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Acute ischemic stroke presentation of otherwise asymptomatic covid-19 patient

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Objective: Coronavirus disease 2019 (COVID-19), first identified in Wuhan, China in December 2019, become widespread and may be mortal, especially in some high-risk group. Most of the reported experiences suggested that COVID-19 is associated with a distinct coagulation disorder resulting in fibrin thrombi within small vessels and capillaries. Data focusing on arterial thrombotic events is few. In milder COVID cases, both hemorrhagic and ischemic stroke may occur. Acute ischemic stroke seems to be higher than the rate identified among patients who visited the emergency departments (ED). On the other hand, SARS-CoV-2 has the potential for neurotropism. We here present a case who had neurological symptoms during pandemic days and has been diagnosed with imaging-proven ischemic stroke with COVID-19.

Case report: A 40-year-old female patient presented to the ED with an articulation of speech and numbness in the right arm and leg. She is not a smoker and denied any environmental exposure. Physical examination revealed fever and hypotension with a respiratory rate was 18 breaths/min. She had dysarthria, hypoesthesia, and frustrated hemiparesis on the right arm and leg. Oxygen saturation was 98% on room air. Mild normocytic anaemia and lymphopenia associated with a mild elevation in transaminases (AST 73 U/L, ALT 103 U/L) and in D-Dimer (1440 ng/ml) associated the clinical picture. Thoracic CT showed bilateral multifocal peripheral ground glass infiltrations (Picture-1). Conventional MRI imaging is consistent with acute ischemia of millimetre in size on the left parietal lobe (Picture-2). The patient was accepted as having COVID-19 and acute ischemic stroke. She commenced on hydroxychloroquine and azithromycin with enoxaparin. Nasopharynx swab sample was found to be severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) positive by RT-PCR. She did not progress to the hyperinflammation phase and discharged on 10th day of admission. One month later on, outpatient visit her neurological findings resolved, no weakness was detected.

Conclusion: For each patient with an acute stroke clinic, thoracic CT and SARS-CoV-2 PCR should be performed before transferring to stroke or neurointensive care unit. For our patient, she did not have apparent risk factors for stroke. She was nearly asymptomatic apart of the stroke-related clinic, which points to the direct effect of coronavirus on vascular endothelial cells apart of the relationship between inflammation and coagulopathic complications in COVID-19.

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LYMPHOMA

PP 21

Isolated primary spinal mucosa-associated lymphoid tissue (malt) lymphoma: a rare case report

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Objective: Mucosa-associated lymphoid tissue (MALT) lymphoma, also known as extranodal marginal zone lymphoma (MZL), is a subtype of indolent B-cell non-Hodgkin's lymphoma (NHL). MALT lymphomas are encountered mainly in mucosal organs such as the stomach, however, they can also be found in non-mucosal organs and tissue regions. MALT lymphoma of the spinal dura is a very rare condition. Here, we present the clinical presentation pattern, histopathologic and radiographic findings, treatment options, and response to treatment in a rare case of isolated primary spinal MALT lymphoma.

Case report: A 74-year-old male presented to our hospital with progressive weakness and loss of sensation in bilateral lower extremities, and fecal and urinary incontinence. Spinal MRI examination visualized an extra-axial mass lesion of approximately 45 mm × 11 mm between the vertebral levels T5 and T7. The lesion markedly compressed the spinal cord, severely narrowing the spinal canal and bilateral neural foramina. In order to ensure early decompression of the spine and histopathological diagnosis of the epidural mass, a total laminectomy of T6 and a subtotal resection of the mass were performed. On immunohistochemical examination of the mass, neoplastic cells showed: LCA(+), CD20(+), CD79a(+), PAX5(+), bcl-6(−), fascin(−), CD3(−), CD5(−), cyclin D1(−),CD23(−), CD138(−), kappa (−), lambda (−), MUM1(−), CD10(−), tdt(−), CD15(−), CD30(−), reticulin(−), and a Ki67 proliferation index of 20%; and the pathology department reported the findings to be consistent with MALT lymphoma of the dura. Following mass resection, FDG-PET CT) was performed to determine the extent of the disease, and other regions of the body did not show 18-FDG uptake. Bone marrow aspiration and biopsy showed that there was no infiltration. Only systemic chemotherapy was planned as the patient refused to undergo radiotherapy. A systemic combination therapy with R-CHOP protocol every 3 weeks and central nervous system prophylaxis with intrathecal cytarabine and dexamethasone were carried for the patient. After

two chemotherapy cycles, there was a significant improvement in motor weakness and the fecal and urinary function impairment. After a total of 6 cycles, spinal MRI and FDG-PET CT showed complete disappearance of the lesion. The patient remains in remission, at 1-year follow-up.

Conclusion: This report presents a case of primary spinal MALT lymphoma, which is extremely rare. Lymphoma should be considered in the differential diagnosis of patients who present with a spinal mass and the subtype of the lymphoma must be identified. The management of MALT lymphomas is quite heterogenous and there exist no universally-accepted therapeutic guidelines for this rare condition. A treatment option must be selected in consideration of the disease subtype, stage, and the clinical characteristics of the patient. In spinal MALT lymphoma, both local and systemic treatment options are available. Local treatments such as surgical resection or radiotherapy can achieve complete remission in patients with MALT lymphomas confined to a single site or at early stages. Systemic treatment is an option for patients who are not suitable for local treatment and appropriate patients may be administered systemic chemotherapy regimens that include anti-CD20 monoclonal antibodies.

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PP 22

Ir2 leading to complete remission in r/r richter syndrome – a case report

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Introduction: Relapsed and refractory diffuse large B Non-Hodgkin lymphoma (r/r DLBCL) is a severe condition with fatal outcome for the majority of the patients. (1) Richter Syndrome is defined as a transformation of chronic lymphatic leukemia in a highly aggressive B-Non-Hodgkin lymphoma, mainly DLBCL. 20% of Richters Syndromes are de novo DLBCL, implying comparable prognosis to other aggressive Non-Hodgkin Lymphoma, whereas 80% are clonally related to the CLL cells and imply a poor prognosis of one-year median overall survival. (2) Despite huge efforts that have been achieved recently by implementing CAR-T Cells for r/r DLBCL and transformed Follicular Lymphoma, treatment of r/r Richter syndrome remains desperate with poor outcome. Allogenic stem cell transplantation is recommended for eligible patients. The combination of Anti CD 20 Antibody Rituximab with IMiD Lenalidomide and Bruton-kinase inhibitor Ibrutinib iR2 has shown safety and efficacy in a breaking phase II study. (2)

We present the rare case of a patient with refractory DLBCL after CLL (Richter Transformation) who achieved complete remission with iR2 and was successfully transplanted.

Case report: Our by now 74-year old patient was first diagnosed with CLL in 08/2014. He showed ubiquitous lymph nodes and evidence of p53 mutation, Binet stage B & RAI I.

He was treated with Ofatumumab + Bendamustine in the first line, Rituximab + Idelalisib in first relapse and Ibrutinib in second relapse before evolving to highly aggressive B-NHL in 10/2019. Richters Syndrome was first treated with Standard Immunochemotherapy (R-CHOP), before switching to Rituximab + Ifosphamid + Etoposid + Carboplatin (R-ICE) for refractory disease. There was further progress (clearly progressive lymph nodes cervical) after first cycle R-ICE chemotherapy, we decided to treat with a combination of immunotherapy with the Anti CD 79a-Antibody Polatuzumab in combination with Rituximab. Unfortunately, we saw again progressive disease after three cycles, that lead to the decision of experimental application of Ibrutinib in combination with Rituximab and Lenalidomid.

We saw an immediate effect as Lactat-dehydrogenase normalized very soon and lymph nodes disappeared completely.

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PP 23

Primary spinal extramedullary diffuse large B-cell lymphoma presenting with initial spinal cord compression: a case report

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Objective: Extranodal lymphomas, by definition, can involve any organ or tissue. Brain parenchyma, spinal cord, eyes, cranial nerves, and meninx are extranodal regions that show involvement at much lower rates. It is quite rare for lymphoma patients to present to the hospital with symptoms and findings associated with spinal cord compression as the initial presentation. This condition can lead to irreversible autonomic dysfunction, and motor and sensory loss. Here, we present a rare primary spinal intradural extramedullary diffuse large B-cell lymphoma (DLBCL) case who presented with acute neurological symptoms and no findings of cerebral involvement or involvement at any other site.

Case report: A 41-year-old male patient presented to our hospital with thoracic back pain and progressive complaints of weakness, numbness and difficulty in ambulation in bilateral lower extremities. On spinal MRI examination, a well-circumscribed intradural extramedullary mass with a craniocaudal extension of 6 cm and an AP diameter of 1 cm that was isointense to the spinal cord on T1-weighted sequences and slightly hyperintense on T2-weighted series, and showed diffuse homogenous contrast enhancement after intravenous contrast agent injection was determined between the vertebral levels T6 and T8. In the surgical operation, the mass showed partial invasion of the vertebral bone and the surrounding muscle. The mass invading the dura was resected and laminectomy was performed at T6-T9. On histopathological examination of the mass, there was diffuse malignant