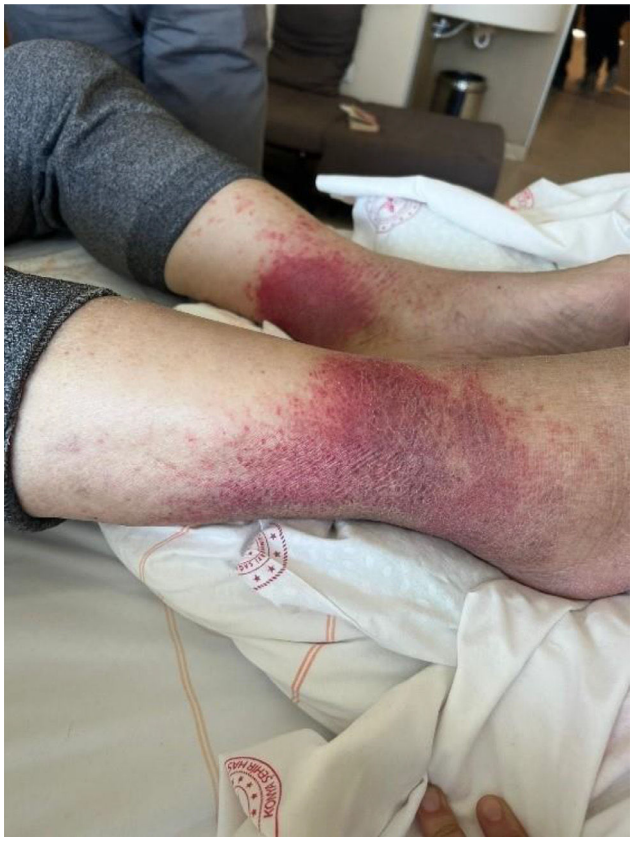

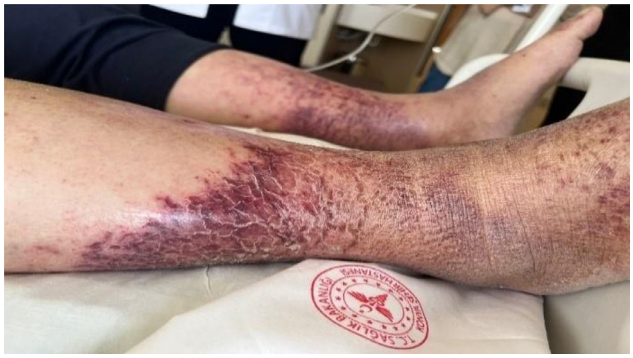

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PP 02

ACUTE MYELOID LEUKEMIA DIAGNOSED WITH CUTANEOUS INVOLVEMENT; A RARE CASE

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Objective: Acute myeloid leukemia (AML) is a heterogeneous hematologic malignancy characterized by clonal expansion of myeloid blasts in peripheral blood, bone marrow, and/or other tissues. It is the most common type of acute leukemia in adults with an age-adjusted incidence of 3.6/100,000 in the population (1). Extramedullary leukemia (EM AML), also known as myeloid sarcoma, is a rare manifestation of acute myeloid leukemia and is usually accompanied by bone marrow involvement (2). Leukemia cutis characteristically demonstrates the infiltration of the skin by neoplastic leukocytes(3). While the extramedullary collection of leukemic cells is generally regarded as myeloid sarcoma (previously chloroma/granulocytic sarcoma), leukemia cutis is a generic term to describe specific cutaneous involvement. Although any subtype of leukemia can involve the skin, the most common types seen in clinical practice are chronic lymphocytic leukemia (CLL) and acute myeloid leukemia (AML) with monocytic or myelomonocytic morphology (4). We present a case diagnosed with Extramedullary AML with skin involvement, but without bone marrow involvement. **Case report:** Case: A 60-year-old female patient who presented to the dermatology outpatient clinic in March 2023 due to painful lesions on the trunk for the past 3 months. Physical examination revealed widespread palpable firm nodular lesions on the trunk and back(figüre-1). **Methodology:** The patient underwent a punch biopsy with differential diagnoses including eosinophilic angiomatous hyperplasia, cutaneous metastasis, lupus tumidus panniculitis, T/B-cell lymphoma. CD68, Lysozyme, CD 33, CD16, CD123, TCL-1, TdT were investigated as antibodies.Immunohistochemical examination revealed widespread positivity for lysozyme, CD68, and faint diffuse CD33 in infiltrative cells. CD16, TdT, CD123, TCL-1 were negative. Histopathological diagnosis suggests compatibility with myeloid sarcoma characterized by blast cells with myelomonocytic features, demonstrating infiltration of immature atypical hemolymphoid cells in the skin and subcutaneous biopsy material. The patient was referred to our clinic due to compatibility with myeloid sarcoma and extramedullary myeloid leukemia. Initial tests during admission showed:WBC: 3.6 10^3/μL, HGB: 11.2 g/dL, PLT: 215 10^3/μL, NE: 2.3 10^3/μL, EO: 0.1 10^3/μL, BA: 0.0 10^3/μL, LDH: 297 U/L, with other biochemical values within normal range.In the bone marrow biopsy pathology of the patient revealed increased cellularity in the bone marrow elements, grade 1 increase in reticulin and reticular fibers,positive CD34 in vascular structures, blast cell ratio of 2-3%, mild increase and aggregation of megakaryocytes with CD61, decrease in myeloid series with MPO, and increase in erythroid cell islands with Glycophorin A. Flow cytometry showed 4.6% blast cells. The cytogenetic evaluation of the patient resulted in FLT3 negative, t (15, 17), (q22, q21) PML/RARA negative. The patient received ARA-C+Mitoxantrone (7+3) induction chemotherapy for extramedullary AML and recovered from neutropenia on the 18th day of treatment. Subsequent evaluations showed near-complete improvement (figüre-2). **Results:** After the patient's discharge, BMT was planned. However, the patient was excluded at the center where they applied for BMT **Conclusion:** A variant of extramedullary leukemia is leukemic skin involvement. This condition may or may not be accompanied by bone marrow involvement. The case presented here is a rare instance of Leukemia Cutis without bone marrow involvement. The patient received a myeloid leukemia treatment protocol,

and significant regression was observed in skin lesions after treatment. However, our patient was excluded prior to BMT."

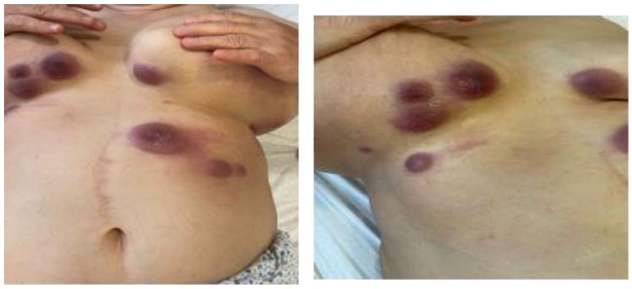

Figure 1: Palpable firm nodular lesions on the trunk and back

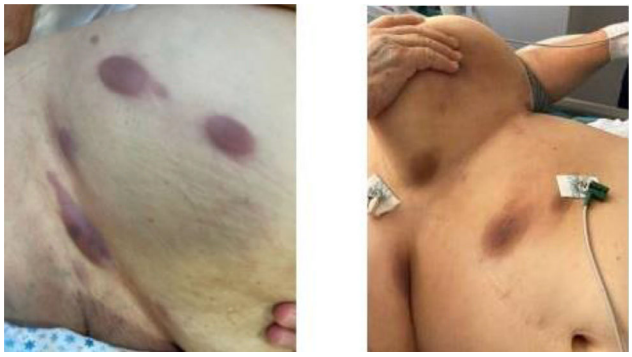

Figure 2: After treatment

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Adult Hematology Abstract Categories, Chronic Leukemias, PP 03

ADRENAL INSUFFICIENCY DETECTED BEFORE TREATMENT IN A PATIENT DIAGNOSED WITH BILATERALLY PRIMARY ADRENAL DIFFUSE LARGE B CELL LYMPHOMA:A CASE REPORT

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Case report: INTRODUCTION: Adrenal glands are one of the organs where malignancies frequently metastasize. However, primary malignancies of the adrenal glands are rare. Primary adrenal lymphomas (PAL) account for less than 1% of extranodal lymphomas. It is seen bilaterally in 75% of cases. The most common subtype is diffuse large B-cell lymphoma. **CASE:** A 57-year-old male patient with no known history of disease applied to an external center with complaints of weight loss (13 kg, more than 10% of body weight), tremors, loss of appetite and lower back pain. As a result of the evaluations made at an external center, thorax CT showed bilateral adrenal masses. PET CT was taken with the preliminary diagnosis of malignancy; In the right adrenal gland, approximately 11.6 × 8.1cm (SUVmax: 25.6) and in the left adrenal gland, approximately 10.1 × 7.2cm (SUVmax: 24.4) in size, heterogeneous dense hypermetabolic solid mass sections with necrotic areas were seen and left paraaortic (SUVmax: 11.7) lymph node with dimensions of 1.6 × 1.2 cm and a few mildly-intensely hypermetabolic lymph nodes were observed in the interaortocaval chain. Primary malignancy storage was evaluated in the foreground of dense hypermetabolic mass regions of heterogeneous structure defined in both adrenal glands. After pheochromocytoma was diagnosed, the patient was referred to our clinic after the tru-cut pathology performed on the mass lesions in the right adrenal gland revealed that the morphological and histochemical findings were consistent with diffuse large B-cell lymphoma. The patient's vital signs were stable upon admission. In the hemogram, Hgb: 9.7g/dL Hct: 31.2% MCV: 96 fL Platlet: 126.000 / mm3. In biochemistry, creatinine:1.83mg/dL urea:80 mg/dL Na:139 mmol/L K:4.36 mmol/L Ca:10.2mg/dL uric acid:9.4mg/dL LD:343U/L. There was no sign of adrenal insufficiency other than dehydration. The patient was started on hydration and allopurinol treatments. During follow-up, urea and creatinine levels decreased to normal limits. The patient's basal cortisol was 12.02 μg/dL and ACTH was 83.8ng/L. Low-dose (1μg) ACTH test was performed on the patient, for whom chemotherapy was planned for his primary disease, with the preliminary diagnosis of adrenal insufficiency. The patient's cortisol levels were detected as 8.23-10.35-8.93-9.75 μg/dL at 30-60-90 and 120 minutes, respectively, and hydrocortisone treatment was started with the diagnosis of adrenal insufficiency. During the follow-up of the patient, R-CHOP chemotherapy was started, and since the patient had prednisolone in the chemotherapy course, hydrocortisone was discontinued during chemotherapy and isolated prednisolone treatment was given. Central Nervous System involvement was detected in the cerebrospinal fluid during intrathecal (IT) chemotherapy (Mtx, Dexamethasone, Cytosine Arabinosine). Intrathecal therapy was initially administered 3 times a week and subsequently twice a week. Since no cells were detected in the cytocentrifuge, intrathecal chemotherapy was given 4 times. After 6 cycles of R-CHOP chemotherapy, the patient underwent Autologous peripheral stem cell transplantation because of high risk disease in December 2023. The patient, whose general condition is good during follow-up, is currently being followed in remission under replacement dose hydrocortisone treatment.

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PP 04

A FALSE POSITIVE PET-CT RESULT AFTER TREATMENT OF A PATIENT WITH DIFFUSE B-CELL LARGE CELL LYMPHOMA. A CLINICAL CASE.

Artem Vovchenko [1], Anastasia Galitsyna [2], Andrey Danilenko [1], Natalya Falaleeva [1], Alena Terekhova [1], Daniil Manaenkov [1], Sergei Ivanov [1], Andrey Kaprin [1]