patients had normal karyotype.Venetoclax+azacytidine treatment was started in all patients as first-line treatment after obtaining off-label consent.The average number of courses of venetoclax + azacitidine administered 3.5 (1-8).Patients received 200 mg/day venetoclax because of fluconazole usage concomittantly.One patient died with a FEN attack at the end of the second cycle, and 5 patients are still being followed up. **Conclusion:** Azacitidine or decitabine monotherapy yields low response rates (10%-50%, including hematologic improvement), require 3.5 to 4.3 months to achieve best response, and are not curative, with a median OS of less than 1 year.Targeted therapies capable of rapidly inducing a high rate of clinical response, with better tolerability and durable responses for elderly patients with AML. The novel combination of venetoclax with decitabine or azacitidine was effective and well tolerated in elderly patients.

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PP 03

A REGISTRY-BASED, OBSERVATIONAL SAFETY STUDY OF INOTUZUMAB OZOGAMICIN (INO) IN PATIENTS WITH B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) PROCEEDING TO HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT)

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Objective: InO is a CD22-directed antibody-drug conjugate indicated for treatment of relapsed/refractory (R/R) ALL. InO has been associated with hepatotoxicity and hepatic veno-occlusive disease/sinusoidal obstruction syndrome (VOD/SOS), particularly post-HSCT. Registry data from the Center for International Blood and Marrow Transplant Research (CIBMTR) was analyzed to assess toxicity in patients (pts) with ALL who received InO prior to HSCT. **Methodology:** CIBMTR patient data are being collected from 2017-2022 after US approval of InO. Data accrued from 2017–2020 from 131 US adult pts (median age 40 y) treated with InO who proceeded to allogeneic HSCT were included. Using interim data at 3 y, we evaluated post-HSCT outcomes, including clinical status, overall survival (OS), non-relapse mortality (NRM), relapse, death after relapse, and investigator-defined adverse events, including hepatic VOD/SOS. All statistical analyses are descriptive. **Results:** Before HSCT, 36% of pts received 1 InO cycle, 46% had 2 cycles, 17% had ≥3 cycles. Median time from last InO dose to HSCT was 2.0 mos (range: 0.4–26.2). At data lock (Nov 2020, n=131), VOD/SOS incidence within 100 d post-HSCT was 13% (18% of R/R ALL pts, n=91). Post-HSCT 12 mo OS was 55%; post-HSCT 12 mo NRM was 21%; post-HSCT 12 mo relapse was 36%; non-HSCT-related 12 mo mortality was 25%. Most pts (89%) who underwent HSCT during complete remission (CR) experienced continued CR post-HSCT. **Conclusion:** Incidence of VOD/SOS after first HSCT in InO-treated pts with R/R ALL in this study was similar to the 18-19% reported in pooled analyses of 2 clinical trials among InO-treated pts with R/R ALL and in the INO-VATE study. The NRM at 1 y of 21% (23% R/R ALL) is lower than the NRM at 1 y of 38% reported in the pooled analyses of R/R ALL InO recipients.

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PP 04

ANTI-CD52 TREATMENT EXPERIENCE IN A T-CELL PROLYMPHOCYTIC LEUKEMIA PATIENT:CASE REPORT

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Objective: T-cell prolymphocytic leukemia (T-PLL) is a rare and highly aggressive T cell neoplasm with rapidly progressing clinical course. T-PLL accounts for 2% of mature lymphocytic leukemia in adults. Median overall survival with modern therapy is reported one to three years. Here we report a T-PLL patient with peritoneum involvement and progressive ascite despite anti-CD52 treatment. **Case report:** A 65-year-old man with diabetes mellitus was admitted to hospital due to fatigue for a few weeks. Laboratory workup revealed that white blood cell count $469 \times 103/\mu l$ (90% lymphocytes), haemoglobin of 11.4 g/dl, platelets of $104 \times 103/\mu l$. Medium sized atypical lymphoid cells with partial chromatin condensation and a visible nucleolus were observed on blood smear. **Methodology:** On physical examination, palpable inguinal lymph nodes, splenomegaly 3 cm below the rib margin and a palpable lesion on the helix of left ear were noticed. Punch biyopsy of skin lesion was reported as a mature and immature T cell infiltration which are CD3 and CD10 positive and Tdt, CD34, CD20, CD99 negative. Flow cytometric study of peripheral blood sample was revealed that T-Chronic Lymphocytic Leukemia (T-CLL). **Results:** FMC protocol (fludarabine, mitoxantrone, and cyclophosphamide) was initiated and followed by intravenous alemtuzumab at a dose of 3 mg on day 1, 10 mg on day 2 and 30 mg on day 3. However after two months of

anti-CD52 treatment, his general situation dete-riorated and pleural effusion and abdominal distension developed due to massive ascites. Small, mature lymphocytic cell infiltration was shown in ascites fluid on cytological examination. He died after six months of diagnosis. **Conclusion:** T-PLL is a very aggressive disease with a median survival of less than 1 year. Not all patients diagnosed with T-PLL require treatment immediately.Currently, IV alemtuzumab (anti-CD52) is the accepted best avaliable treatment with very high response rates when given as first-line treatment. However, treatment is notcurative and a minority of T-PLL patients experience long-term disease-free survival.

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PP 05

RETROSPECTIVE EVALUATION OF PATIENTS WITH ACUTE MYELOID LEUKEMIA RECEIVING VENATOCLAX-BASED TREATMENT

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Objective: Acute myeloid leukemia (AML) is the disease of elderly patients. Therefore, a significant number of patients are not suitable for intensive induction chemotherapy. In this study, it was aimed to retrospectively evaluate patients with AML who were treated Venatoclax-based regimens in our center. **Methodology:** The data of the patients who were treated Venatoclax-based regimens with the diagnosis of AML in the Bozyaka Training and Research Hospital Department of Hematology were scanned retrospectively from their files. **Results:** Data of 11 patients in total were reached. The mean age of the patients was 73.9. 8 of 11 patients were follow-up with diagnosis of AML , 3 patients with MDS RAEB II. Average follow-up time was 13.6 months. 5 patients died during follow-up. HMA +venatoclax was given to 6 patients as first-line, 4 patients second-line and 1 patient third-line therapy. Complete response was found in 3 patients, partial response in 1 patient, stable disease in 1 patient, and refractory disease in 1 patient. **Conclusion:** Venatoclax is a promising treatment option because it is an oral agent that can be tolerated by elderly patients and improves response rates and survival.

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PP 06

BONE MARROW NECROSIS IN ACUTE LYMPHOBLASTIC LEUKEMIA: A CASE REPORT

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Objective: Bone marrow necrosis (BMN) is an entity that necrotic cells are seen on amorphous eosinophilic ground with medullary infarctus but withouth cortical bone involvement. BMN is a postmortem diagnosis in most of the reports. Bone marrow biopsy and aspiration is essential for the diagnosis. The case we report here is a patient who is diagnosed BMN and ALL at the same time with the first bone marrow biopsy, which is showed extensive necrosis. **Case report:** A 42-year-old man applied to our E.R. with lumbal pain. The initial blood count showed leukocyte:5.13 × 109/l, neutrophil:2.68 × 109/l, Hgb:10.7 g/dl, Hct: %31.5, thrombocyte:127 × 109/l, LDH:539 u/l (N:0-250), ALP:185 u/l (N:40-150), Total Bilirubin:0.81 mg/dl, CRP:337mg/l (N<5)), ESH: 94mm/h, folic acide: 2.8ng/ml (N>5.4), Vitamin B12:398 pg/ml (N:210-900), ferritin: 5607 ug/l (N:22-320), fibrinogen:1304 mg/dl (N:200-400), D-Dimer:646 ug/l (N<243) and a normal range for PZ, aPTZ, INR. **Methodology:** Peripheral smear showed %38 PMN, %56 lymphocyte, %6 monocyte, normoblasts, rare tear drop cells and rare thrombocytes. Pathological evaluation revealed hypercellular bone marrow (%95), extensive necrosis, CD3(-) CD5(-) CD20(+), CD38(-), CD10 diffuse(+), BCL2(+) MPO(-) CD117(-), CD34(+) CD79a, Pax5 and TdT suboptimal (+). Flow cytometry showed no significant result because of the deficiency of material. PCR revealed no BCR-ABL transcript. **Results:** The patient diagnosed B precursor ALL. With the BFM IA protocol complete remission obtained. At the control BMB CD3, CD20, CD79a, Pax5, TdT, MPO, CD34 was applied but there was no neoplastic involvement. After the BFM IB protocol, complete remission has been pursued. The patient is currently receiving the BFM IC protocol. **Conclusion:** BMN is an uncommon pathology with poor prognosis. Primary etiology is malignancies, especially hematologic malignancies, at %90 of the cases. As we see at this case, while the clinical and laboratory findings are insignificant; when a patient shows fever with unknown origin, bone pain, newly developed cytopenias, we must keep in mind the diagnosis of BMN and if a patient is diagnosed BMN, necessary scaning must be done immediately for malignancies as the primary cause.

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PP 07

NEXT GENERATION SEQUENCING PRACTICES IN HEMATOLOGY: A RECENT EXPERIENCE OF A SINGLE CENTER

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