replacement during labor with PCC or FFP, but with different regimens [9]. Our patients were treated with PCC prophylaxis during pregnancy and 25 units/kg during labor. No bleeding nor thrombosis was seen in both cases. The British guidelines recommend PCC 20–40 iu/kg during the third trimester for women with history of bleeding and with FX activity <03 iu/ml with the goal of achieving FX activity >04 iu/ml. They also recommend, to consider further PCC 10–20 iu/kg once daily to maintain FX activity >03 iu/ml for at least 3 days post-partum. [10] **Conclusion:** Prophylactic PCC resulted in excellent hemostasis in two of our patients, including one that delivered by C-section.

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LYMPHOMA

PP 07

PREVENTION CAN BE THE BEST TOOL FOR ADULT T-CELL LEUKEMIA. UPDATED T-CELL BRAZIL PROJECT

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Objective: T-cell Brazil project started in April 2017 an ambispective study focusing to collecting epidemiological and clinical data from the most frequent subtypes of PTCL, among them the ATL. As of July 2022 T-cell Brazil database contained 81 (16%) ATL out of 520 registered cases. Our goals are to describe demographic and clinical features, analyze the overall and progression-free survival (OS and PFS), and try to identify factors that could influence outcome. **Methodology:** Brazilian Registry using REDcap Platform by Vanderbilt realized descriptive and bivariate analyses, then it was applied Kaplan-Meier method and log-rank test to obtain survival estimates, and besides that, it was used the Cox Regression to identify any factor that could influence the OS and PFS. **Results:** The median age was 52 years (24-91); 32 (39%) male; the majority of clinical subtypes were 52% lymphoma type; 81% received chemotherapy. The best response assessment after first-line treatment was: progression or no response in 31%; 26% complete response; 21% partial response, 21% not available (NA) due to death or on treatment; 34% of patients were alive and the 24-month OS and PFS was 33% and 21%, respectively. As predictors for PFS and OS were B symptom and elevated LDH values. **Conclusion:** This study, even recognizing a limited sample size, highlights the poor prognosis associated with ATL, mainly acute and lymphoma type, with high mortality rates. Hence, apparently, a good shot, it would be one of the bases for the prevention of ATL to establish a disease entity of "chronic active HTLV-1 infection" that defines high-risk carriers for ATL development, and then, enables preventive intervention.

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PP08

AN UNUSUAL OCULAR LYMPHOMA, PRIMARY INTRAVITREAL LYMPHOMA DIAGNOSED INCIDENTALLY

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Objective: Ocular lymphoma involvement can be either secondary during systemic lymphoma or primary. Diagnosis can be troublesome due to insidious disease onset. Uveitis is the main differential diagnosis. The prognosis is poor. **Case report:** A 62-year-old male patient was evaluated during a periodical check-up for hypertensive retinopathy. The unexpected good vision quality with severe left vitreous infiltration and not associated macular edema contributed to malignancy suspicion. A diagnostic procedure was performed bilaterally. Both of the vitreal tissue revealed atypical lymphoid cells with B-Cell phenotype. Cranial MRI, PET-CT, and CSF analysis documented the case as primary vitreoretinal lymphoma (VRL). **Methodology:** First-line treatment was with intravitreal methotrexate (MTX). After 10 courses, high-dose cytarabine-based treatment was given as consolidation. Considering high recurrence rates, stem cells were mobilized and cryopreserved for future use for autologous stem cell transplantation (ASCT). **Results:** Follow-up was 3 monthly. After 10 months of remission period, retinal disease relapse was spotted. After 5 cycles bilateral intravitreal

MTX, disease progressed as leukemic invasion of left optic nerve. High dose chemotherapy followed by ASCT was performed. **Conclusion:** Diagnosis of IVL is challenging due to late onset macular edema. Related with high relapse rates with-high mortality, high-dose chemotherapy is the recommended management type currently.

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PP09

THE RELATIONSHIP BETWEEN FERRITIN LEVEL AND THROMBOSIS IN PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA

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Objective: Cancer is a well-known condition associated with its treatment and follow-up and increases the risk of thrombosis. As with solid tumors, the risk of venous thromboembolism (VTE) is quite high in lymphomas, especially high-grade B-cell lymphomas. Diffuse large B-cell lymphoma (DLBCL) patients are the most important part of this group. The aim of our study is to determine the effect of ferritin level at the time of diagnosis on thrombosis in DLBCL patients. **Methodology:** In this retrospective study, 133 patients who applied to SBU Dışkapı Yıldırım Beyazıt Training and Research Hospital Hematology clinic and were diagnosed with DLBCL were included in this retrospective study. Demographic characteristics, disease-related findings, presence of central venous catheter and laboratory results of the patients were recorded. **Results:** The median age of the patients included in the study was 63.13±14.85 years. There were 67 female and 66 male patients, stage 1-2: 54 patients, stage 3-4: 79 patients at the time of diagnosis. Thrombosis was observed in 16 of the patients. Median ferritin levels were 357.42 ug/L and 253.07 ug/L, respectively, between the group with and without thrombosis (p:0.026). The ferritin value, which was examined for the presence of thrombosis, was determined as 227 ug/L as a result of the ROC analysis. In the logistic regression analysis, the risk of developing thrombosis was 6.1 times higher in those with a ferritin level ≥227 ug/L. **Conclusion:** Hyperferritinemia may be an independent risk factor for the development of thrombosis in DLBCL patients. In case of hyperferritinemia in patients, initiation of thromboprophylaxis may be an appropriate approach.

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PP 10

RITUXIMAB INDUCED LUNG DISEASE IN A MANTLE CELL LYMPHOMA PATIENT RECEIVING MAINTENANCE: CASE PRESENTATION

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Introduction: Rituximab-induced lung disease (R-ILD) is a rare entity that should be considered in patients treated with rituximab who present with dyspnea, fever, and cough but no clear evidence of infection. We describe the clinical presentation, management, and response to rechallenge in one mantle cell lymphoma patient who developed R-ILD during maintenance rituximab. Case report **Case:** 66 years old male with history of mantle cell lymphoma (MCL), who had been treated with RCHOP and underwent autologous stem cell transplantation (ASCT), was diagnosed with relapse 5 years after ASCT. Six courses of rituximab-bendamustine resulted in 2nd complete response and 2-monthly rituximab maintenance was initiated.10 days after 3rd rituximab , he presented with a 1 week history of progressive exertional dyspnea and cough. He was tachypneic and hypoxemic. **Methodology:** Thorax HRCT showed peripheral bilateral patchy ground glass opacities and nodular opacities. Bronchoalveolar lavage identified no bacterial,viral or fungal pathogen. With presumptive diagnosis of late R-ILD, methylprednisolone(MP) 1 mg/kg/day was started. In absence of rapidly progressing respiratory failure and fever, the patient was evaulated as non severe R-ILD. Thus, rechallenge with rituximab is being considered due to the risk of relapse of MCL. **Results:** Discussion: Reported rate of possible R-ILD is <0.03% in over 540,000 patients. Pulmonary complications of rituximab are hypersensitivity pneumonitis, ARDS, interstitial pneumonitis, organizing pneumonia, pulmonary fibrosis, and alveolar haemorrhage. Symptoms of R-ILD are dyspnea, fever, and hypoxemia and HRCT findings include focal alveolar densities, ground glass opacities and alveolar opacification. Time to symptom onset ranges from 1 day to several weeks after 1st infusion with mean **Conclusion:** mean duration of 3 months. Our patient had received rituximab prior to relapse and developed R-ILD after 9 doses of rituximab for relapse, which is a rare finding. All other causes of potential lung injury had to be meticulously excluded. ILD is a rare but potentially fatal pulmonary toxicity due to rituximab. As the symptoms at presentation are nonspecific, physicians must maintain a high index of suspicion to recognize it early and initiate treatment to avoid severe morbidity and mortality.

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