dry eyes and joint pains. The presence of anti-SSA antibodies and diminished results of the Schirmer test supported the diagnosis of Sjögren's syndrome; thus, hydroxychloroquine and prescription of artificial tears were started. Symptomatic treatment was begun because the development of albumin and total protein inversion suggested plasma cell dyscrasia. Further work-up for immunofixation electrophoresis and bone marrow biopsy confirmed IgG lambda-positive MM. She was subsequently treated with VRD (bortezomib, lenalidomide, and dexamethasone), followed by an autologous BMT in May 2024. Post-transplant maintenance was given with lenalidomide. She also developed sensory neuropathy, which was managed with pregabalin, with no recurrence of MM on follow-up. **Discussion:** The case epitomizes the complex diagnostic interplay between MM and Sjögren's syndrome. Symptoms of fatigue and protein abnormalities can easily be attributed to an autoimmune condition, with a delayed diagnosis of MM. Multidisciplinary collaboration has been critical for management of comorbidities and assurance of timely diagnosis. The patient responded well to BMT and maintenance therapy, proving personalized care. Furthermore, long-term treatment shows the necessity of monitoring drug-induced neuropathy. This case report adds to the growing awareness of rare concomitant autoimmune disorders and hematologic malignancies, with a reminder for vigilance in complex presentations and the delivery of adaptive multidisciplinary care.

Keywords: Multiple Myeloma, Sjögren's Syndrome, Bone Marrow Transplantation, Lenalidomide, Neuropath.

https://doi.org/10.1016/j.htct.2024.11.076

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PRIMARY PALATAL ALK-NEGATIVE ANAPLASTIC LARGE CELL LYMPHOMA: RARITY TREATED SUCCESSFULLY WITH BRENTUXIMAB VEDOTIN

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Introduction: ALCL is an extremely rare T-cell non-Hodgkin lymphoma subtype made up of CD30-positive tumor cells, which are very aggressive. Though it most frequently involves lymph nodes and skin, less frequently, it affects other organs as well. Primary oral involvement, particularly of the palate, is highly uncommon. The paper reports a peculiar case of localized primary ALK-negative ALCL of the palate in a 73-year-old female patient treated successfully with brentuximab vedotin, pointing to the importance of identifying atypical presentations. **Case Report:** A 73-year-old female with a history of presenting a painless ulcer on her palate, which did not heal with local treatments for two months, presented to the otolaryngology clinic and underwent an incisional biopsy. Histopathological findings showed large atypical lymphoid cells with prominent nucleoli, consistent with ALCL. Immunohistochemical staining was positive for CD30 and negative for ALK; in addition, Epstein-Barr virus testing returned negative. PET-CT showed localized uptake of FDG in the palate, SUVmax 8.5, with no significant lymphadenopathy and no systemic involvement. Bone marrow biopsy showed normal hematopoiesis with no evidence of infiltration. The patient was diagnosed with primary breast ALK-negative ALCL and started on brentuximab vedotin. The patient went into complete remission after three cycles of therapy with no residual disease evident on follow-up imaging. **Discussion:** This case illustrates the need to consider ALCL in the differential diagnosis of atypical sites, such as the palate, when lesions fail to respond to conventional therapy. Early biopsy and a wide panel of immunohistochemical tests are crucial for accurate diagnosis. Due to the high recurrence rates as well as poor prognosis associated with ALK-negative ALCL, highly active targeted therapies include brentuximab vedotin. The complete remission attained in this patient underlines the promise of personalized therapies in dealing with rare malignancies. Awareness of such atypical presentations may help in early diagnoses and improve patient outcomes. This case further stresses that management of lymphoma with such unusual presentations may be effectively accomplished using an interdisciplinary approach.

Keywords: anaplastic large cell lymphoma, ALK-negative, CD30, brentuximab vedotin, palatal lymphoma.

https://doi.org/10.1016/j.htct.2024.11.077

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PRIMARY EXTRAMEDULLARY PLASMACYTOMA OF THE LYMPH NODES

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Introduction: Extramedullary plasmacytomas are rare malignant neoplasms that can arise in various organs; however, lymph node involvement is uncommon. The cervical lymph nodes are most frequently affected. We present the case of a 68-year-old female diagnosed with a primary extramedullary plasmacytoma involving multiple lymph nodes, primarily in the cervical region. **Case Report:** A 68-year-old female patient presented with a one-month history of progressive enlargement and painful swelling of the right subclavicular and cervical areas. Imaging revealed pathological lymphadenopathy, and excisional biopsy was performed from the right cervical level 5 lymph node. Histopathological analysis confirmed the diagnosis of a plasmacytoma. A subsequent bone marrow biopsy revealed normocellular marrow without any evidence of infiltration. Positron emission tomography-CT staging

demonstrated further lymph node involvement in the right cervical, subclavicular, supraclavicular, axillary, and mediastinal regions. **Discussion:** This case was classified as a primary extramedullary plasmacytoma of the lymph nodes, given the absence of multiple myeloma markers in the bone marrow and immunoelectrophoretic studies. Lymph node plasmacytomas are exceedingly rare, comprising approximately 2% of all extramedullary plasmacytomas. Clinically, these patients often present with localized masses and minimal systemic symptoms. While recurrence is possible, primary lymph node plasmacytomas rarely progress to multiple myeloma and are associated with a more favorable prognosis than other solitary extramedullary plasmacytomas. The distinct clinical behavior of these lesions suggests that they may represent a unique subset of plasmacytomas with a lower risk of transformation into multiple myeloma. Most patients respond well to surgical excision, with minimal risk of recurrence or progression, even in the absence of adjuvant therapy. Although some patients develop osseous plasmacytomas, none have progressed to multiple myeloma in reported series.

https://doi.org/10.1016/j.htct.2024.11.078

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MANAGEMENT OF CHEMOTHERAPY-RESISTANT GASTRIC DIFFUSE LARGE B-CELL LYMPHOMA: A CASE REPORT

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Introduction: Diffuse large B-cell lymphoma (DLBCL) is the most common subtype of non-Hodgkin lymphoma, often affecting extranodal sites like the stomach. While R-CHOP chemotherapy is the standard treatment, some patients fail to respond, requiring alternative approaches. In this report, we describe a case of gastric DLBCL in a 68-year-old man who became resistant to R-CHOP but achieved remission with R-DHAP. **Case Report:** A 68-year-old man came to the hospital with symptoms of persistent indigestion. After undergoing an endoscopic biopsy in October 2020, he was diagnosed with high-grade gastric diffuse large B-cell lymphoma. A PET-CT scan revealed a large mass in his stomach. He started R-CHOP chemotherapy, completing eight cycles. However, after five cycles, imaging showed remaining disease in the stomach, along with new lesions in the left lung. Despite ongoing treatment, a biopsy after the sixth cycle confirmed that the lymphoma was still active. The situation worsened—his disease had become resistant to R-CHOP. In response, his treatment shifted to R-DHAP chemotherapy. After just two cycles, an endoscopic biopsy revealed no active lymphoma, and only signs of chronic atrophic gastritis remained. PET-CT scans over the following months showed no recurrence of lymphoma. However, in March 2023, a PET-CT showed some hypermetabolic lymph nodes in the cervical region, but these had regressed significantly compared to previous scans. As of October 2024, the patient continues to be closely monitored and remains asymptomatic. **Discussion:** This case highlights the challenges faced when dealing with chemotherapy-resistant DLBCL. It emphasizes the need to pivot quickly to alternative therapies, like R-DHAP, when first-line treatments fail. The successful response in this patient demonstrates that adjusting treatment strategies can make a significant difference in outcomes. Additionally, it shows the importance of long-term follow-up, especially with extranodal lymphomas, where the risk of relapse is ongoing.

Keywords: Diffuse large B-cell lymphoma, R-CHOP, Chemotherapy resistance, R-DHAP, Gastric lymphoma.

https://doi.org/10.1016/j.htct.2024.11.079

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SYSTEMIC NODULAR SCLEROSING HODGKIN LYMPHOMA WITH UNUSUAL HEPATIC AND GASTRIC INVOLVEMENT: A CASE REPORT

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Introduction: Hodgkin lymphoma (HL) is typically known for presenting as enlarged lymph nodes, but occasionally, it takes an unexpected turn, spreading to less common locations. In this report, we dive into a rare case of nodular sclerosing Hodgkin lymphoma, where the disease had aggressively spread, invading the liver and stomach—locations rarely associated with HL. **Case Report:** A 40-year-old woman came to the clinic with persistent back pain, trouble walking, and noticeable weight loss. At first, these symptoms seemed to point to a spinal issue, prompting an L4 kyphoplasty. However, things quickly worsened, and her condition began to deteriorate. A PET-CT scan soon revealed troubling results—multiple areas of hypermetabolic activity across her lymph nodes and bones, which were now lighting up with disease. A biopsy of the inguinal lymph node confirmed the diagnosis: classical Hodgkin lymphoma, nodular sclerosing type. Treatment started with Brentuximab vedotin paired with the AVD regimen (Adriamycin, Vinblastine, and Dacarbazine), but complications arose. During therapy, she developed a painful perianal abscess,