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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

scanned and no reduction in the mass was observed. Glofitamab therapy was initiated with off-label consent. The first and second cycle was completed. The patient did not develop cytokine release syndrome or neuropathy. A PET-CT scan was scheduled for 3 weeks later for response evaluation. The PET-CT scan showed that the intra-abdominal mass had regressed to 8 mm and the SUV(max) value to 3.44. The patient, who responded to glofitamab treatment, was offered autologous stem cell transplantation or CAR-T (Chimeric Antigen Receptor T-cell) therapy options. The patient requested to be referred to a center where CAR-T therapy could be performed. The patient is currently awaiting CAR-T therapy. **CONCLUSION:** In eligible DLBCL patients, salvage chemoimmunotherapy and/or monoclonal antibodies can be used as bridge therapies to OKIT or CAR-T therapies. Glofitamab is a bispecific antibody targeting CD20 and CD3, approved for r/r DLBCL patients after at least two prior lines of therapy. In a study, Glofitamab demonstrated a 46% ORR (27% CR; 19% PR) and manageable safety in heavily pretreated r/r DLBCL patients.

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A CASE OF REFRACTORY MULTIPLE MYELOMA WITH HYPOGLOSSAL NERVE INVOLVEMENT

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Multiple myeloma (MM) is a clonal stem cell disease originating from plasma cells. The development of MM neurological findings is mostly caused by hyperviscosity, hypercalcemia, amyloidosis, vertebral bone involvement and spinal cord compression due to fractures or nerve compression, neuropathy due to paraproteinemia. Brain involvement is very rare. It may present as cerebral lesion, parenchymal disease or leptomeningeal involvement. A case of isolated hypoglossal nerve involvement under MM treatment at the age of 52 will be presented. Cranial nerve involvement in multiple myeloma patients can occur without the development of plasmacytoma at the skull base, but rather through infiltration of the nerve sheath with plasma cells. Combination therapies must be administered to the patient. Isolated cranial nerve involvement is a very rare complication of multiple myeloma. INTRODUCTION: Multiple myelom is clonal stem cell disease originating from plasma cells. These cells produce monoclonal immune globulins, most commonly Immunoglobulin G (IgG) or Immunoglobulin A (IgA). The disease often leads to a variety of symptoms, including anemia, bone pain, increased incidence of fracture, hypercalcemia, renal failure and increased susceptibility to infections(1).Neurological complications in MM most commonly occur due to spinal cord compression from bone lesions, paraprotein associated neuropathy, hypercalcemia, hyperviscosity or amyloidosis(2). Central nervosus system (CNS) involvement may manifest as either a solitary cerebral lesion, intra-parenchymal infiltration, or diffuse leptomeningeal disease such as CNS myelomatosis(3). The average survival after CNS involvement is 3 months (1,3). **Clinical Presentation:**A 46-year-old male patient presented with complaints of pain in the left shoulder and chest that started on January 0, 2019, in addition to weight loss, weakness in the legs, and difficulty in walking. Laboratory Findings:In the examinations performed, wbc: 8.24 10e3/uL hbg: 9.23 gr/dl, plt: 118 10e3/uL, pnl: 5.65 10e3/uL, urea: 117 mg/dl, creatinine: 3.85 mg/dl, albumin: 2.79 gr/dl, globulin: 3.81 gr/dl, corrected calcium: 9.16 mg/dl, beta2 microglobulin: 0.44 mg/dl, serum free lambda light chain: 1190 mg/l increased and serum free kappa light chain: 5.25 mg/l, 24-hour urine immunofixation electrophoresis revealed free lambda light chain: 5.65 mg/l, Chain band was detected. In the MR imaging, there were nodular lesions in the iliac bone and sacrum, immunoglobulin values were IgA: 25 mg/dl, IgG: 293 mg/dl, IgM: 68 mg/dl, 80% plasma cells in the bone marrow. Treatment: The patient was diagnosed with multiple myeloma and started on bortezomib, cyclophosphamide, dexamethasone (VCD) chemotherapy. After 4 cycles of VCD and radiotherapy (RT), an increase in light chains was observed in the control evaluation, and a bortezomib, lenalidomide and dexamethasone (VRD) course was started. The patient, who underwent autologous BMT in December 2019, was followed up under lenalidomide cordexa maintenance treatment, and a relapse was detected in the control evaluations in June 2022. Ixazomib, lenalidomide and dexamethasone (IRD) treatment was started, and daratumumab VCD treatment was switched to due to lack of response. Outcome: The patient, who was followed up under daratumumab VCD treatment, developed complaints of decreased hearing and numbness in the jaw. In addition to the atrophy in the left half of the tongue and the complaint of shifting to the left when the tongue was taken out of the mouth, speech and swallowing were impaired. (Figure 1)Neurology consultation and detailed brain imaging showed increased thickness in the right maxillary sinus. In the PET-CT imaging, although there was no pathological involvement in the head, neck and mediastinal structures, widespread lytic lesions were seen especially in various vertebrae, femur and tibia, and it was evaluated as progressive disease. No plasma cells or other pathology was detected in intrathecal sampling. Peripheral smears were examined daily with suspicion of plasma cell leukemia, but plasma cells were not detected. No signs of neurological diseases such as cranial hemorrhage or embolism were found that would cause this clinic. Conclucion and Results: The patient was evaluated in the council with neurology and it was evaluated that there was isolated myeloma involvement of nervus hypoglossus and the treatment was arranged as dartumumab, pomalidomide and dexamethasone. Brain RT was performed. After 2 cycles of chemotherapy and radiotherapy, the patient's tongue numbness, speech and swallowing disorders improved. The complaint of left shift when the tongue came out of the mouth regressed(Figure 2). The patient's isolated nervus hypoglossus involvement improved with treatment, and his follow-ups are continuing. In conclusion, cranial nerve involvement in multiple myeloma patients can occur without the development of plasmacytoma at the skull base, but rather through infiltration of the nerve sheath with plasma cells. Combination therapies must be administered to the patient. Conclusion: Brain involvement may very rarely develop in 1% of patients with multiple