-pruritic widespread maculopapular rash, which affects the oral mucosa and also the skin in the genital area, palmar and plantar region. SJS was diagnosed affecting 12% of total body surface area according to the Lund-Browder Burn calculator. Rituximab therapy was stopped and immediate treatment of SJS has started. Patients received supportive care measures including hydration, wound debridement, systemic and topical antibiotics, topical and systemic corticosteroids, nutritional support, and pain management for 4 weeks with a total recovery of skin and mucosal lesions.

Conclusion: Although SJS is a rare complication of Rituximab therapy (0.01% in a series of 167,000 patients), it remains a dreaded complication with a 30% mortality rate among patients who develop it. Recognition of clinical signs and prompt diagnosis along with complex therapy can ensure adequate recovery of the case.

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CHRONIC MYELOPROLIFERATIVE DISEASES

PP 12

Concomitant essential thrombocythemia and mature B-lymphoproliferative disorder in a patient

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Objective: ET and B-LPD are two distinct, clonal hematologic malignancies with their concomitant existence in a single individual being exceedingly rare.

Case report: A 64-year-old male was admitted with cough, weight loss, maculopapular rash and elevated platelet counts. The rash was present on his face and trunk for 20 days and he had non-productive cough for the past two weeks. On examination, he was found to have cervical lymphadenopathy and splenomegaly (5 cm below left costal margin). His blood counts were as follows: hemoglobin 10.8 g/dl, hematocrit 37.2%, RBC mass 5.34×10^{12}/L, WBC 62.1×10^9/L, platelets 1169×10^9/L. LDH was found to be 816 IU/L and C-reactive protein was 2.43 mg/dl. Peripheral blood film showed anisocytosis, poikilocytosis, elliptical cells, tear-drop cells, nucleated red blood cells, myelocytes and metamyelocytes. Platelets were markedly increased on film. Leucoerythroblastic blood picture was noted. Suspecting a myeloproliferative disorder, additional investigations were sent while the patient was started on hydroxyurea 1gm daily and allopurinol 100 mg daily in addition to antibiotics. Bone marrow aspirate depicted increase in lymphoid cells that constituted around 35% of the total nucleated non-erythroid cell population. M:E ratio was 4:1. Bone trephine showed hypercellularity for age with overall cellularity 90 to 95%. Cellular areas exhibited increase in myeloid precursors along with prominent lymphoid cells and abundant megakaryocytes. Pan-T (CD03) and Pan-B (CD20) marker by immunohistochemistry was applied on bone trephine biopsy specimen which was interpreted as increase in B-lymphocytes. Reticulin stain showed grade MF-2 reticulin fibrosis. Overall findings were suggestive of essential thrombocythemia. In view of increased CD20 positive cells, immunophenotyping by flow cytometry was recommended. CD45 positive lymphoid cells population was 31%. This population showed reactivity to Pan-B-markers i.e. CD19 (26%), CD20 (27%), CD22 (26%), CD23 (11%) and cCD79a (30%) along with HLA-DR (12%) and CD45 (35%). Double bright positivity of CD19 and CD5 typical of CLL was absent. This population also showed positivity to lambda light chains restriction (kappa 0%, lambda 13%). Results were consistent with mature-B-lymphoproliferative disorder (B-LPD). JAK2 mutation was detected by PCR while BCR-ABL1 translocation was not detected by fluorescence in situ hybridization (FISH). Since double bright positivity for CD19 and CD5 was absent along with absence of FMC7, a diagnosis of mature-B-lymphoproliferative disorder was made. Cyclin D1 was applied on bone trephine, which was negative, and the infiltration did not reveal a follicular pattern. Ki67 was approximately 30%. A diagnosis of ET progressing to myelofibrosis and B-LPD was made. Patient was discharged in a stable condition and followed up on an outpatient basis. Ruxolitinib at a dose of 5 mg twice daily was initiated while hydroxyurea was reduced to 500 mg daily and then later to alternate day dosing. A wait and watch approach was adopted for the B-LPD Ruxolitinib was later increased to 10 mg twice daily. After a few months, ruxolitinib was switched to 15 mg daily with the counts remaining stable. The patient remains stable and asymptomatic two and half years later. The most recent blood counts show hemoglobin at 10.9 g/dl, WBC 31.1×10^9/L, and platelets 445×10^9/L.

Methodology: Retrospective review of case.