(moderate risk) and Binet B (moderate risk). However, in consideration of his weight loss and symptomatic extranodal involvement, a chemotherapy protocol with bendamustine and the CD20 antibody rituximab (BR) was initiated. BR treatment was administered every 28 days for up to 6 courses. The patient's symptoms demonstrated marked improvement after two cycles of chemotherapy. After a total of 4 courses, lymphocytosis in the peripheral blood showed complete remission and the involvement that had been visualized on direct chest radiography and CT showed nearly complete remission. After 6 cycles of chemotherapy, the patient was considered in complete remission and follow-up was started.

Conclusion: Pulmonary complications and involvement in CLL typically occur after the diagnosis, in the course of the disease, while there are cases who present as pulmonary involvement (broncho-pulmonary infiltrates, hilar and mediastinal lymphadenopathies, pleural effusion, etc.), although much less frequently. Pulmonary involvement must be considered in patients diagnosed with CLL who have symptoms associated with the respiratory system. Particularly in patients diagnosed with broncho-pulmonary lesions based on peripheral blood analysis or lymph node biopsy, CLL-associated involvement should certainly be included in the differential diagnosis when the most common causes are excluded.

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PP 08

Frequency of brucellosis and hepatitis b virus seropositivity in patients with chronic lymphocytic leukemia

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Objective: Chronic lymphocytic leukemia (CLL) is a disease characterized by an increase in mature neoplastic lymphocytes in tissues with a lymphoid component, such as peripheral blood, bone marrow, lymph node, spleen, and liver. Patients with CLL show defective cellular and humoral immune responses. Although such immune failure is known to be associated with an increase in the frequency of particularly gram-positive and -negative bacterial infections, data on the increase in the frequency of zoonoses such as brucellosis and viral infections such as the hepatitis B virus (HBV) are inconclusive. This study aims to investigate the frequency of brucellosis and HBV seropositivity in patients diagnosed with CLL.

Methodology: Patients followed-up for CLL between 2005 and 2019 were evaluated. Results of patients who were tested for HBsAg and anti-HBs serology using the ELISA assay and for Brucellosis using the serum (Wright) agglutination test were recorded. Demographic data and laboratory results of all patients included in the study were evaluated.

Results: This study included 188 patients diagnosed with CLL, of whom 56 (29.8%) were female and 132 (70.2%) were male. The median age was 62 (range: 33–92) years. Complete blood count parameters at diagnosis were as follows: median leukocyte count, 54.4×10^9/L; median lymphocyte count, 42.3×10^9/L; median platelet count, 148×10^9/L; median hemoglobin level, 13.4 g/dL. HBsAg and anti-HBs were tested in 142 patients. A total of 16 (11.27%) patients were HBsAg-positive; with 5 (3.52%) positive cases in females and 11 (7.75%) in males. A total of 105 (73.95%) patients were anti-HBs-positive; with 32 (22.54%) positive cases in females and 73 (51.41%) in males. The Wright agglutination test was performed on 82 patients. A total of 4 (4.88%) patients reacted positively to the Wright test; with 3 (3.66%) positive cases in females and 1 (1.22%) in males.

Conclusion: The immune system disorders that develop due to the nature of CLL make the patient more vulnerable to infections. Accordingly, many patients lose their lives due to a clinical picture of severe infection. Based on the present study, compared with the epidemiological studies conducted in the same region; the rate of positive reactions to the Wright agglutination test was consistent with the literature data; however, a higher rate of HBsAg positivity was determined. This may be linked to the increase in the risk of HBV transmission due to the immune defect caused by CLL or the immunosuppressive picture induced by the medication used in the treatment, or viral reactivation.

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PP 09

Epidemiological spectrum and diagnosis patterns of hematological malignancies in the republic of moldova

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Objective: Hematological malignancies (HM) are the relatively frequent nosological entities within the structure of morbidity by malignant tumors, exhibiting a severe evolution, restrained prognosis and negative socio-economic impact in the advanced stages and phases. The objective of the study was to analyze the incidence and diagnosis patterns of HM in Moldova.

Methodology: The following research methods were used: epidemiological, descriptive statistics, clinico-analytic. The type of HM was identified according to the Revised 2017 WHO Classification of Tumours of Hematopoietic and Lymphoid Tissues. The diagnosis was proved by histopathological, cytological, cytogenetic, molecular and immunophenotyping examinations. The quantitative real-time PCR was used in order to assess the expression of BCR-ABL p210 and p190 transcripts for CML diagnosis. The quantitative detection of JAK2 V617F mutation served as a major criterion for diagnosis of polycythemia vera (PV) and primary myelofibrosis (PMF).

Results: The number of newly diagnosed and followed-up patients with HM at the Institute of Oncology in 2016, 2017, 2018 and 2019 amounted respectively to 725, 802, 613 and 628, the incidence (new cases per 100,000 population) being 17.6,

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