ALL followed at our center, diagnosed between 16. August.2019 and 17.June.2025 were retrospectively evaluated. The relationship between the patients' coagulation parameters and clinical data at diagnosis and during the induction period was investigated. **Results:** The median age at diagnosis was 39 (18-79), and the majority of the patients were male (31/19). Nine of the patients had T-ALL, 17 had Ph-positive B-ALL, and 24 had Ph-negative B-ALL. The median follow-up duration was 15.3 (0.2-71.9) months. At the time of diagnosis, mild hypofibrinogenemia (<200 mg/dL) was detected in 8 (17%) and severe hypofibrinogenemia (<100 mg/dL) was detected in 2 (4%) patients. During the induction phase, mild hypofibrinogenemia was detected in 36 (72%) and severe hypofibrinogenemia was detected in 11 (22%) patients. No statistically significant association was found between mild or severe hypofibrinogenemia at diagnosis and induction phase with age, gender, and ALL subtype. Fibrinogen level at diagnosis was lower in patients who developed mild hypofibrinogenemia at induction phase compared to those who did not (median 278 vs. 453) (p=0.004). In patients who received an asparaginase-containing induction regimen, both mild hypofibrinogenemia (92.9% vs. 63.9%) and severe hypofibrinogenemia (42.9% vs. 13.9%) were observed more frequently at induction phase (p=0.039 and p=0.036, respectively). In patients with mild hypofibrinogenemia at induction, the requirement for cryoprecipitate or fresh frozen plasma (FFP) was higher than in patients with normal fibrinogen levels (55.6% vs. 21.4%, p=0.030). D-dimer levels at diagnosis were higher in Ph-positive B-ALL than in Ph-negative B-ALL (median 15 vs. 4.3; p=0.030). D-dimer levels at induction phase were also higher in patients requiring cryoprecipitate or FFP (median 14.6 vs. 7.1; p=0.07). Early mortality (in the first 30 days) was 1 (2%), and was not associated with bleeding or thrombosis. No statistically significant association was found between age, gender, disease subtype, fibrinogen and D-dimer levels at diagnosis and induction phase, asparaginase use, or cryoprecipitate or FFP requirement and overall survival. **Conclusion:** In this study, we demonstrated that hypofibrinogenemia, while observed at diagnosis of ALL, is particularly prevalent during the induction phase. Hypofibrinogenemia at induction phase is determined by the fibrinogen levels at diagnosis and the use of asparaginase-containing regimens. Following, consumption of the blood products containing coagulation factors determined by the hypofibrinogenemia at induction phase. Although coagulopathy increased the frequency of blood product use, it was observed that it did not negatively impact patient survival. Clinical guidelines should be reviewed for newly diagnosed ALL patients with and without asparaginase use and updated based on large-scale studies.

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PP 03

RAM-like Acute Myeloid Leukemia in an Elderly Patient: A Rare Phenotypic Variant

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Introduction: Acute myeloid leukemia (AML) is a heterogeneous hematologic malignancy with diverse morphologic and immunophenotypic subtypes. The RAM (rapidly maturing) phenotype is a rare and poorly characterized variant, initially described in pediatric acute leukemia, but has also been identified in older adults (Wells et al., 2018). It is typically defined by CD45^dim, CD34−, CD117+, CD33++, and aberrant CD7 expression, with aggressive clinical behavior and poor prognosis (Nguyen et al., 2021). Here, we present a case of elderly-onset AML with RAM-like immunophenotypic features. **Methods:** A 81-year-old female presented with pancytopenia and recurrent subdural hemorrhages. Flow cytometry revealed CD45^dim, CD34−, CD117+, CD33++, and aberrant CD7+ blasts, consistent with RAM-like AML. Cytogenetic analysis showed no recurrent AML-defining translocations by FISH. Comprehensive molecular testing, including FLT3, NPM1, and CEBPA, was negative. Clinical frailty assessment demonstrated a high CIRS score, limiting intensive treatment options. **Results:** Bone marrow examination confirmed AML with RAM-like immunophenotype. Given the patient's age, comorbidities, and recurrent intracranial hemorrhages, intensive induction chemotherapy was contraindicated. Supportive care and hypomethylating agent-based therapy were considered but deferred due to poor functional status and ongoing hemorrhagic risk. The patient remained under best supportive care, including transfusions and infection prophylaxis. Prognosis was explained to the family as extremely poor, consistent with published literature (Al-Kershi et al., 2023). **Discussion:** RAM-like AML represents a high-risk immunophenotypic subset, characterized by treatment resistance and inferior outcomes (Wells et al., 2018). Most reported cases occur in children; however, adult and elderly cases are being increasingly recognized (Nguyen et al., 2021). This case highlights the diagnostic challenge and limited therapeutic options in elderly patients, particularly when performance status and comorbidities preclude intensive therapy. Early recognition through flow cytometry is essential for risk stratification and counseling. **Conclusion:** We report an elderly female with AML exhibiting RAM-like phenotype, an aggressive and rare immunophenotypic variant. Awareness of this entity is important for hematologists, as it informs prognosis and guides therapeutic decision-making, even when curative approaches are not feasible.

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PP 04

Incidentally Detected Precursor B-Cell Acute Lymphoblastic Leukemia in a Patient Monitored for Myocarditis: A Case Report

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Introduction: Hematologic abnormalities in young adults are frequently attributed to infections or reactive processes, yet concurrent cytopenias and lymphocytosis may herald

malignant conditions. Acute lymphoblastic leukemia (ALL) is uncommon in adults but should be considered in the presence of persistent unexplained hematologic abnormalities (Inaba et al., 2021). Here, we present a 29-year-old male patient initially hospitalized with myocarditis, in whom incidental hematologic findings prompted further investigation and ultimately led to the diagnosis of precursor B-cell acute lymphoblastic leukemia (B-ALL), Türkiye. **Methods:** The patient, with comorbid obesity, hyperlipidemia, prediabetes, and coronary artery disease, was admitted to the coronary intensive care unit due to myocarditis. Laboratory evaluation revealed neutropenia, lymphocytosis, anemia, and severe thrombocytopenia. Hematology consultation was obtained, and systematic infectious and metabolic workup was performed, including TORCH, hepatitis panel, HIV, brucella, and syphilis, all of which were negative. Nutritional deficiencies were excluded. Bone marrow aspiration and biopsy were conducted to clarify the unexplained cytopenias. **Results:** Peripheral smear showed marked lymphocytosis. Bone marrow evaluation demonstrated precursor B-cell blasts consistent with B-ALL. The patient had a prior history of episodic polycythemia treated with phlebotomy at an external center, but no prior evaluation for myeloproliferative neoplasm was documented. Physical examination was remarkable for obesity and cervical lymphadenopathy. Despite the confirmed diagnosis of B-ALL, the patient declined further therapy and left the clinic against medical advice. **Discussion:** This case underscores the diagnostic challenge posed by overlapping cardiac and hematologic findings. While myocarditis can present with systemic manifestations that mimic hematologic disorders, persistent cytopenias with lymphocytosis should prompt early hematology evaluation (Terwilliger & Abdul-Hay, 2017). Adult B-ALL often carries a poor prognosis compared to pediatric cases, and early initiation of therapy is critical to improving outcomes (Kantarjian et al., 2017). Moreover, this case highlights the importance of considering hematologic malignancy in young adults with incidental laboratory abnormalities, even in the context of alternative explanations such as infection or cardiac disease. Systematic diagnostic workup, including bone marrow biopsy, remains the gold standard for definitive diagnosis (Hunger & Mullighan, 2015). **Conclusion:** We report a young adult male followed for myocarditis in whom incidental hematologic abnormalities revealed underlying precursor B-cell ALL. This case emphasizes the necessity of maintaining a broad differential diagnosis in young adults with unexplained cytopenias and lymphocytosis, and of not delaying bone marrow evaluation. Prompt recognition is essential for timely treatment initiation and improved patient outcomes.

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Adult Hematology Abstract Categories

Chronic Leukemias

PP 05

A CASE OF CHRONIC LYMPHOCYTIC LEUKEMIA WITH CENTRAL NERVOUS SYSTEM INVOLVEMENT

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Although chronic lymphocytic leukemia (CLL) is very common in adults, complications associated with CLL involvement of the nervous system are very rare (1). The case report describes a CLL patient with leptomeningeal and orbital involvement. There is no standard treatment protocol for this pattern of involvement. Our patient received maintenance therapy with ibrutinib after chemoimmunotherapy, and her neurological symptoms completely resolved. CASE: A 48-year-old female housewife was diagnosed with CLL in 2018. The 17p deletion-negative patient is being followed without treatment. She has no known history of the disease. The patient presented with complaints of decreased vision, severe headache, and double vision. Her symptoms had been present for approximately two weeks. Laboratory tests revealed WBC: 156 10e3/uL, HBG: 9.2 g/dL, platelets: 188 10e3/uL, lymphocytes: 128.41 10e3/uL, creatinine: 1.07 mg/dL, urea: 48 mg/dL, LDH: 534 U/L, sodium: 134 mmol/L, potassium: 3.38 mmol/L, and sedimentation rate: 38 mm/h. Imaging revealed a liver of 180 cm and a spleen of 180 cm. Additionally, multiple lymphadenomegaly was detected in the axillary, inguinal and neck regions.An ophthalmology consultation was performed for the patient's complaints of headache, decreased vision, and diplopia. The evaluation revealed bilateral grade 3 papilledema. Detailed cranial imaging revealed no pathology during the neurological evaluation. Cerebrospinal fluid (CSF) sampling was performed. Results for neuromyelitis optica and other neurological disorders were negative. Results for meningitis were also negative. Direct microscopic examination of the CSF revealed widespread lymphocytosis consistent with CLL. The patient's headache and visual symptoms were interpreted as CLL neurological involvement. A course of R-FC was administered. A follow-up fundus examination after the course revealed resolution of the patient's grade 3 bilateral papilledema, and her headache complaints significantly decreased. Ibrutinib was initiated as maintenance therapy and the patient was discharged for routine follow-up visits. Conclusion: DISCUSSIONOur patient