We aimed to explore the association between the NLR/PLR and prognosis in diffuse large B-cell lymphoma (DLBCL).

Methodology: The study was carried out retrospectively. A systematic search of the hospital database regarding DLBCL patients was performed between April 2004 and March 2019. Completely accessible data were included in the study.

Results: Overall, 122 patients included in the study. There were 64 males and 58 females. At the time of diagnosis, the mean age was 51.3 ± 14.3 years, whereas 26 (21.3%) were under 40 years, 26 (21.3%) between 40–49 years, 35 (28.7%) between 50-59 years, and 35 (28.7%) were over 60 years old. Approximately 50% were at an advanced stage. At the time of diagnosis, the mean NLR was 3.8 with an absolute neutrophil count of 4852.4/μL (0.600–16.000/μL), and the absolute lymphocyte count of 1757.9/μL (0.100–15.000/μL). The mean PLR was 213.6, with a mean platelet count of 250,000/μL (range 260,000–715,000/μL). ROC analysis gave the cut-off point for PLR as >152.86, and NLR >3.05. All patients (90.2%) received R-CHOP based therapy. The median follow-up time was 69 months (range 3–244). During the follow-up period, 8.2% of patients died. Patients with high NLR levels showed more frequent B symptoms ($p = 0.034$). Patients with high PLR levels had a statistically significant lower overall survival (OS) and progression-free survival (PFS) ($p = 0.012$ and $p = 0.004$, respectively). In patients with high NLR levels, the OS rate proved to be shorter, but this finding has not achieved a statistical significance. However, PFS was statistically significantly shorter ($p = 0.022$). In the multivariate analysis of PLR and clinical factors in terms of non-progressive survival, age, IPI score, and high PLR level are independent risk factors for non-progressive survival ($p = 0.013$, $p = 0.039$ and $p = 0.031$, respectively). In multivariate analysis of NLR and clinical factors, age and IPI score are independent risk factors for non-progressive survival ($p = 0.026$ and $p = 0.046$, respectively).

Conclusion: This study demonstrated that elevated pretreatment PLR was significantly associated with poor prognosis in DLBCL patients. PLR could be helpful as a potential prognostic biomarker to guide clinical decision-making and select individualized treatment strategies for DLBCL patients.

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PP 26

Two diseases in a single lymph node: nodular lymphocyte predominant hodgkin lymphoma and kaposi's sarcoma

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Objective: Kaposi's Sarcoma (KS) is the most common low-grade mesenchymal angioproliferative disease seen in patients infected with the human immunodeficiency virus (HIV). Lymph node involvement is rare in classical KS, but it is common in endemic and epidemic (AIDS-related) KS. Kaposi's sarcoma-associated herpesvirus (KSHV), also known as human herpesvirus type 8(HHV8), was first described in HIV-associated KS. Nodular lymphocyte predominant Hodgkin Lymphoma (NLPHL)is a rare lymphoma with an incidence of 0.1 to 0.2/100,000/y. Significant histological feature is the presence of CD20 (+) CD15 (–) CD30 (–) variants in a nodular infiltration lymphocyte pattern of Reed-Sternberg cells. The coexistence of Hodgkin's disease (HD) and KS is a rare condition.

Case report: A 41-year-old male patient presented to the hematology outpatient clinic with painless swelling in the left armpit. There were no B symptoms at the patient's presentation. He had a history of RAI due to hyperthyroidism in 2004 and using 100 mcg of Levothyroxine. He also had a history of 7 packs/year of cigarette (exsmoker) and alcohol use as a social drinker. On physical examination, a well-demarcated, flip, painless lymphadenomegaly (LAM) was detected in the left axillary region, and hepatosplenomegaly (HSM) was not spresent. The laboratory results were as follows: wbc: 8300 UL; 15.1 g/dL, lymphoyte: 1450 mm^3, plt: 197,000 UL, albumin: 4.5 g/L, calcium: 10.9 mg/dL, ldh: 156 U/L, uric acid: 6.5 mg/dL. The serological tests were negative, other biochemical parameters were normal. The peripheral smear of the patient was evaluated as normal morphology. An cxcisional lymph node biopsy was taken from the left axilla. The pathology result was interpreted as nodular lymphocyte predominant Hodgkin's lymphoma (NLP) classical type and Kaposi's sarcoma with diffuse HHV-8 positivity. Bone marrow biopsy revealed no Kaposi's or Hodgkin's lymphoma infiltration. PET-CT imaging was performed for lymphoma staging. Lymphoproliferative disease involvement was observed at the left axilla level 2, 3 in bilateral, cervial, left infraclavicular, retropectoral area and along the medial line of the spleen. It was evaluated as stage II S. No additional lesion was detected in the patient evaluated by dermatology for Kaposi's sarcoma. Gastroscopy and colonoscopy were performed for gastrointestinal tract involvement and evaluated with biopsy. Helicobacter Pylori was observed in gastroscopy and eradication treatment was given. No pathological finding was seen in colonoscopy. By evaluating as early-stage NLP Hodgkin's Lymphoma, the patient was initiated on radiotherapy.

Methodology: Except for the need for an impaired immune system for the development of KS, it is thought that the relationship of KS with HD may be related to common pathogenic mechanisms instead of a direct causal relationship.

Results: Recently, HD and KS development has been associated with EBV and HHV-8, respectively. Although there are cases of KS and classical HD coexistence in the same lymph node, the coexistence of KS and NLPHL subtype in the same lymph node is quite rare.

Conclusion: Although KS is most commonly associated with immunodeficiency due to HIV infection or other causes of immunosuppression, it was not associated with any immunodeficiency status in our case. Due to the fact that KS and NLPHL were present in the same lymph node as two separate primers and were not immunosuppressed, we presented our

case below. It was also unusual for KS to have primary lymph node involvement without cutaneous involvement.

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PP 27

Extranodal marginal zone lymphoma of the ocular adnexa

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Objective: Ocular manifestations of non-Hodgkin lymphoma are rare, and the diagnosis can be delayed because of nonspecific symptoms and a tendency to mimic the appearance of other ocular diseases. Suspicious presentations will require confirmation of the lymphoma through surgical biopsy. The aim of this study was to present an ocular non-Hodgkin marginal zone lymphoma without systemic involvement, which was successfully managed with external beam radiation.

Case report: A 77-year-old female developed redness and swelling in the right eye which was initially treated as a nodular episcleritis and applied to our outpatient clinic. When the situation did not resolve, a subsequent biopsy diagnosed a low-grade non-Hodgkin marginal zone lymphoma. Systemic involvement was not detected in the images performed. Magnetic resonance imaging did not demonstrate any uveal or orbital extension and no intraocular involvement was noted. The lesion was treated with 30 Gy external beam radiation for a total of 10 days, resulting in significant tumor regression. Six month after the radiotherapy, the tumor has not recurred, and there has been no systemic involvement.

Conclusion: It is not unusual for ocular adnexa lymphomas to masquerade as another clinical entity, sometimes making the initial diagnosis challenging. A biopsy to rule out malignancy should be considered. We wanted to present this case because it is a rare case.

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PP 28

Alk (–) anaplastic large cell lymphoma diagnosed by tongue root biopsy: case report

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Objective: Anaplastic large cell lymphoma(ALCL) which was described in 1985, is rare subtype among non-hodgkin lymphomas with rate of 2%. ALCL is located' mature T and NK neoplasms' group in 2016 WHO' mature lymphoid, histiocytic and dendritic neoplasms' classification. Besides ALCL subdivided into anaplastic lymphoma kinase (ALK) negative (–), ALK positive (+), primary cutaneous, group of associated with breast implant. CD30 and ALK are key molecules at pathology, diagnosis, treatment of ALCL. ALK (+) ALCL has a better prognosis than ALK (–) ALCL. Peripheral and mediastinal-abdominal lymphadenopathies (LAP), appears in more than half of patients. Approximately 60% of patients have extranodal involvement. The most common extranodal involvement sites are; skin, bone, liver, lung, spleen, bone marrow and soft tissue. Rare involvement occurs in the central nervous system and gastrointestinal tract. We wanted to our patient with ALK (–) ALCL diagnosed with tongue root biopsy in order to contribute to the literature.

Case report: It was learned that a-60-year old female patient applied to the otolaryngology department with the complaint of swelling in the neck, and in her detailed examination, tonsillectomy and tongue root biopsy was performed due to suspicious mass. The patient direct to us on the reporting of tongue root biopsy pathology as ALK(–) ALCL. PET-CT was taken for staging. As a result of PET-CT: left submandibular 15 mm × 8 mm LAP (SUVmax: 4.15), right submandibular 14 mm × 10 mm LAP (SUVmax: 6.32), left jugular 27 mm × 37 LAP (SUVmax: 15.91), left deep servical 11 mm × 8 mm (SUVmax: 10.35), left supraclavicular 13 mm × 10 mm (SUVmax: 15.08) was detected and there was no involvement in bone marrow biopsy. The patient was considered stage ll ALK (–) ALCL. A total of 6 cure of CHOEP (cyclophosphamide 100 mg/day, vincristine 2 mg/day, adriamycin 85 mg/day,etoposide 150 mg/day and methlylprednisole 100 mg/day) were planned. In the evaluation after 6 cure chemotherapy:the patient with complete remmision was followed up.

Conclusion: Although ALCL is rare, it is a disease that needs to be diagnosed and treated quickly due to its clinical course. Although skin, bone, liver, lung, spleen, bone marrow and soft tissue involvement are common, it should be kept in mind that it can be seen rare cases such as central nervous system, gastrointestinal system and tongue root as that our case. Protocols containing anthracycline such as CHOP/CHOEP (cyclophosphamide, doxorubucin, vincristine, prednisone/cyclophosphamide, doxorubucin, vincristine, etoposide, prednisone) form the basis of treatment. Non-CHOP induction strategies:ifosfamide, carboplatin, etoposide (ICE), autologous stem cell transplant/allogeneic stem cell transplant after ICE plus intrathecal methotrexate. Despite this protocols and new treatment agents (pralatrexate, ibrutinib, etc.) early diagnosis is very important at ALCL.

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