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## CD5-positive Grade 3A Follicular Lymphoma Following Resected Cutaneous Squamous Cell Carcinoma: A Case Report

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**Introduction:** Follicular lymphoma (FL) is a germinal-center B-cell neoplasm that typically expresses CD10/BCL6 and lacks CD5. CD5-positive FL is uncommon and may mimic mantle cell lymphoma (MCL), creating critical diagnostic and therapeutic implications. We report an older male with a history of resected cutaneous squamous cell carcinoma (SCC) who presented with a new inguinal lymphadenopathy ultimately diagnosed as FL grade 3A, despite an atypical CD5-positive flow phenotype. **Methods:** This single-patient case report summarizes clinical data, ^18F-FDG PET/CT findings, flow cytometry, histopathology, and management. PET/CT was performed for staging. Lymph node excision provided tissue for histology and immunohistochemistry (IHC). Peripheral blood flow cytometry used a chronic lymphocytic leukemia (CLL) panel. Bone-marrow aspirate/biopsy were attempted for staging. **Results:** A 70-year-old man with previously excised cutaneous SCC (disease-free) was evaluated for new left inguinal lymphadenopathy. PET/CT demonstrated a metabolically active left inguinal node (~17 × 15 mm, SUVmax 12.18) with no other pathologic uptake in the neck, chest, liver, spleen, or adrenals. A posteromedial femoral hypodense nodule (~20 × 15 mm) and a subcutaneous scapular lesion (~26 × 20 mm) showed no increased FDG uptake. Excisional biopsy of the inguinal node revealed non-Hodgkin lymphoma, classic follicular lymphoma, grade 3A (WHO 2016). IHC showed CD20+, BCL6+, BCL2+, CD10+, CD21 positivity in follicular dendritic cells, CD3−, and Ki-67 ~25%. Peripheral blood flow cytometry demonstrated B-cell markers with CD5 high (~71%), CD23 low/negative (~16%), CD10 low (~4%), CD43 (~78%), and mild kappa predominance; findings raised concern for MCL. However, nodal histomorphology with CD10/BCL6 positivity supported FL. Bone-marrow aspirate was suboptimal (particle-poor), and iron score could not be assessed; marrow staging biopsy was planned. Given grade 3A FL and PET-positive nodal disease, the multidisciplinary tumor board recommended R-CHOP chemoimmunotherapy. Additional work-up (cyclin D1/SOX11 IHC and/or t(11;14) FISH) was advised to definitively exclude MCL due to CD5 expression. **Discussion:** This case highlights two challenges: (1) Dual malignancy in the same patient (prior SCC, now FL) and (2) immunophenotypic discordance between flow cytometry and histology. CD5-positive FL is rare and easily misclassified as MCL; mislabeling could alter therapy (e.g., bendamustine-rituximab vs R-CHOP and consideration of BTK inhibitors in MCL). When flow suggests MCL but node histology/IHC favors FL, tissue-based cyclin D1/SOX11 and t(11;14) are decisive. Suboptimal marrow underscores the need for core biopsy to complete staging. The absence of systemic FDG-avid disease supports localized nodal involvement at presentation. **Conclusion:** An older male with previously cured cutaneous SCC developed CD5-positive FL grade 3A presenting as isolated FDG-avid inguinal lymphadenopathy. Despite CD5 expression on flow cytometry, nodal morphology and germinal-center IHC secured an FL diagnosis, and R-CHOP was initiated. This case emphasizes rigorous correlation of flow cytometry with histopathology and the importance of cyclin D1/SOX11/t(11;14) testing when CD5 positivity creates ambiguity.

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## A CASE REPORT OF PRIMER REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA

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**INTRODUCTION:** Diffuse large B-cell lymphoma (DLBCL) is the most common histological subtype of non-Hodgkin lymphoma (NHL) and accounts for approximately one-quarter of NHL cases. Patients typically present with enlarged lymph nodes in the neck or abdomen. DLBCL's first-line immunochemotherapy such as R-CHOP (rituximab, cyclophosphamide, doxorubicin, Oncovin and prednisone) curing approximately two-thirds of patients. The prognosis is poor for DLBCL patients who receive first-line chemoimmunotherapy but develop early relapse or refractoriness. Treatment options for refractory patients include salvage chemoimmunotherapy, monoclonal antibodies, CAR-T or autologous stem cell transplantation. We will present a case of primary refractory DLBCL. **CASE:** A 57-year-old male patient with no chronic illness presented to the internal medicine outpatient clinic complaining of abdominal pain and was referred to us due to the detection of conglomerate lymphadenopathy (LAP) in the abdomen on imaging. Positron Emission Tomography (PET-CT) revealed multiple LAP's within the abdomen, the largest measuring 80 mm in diameter and with an SUV(max) value of 21.8. A tru-cut biopsy was performed from the large intra-abdominal LAP. The results were DLBCL with Bcl-2 (+), Bcl-6 (+), and Ki-67 85-90%. Myc could not be tested for technical reasons. No infiltration was detected in the bone marrow biopsy. The patient received 3 cycles of R-CHOP chemotherapy protocol, and a PET-CT scan was performed for interim evaluation. The PET-CT scan showed persistent conglomerate LAP's with an SUV(max) value of 27.02 and a maximum diameter of 58 mm. The patient, considered refractory, received two cycles of R-DHAP (Rituximab-Dexamethasone, Cytarabine Cisplatin) chemotherapy protocol and a PET-CT scan was performed for response evaluation. The PET-CT scan showed multiple LAPs, the largest of which was 83 mm in diameter and had an SUV(max) of 31.45. A tru-cut biopsy was performed again from the largest intra-abdominal lymph node for confirmation of the diagnosis. Pathology was similar to the previous biopsy and c-myc was weak (+) (10-15%). The patient received two cycles of the R-GemOX (rituximab, gemcitabine, oxaliplatin) protocol. Only abdominal CT was