finding is consistent with results reported during the pandemic period. Although immunosuppressive and cytokine-blocking therapies (steroids, tocilizumab) were administered, they failed to prevent mortality. **Conclusion:** Patients undergoing allogeneic HSCT and their caregivers should undergo comprehensive pre-transplant infectious disease screening. In addition, early initiation of cytokine-targeted therapies may play a role in reducing mortality in this high-risk patient population.

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Autologous Transplant Alone Achieving Decade-Long Remission in AML: A Single-Center Two-Patient Case Report

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Introduction: Allogeneic HSCT is the conventional curative strategy in fit AML patients lacking favorable biology. Autologous HSCT (auto-HSCT) is rarely curative and is typically considered consolidation in selected complete remissions (CR). We report two adults with de novo AML who achieved and maintained extraordinarily long complete remissions after auto-HSCT as the sole transplant approach—highlighting potential patient-selection signals and the under-recognized curative potential of auto-HSCT in carefully chosen cases. **Methods:** This single-center, retrospective two-patient case report summarizes baseline features, induction/consolidation regimens, transplant details, and long-term outcomes from clinic records. Both patients received standard 7+3 induction, high-dose cytarabine (HiDAC) consolidation, and auto-HSCT due to the absence of suitable allogeneic donors. Follow-up included serial clinical assessment, complete blood counts, and routine biochemistry. **Results:** Case A (FM, male): Diagnosed 2017–2018 with AML; marrow blasts >20%. Immunophenotype at diagnosis included MPO positivity with CD34 −/CD117− profile. He achieved CR after 7+3 and completed four cycles of HiDAC. In 2008, he underwent auto-HSCT (G-CSF–mobilized peripheral blood). Engraftment was uneventful. Over serial evaluations he has remained in continuous first remission without relapse, secondary malignancy, or organ dysfunction. Current remission duration: 7+ years (2018→2025). Case B (MA,male): Diagnosed in 2010 with AML (marrow blasts ∼40%). After CR with 7+3 and HiDAC consolidation, lack of a matched donor prompted auto-HSCT the same year using mobilized peripheral blood stem cells. Early and late post-transplant courses were uncomplicated. He remains in continuous first remission with stable counts and no major late toxicities. Current remission duration: ∼15 years (2010→2025). **Discussion:** These two cases share three notable features. First, both achieved rapid CR to anthracycline–cytarabine induction and completed HiDAC—conditions associated with deeper molecular remissions and lower relapse risk. Second, in the absence of a donor, auto-HSCT alone consolidated remission and, in these patients, appears functionally curative across one and a half decades. Third, neither patient developed clinically significant late toxicities or second cancers during long follow-up. Although contemporary risk genomics were unavailable, the CD34-negative/MPO-positive phenotype in Case A and the brisk chemo-sensitivity in both suggest favorable disease biology. These observations reinforce that, for rigorously selected AML patients in high-quality CR—particularly when allografting is not feasible—auto-HSCT may deliver durable disease control approaching cure. The report is limited by the small sample size and absence of uniform molecular profiling; nonetheless, the remission lengths (≥15 and ≥17 years) are exceptional and educational. **Conclusion:** Two adults with AML achieved very long, ongoing first remissions (≈15 and >17 years) after autologous HSCT following 7+3 and HiDAC, without allogeneic rescue. In carefully selected CR patients lacking donors, auto-HSCT can be a valid, potentially curative strategy that merits consideration within individualized treatment algorithms.

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Adult Hematology Abstract Categories

Chronic Leukemias

PP 22

Richter Transformation with Spontaneous Splenic Hematoma: A Life-threatening Complication in Chronic Lymphocytic Leukemia

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Introduction: Richter transformation occurs when chronic lymphocytic leukemia transforms into aggressive lymphoma, most commonly diffuse large B-cell lymphoma (DLBCL), in approximately 5-10% of CLL patients. While typically presenting as rapidly enlarging lymph nodes, extranodal involvement can occur. Splenic transformation is uncommon, and spontaneous splenic hemorrhage represents an extremely rare, life-threatening complication requiring immediate recognition and intervention. **Case Report:** A 71-year-old female with established CLL presented with progressive abdominal pain, fatigue, and anorexia. She had previously received CLL-directed therapy with initial lymph node regression during follow-up. Physical examination revealed poor general condition, left upper quadrant tenderness with fullness, and minimal peripheral edema. No palpable lymphadenopathy was detected. Laboratory evaluation demonstrated cytopenias: hemoglobin 9.1 g/dL, leukocytosis $13.6 \times 10^3/\mu$L (lymphocyte-predominant), and thrombocytopenia $83 \times 10^3/\mu$L.