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.

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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.

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PP 52

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,

which needed surgical drainage. Yet the disease kept advancing. New imaging showed a more aggressive spread: multiple hypermetabolic lesions were found in the liver, and another was detected in the gastric fundus. Despite a clear endoscopy, which didn't show any visible abnormalities in the stomach, a liver biopsy confirmed what the team feared—Hodgkin lymphoma had infiltrated her liver. Her treatment continues with careful monitoring as the medical team adapts to these complications. **Discussion:** This case paints a picture of the diagnostic and treatment challenges that arise when Hodgkin lymphoma doesn't follow the expected path. Instead of typical lymphadenopathy, the disease made itself known through musculoskeletal pain and neurological issues, creating a complex clinical puzzle. The rare involvement of the liver and stomach emphasizes just how unpredictable the systemic spread of this disease can be. While hepatic involvement in HL is unusual, it's critical to confirm this through biopsy, as it can easily be mistaken for other liver-related conditions. Gastric involvement, though rare, must be kept in mind when dealing with extensive disease spread. Advanced imaging, particularly PET-CT, played a pivotal role in uncovering these unexpected sites of involvement, guiding the treatment plan. This case is a testament to the importance of recognizing atypical presentations of Hodgkin lymphoma and the need for flexible, evolving treatment strategies. The use of Brentuximab vedotin in combination with AVD has shown promise, especially in complicated cases like this one, where the disease has spread far beyond the usual lymphatic system. Understanding HL's ability to infiltrate uncommon sites like the liver and stomach is essential for improving patient outcomes. This case reminds us of the disease's unpredictable nature and the need for vigilance in detecting and managing its spread to rare locations.

Keywords: Nodular Sclerosing Hodgkin Lymphoma, Hepatic Infiltration, Gastric Involvement, Systemic Spread, Brentuximab Vedotin Treatment.

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SYSTEMIC AMYLOIDOSIS PRESENTING WITH LYMPHADENOPATHY: A DIAGNOSTIC OVERLAP WITH MULTIPLE MYELOMA AND POSSIBLE CARDIAC INVOLVEMENT

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Introduction: Systemic amyloidosis is a condition where amyloid proteins accumulate in organs and tissues, causing multisystem dysfunction. Its presentation often overlaps with other conditions like lymphoproliferative disorders and multiple myeloma (MM). Lymphadenopathy is rare in amyloidosis but can complicate the clinical picture, mimicking more common hematological diseases. We present a case of systemic amyloidosis in a patient initially suspected of having lymphoma, complicated by underlying multiple myeloma and probable cardiac amyloidosis. **Case Report:** A 63-year-old male with a history of heart failure and chronic kidney disease presented with frequent hospital admissions due to dyspnea. Axillary lymphadenopathy prompted referral to hematology. PET-CT revealed widespread FDG-avid lymphadenopathy, suggesting lymphoma. Biopsy showed plasma cell infiltration (10-11%) with kappa light chain monotypic plasma cells and amyloid deposits, indicating systemic amyloidosis. Concurrent imaging revealed pleural effusions, calcified lymphadenopathies, and findings consistent with granulomatous disease. Further hematological evaluation suggested underlying plasma cell dyscrasia, likely multiple myeloma. The patient's history of heart failure raised the suspicion of cardiac amyloidosis, a common complication in systemic amyloidosis, warranting cardiology evaluation and planned cardiac MRI. **Discussion:** This case underscores the diagnostic challenge posed by systemic amyloidosis, especially when lymphadenopathy is present, leading to initial misdiagnosis as lymphoma. Amyloidosis-related lymphadenopathy is uncommon but should be considered, especially when plasma cell dyscrasias like multiple myeloma are involved. The concurrent diagnosis of multiple myeloma further complicates the clinical course, necessitating a tailored therapeutic approach. Cardiac amyloidosis is a serious complication often seen in patients with systemic amyloidosis, especially AL-type, where amyloid deposits infiltrate the myocardium, leading to restrictive cardiomyopathy. In this case, the patient's long-standing heart failure and arrhythmia raised the likelihood of cardiac involvement. Early detection is crucial, as cardiac amyloidosis is associated with a poor prognosis. The integration of advanced cardiac imaging, such as MRI, is essential in confirming the diagnosis and guiding treatment. This case illustrates the importance of considering systemic amyloidosis in patients with unexplained lymphadenopathy and highlights the need for multidisciplinary management, particularly when cardiac involvement is suspected.

Keywords: Amyloidosis, Lymphadenopathy, Multiple Myeloma, Cardiac Amyloidosis, Plasma Cell Dyscrasia.

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