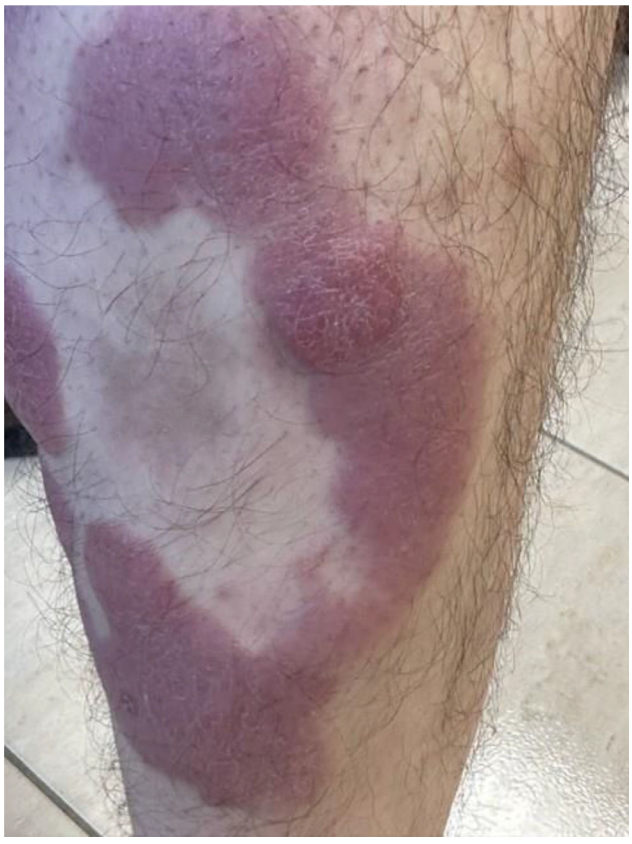

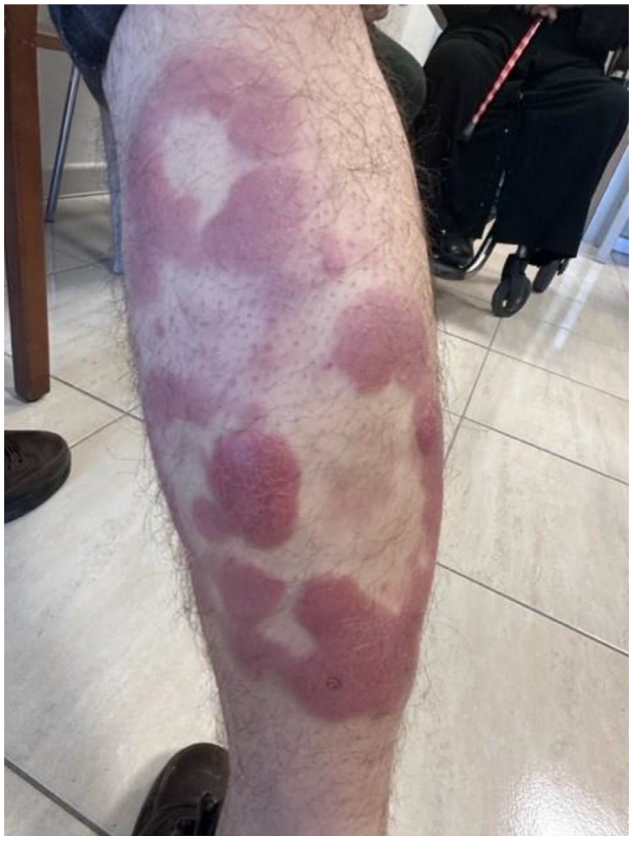

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PP 06

A CASE OF RECURRENT DIFFUSE LARGE B CELL NONHODGKIN LYMPHOMA WITH SKIN INVOLVEMENT

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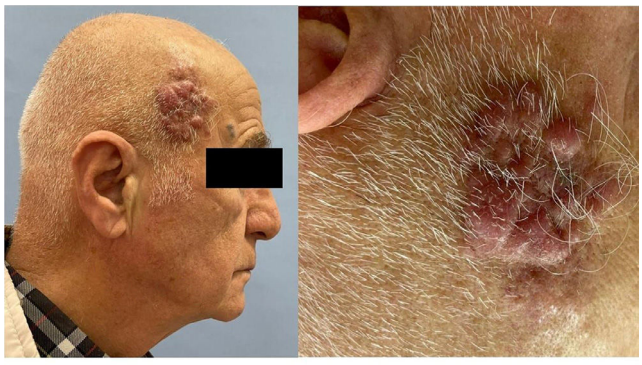
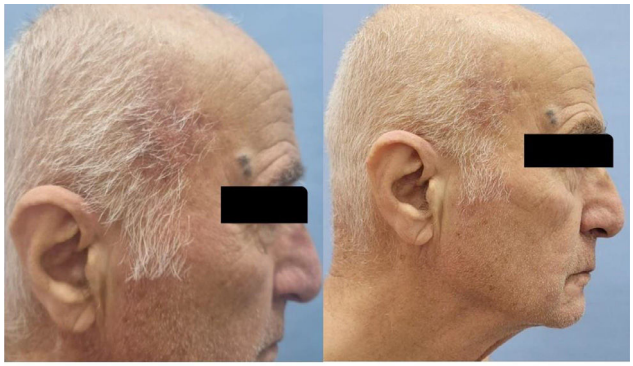
Objective: Diffuse large B-cell lymphoma (DLBCL) is the most common histological subtype of non-Hodgkin lymphoma (NHL). Extra nodal involvement of B-cell lymphoma is usually seen in the gastrointestinal system, followed by the skin. Skin involvement of B-cell lymphomas can be primary or secondary. In this article, we aimed to present a case of DLBCL which did not have skin involvement before but showed recurrence with skin involvement. **Case report:** A 77-year-old male patient presented with a diagnosis of DLBCL based on excisional LAP biopsy in the inguinal region conducted in November 2022. Laboratory tests revealed Hgb 14.3 g/dL, WBC 4.6 × 10^3/μL, plt 191 × 10^3/μL. Following 4 cycles of R-mini CHOP based on the stage 4 DLBCL diagnosis from PET-CT, interim PET-CT showed regression in existing lesions. Methodology: The R-miniCHOP regimen was completed with 8 cycles. In December 2023, a nodular lesion with raised erythematous ground and vascularity in the temporal region was identified (Figure 1). Dermatological evaluation and biopsy revealed infiltration consistent with high-grade B-cell lymphoma. PET-CT detected increased FDG uptake (SUVmax: 10.13) in a soft tissue-density lesion in the right parietal region. Due to age and performance status, the patient was planned for Rituximab-Lenalidomide protocol. Results: Starting from the 1st cycle, lesions showed regression, and by the 2nd week of the 1st cycle, complete disappearance of lesions was observed (Figure-2). Conclusion: In conclusion, while NHL usually recurs in the same sites of involvement, widespread secondary cutaneous involvement has also been reported in the literature. In our patient who did not have primary skin involvement, disease recurrence occurred in the cutaneous region.In cases like ours, the optimal treatment option is salvage chemotherapy followed by autologous stem cell transplantation.



Figüre-1: Infiltrating nodular lesion in the temporal region with vascularisation on a raised erythematous background



Figüre-2: Post-treatment

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PP 07

A RARE CASE OF A RESISTANT EXTRANODAL FOLLICULAR LYMPHOMA WITH PLASMACYTIC DIFFERENTIATION TRANSFORMED IN DIFFUSE LARGE B CELL LYMPHOMA TREATED SUCCESSFULLY WITH AUTOLOGOUS BONE MARROW TRANSPLANTATION.

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Case report: Context: The incidence of extranodal presentation of the disease is less than 10% in follicular lymphomas. Follicular lymphoma with plasmacytic differentiation arising in an extranodal site like subcutaneous tissue and bone is uncommon and its natural history and treatment are poorly described in the literature. **Objective:** Sharing an unusual case report of a resistant extranodal follicular lymphoma with plasmacytic differentiation transformed in Diffuse Large B Cell lymphoma ABC subtype undergoing successful treatment with bone marrow transplantation. **Case report:** In November 2012 a 48-year-old woman was complaining about knee pain during movements. A CT done at that time demonstrated an osteolytic lesion in her right knee in the lateral condyle. The biopsy of the lesion was consistent with the diagnosis of follicular lymphoma with plasmocytic differentiation. Bone marrow aspiration and total body CT were normal without evidence of other tumor masses. The patient underwent radiation therapy and was in perfect condition until late 2017 when she was presented to the hematology consultation because of some subcutaneous masses on her body. PET CT scan revealed several subcutaneous masses with high FDG uptake, one in her right shoulder (3.5 × 1.8 cm), two on her right breast (6.0 × 3.4 cm and 2.1 × 1.3 cm), one on the left side of her neck (1.5 × 0.6 cm), and one on her left inguinal region (4.0 × 2.3 cm). A biopsy of the mass in her inguinal region revealed the diagnosis of follicular lymphoma with plasmacytic differentiation (CD10, CD20, CD138, and MUM1 positive). She was referred to the hematology department for further evaluation and treatment. On admission, the bone marrow aspiration and biopsy showed no malignant diseases. Due to the perfect clinical condition of the patient, we decided to go with Rituximab monotherapy. But after 4 courses no improvement was seen. So, we decided to go with RCVP therapy but still, the disease was refractory, and the PET CT showed other than the subcutaneous masses, a lytic bone lesion in her left talus. We went with 2 RCHOP therapies and 4 RCHOEP plus Bortezomib and only after that, the patient went into total remission. One year later, the masses started to grow in the same location. A second biopsy revealed high-grade follicular lymphoma. We continued with R-lenalidomide but the disease was still refractory. A third biopsy performed showed a high-grade DLBCL ABC subtype. In this condition, we started salvage therapy with 2 cycles of R-BEGEV protocol and referred the patient to a clinic abroad for autologous bone marrow transplantation. The patient underwent total remission after the protocol and autologous bone marrow transplant. She has been in remission since July 2022. **Discussion:** The transformation of follicular lymphoma with plasmacytic differentiation, positive for MUM1 has a high probability according to literature to be resistant to standard therapy and to progress to diffuse large B cell lymphoma ABC subtype. Therefore, the need for aggressive treatment combined with bone marrow transplantation is important.

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PP 08

MEDIASTINAL GRAY ZONE LYMPHOMA; SHADES OF GRAY

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Objective: Mediastinal gray zone lymphoma (MGZL) is a rare B cell lymphoma originated from the thymic niche. An incostistency between morphological and immunohistochemical findings is the hallmark of the disease . Both 2022 WHO classification and International Consensus Classification renamed the disease as Mediastinal Gray Zone Lymphoma which excluded non-mediastinal forms. Due to rarity and clinical presentation of mediastinal bulky disease prospective trials for the management of MGZL is limited. Case report: Twenty-nine years old female patient admitted to hospital with dyspnea and night sweats. Basal scans showed an anterior mediastinal mass lesion of 5 × 5 × 6 cm diameter. Tru-cut biopsy of the lesion showed MGZL, cHL -like subtype with immunohistochemically CD 30, CD15, PAX-5 positivity and strong CD20 positive giant cell containing atypical lymphoproliferative mass in a sclerotic background . Background consisted of numerous mature lymphocytes, rare eosinophils, histiocytes and plasma ce **Methodology:** PET-CT showed anterior mediastinal mass of 8,7 X 6,2 cm standing just behind pericardium with a SUVmax of 28,3 . Along with mediastinal mass right prevascular,preparacardiac and anterior diaphragmatic lympadenopaties of maximum length of 2,5 cm and