(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

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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

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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

bendamustine treatment, and the lesion in the right orbit was not observed in the current follow-up imaging after 3 cycles of treatment. (Fig. 1B) The patient continued with rituximab and bendamustine treatment. **Case 2:** When the 52-year-old female patient first appeared two years ago, a conjunctival biopsy revealed that she had EMZL. Radiotherapy was recommended for her localized disease, but she declined it. She received eight cycles of rituximab treatment and was monitored in remission. One year later, salmon-colored lesions were found in the inner corner of both eyes. EZML was also found in the new biopsy. There was no ocular involvement. The patient received 6 cycles of rituximab bendamustine and maintenance rituximab for recurrent and bilateral lesions. We are currently monitoring the patient and the disease is in complete remission. **Discussion:** Lymphoma is one of the most frequently occurring malignant tumors of the conjunctiva. In patients with lesions that like a "salmon patch" and unexplained chronic follicular conjunctivitis, lymphoma should be suspected.

(Fig. 1A) (Fig. 1B)

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A RARE CASE: NODAL FOLLICULAR T HELPER CELL LYMPHOMA, ANGIOIMMUNOBLASTIC TYPE

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Objective: Angioimmunoblastic T-cell lymphoma (AITL) is the second most common subtype of mature T-cell lymphoma (MTCL). It is caused by monoclonal proliferation of T-follicular helper (TFH) cells. Although advances have been made in its biological knowledge, its treatment is still an unmet medical need. We would like to present a case of Nodal-TFH; AITL that we followed in our clinic. **Case Report:** A 67-year-old male patient presented with cough. Thorax CT revealed left supraclavicular-mediastinal multiple lymphadenopathy with pleural effusion. Supraclavicular LN excision was reported as NHL; nodal follicular T helper cell lymphoma, angioimmunoblastic type. Immunohistochemical CD3, PD-1 and CXC13 were positive, CD4, CD8 and CD10 were sparse, CD21 and 23 were positive in increased dentritic cells, CD20, CD30, EBER and IDH-1 were negative. PET-CT revealed Stage 4BS (multiple LNs with FDG uptake in head-neck, thorax-mediastinum and abdominopelvic FDG uptake, increased FDG uptake in bone marrow-spleen; B symptom: positive). Subcutaneous (sc) Azacitidine + intravenous CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) was started. The 1st course of azacitidine was administered at 75 mg/m2 for 7 days 1 week before CHOP treatment and the following courses were administered at 75 mg/m2 for 14 days 2 weeks before CHOP treatment. After 4 cycles of Azacitidine+CHOP, PET-CT regressed and 2 more cycles of treatment were administered. During the follow-up, the patient's general condition deteriorated and he went into septic shock. **Discussion:** AITL-containing T-follicular helper; nodal PTCL is characterized by recurrent mutations affecting epigenetic regulators. The association of abnormal DNA methylation with lymphomagenesis provides rationale for the administration of hypomethylating agents. The epigenetic modifier azacitidine, which inhibits DNA methyltransferase, has demonstrated clinical activity alone or in combination in relapsed/refractory PTCL. In a phase-2 clinical trial of 20 patients who experienced oral azacitidine + CHOP as initial treatment for PTCL, CR was 76.5%, 1-year PFS 61.1%, 1-year OS 88.9%. In our case, we added the hypomethylating agent azacitidine to the CHOP protocol and aimed to evaluate the efficacy of this combination in the initial treatment of CD30 negative PTCL.

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SINGLE-CENTER EXPERIENCE IN DIFFUSE LARGE B-CELL LYMPHOMA: PROGNOSTIC VALUE OF DEMOGRAPHIC AND MOLECULAR CHARACTERISTICS

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İntroduction: Diffuse large B-cell lymphoma (DLBCL) is a heterogeneous hematological malignancy, accounting for approximately 30% of all lymphomas, and is associated with diverse clinical outcomes. The onset of DLBCL typically occurs in the sixth decade of life, with a higher incidence in males. The morphological, clinical, and biological diversity of DLBCL underscores the presence of multiple subtypes, each exhibiting distinct behavior. **Objective:** The objective of this study is to assess the demographic characteristics and clinical outcomes of DLBCL patients, as well as to evaluate the prevalence and prognostic significance of MYC and BCL2 co-expression on survival. **Methodology:** A retrospective study was performed on 51 patients with a confirmed diagnosis of DLBCL. We conducted an analysis of the demographic data