HEMATOLOGY, TRANSFUSION AND CELL THERAPY

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Oral Presentations

Adult Hematology Abstract Categories, Chronic Myeloproliferative Diseases

OP 01

RETROSPECTIVE ANALYSIS OF PRIMARY MYELOFIBROSIS PATIENTS IN AZERBAIJAN

Elmir Guluyev [1], Madad Abbasov [1], Azer Kerimov [2]

[1] *Main Clinical Hospital of the Ministry of Defense of Azerbaijan*
[2] *National Hematology and Transfusiology Center of Azerbaijan*

Objective: Primary myelofibrosis (PMF) is a rare Ph chromosome-negative chronic myeloproliferative neoplasm characterized by the proliferation of atypical clonal megakaryocytes and fibrosis of the bone marrow. The activation of the JAK-STAT pathway plays a central role in the pathogenesis of the disease. The majority of patients with primary myelofibrosis have one of three main genetic mutations, including JAK2 V617F, CALR exon 9, or MPL W515. The clinical features of the disease are highly heterogeneous. Common symptoms and signs include fatigue, constitutional symptoms, itching, abdominal discomfort, bone pain, anemia, leukocytosis, thrombocytopenia, and splenomegaly. A number of clinical studies on the demographic and clinical features of myelofibrosis have been carried out in different countries. Detailed demographic and clinical characteristics of patients with BMF have not been thoroughly studied in Azerbaijan. The aim of our study was to characterize the demographic, clinical, and laboratory parameters of patients with primary myelofibrosis in Azerbaijan. All patients were registered at the Azerbaijan National Center for Hematology and Transfusion. **Methodology:** A retrospective analysis was conducted on the demographic, clinical, and laboratory data of 131 patients diagnosed with PMF between January 1, 2011, and December 1, 2023. The diagnosis of all patients was revised according to the WHO 2016 criteria for PMF. The fibrosis of the bone marrow was assessed histologically according to the Thiele grading system. Ultrasound examination was used to assess splenomegaly, with a craniocaudal size of >14 cm being considered as splenomegaly. All data were collected from clinical records. This was a retrospective, observational, single-center study. **Results:** A total of one hundred thirty-one (131) patients with primary myelofibrosis were analyzed. Of these, 65 (49.6%) were male. The median age of the patients was 57.5 years (range 19-80), with 9 (6.87%) patients being under 40 years of age. The median hemoglobin level was 10.7 g/dl (range 2.1-19.4), median white blood cell count was 12.86 × 10^12/l (range 0.45-121), median platelet count was 322 × 10^12/l (range 24-1940), and median LDH was 530 U/l (range 181-1586). Splenomegaly was detected in 96 patients, with an average spleen size (19.5 cm)reported. Fifty-one patients had Hgb < 10 g/dl. At the time of diagnosis, the pre-fibrotic stage was identified in the bone marrow examination of sixteen patients (17.8%). Splenomegaly was detected in 96 (91.4%) patients. Of the 66 patients who underwent genetic testing, 44 had a positive Jak2V617F mutation, 2 had a positive CALR mutation, and 1 had a positive MPL mutation. **Conclusion:** Thus, this study has investigated the demographic, clinical, and laboratory characteristics of patients with primary myelofibrosis in Azerbaijan.

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OP 02

BIOCHEMICAL PROPERTIES OF RED BLOOD CELLS IN POLYCYTHEMIA VERA

Weronika Lebowa [1], Jakub Dybaś [2], Stefan Chłopicki [2], Tomasz Sacha [1]

[1] *Jagiellonian University Medical College*
[2] *Jagiellonian Centre for Experimental Therapeutics*

Objective: Polycythemia vera (PV) is a chronic myeloproliferative neoplasm characterized by an increase in red blood cell mass. Thrombotic complications are the main cause of morbidity and mortality in PV. Elevated hematocrit and increased blood viscosity are crucial risk factors for thrombus formation. The aim of our analysis is to evaluate the biochemical alterations in red blood cells (RBCs) and the hemoglobin structure in patients with PV that may be associated with thrombotic complications. **Methodology:** Blood samples were taken from 20 PV patients and 16 healthy individuals. The isolated RBCs were examined using Raman spectroscopy. **Results:** We found a larger contribution of ferrous heme iron, which is a molecular state typical for deoxyhemoglobin in PV samples compared to the control samples. Furthermore, a significant increase in the Fe II/Fe III ratio in PV samples was correlated with a higher hematocrit (Hct) to hemoglobin (Hgb) ratio. A positive trend between a higher Fe II/ Fe III ratio and a higher RDW-SD and RDW-CV was observed in PV samples. In RBCs collected from PV patients we observed a less stable hemoglobin structure. **Conclusion:** Higher values of RDW-SD and RDW-CV may reflect a higher Fe II/ Fe III and be a simple indicator of biochemical alterations in RBCs. A higher Hct/ Hgb ratio could indicate higher clonal myeloproliferative potential and be associated with shorter time to thrombosis in patients with PV. Our future analysis will focus on correlating the above observations with the prothrombotic activity to demonstrate a possible link between the biochemical alterations of RBCs and the thrombotic complications in PV.

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OP 03

SECONDARY SOLID CANCER FREQUENCY AND RISK FACTORS IN PHILADELPHIA- NEGATIVE CHRONIC MYELOPROLIFERATIVE NEOPLASMS

Fehmi Hindilerden [1], Özge Nuran Akay [1], Elif Aksoy [1], Aynur Daglar Aday [2], Emine Gültürk [1], Meliha Nalçacı [3], İpek Yönal Hindilerden [3]

[1] *University of Health Sciences Türkiye Bakırköy Dr. Sadi Konuk Training and Research Hospital, Clinic of Hematology, İstanbul, Türkiye*
[2] *İstanbul University İstanbul Medical Faculty, Department of Internal Medicine, Division of Medical Genetics, İstanbul, Türkiye*
[3] *İstanbul University İstanbul Medical Faculty, Department of Internal Medicine, Division of Hematology, İstanbul, Türkiye*

Objective: Philadelphia chromosome-negative myeloproliferative neoplasms (Ph- MPNs) are characterized by clonal myeloproliferation and somatic mutations. Major complications of Ph-MPNs are thrombosis, bleeding, transformation to myelofibrosis and leukemia. One important concern in the course of Ph-MPNs is risk of development of secondary solid cancers (SSC). In a large cohort of Turkish Ph-MPN patients, we aimed to determine the types and frequencies of SSC, to identify risk factors for SSC including role of cytoreductive therapies and to study impact of SSC on survival in Ph-MPNs. **Methodology:** 1013 patients diagnosed with Ph-MPN from 1995 and 2022 under follow up at adult hematology sections of Istanbul Bakırköy Dr Sadi Konuk Hospital and Istanbul University Medical Faculty were included in this retrospective study. **Results:** Of the 1013 Ph- MPN patients enrolled in our study, 65, 46 and 37 patients were diagnosed with essential thrombocythemia (ET), polycythemia vera (PV) and primary myelofibrosis (PMF), respectively. Patient clinical and laboratory characteristics are summarized in Table 1. Sixty-seven patients (6.6%) developed SSC, predominantly carcinoma (64.2%), non-melanoma skin cancer (23.9%), sarcoma (4.5%), and melanoma (3%). Median time to SSC diagnosis was 80.03 ± 60.5 months with no significant difference among Ph-MPN subtypes. Compared to patients with no diagnosis of SSC, patients with SSC were older at time of Ph- MPN diagnosis (63 vs. 54 years; $p<0.001$) and included a higher proportion of males ($p=0.025$). Ph- MPN patients with SSC and without SSC showed no significant difference for complete blood count parameters, spleen size, Ph-MPN diagnosis groups, driver mutation frequencies and follow-up time. Arterial thrombosis frequency was higher in patients with SSC (37.3% vs. 25.3%; $p=0.030$). SSC rates were 5.7% in patients not exposed to cytoreductive treatment and 5.3%, 4% and 2.1% with exposure to ruxolitinib, anagrelide, and interferon (IFN), respectively. A trend toward lower SSC rates was noted with IFN therapy (3% vs. 97%; $p=0.066$). SSC incidence was significantly higher in patients exposed to hydroxyurea (HU) as first-line monotherapy compared to other treatment groups (7.8% vs. 4.6%; $p=0.046$). Median OS in patients with SSC and patients with no diagnosis of SSC group were 273 months and 195 months, respectively. PV patients, who developed SSC, had significantly worse median OS compared to PV patients without SSC (Figure-1). **Conclusion:** The strengths of our study are that it enrolls a larger patient population, includes PV, ET and PMF subgroups, separately examines development of SSC after MPN, has a long follow-up period and has multicenter design. In MPN patients, malignancy screening gains more importance for those aged ≥65 and males. Our study evaluated with data from previous studies suggest that increased risk of developing SSC in MPN patients may be associated with cytoreductive therapy. Further studies with more pateints are needed

to determine whether Ph- MPN patients are predisposed to development of SSC independent of cytoreductive therapy, to better assess risk of HU or RUX in promoting SSC development in MPNs, and to elucidate the potential protective effect of IFN.

Table-1 Ph- MPN clinical and laboratory characteristics

	MPN (n=1013)	PV (n=380)	ET(n=419)	PMF(n=214)	p**	PV vs ET*	PV vs PMF*	ET vs PMF*
Gender Female, n (%) Male, n (%)	497 (49.1%) 516 (50.9%)	122 (32.1%) 258 (67.9%)	266 (63.5%) 153 (36.5%)	109 (50.9%) 105 (49.1%)	<0.001	<0.001	<0.001	0.002
Age at MPN diagnosis, median (range) <65, n (%) ≥65, n (%)	54 (12-88) 736 (72.7%) 277 (27.3%)	55 (17-84) 284 (74.7%) 96 (25.3%)	51 (12-88) 312 (74.5%) 107 (25.5%)	57.5 (21-84) 140 (65.4%) 74 (34.6%)	<0.001 0.028	0.029 0.926	0.008 0.016	<0.001 0.017
JAK2V617F n (%)	730 (72.1%)	305 (80.3%)	269 (64.2%)	156 (72.9%)	<0.001	<0.001	0.039	0.019
CALR n (%)	71 (7%)	.	58 (13.8%)	13 (6.1%)	.	.	.	0.003
MPL n (%)	4 (0.4%)	.	3 (0.7%)	1 (0.4%)	.	.	.	1.000
Triple negative n (%)	136 (13.4%)	.	90 (21.5%)	46 (21.5%)	.	.	.	0.996
WBC at MPN diagnosis, median (range)	10400 (2300-94000)	10795 (2510-34300)	9900 (4200-51400)	11350 (2300-94000)	<0.001	<0.001	<0.001	<0.001
HB at MPN diagnosis, median (range)	14.7 (5.5-24.5)	17.8 (11.4-24.5)	13.6 (6.7-17.1)	11.4 (5.5-19.5)	<0.001	<0.001	<0.001	<0.001
HCT at MPN diagnosis, median (range)	44.5 (14-85)	54 (36-85)	41 (21-55.5)	35.4 (14-62.7)	<0.001	<0.001	<0.001	<0.001
PLT at MPN diagnosis, median (range)	636000 (28000-2786000)	(40600-1818000)	853000 (110000-2786000)	425500 (28000-230	<0.001	<0.001	0.204	<0.001
Spleen size at MPN diagnosis, median (range)	120 (70-340)	120 (87-260)	120 (75-301)	178 (70-340)	<0.001	0.113	<0.001	<0.001
CV Risk n(%)	716(70.7%)	300(78.9%)	278(66.3%)	138(64.5%)	<0.001	<0.001	<0.001	0.640
Thrombosis, n (%) Arterial, n (%) Venous, n (%)	356 (35.1%) 264(25.1%) 92(12.3%)	144(37.9%) 110(28.9%) 42(11.1%)	138(32.9%) 107(25.2%) 48(11.5%)	74(34.6%) 47(22%) 34(15.9%)	0.335 0.168 0.184	0.143 0.279 0.857	0.421 0.064 0.090	0.678 0.321 0.116
Cytoreductive Therapy, n (%) Hydroxyurea, n (%) IFN, n (%) RUX, n (%)	871(86%) 831(82%) 94(9.3%) 95(9.4%)	314(82.6%) 311(81.8%) 16(4.2%) 15(3.9%)	355(84.7%) 327(78%) 59(14.1%) 5(1.2%)	202(94.4%) 193(90.2%) 19(8.9%) 75(35%)	<0.001 <0.001 <0.001 <0.001	0.425 0.181 <0.001	<0.001 0.006 0.02 <0.001	<0.001 <0.001 0.06 <0.001
Secondary Solid Cancer n (%)	67 (6.6%)	31 (8.4%)	26 (6.2%)	10 (4.7%)	0.236	0.284	0.108	0.431

Table-2 Clinical and laboratory characteristics of patients with secondary solid cancer

	SSC (n=67)	Non-SSC (n=946)	P.
Gender Female n (%) Male n (%)	24 (35.8%) 43 (64.2%)	473 (50.0%) 473 (50.0%)	0.025
Age at MPN diagnosis, median (range) <65 n (%) ≥65 n (%)	63 (37-78) 24 (35.8%) 43 (64.2%)	54 (12-88) 24 (35.8%) 43 (64.2%)	<0.001 0.001
WBC at MPN diagnosis, median (range)	10160 (3900-57260)	10400 (2300-94000)	0.457
HB at MPN diagnosis, median (range)	15.6 (5,8-21)	14.6 (5.5-24.5)	0.734
HCT at MPN diagnosis, median (range)	45.12 (19-69.5)	44,40 (14-85)	0.882
PLT at MPN diagnosis, median (range)	621000 (80000-2786000)	645500 (28000-2631000)	0.803
Spleen Size (mm) at MPN diagnosis, median (range)	120 (102-320)	120 (70-340)	0.658
Diagnostic Group PV n (%) ET n (%) PMF n (%)	31 (46.2%) 26 (38.8%) 10 (14.9%)	349 (36.9%) 393 (41.5%) 204 (21.6%)	0.236
Driver mutation JAK n (%) CALR n (%) MPL n (%) Triple Negative n (%)	49 (73.1%) 7 (10.4%) 1 (1.6%) 10 (14.9%)	681 (84.9%) 65 (8.1%) 3 (0.4%) 53 (6.6%)	0.201
Thrombosis n (%) Arterial n (%) Venous n (%)	30 (44.8%) 25 (37.3%) 6 (9.0%)	326(34.5%) 239 (25.3%) 118 (12.5%)	0.069 0.03 0.396
Cytoreductive Therapy None Cytoreductive Therapy Hydroxyurea Hydroxyurea monotherapy Interferon Therapy Interferon monotherapy Ruxolitinib Ruxolitinib monotherapy Anagrelide Anagrelide monotherapy	8(5.7%) 58(7.0%) 49 (7.8 %) 2 (2.1%) 1 (4.5 %) 5 (5.3%) 0 (0.0 %) 4 (4.0%) 0 (0.0 %)	133 (94.3%) 773 (93.0%) 576 (92.2%) 92 (97.9%) 21 (95.5%) 90 (94.7%) 7 (100.0%) 96 (96.0%) 4 (100.0%)	0.628 0.317 0.046 0.066 1,000 0.578 1,000 0.268 1,000

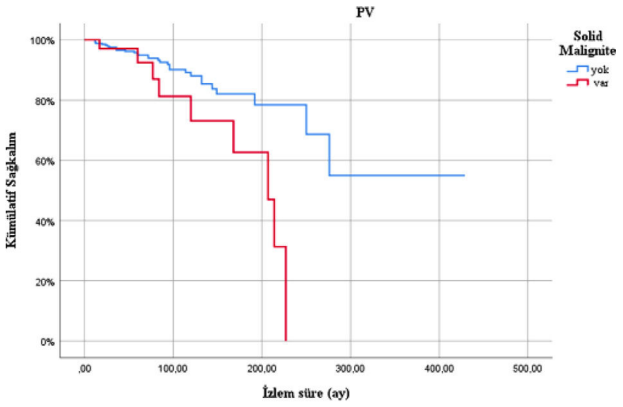

Figure-1 Overall Survival PV patients

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Adult Hematology Abstract Categories, Coagulation Diseases

OP 04

EFFECT OF HEREDITARY THROMBOPHILIA ON ARTERIAL THROMBOSIS

Tansu Büyükgül [1], Ferda Can [2], Nuray Yılmaz Cakmak [1], Ihsan Ates [1], Vehap Topcu [3], Said Furkan Yıldırım [3], Sema Akıncı [2]

[1] *Ankara Bilkent City Hospital Internal Medicine Department*
[2] *Ankara Bilkent City Hospital Hematology Department*
[3] *Ankara Bilkent City Hospital Department of Genetics*

Objective: Screening for hereditary thrombophilia is recommended for venous thrombosis, but there is conflicting information about the causal relation with arterial thrombosis. In this study, in order to clarify these conflicting results and recommendations, it was aimed to determine whether there is a relation between arterial thrombosis and hereditary thrombophilia tests, to determine whether the treatment plan changes according to the test results of patients with hereditary thrombophilia panel, and t **Methodology:** In this single-centre, non-intervention, retrospective cohort study, 200 patients over the age of 18 who were performed hereditary thrombophilia tests by various clinics between 12/02/2019 and 01/07/2022 were included. The patients had no history of disease predisposing to thrombosis, no rheumatological disease, negative antiphospholipid antibodies, and arterial thrombosis. As a control group, 50 patients without arterial and venous thrombosis were included. **Results:** When the

patient group with arterial thrombosis was compared with the control group, no difference was found in the risk of thrombosis in terms of factor V Leiden, prothrombin, Factor XIII, MTHFR 677, MTHFR 1298, PAI-1 gene mutation (p=0.084, p=0.82, p=1, p=0.65, p=0.064, p=1, respectively). In our study, no significant difference was found in the increased risk of thrombosis in the detection of thrombophilic gene tests in arterial thrombosis compared with the control group. **Conclusion:** In our study, thrombophilia gene panel screening was not considered necessary in patients with arterial thrombosis, and it was observed that factor V Leiden, prothrombin, Factor XIII, MTHFR 677, MTHFR 1298, PAI-1 gene mutations in the hereditary thrombophilia panel did not lead to an increased risk of arterial thrombosis. Hereditary thrombophilia testing is not recommended in patients with arterial thrombosis according to current guidelines.

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OP 05

SURGICAL INTERVENTIONS IN FACTOR VII DEFICIENCY: A SINGLE CENTER EXPERIENCE

Betül Kübra TÜZÜN [1], Zühal DEMİRCİ [1], Bahar SEVGİLİ [1], Güray SAYDAM [1], Fahri ŞAHİN [1,2]

[1] *Ege University Hospital Department of Hematology*
[2] *Ege University Hospital Adult Hemophilia and Thrombosis Center*

Objective: FVII deficiency is the most common of the rare congenital bleeding disorders with a prevalence of about 1:500,000. Bleeding symptoms are considerably variable in terms of both location and severity, and may have a heterogenous spectrum ranging from asymptomatic conditions to serious/life-threatening bleeds In surgical interventions, the duration of treatment and factor dose should be determined by considering the patient's previous and current bleeding clinic, factor level and comorbidities. **Methodology:** We aimed to share our experience of surgical interventions and bleeding management in individuals with factor VII deficiency between January 2023 and January 2024 who followed up in our outpatient clinic. **Results:** A total of 14 surgical interventions were performed in 12 patients with factor VII deficiency between January 2023 and January 2024 at Ege University Hemophilia Outpatient Clinic. 4 tooth extractions, 2 septorhinoplasties, 1 tympanoplasty, 1 tympanomastoidectomy, 1 lung wedge resection, 1 cataract and 4 orthopedic procedures (arthrodesis, radius fracture repair, total hip replacement and arthroscopy) were performed. The median age was 43 years (20-78 years), 7 of patients were female and 5 were male. 7 patients had ISTH bleeding score below 5 and 4 patients had no bleeding diathesis. Preoperative factor VII levels of the patients varied between 5-36%. Recombinant factor VIIa (rfVIIa) was used in 85% (n=12) and FFP in 15% (n=2) of the procedures. Median duration of treatment was 2.5 days (1-8 days). The median preoperative rfVIIa dose was 15 mcg/kg (10-30 mcg/kg), while the median single dose given in the postoperative period was 16.7 mcg/kg. While a single dose was administered in minor interventions such as tooth extraction, the mean number of total doses administered during treatment in other interventions was 11. In one patient, the procedure was performed with TDP due to the presence of both factor VII deficiency (FVII:36) and hypofibrinogenemia, low bleeding score and no previous history of postoperative bleeding. In another patient who underwent tooth extraction, the procedure was performed with FFP because the factor level was >30% and there was no previous bleeding history. The preoperative FFP dose was 15-20 ml/kg in patients that receiving FFP. Effective bleeding control was achieved and no thrombosis was observed in patients receiving both FFP and rFVIIa. **Conclusion:** The correlation between FVII activity and bleeding tendency is poor, although severe bleeding is most commonly associated between low FVII activity levels and the surgical risk of bleeding.Plasma-derived and recombinant FVII concentrates are currently used for treatment. In countries where access to these products is lacking, fresh frozen plasma and prothrombin complex concentrates are also used, though they contain low amounts of factor FVII. In patients included in the recording system established for patients with FVII deficiency (STER) and who underwent surgical procedures, use of rFVIIa was evaluated in 110 elective surgical procedures performed on 95 patients were examined, and it was shown that neither FVII level nor surgical procedure influenced rFVIIa replacement treatment, and only the patient's phenotype of bleeding was effective in replacement treatment. it was shown that the lowest effective dose of rFVIIafor hemostasis was 13 μg/kg on the day of surgery, and at least three doses were needed.In same study, it was recommended to give a mean total dose of 20 micrograms/kg rFVIIa in invasive interventions and minor surgeries. Furthermore in majör surgeries it is recommended to give rFVIIa at a single dose of 13 mcg/kg in the first 24 hours after operation and at least three administrations needed. Similarly, in our clinic, a median dose of 15 mcg/kg was administered before surgical interventions. Before invasive procedures and minor interventions, rFVIIa was administered in the range of 10-30 mcg/kg. Afterall rFVIIa for factor VII deficiency was well tolerated and maintained effective hemostasis with good clinical outcomes. In factor VII deficiency, surgical intervention and management of spontaneous bleeding may be difficult due to the variability of symptoms and bleeding clinic and the independence of bleeding risk from factor level. However, a road map can be drawn by considering published studies, center experiences and evaluating the clinical characteristics of the patient.

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Adult Hematology Abstract Categories, Lymphoma

OP 06

AUTOLOGOUS PERIPHERAL BLOOD STEM CELL TRANSPLANTATION IN PATIENTS WITH HIV-ASSOCIATED LYMPHOPROLYPHERATIVE DISORDER

Vera Kovalskaya, Natalya Falaleeva, Stanislav Shklyaev, Andrey Chelmakov, Ludmila Grivtsova

A. Tsyb Medical Radiological Research Centre - branch of the National Medical Research Radiological Centre of the Ministry of Health of the Russian Federation, Obninsk, Russian Federation

Objective: Autologous transplantation of bone marrow/peripheral blood stem cells in patients with HIV-associated lymphopoliferative disorder is a feasible and relatively safe therapeutic option. However, at the moment there are a number of unsolved problems, including optimal risk/benefit pre-transplant conditioning, taking into account drug-drug interactions and indications for hematopoietic stem cell transplantation. **Methodology:** Since 2020 PBSCT has been performed in 15 patients with HIV in our center. The 12 (80%), had diagnosis of HIV-associated plasmablastic lymphoma (HIV-PBL), 3 patients (20%) were with HIV-associated Hodgkin' lymphoma (HIV-HL). All of the patients with HIV-PBL were transplanted after completion of a first-line treatment and achievement of at least a partial response. The pre-transplant conditioning was performed using BEAM-like regimens. **Results:** Toxicity from organs and systems did not exceed grade 2 (moderate) mainly from the gastrointestinal tract, no need antiretroviral therapy in all of the cases. Median time to neutrophil engraftment was +12 days, while to platelet engraftment was +13 days. At the time of submitting the abstract all of the transplanted patients described above except one (lethal case due to progression of concomitants hepatitis C virus (HCV) infection) are in the state of remission. **Conclusion:** Autologous transplantation of peripheral blood stem cells in patients with HIV is a feasible and relatively safe option with clear planning of the patient's treatment strategy from the first day of therapy and accompanying consideration of drug-drug interactions which is confirmed both by world literature and our Center's own experience.

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Adult Hematology Abstract Categories, Platelet Diseases

OP 07

MAINTENANCE LOW-DOSE CORTICOSTEROID THERAPY IN PATIENTS WITH CHRONIC ITP: SINGLE CENTER RESULTS

Birsen Sahip Yesiralioğlu, Hatice Ayağ, Müzeyyen Aslaner Ak, Şehmus Ertop

Zonguldak Bulent Ecevit University Faculty of Medicine Hematology Department

Objective: Immune thrombocytopenia (ITP) is an acquired, autoimmune disease affecting 2 to 4 individuals per 100,000 annually. ITP is characterized by an isolated platelet count of $<100 \times 10^3/\mu$L. The diagnosis of primary ITP relies on excluding non-immune causes of thrombocytopenia (myelodysplastic syndrome, inherited thrombocytopenia) and secondary immune thrombocytopenia caused by other conditions such as autoimmune diseases (systemic lupus erythematosus), malignancies (chronic lymphocytic leukemia), infections (hepatitis C virus and HIV), and medications. The clinical manifestations of ITP range from entirely asymptomatic patients to increased petechiae-ecchymosis and rarely major or life-threatening bleeding. Corticosteroids are the first-line treatment. Initial treatment for ITP consists of methylprednisolone at a dose of 1mg/kg/day or dexamethasone administered at 40mg/day for 4 days, repeated every 14-28 days. While >75% of adult patients respond to corticosteroids, only 20-30% remain in continuous remission after cessation." **Methodology:** We have 114 registered patients with immune thrombocytopenia (ITP) in our clinic over the past 5 years. Among these patients, a subgroup of 45 who received high-dose corticosteroid treatment as first-line therapy, responded to corticosteroids, but subsequently experienced loss of response, was identified as corticosteroid-sensitive. This group was selected for follow-up with maintenance low-dose steroid (LDS) therapy for 1 year. Patients were treated with 4 mg of methylprednisolone for 4 days per month and followed up for 12 months. Among our patients, 18 achieved response with platelet levels $>30 \times 10^3 / \mu$ L without signs of bleeding (see Table 1), while in 27 patients, additional corticosteroid doses were added or second-line treatment modalities such as splenectomy or eltrombopag were initiated due to platelet levels dropping below $30 \times 10^3 / \mu$ L " **Results: Conclusion:** The goal of treatment in a patient with ITP is not only to normalize platelet counts but also to achieve a level of platelets that can prevent clinically significant bleeding. Based on this premise, we have demonstrated that maintenance corticosteroid therapy at an acceptable cumulative dose can reliably maintain platelet levels within a safe range. We believe that this should be further supported by larger multicenter studies."

Table 1: Demographic characteristics of patients responsive to low-dose steroid treatment"

Female/Male	12/6
Median age	52
1.month median trombocyte	$32 \times 10^3 / \mu$ L
3. month median trombocyte	$55 \times 10^3 / \mu$ L
12. month median trombocyte	$87 \times 10^3 / \mu$ L

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Adult Hematology Abstract Categories, Stem Cell Transplant

OP 08

FLUDARABINE-INDUCED BRADYCARDIA IN ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION

Serhat Çelik [1], Zeynep Tuğba Güven [2], Abdullah Altınsoy [3], Şaziye Esra Tubay [4], Muzaffer Keklik [5], Ali Ünal [5]

[1] *Department of Hematology, Yenimahalle Training and Research Hospital, Yıldırım Beyazıt University, Ankara, Türkiye*
[2] *Department of Hematology, Adana City Hospital, Adana, Türkiye*
[3] *Department of Internal Medicine, Faculty of Medicine, Erciyes University, Kayseri, Türkiye*
[4] *Department of Clinical Pharmacy, Faculty of Pharmacy, Erciyes University, Kayseri, Türkiye*
[5] *Department of Hematology, Faculty of Medicine, Erciyes University, Kayseri, Türkiye*

Objective: Fludarabine, a purine analog, is getting more attention with the increasing use of reduced intensive conditioning regimens in allogeneic hematopoietic stem cell transplantation (allo-HSCT). Bradycardia was observed in only a few cases reported in the literature. In clinical practice, bradycardia can be asymptomatic or cause syncope and cardiac arrest. This study aimed to evaluate the bradycardia side effect of fludarabine used in allo-HSCT recipients and to increase awareness of this issue. **Methodology:** This retrospective study included 73 patients who received fludarabine in the allo-HSCT conditioning regimen between January 2015 and January 2021. Patients with and without bradycardia were compared regarding demographic data, allo-HSCT characteristics, electrolyte values, fludarabine administration dose and duration, and survival. Univariate and multivariate analyzes were performed to evaluate independent predictors for fludarabine-induced bradycardia (FİB). **Results:** Fludarabine doses were higher in the bradycardia group, but not statistically significant. Age was the only independent predictor of FİB (OR 0.93, 95% CI: 0.89-0.98, p =0.007). The median age in the group with bradycardia was 19 years younger than those without bradycardia (34 (19-49) vs 53 (19-69), p=0.005). In 11 (84.6%) of the patients who had bradycardia, bradycardia improved with the discontinuation of fludarabine alone, but atropine was administered in 2 (15.4%) patients. **Conclusion:** Bradycardia was observed in 17.8% of our patients who used fludarabine in the conditioning regimen. Age was the only independent predictor of fludarabine-induced bradycardia; therefore, close heart rate monitoring is recommended during fludarabine administration, especially in younger patients. Although our results are promising, further studies evaluating the fludarabine intermediate fluoroadenosine are needed to support our results.

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Adult Hematology Abstract Categories, Other Diseases

OP 09

A STRATEGY FOR DIRECT DELIVERY OF ANTIGENIC CONSTRUCTS TO DENDRITIC CELL RECEPTORS

Anzhelika Melnikova, Tatiana Mushkarina, Lyudmila Grivtsova

A. Tsyb Medical Radiological Research Centre - branch of the National Medical Research Radiological Centre of the Ministry of Health of the Russian Federation, Obninsk, Russian Federation
Presentation Type Oral

Objective: C-type lectin receptors (CLRs) expressed by DC are considered attractive targets for effective targeting of antigen to antigen-presenting cells, since the participation of CLRs can additionally stimulate antigen presentation and, accordingly, subsequent activation of T cells. To study the ability of DC to enhance antigen capture and presentation using a library of fluorescein-labeled polyacrylamide glycoconjugates. **Methodology:** DC was obtained by culturing human peripheral blood monocytes in a complete RPMI-1640 nutrient medium containing GM-CSF, IL-4 and TNFa. Immunophenotypes were analyzed using flow cytometric analysis. In our study, synthetic FSL (Function-Spacer-Lipid) constructs will be used: polyacrylamide glycoconjugate (Adi-sp)3-βDD-PAA-Fluo, conjugate N-acetyllactosamine, glycolipid (Adi-sp)3-βDD ((Adi-sp)3-βDD-DOPE). Next, the binding of these cells to glycoprobes was investigated. **Results:** A new class of glycoconjugates specific for binding to C-type lectin receptors has been synthesized. The key cytokines for the cultivation of DC are GM-CSF (final concentration 80 ng/ml), IL-4 (final concentration 10 ng/ml), as well as differentiation inducers: TNF-α, PGE2. Mapping of human blood cells using a library of fluorescein-labeled polyacrylamide glycoconjugates showed that the studied glycoprobes bind to more than 15% of the human leukocyte population. **Conclusion:** In our proposed research project, a new approach will be used to study the strategy of enhancing the capture and presentation of antigen by dendritic cells by targeting C-type lectin receptors.

https://doi.org/10.1016/j.htct.2024.04.011

OP 10

SHIFTING PARADIGMS: EXPLORING ENARODUSTAT FOR ANEMIA IN CHRONIC KIDNEY DISEASE IN A META ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

Lokman Hekim Tanrıverdi [1], Ahmet Sarıcı [2]

[1] *Section of Hematology, Department of Internal Medicine, Faculty of Medicine, İnönü University, Malatya, Türkiye*
[2] *Department of Medical Pharmacology, Faculty of Medicine, İnönü University, Malatya, Türkiye*

Objective: Anemia commonly accompanies chronic kidney disease (CKD). Erythropoiesis-stimulating agents (ESAs), such as darbepoetin, are initiated for anemia in CKD. Additionally, hypoxia-inducible factor (HIF) prolyl hydroxylase inhibitors have demonstrated efficacy in treating CKD-associated anemia. This meta-analysis aims to compare the efficacy, safety, and tolerability of enarodustat in anemic CKD patients. **Case report Methodology:** A systematic search of Cochrane CENTRAL, Ovid Medline R, PubMed, and Web of Science databases up to March 1, 2024, was conducted. Randomized controlled trials (RCTs) directly comparing enarodustat with darbepoetin were included. Data from four unique RCTs comprising an inverse variance-weighted random-effects model were utilized for the main analysis. Primary efficacy outcome measures included hemoglobin (Hb) change at weeks 4-6 and during follow-up, while primary safety outcomes focused on serious adverse events (SAEs). Subgroup analyses were performed based on dialysis status and prior use of ESA for the primary outcome. **Results:** Four RCTs with 7 reports involving 586 patients were included in the main analysis. Enarodustat demonstrated superiority to control in terms of change in Hb levels at week 4-6 (RR 0.76, 95% CI 0.02 to 1.50, I2=96%, p=0.04) but non-inferiority during follow-up (MD 0.66, 95% CI -0.22 to 1.53, I2=91%, p=0.14). Enarodustat exhibited comparable effects for safety and tolerability parameters such as SAEs (RR 1.17, 95% CI 0.72 to 1.91, I2=0%, p=0.52), any adverse events (RR 0.95, 95% CI 0.82 to 1.08), any adverse events leading to discontinuation (RR 0.90, 95% CI 0.37 to 2.20), diarrhea (RR 1.50, 95% CI 0.05 to 43.15), hypertension (RR 0.89, 95% CI 0.43 to 1.84), and all-cause mortality (RR 0.63, 95% CI 0.08 to 5.08). Subgroup analysis by dialysis status revealed nonsignificant differences for change in Hb levels at week 4-6 and during follow-up, but comparator-based subgroup analysis demonstrated a significant difference only when comparing to placebo at week 4-6. **Conclusion:** Enarodustat exhibits promise as a treatment option for anemia associated with CKD, demonstrating superiority to control in terms of Hb change at week 4-6 and non-inferiority during follow-up. Moreover, it demonstrates comparable safety and tolerability profiles to darbepoetin, making it a potential alternative in the management of CKD-related anemia.

https://doi.org/10.1016/j.htct.2024.04.012

OP11

A VERY RARE RELAPS TYPE IN MULTIPLE MYELOMA: LEPTOMENGEAL AND CRANIAL INVOLVEMENT

orhan Ayyildiz *, Songul Beskisiz, Abdullah Karakus

Dicle University Hospital, Department of Hematologyi Diyarbakir

Case report: Multiple myeloma is a hematological malignancy that develops as a result of clonal proliferation of plasma cells and progresses with remissions and relapses. It is clinically characterized by many symptoms and signs such as osteolytic bone lesions, hypercalcemia, renal dysfunction, hypergammaglobulinemia and anemia. However, involvement of the central nervous system, especially the leptomeningeal/cranial region, is a rare and prognostically important form of relapse of the disease. Nervous syste

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Adult Hematology Abstract Categories, Stem Cell Transplant

OP 12

Can autologous stem cell transplantation be a treatment option in a patient diagnosed with secondary progressive multiple sclerosis?:Case report

Kemal Fıdan, Gülşah Akyol, Ali Ünal

Erciyes University Faculty of Medicine, Department of Internal Medicine Hematology, Kayseri, Türkiye

Case report: İntroduction: Multiple sclerosis (MS) manifests itself with plaque formation as a result of defensive T and B cells in the immune system perceiving the myelin sheath around nerve cells as a foreign substance to the body and trying to destroy it, for an unknown reason.In short, it is an autoimmune inflammatory demyelinating disease of the central nervous system. In multiple sclerosis, various interventions such as medication, physical therapy, and stem cell therapy are used to improve patients' quality of life. The goal of autologous hematopoietic stem cell transplantation (AHSCT) is to eliminate and replace the patient's pathogenic immune system to achieve long-term remission of MS. Here, we will present our experience with autologous stem cell transplantation performed in our center for an MS case that had previously received both medical and physical therapy and failed to respond.

Key words: multiple sclerosis, autologous stem cell transplantation

Case report: The 41-year-old male patient was diagnosed with MS in 2012 and has been wheelchair-bound for about 3 years. Glatiramer acetate was started at the time of diagnosis. As the patient's complaints increased, fampridine and ocrelizumab treatments were given, respectively. The patient, who did not respond to treatment, was evaluated as having secondary progressive MS and an autologous stem cell transplant was planned. Mobilization was performed with cyclophosphamide + G-CSF in July 2023. In September 2023, AHSCT was performed with cyclophosphamide (40 mg/kg, 2400 mg in total, 5 days), Mesna (40 mg/kg/day, 2400 mg in total, 5 days) and ATG (360 mg in total) protocol. The patient, who had platelet engraftment on day +9 and neutrophil engraftment on day +11 after AHSCT, was discharged with outpatient clinic control. **Discussion and conclusion:** Despite many advances in MS treatment, there is still no definitive treatment answer. Autologous hematopoietic stem cell transplantation may be promising, as observed in several studies. The aim of AHSCT is to eliminate and replace the patient's pathogenic immune system to ensure long-term remission of

MS (1). In the MIST study; One group of patients with relapse-refractory MS (RRMS) underwent myeloablative AHSCT with cyclophosphamide (200 mg/kg) and antithymocyte globulin (ATG), and the other group was given disease-modifying therapy. During an average follow-up of 2 years, disease progression was 5% in the AHSCT group and 62% in the other group. In addition, those who underwent AHSCT had fewer relapses, and the rate of lesion healing on MRI was observed to be higher in the AHSCT group (2). In the HALT-MS study, event-free survival and improvement in neurological functions were observed at higher rates in patients who underwent AHSCT after high-dose immunotherapy (3-4). In a study conducted in Sweden, no recurrence or progression was observed in the first 3 years of treatment after AHSCT, and it was also stated that no new lesions developed on MRI (5). Although studies show the potential benefits of AHSCT, more long-term data from randomized controlled trials are needed to evaluate the effectiveness and safety of this intervention in the treatment of RRMS.

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OP 13

Autologous stem cell transplantation experience in an adult recurrent medulloblastoma patient: Case report

Kemal Fıdan [1], Ali Ünal [1], Neslihan Mandacı Şanlı [2], Ebubekir Sıddık İpekçi [3]

[1] *Erciyes University Faculty of Medicine, Department of Internal Medicine Hematology, Kayseri, Türkiye*
[2] *Erciyes University Faculty of Medicine, Department of Internal Medicine Hematology, Kayseri, Türkiye*
[3] *Erciyes University Faculty of Medicine, Department of Internal Medicine, Kayseri, Türkiye*

Case report: Introduction: Medulloblastoma is the most common malignant primary embryonal brain tumor in children and occurs in the cerebellum. Approximately 70% of patients are diagnosed before the age of 20. The disease is rare after the 4th decade of life. It originates from the brainstem and metastasizes to other brain tissue, ventricles and medulla spinalis via CSF. Metastasis to bone, bone marrow, lung or lymph nodes outside the CNS is a very rare condition. Surgery, chemotherapy and radiotherapy are used in the treatment of medulloblastoma. In some patients (patients in the high-risk group, relapsed/refractory patients), autologous stem cell transplantation(ASCT) is performed following high-dose chemotherapy to increase survival rates. Here, we will present a case of medulloblastoma in which we performed autologous stem cell transplantation in our center.
Key words: Medulloblastoma, autologous stem cell transplantation
Case report: A 30-year-old male patient applied to the neurology clinic in May 2020 with complaints of headache, dizziness, nausea, vomiting and fainting. In the brain imaging, a 6×4 cm mass lesion was observed in the posterior fossa, located in the ventricle and causing compression symptoms (Cystic Astrocytoma? Medulloblastoma?). The patient underwent ventriculoperitoneal shunt and subtotal mass excision at the neurosurgery clinic. The biopsy pathology result was reported as medulloblastoma (classical type, p53 mutation positive). Chemotherapy was recommended by the oncology clinic, but the patient did not accept the treatment. In August 2020, the patient was given cranial RT and was subsequently followed without medication. in June 2023 due to complaints of pain and weakness in both lower extremities, there was an intradural mass lesion (25×19 mm) obliterating the spinal cord at the T11-T12 level and extending to the extraspinal area, and a diffuse mass lesion within the spinal cord at the T10 level with a craniocaudal length of 17 mm. Mass excision as a result of pathology; It was reported as classical medulloblastoma (non-WNT/non-SHH group (grade 4)). After the patient was given 2 courses of mini-ICE chemotherapy, a nearly complete response in the imaging. The patient was mobilized with G-CSF. In our center, the patient was performed autologous stem cell transplantation (6.55×10^6 /kg cells) with temozolamide ($2 \times 200 mg/m^2$ on days -6,-5,-4), etoposide (100 mg/m^2 on days -7,-6,-5,-4,-3,-2), thiotepa (300 mg/m^2, on days -4,-3,-2) protocol in November 2023.The patient, who had neutrophil and platelet engraftment on the 10th day after transplantation, was discharged with outpatient clinic control. **Discussion and conclusion:** Although the prognosis has improved in children with medulloblastoma, an estimated 20-30% will relapse following initial treatment (1). Recurrences may be local or widespread (brain and vertebra) (2,3,4). In case of recurrent disease after initial treatment, the likelihood of long-term survival is significantly reduced. Autologous hematopoietic cell transplantation after high-dose chemotherapy has been evaluated in small series and resulted in prolonged disease-free survival in approximately 20-25% of patients (7,8). In the study conducted by Eduvian et al., they showed that autologous stem cell transplantation after chemotherapy has a definite, albeit limited, role for selected pediatric brain tumors with poor prognosis and complete/partial remission before transplantation(9).

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OP 14

AUTOLOGOUS STEM CELL TRANSPLANTATION EXPERIENCE IN B-ALL DEVELOPING DURING MAINTENANCE LENALIDOMIDE TREATMENT:CASE REPORT

Kemal Fıdan [1], Gülşah Akyol [1], Ali Ünal [1], Muzaffer Keklik [1], Nursima Çukadar [2]

[1] *Erciyes University Faculty of Medicine, Department of Internal Medicine Hematology, Kayseri, Türkiye*
[2] *Erciyes University Faculty of Medicine, Department of Internal Medicine, Kayseri, Türkiye*

Case report: Introduction: Secondary leukemias that occur after chemotherapy are mostly myelodysplastic syndrome and acute myeloid leukemias.With the recent increased use of immunomodulatory (IMID) drugs (pomalidomide, thalidomide and lenalidomide); It has been shown that secondary leukemias increase. Acute lymphoblastic leukemia (ALL) has frequently been described in association with IMID. Here, we present our second ASCT experience in a case who underwent autologous stem cell transplantation (ASCT) with the diagnosis of multiple myeloma and developed B-ALL during the maintenance lenalidomide treatment.

Key words: Multipl myelom, B-ALL, autologous stem cell transplantation

Case report: A 62-year-old female patient was diagnosed with multiple myeloma (MM) in 2017.The patient was given 4 cycles of BED (bortezomide, cyclophosphamide, dexamethasone) treatment.The patient, who was in remission, underwent ASCT with Melphalan 200 mg/m2 preparation regimen in 2018.After ASCT, the patient was started on lenalidomide maintenance treatment. Approximately 4 years later, in 2022, during the course of lenalidomide treatment, CALLA+ B-ALL was diagnosed with a bone marrow biopsy.The patient was given hyper-CVAD Chemotherapy. The patient, who was in remission after the treatment, underwent ASCT again in 2023, for the second time with the TBI + endoxan protocol (3.8×106/kg cells) with peripheral blood stem cells collected during the previous MM disease period. **Discussion and conclusion:** ALL can develop due to cytotoxic agents and immunomodulatory (IMID) drugs such as alkylating agents and topoisomerase inhibitors. Alkylating agents such as Melphalan can cause the development of AML or MDS, often through unbalanced chromosomal abnormalities from first use. The incidence of secondary ALL developing after primary malignancy is 2.3%. Secondary malignancies are a known, albeit rare, complication of long-term lenalidomide therapy. However, the incidence of secondary ALL due to lenalidomide is very low. Parrondo et al demonstrated a significant increase in the risk of secondary malignancies following lenalidomide maintenance following high-dose melphalan and autologous hematopoietic stem cell transplantation in patients with multiple myeloma (MM). 4-17% of these malignancies are hematological malignancies. After ASCT, maintenance lenalidomide has now become the standard treatment for multiple myeloma. Lenalidomide creates a basis for the development of hematological malignancy secondary to treatment in these patients. However, considering the use of melphalan in the chemotherapy regimen before ASCT, lenalidomide alone cannot be blamed for treatment-related ALL. However, as a result of our literature review, there is a stronger association between lenalidomide maintenance therapy and treatment-associated ALL in multiple myeloma patients. Therefore, in case of suspicious hematological findings in patients receiving maintenance lenalidomide treatment, bone marrow aspiration and biopsy samples should be carefully evaluated for leukemia.

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OP15

A Case of Multiple Myeloma with Atypical Cutaneous Presentation Treated by Daratumumab + CYBORG

Bengisu Ece DUMAN [1,*], Candas MUMCU [1], Berra Nur ISCI [1], Emre BAL [1], Meryem SENER [2], Hande Yanar [3], Arbil ACIKALIN [3], Birol GUVENC [2]

[1] *Cukurova University, Department of Internal Medicine, Adana, Turkey*
[2] *Cukurova University, Department of Internal Medicine, Department of Hematology, Adana, Turkey*
[3] *Cukurova University, Department of Pathology, Adana, Turkey*

This case report illustrates the unconventional progression of multiple myeloma (MM) in a 57-year-old male, primarily highlighted by a cutaneous manifestation on the right cheek malar region, indicative of disease recurrence. Initially diagnosed following back pain and dyspnea, the patient's journey took a distinctive path from standard multiple myeloma treatments to the innovative application of daratumumab + CYBORG therapy. The biopsy from the lesion confirmed the recurrence of plasma cell neoplasia, leading to the adoption of daratumumab + CYBORG therapy. This innovative treatment strategy underscores the evolving landscape of MM management, particularly in cases presenting with atypical symptoms such as cutaneous involvement. The implementation of daratumumab + CYBORG therapy in this context not only highlights its potential as a significant advancement in MM treatment.

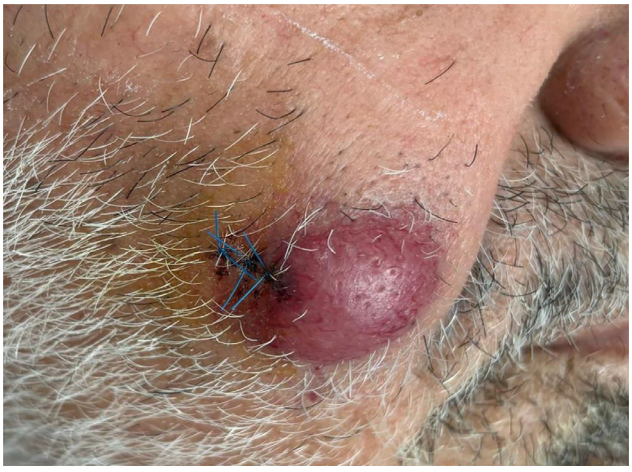

Image 1. Skin lesion on face._

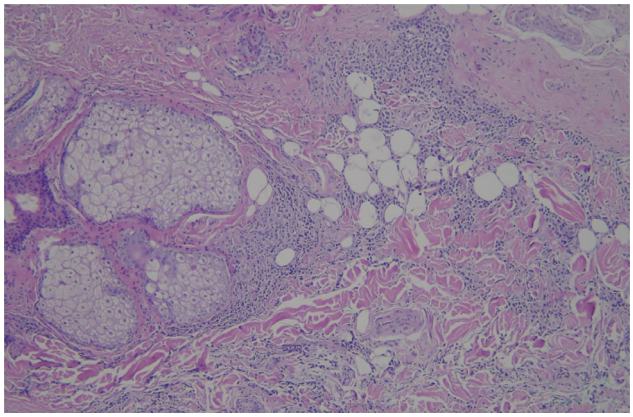

Image 2. Microscopic image of a biopsy taken from skin lesion.

https://doi.org/10.1016/j.htct.2024.04.017

OP16

Essential Thrombocythemia Complicated by Addison's Disease: A Case of Overlapping Endocrine and Hematological Disorders

Meryem SENER [1], Kaan NISANOGLU [2], Candas MUMCU [2], Bengisu Ece DUMAN [2], Berra Nur ISCI [2], Emre BAL [2], Irem KABALCI KADIOGLU [2], Birol GUVENC [1]

[1] *Cukurova University, Department of Internal Medicine, Department of Hematology, Adana, Turkey*
[2] *Cukurova University, Department of Internal Medicine, Adana, Turkey*

This case report delves into the intricacies of managing a patient diagnosed with both essential thrombocythemia and Addison's disease, illustrating the challenges and importance of an integrated approach to complex, coexisting conditions. A 47-year-old woman presented with enduring symptoms of fatigue, skin darkening, and appetite loss, which progressively led to substantial weight loss. Initially treated for essential thrombocythemia, a common yet serious myeloproliferative disorder, her condition did not fully improve with standard therapy, including hydroxyurea. Further evaluation was prompted by her deteriorating clinical status, characterized by severe hypotension and exacerbated systemic symptoms, leading to the diagnosis of primary adrenal insufficiency or Addison's disease. The confirmation of Addison's disease, alongside essential thrombocythemia, necessitated a tailored therapeutic strategy that addressed both endocrine and hematological aspects. With the initiation of appropriate therapy targeting Addison's disease, alongside ongoing management of essential thrombocythemia, the patient experienced a significant alleviation of symptoms and stabilization of her condition. This case underscores the necessity for vigilance and comprehensive evaluation in patients with non-specific systemic symptoms, highlighting the potential for concurrent, serious medical diagnoses.

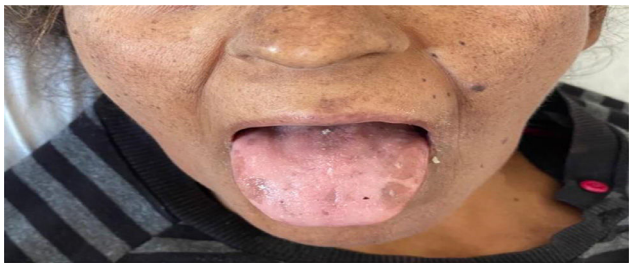

Image 1. Mucosal and skin hyperpigmentation in Addison's disease.

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OP17

A Rare Intersection: Case Study on Sickle-Cell Thalassemia and Lymphoma

Birol GUVENC [1], Meryem SENER [1], Candas MUMCU [2], Bengisu Ece DUMAN [2], Berra Nur ISCI [2], Emre BAL [2], Irem KABALCI KADIOGLU [2]

[1] *Cukurova University, Department of Internal Medicine, Department of Hematology, Adana, Turkey*
[2] *Cukurova University, Department of Internal Medicine, Adana, Turkey*

This case study explores the rare and complex coexistence of sickle-cell thalassemia (S-talassemia) and lymphoma in a 37-year-old individual, presenting an exceptional diagnostic and therapeutic challenge. Initially evaluated for non-specific symptoms including abdominal pain, nausea, and vomiting, the patient underwent extensive diagnostic investigations revealing a multifaceted clinical picture. Advanced imaging identified multiple abnormal findings, including hyperdense gallbladder stones, increased reticular density in the mesenteric root, and nodular lesions in the thyroid gland, without the presence of mass lesions in the lung parenchyma. Biopsies confirmed the presence of high-grade B-cell, diffuse large B-cell lymphoma (DLBCL), showcasing an aggressive non-germinal center phenotype. Interestingly, immunohistochemistry results pointed towards a complex interplay of markers, with notable findings such as cMYC 80% positivity and a Ki67 proliferation index of 80% positive. The dual diagnosis of S-talassemia and lymphoma, especially considering the rarity of their co-occurrence, posed a significant challenge in terms of treatment decision-making and highlighted the critical need for patient-centered care, taking into account the ethical and autonomy considerations. This case contributes to the limited literature on the intersection of hemoglobinopathies and lymphoma, offering insights into the diagnostic dilemmas and therapeutic strategies in managing such rare comorbid conditions.

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OP18

Peripheral T-cell Lymphoma with Jaundice: Insights from a Complex Case

Candas MUMCU [1], Bengisu Ece DUMAN [1], Berra Nur ISCI [1], Emre BAL [1], Irem KABALCI KADIOGLU [1], Bulut SAT [1], Meryem SENER [2], Hayriye TEZCAN [3], Arbil ACIKALIN [3], Birol GUVENC [2]

[1] *Cukurova University, Department of Internal Medicine, Adana, Turkey*
[2] *Cukurova University, Department of Internal Medicine, Department of Hematology, Adana, Turkey*
[3] *Cukurova University, Department of Pathology, Adana, Turkey*

CASE: Peripheral T-cell lymphomas (PTCLs) are a heterogeneous group of aggressive non-Hodgkin lymphomas with a rare occurrence, representing less than 15% of all adult non-Hodgkin lymphomas. The diagnosis and treatment of PTCLs pose significant challenges due to their diverse presentations and the aggressive nature of the disease. This case report discusses a 58-year-old male with a long-standing history of diabetes mellitus and previous bypass surgery, who presented with jaundice, hepatosplenomegaly, and ascites. Laboratory findings showed anemia, elevated liver enzymes, and hyponatremia. Imaging and biopsy results revealed nodular lung lesions, hepatosplenomegaly, liver mass lesions, bile duct dilatation, abdominopelvic lymphadenopathies, and T-cell lymphoma infiltration. The patient's treatment protocol included the CHOEP + BV regimen, alongside interventions for hyperbilirubinemia and renal failure. This case underscores the atypical presentation of PTCL with jaundice and the complexities involved in diagnosing and managing such cases, highlighting the need for a thorough and multidisciplinary approach.

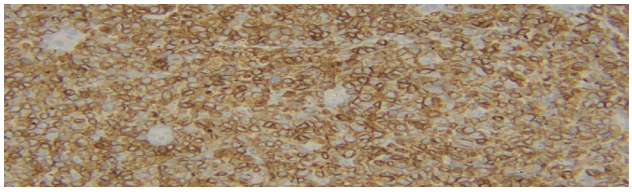

Image 1. Microscopic image of a biopsy taken from the liver (CD3 staining).

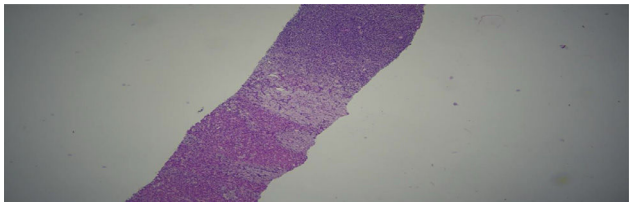

Image 2. Microscopic image of a biopsy taken from the liver (with normal liver tissue) (H&E staining).

https://doi.org/10.1016/j.htct.2024.04.020

OP19

Two Follicular Dendritic Cell Sarcoma (FDCS) patients treated with Chemoimmunotherapy

Berksoy Sahin, Birol Guvenc

Cukurova University, Medical Faculty Depts of Medical Oncology and Hematology

Here we report 2 patients presenting with bulky lymphadenopathy in the abdominopelvic region. The first patient was a 64 yr old man and a lymph node biopsy from inguinal region revealed a CD23-positive, CD20-negative, CXCL13-positive and Ki67 40% positive follicular dendritic cell sarcoma. The patient received 6 courses of chemotherapy combined with PD-1 MoAb (pembrolizumab. A gemcitabine plus docetaxel regimene (GemDoc) combined with 200 mg pembrolizumab. At the end of 6 courses, PET/CT presented a metabolic CR. We continue the same cheomoimmuno regimene as maintenance treatment. The second patient is a 44 year old man who has an intraabdominal bulky tumor and multiple hepatic metastasis. Core biopsies from liver lesions and intra-abdominal mass revealed FDCS. The patient took the first course of the same regimene of chemoimmunotherapy composed of a GemDoc+pembrolizumab and felt comfortable because of the decrease in tumor sizes. A very rare entity, FDCS has no a standart treatment, yet. We combine a second line sarcoma regimen (GemDoc) with Anti-PD1 Ab, pembrolizumab as induction systemic treatment and followed by a maintenance Pembrolizumab. This chemoimmunotherapy regimen suggest that it will work in FDCS patients who have intermediate PD-L1 expression in tumor cells.

https://doi.org/10.1016/j.htct.2024.04.021

OP20

Neoadjuvant chemoimmunotherapy for a patient with micro-stallete instabile gastric cancer resulted a pathological complete response

Berksoy Sahin, Birol Guvenc

Cukurova University, Medical Faculty Depts of Medical Oncology and Hematology

Here we presented a 44 yr old male patient with an abdominal pain who had a distal gastric adenocarcinoma in his endoscopic biopsy. The pathology reported a chromogranine negative, CK20-positive, PD-L1 5% positive adenocarcinoma with MLH1 (-)and PMS-2(-) MSI status. PET/CT showed enlarged gastric wall (SUVmax 23.99) and enlarged perigastric lymphadenopathy (SUVmax 22.03) and no distant metastasis. The patient received 4 courses of Nivolumab plus FLOT-4 chemoimmunothrapy in neoadjuvant setting. He experienced Grade 2 myelotoxicity and 2 packages of red blood were transfused. Following 4 courses of chemoimmunotherapy a total gasterectomy was performed and the pathology reported no evidence of tumor in the stomach and also perigastric lymphnodes revealing a pathological complete response. There has

been no standart treatment for MSI-high gastric cancer, yet. Very few phase I-II studies wth limited number of patients suggest an immunotherapy-based treatment. Here we report a combination regimen of original FLOT-4 chemotherapy with an PD-L1 Ab (nivolumab) that resulted a pCR in the neoadjuvant setting. Four courses of the same chemotherapy was planned in the adjuvant setting.

https://doi.org/10.1016/j.htct.2024.04.022