(spleen size: 18 cm). The tumor board assessed the resectability of liver metastases, but surgery was not considered due to the anticipated insufficient remnant liver function, and local ablative therapy was administered. Arterial and venous portal ultrasonography performed to investigate the etiology of the splenomegaly showed normal findings, and no focal lesion was detected in the spleen. No infectious pathology was identified as a cause of the splenomegaly. The cytopenia was attributed to hypersplenism secondary to liver metastasis of rectal cancer. The patient was subsequently treated with 3 additional cycles of FOLFIRINOX and 11 cycles of FOLFOX combined with Bevacizumab. Granulocyte colony-stimulating factor was not administered during the treatment process. The patient remains under oncological follow-up, and chemotherapy treatment is ongoing. **Conclusion:** Splenomegaly and hypersplenism are important causes of pancytopenia. Our clinical experience demonstrated that chemotherapy did not exacerbate cytopenias in a patient with metastatic rectal adenocarcinoma who developed hypersplenism and pancytopenia. We have shown that with close monitoring and supportive care, chemotherapy can be safely administered in patients with pancytopenia due to hypersplenism.

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COEXISTENCE OF BREAST CANCER AND MANTLE CELL LYMPHOMA

Bengü Sezer [1,*], Esra Asarkaya [2], Tolga Köseci [2]

[1] *Cukurova University, Faculty of Medicine, Department of Internal Medicine*
[2] *Cukurova University, Faculty of Medicine, Department of Medical Oncology*

İntroduction: Patients cured of any cancer have an increased risk of developing a new primary malignancy compared to the general population. However, synchronous presentation of two tumours is a very rare condition. Here we aim to review the treatment approach of a case of synchronous mantle cell lymphoma and invasive ductal carcinoma of the breast. **Case Report:** A 64-year-old woman presented with a right breast mass. Physical examination revealed a 3cm diameter mass lesion in the right breast and lymphadenopathy in the right axilla. Her past medical history was unremarkable except hypertension. In her family history, there was a history of breast cancer in her niece. Breast ultrasonography revealed 3 centimetres (cm) of malignant breast and multiple lymph nodes with thick cortex in bilateral axillae with indistinguishable fatty hilus. Tru-cut biopsy was performed for the mass in the breast and bilateral axilla lymph nodes. The breast biopsy was compatible with invasive ductal carcinoma with ER 90%, PR 10%, her2 negative and Ki67 proliferation index 10%. Bilateral axilla lymph node biopsy was reported as mantle cell lymphoma and immunohistochemically CD20: Positive, CD5: Positive, Cyclin D1: Positive, CD23: Negative, Lef1: Negative, Keratin: Negative, Ki67 proliferation index 25-30%. PET-CT revealed a mass in the right breast, lymph nodes with pathological appearance in the axillae, various lymph node stations in the abdomen and inguinal areas, and diffuse involvement suggestive of lymphoma infiltration in the right lung. Bone marrow aspiration/biopsy revealed mantle cell lymphoma involvement. The patient was discussed in the multidisciplinary tumour council and right axillary lymph node dissection was performed for staging. 5 lymph nodes showed ductal carcinoma metastasis and the rest of the lymph nodes showed mantle cell lymphoma involvement. Stage IV MHL and hormone positive IDC (T2N2) were detected and R-CHOP treatment was applied. PET-CT performed after three cycles of treatment showed complete response. The patient was discussed again in the multidisciplinary tumour council and surgical treatment for the breast was planned after completing 6 cycles of R-CHOP treatment. After treatment, the patient underwent modified radical mastectomy and the pathological stage was T3N3. After adjuvant RT, endocrine therapy was started and the patient is being followed in remission. **Conclusion:** Coexistence of breast cancer and mantle cell lymphoma is a rare condition. In the few cases reported in the literature, treatment planning was made by considering the stage and treatment priority of both diseases. We planned to prioritise the treatment of lymphoma because our patient had stage 4 mantle cell lymphoma.

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PRİMARY CONJUNCTIVAL LYMPHOMA, 2 CASES

Günay Süleymanlı [1,*], Yasemin Aydınalp Camadan [2], Tuğba Toyran [3], Berksoy Şahin [2]

[1] *Cukurova University, Faculty of Medicine, Department of Internal Medicine*
[2] *Cukurova University, Faculty of Medicine, Department of Medical Oncology*
[3] *Cukurova University, Faculty of Medicine, Department of Pathology*

Introduction: Extranodal marginal zone lymphoma (EMZL) is the most common subtype of conjunctival lymphoma. Management of conjunctival lymphoma consists of radiotherapy, surgery, chemotherapy, antibiotics and targeted therapies (Anti-CD 20) based on case series and retrospective studies. Appropriate treatment should be chosen based on the type of lymphoma, extent of spread, and patient-specific factors. We present two patients with localized disease diagnosed with primary conjunctival EZML by biopsy, for whom we planned different treatment plans. **Case Reports: Case 1:** A 64-year-old female patient presented with a pink-red mass on the lateral conjunctiva of her right eye. (Fig. 1A) Conjunctival biopsy was reported as Non-Hodgkin lymphoma, EMZL.(CD 20(+) and Ki-67 3-4%) No extraocular involvement on PET/CT. Orbital MRI showed a 2.5 cm soft tissue lesion surrounding the right globe laterally and posteriorly. The patient started rituximab and