classic WAS, treatment selection should be based on the patient's clinical presentation. Studies have shown that IVIG or antibiotic prophylaxis has no effect on the frequency or severity of infections in these patients. Since our patient did not have a history of frequent or severe infections, we did not initiate these treatments. Studies have shown that the incidence of bleeding decreases significantly after splenectomy, but the incidence of infection increases. Our patient's platelet counts returned to normal after splenectomy. To reduce the frequency of infections, we administered encapsulated bacterial vaccines and started penicillin prophylaxis for our patient. Due to the permanent morbidity in XLT, hematopoietic stem cell transplantation (HSCT) is the definitive treatment method. However, considering the side effects of HSCT, this decision should be made according to the patient's clinical condition.

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Adult Hematology Abstract Categories

Stem Cell Transplantation

PP 15

COMPARISON OF FEBRILE NEUTROPENIA IN PATIENTS UNDERGOING AUTOLOGOUS STEM CELL TRANSPLANTATION WITH BEAM AND HIGH-DOSE MELPHALAN CONDITIONING REGIMENS

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Objective: Objective: Conditioning regimens used before autolog stem cell transplantation (ASCT) have a direct impact on post-transplant complications and infectious morbidity. The BEAM regimen (carmustine, etoposide, cytarabine, and melphalan) is frequently preferred for patients with Hodgkin and non-Hodgkin lymphomas, while high-dose melphalan is commonly used in multiple myeloma. This study aims to compare the incidence of febrile neutropenia (FN) in patients undergoing ASCT with either the BEAM or high-dose melphalan conditioning regimen. **Methods:** In this study, febrile neutropenic patients who underwent autologous stem cell transplantation between 2010 and 2023 at the Hematology Department of Bursa Uludağ University Faculty of Medicine were analyzed. We evaluated the patients' demographic and clinicopathological data, duration of FN episodes, depth of neutropenia, and length of hospital stay. Additionally, the causative pathogens of FN and FN-related mortality were also analyzed, Türkiye. **Result:** A total of 164 patients were included in this study. Seventy-three of the patients were female and 91 were male. There were 131 multiple myeloma, 23 Non-Hodgkin lymphoma, and 10 Hodgkin lymphoma. One-hundred thirty one (%80) received high-dose melphalan, 33 (%20) received BEAM. The median dose of CD34+ cells was similar in both groups (p=0,938). The duration of FN episode and length of hospital stay were significantly longer in the BEAM arm (p=0,001 and p=0,001). Invasive pulmonary aspergillosis was significantly more common in the BEAM arm (p=0,013). Of the bacteria isolated in culture, 29% (n=48) were gram-positive and 9% (n=14) were gram-negative. The most frequently isolated gram-positive bacteria were Staphylococcus epidermidis (n=29) and Staphylococcus aureus (n=7), while gram-negative bacteria were Klebsiella pneumoniae (n=5) and Pseudomonas aeruginosa (n=4). CRP and Pitt score were similar in bot groups (p=0,152 vs p=0,247). No significant difference in FN-related mortality was seen between the two arms (p=0,802), Türkiye. **Conclusion:** Conclusion: The BEAM regimen significantly increased the risk of invasive pulmonary aspergillosis, length of hospital stay, and duration of febrile neutropenia. These results suggest that, particularly in lymphoma patients, the risks of FN should be taken into account when selecting the BEAM regimen, Türkiye.

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PP 16

HEMATOLOGICAL APPROACHES IN AUTOIMMUNE ENCEPHALITIS: OFATUMUMAB EXPERIENCE

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Objective: Autoimmune encephalitis (AE) is a group of encephalitides caused by immune-mediated inflammatory disorders of the brain. While B cell–mediated autoimmunity is observed in many patients, some subtypes also involve T cell–mediated mechanisms. AE-related antibodies are classified into three groups: paraneoplastic antibodies, synaptic antibodies, and antibodies of uncertain significance. Paraneoplastic antibodies are frequently associated with systemic tumors and show poor responsiveness to immunotherapy. Synaptic antibodies, on the other hand, display variable associations with systemic tumors but are generally more responsive to immunotherapy. The diagnosis of AE is based on clinical features, radiological findings (such as abnormalities on T2 and FLAIR brain MRI), slow-wave activity in the temporal lobe, cerebrospinal fluid (CSF) pleocytosis, and the exclusion of alternative causes. Although antibody detection remains one of the best diagnostic tools, many cases may still be seronegative. Common paraneoplastic antibodies include anti-Hu, anti-Yo, anti-CV2, anti-Ma2, anti-Ri, anti-amphiphysin, ZIC4, and GAD65. Major synaptic autoantibodies include anti-NMDA, anti-AMPA, anti-GABA-B receptor, anti-CASPR,

and anti-LG1. Antibody-positive AE represents a distinct subgroup of encephalopathies characterized by autoimmune responses against various antigens in the brain parenchyma[1,2]. Due to clinical, imaging, and laboratory similarities with infectious and other autoimmune encephalitides, AE remains a diagnostic challenge. Patients typically present with subacute memory and cognitive decline over days to weeks. Encephalopathic syndromes may include behavioral changes, psychosis, seizures, and coma, reflecting a broad neuropsychiatric spectrum[3]. In addition to supportive and antiepileptic therapies, early initiation of immunosuppressive treatment is essential. First-line immunosuppressive therapies in AE include corticosteroids, intravenous immunoglobulin, and plasma exchange[4,5]. For patients unresponsive to first-line treatments, second-line therapies include anti-CD20 monoclonal antibodies (rituximab and ofatumumab), mycophenolate mofetil, cyclophosphamide, and azathioprine. In refractory cases, third-line therapies such as daratumumab, bortezomib, obinutuzumab, tocilizumab, anakinra, tofacitinib, and intrathecal methotrexate may be considered[5]. Several studies have demonstrated that the use of ofatumumab, a second-generation CD20 monoclonal antibody, results in reduced antibody titers and significant clinical improvement in AE[6,7]. **Case report:** A 22-year-old female patient was admitted to an ICU in Kosovo in June 2025 with impaired consciousness and was intubated. Her Glasgow Coma Scale (GCS) score was 3. She was transferred to our hospital's intensive care unit on June 19, 2025, with a presumptive diagnosis of autoimmune encephalitis. A brain MRI performed externally on June 16 showed symmetric signal abnormalities in the bilateral basal ganglia. A lumbar puncture was performed upon admission, and CSF was sent for paraneoplastic and autoimmune antibody panels. Immunosuppressive therapy with 1000 mg methylprednisolone was initiated. For focal motor seizure control, levetiracetam (3000 mg/day) and valproic acid (2000 mg/day) were added. Plasma exchange (1/1) was started every other day beginning on June 19. Tracheal aspirate cultures grew carbapenem-resistant Acinetobacter baumannii. The patient was started on colistin, to which the isolate was sensitive. Despite therapy, focal motor seizures persisted. A brain MRI performed on June 26 showed widespread encephalitic signal changes in the left fronto-temporal and parieto-occipital regions, as well as in the right temporal region. CSF analysis revealed negative results for both paraneoplastic and autoimmune antibody panels. Given the lack of response to 1000 mg methylprednisolone and seven sessions of plasma exchange, the patient was considered to have autoimmune encephalitis refractory to first-line therapies. Daily IVIG (20 g/day for 5 days, total 100 g) was initiated, followed by second-line therapy with ofatumumab on June 27, 2025. The treatment regimen consisted of 20 mg subcutaneous injections at weeks 0, 1, and 2, followed by monthly subcutaneous injections starting from week 4. Mycophenolate mofetil (2000 mg/day) was added to the regimen. For refractory seizures, lacosamide (2 × 200 mg) was started. Clobazam was added but proved ineffective. High-dose topiramate (800 mg/day) was initiated, which achieved substantial seizure control. Antiepileptic dosages were subsequently optimized. Weekly brain MRI scans demonstrated partial regression of prior lesions. The patient developed anemia following plasma exchange, for which erythrocyte transfusions were administered. The patient was extubated on July 14, 2025, and was able to follow simple motor commands such as eye opening and closing. On July 18, she was transferred from the ICU to a general ward. Due to weight loss, a high-protein diet was initiated. A follow-up brain MRI after extubation showed partial regression and signal changes in prior lesions. Immunosuppressive therapies (ofatumumab and mycophenolate mofetil 2000 mg/day) were continued. PET-CT revealed no evidence of malignancy. Viral serologies were unremarkable. At follow-up on August 11, 2025, neurological examination revealed normal conjugate gaze, full muscle strength (5/5), normal tandem gait, mild action tremor in both hands, negative parkinsonian signs, normal deep tendon reflexes, and absence of ataxia or pathological reflexes. Speech was mildly dysphonic with occasional brief hesitations during reading. Overall, her condition was stable, and she was discharged, Türkiye. **Conclusion:** DISCUSSIONAutoimmune encephalitis is an inflammatory brain disorder that may mimic infectious and other etiologies in terms of clinical, radiological, and serological findings, making diagnosis challenging. Since diagnosis is based on exclusion, immunosuppressive therapy must be initiated promptly. First-line therapies, including corticosteroids, intravenous immunoglobulin, and plasma exchange, are generally effective. In resistant cases, second-line therapy, especially anti-CD20 monoclonal antibodies such as ofatumumab, should be considered. Studies have demonstrated favorable responses with ofatumumab in patients with AE refractory to first-line therapies[8,9]. In our case, ofatumumab led to significant clinical improvement in a patient with severe, treatment-resistant AE. In conclusion, ofatumumab represents a promising treatment option for AE patients who fail to respond to first-line therapies such as corticosteroids, intravenous immunoglobulin, and plasma exchange.

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Adult Hematology Abstract Categories

Akut Lösemiler

PP 17

Long-term Success of Prophylactic Intrathecal Therapy in AML Patients with CNS Involvement: Two Cases with Extended Remission Following Stem Cell Transplantation

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Case 1: A 25-year-old female (born 1993) presented in 2018 with fatigue, anemia, and pancytopenia. Bone marrow biopsy revealed high blast count with flow cytometry showing CD33 (94%), CD117 (73%), MPO (98%) positivity, and limited CD34 (3-4%) expression. Cytogenetic analysis was negative for t(8;21), inv(16), t(15;17), and BCR-ABL, classifying the case as cytogenetically normal intermediate-risk AML. Brain MRI revealed