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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PP 21

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.

Coagulopathy was evident with prolonged PT (17.2 seconds) and elevated INR (1.46). Additional findings included suppressed TSH (0.07 mIU/L) suggesting hyperthyroidism and elevated ferritin (402 ng/mL). PET-CT performed on May 22, 2025, showed regression of previously enlarged cervical, axillary, iliac, and inguinal lymph nodes, indicating prior treatment response. However, a large hypermetabolic splenic lesion measuring 103 × 60 × 61 mm with SUVmax 32.82 was identified, with evidence of lateral capsular invasion. No bone marrow or hepatic FDG uptake was observed. Subsequent CT imaging on July 24, 2025, revealed alarming findings: intraparenchymal and subcapsular splenic hematoma with perihepatic, perisplenic, and pelvic free fluid consistent with hemoperitoneum. Additional incidental findings included a 17 mm right thyroid nodule and minimal left pleural effusion. Splenic tru-cut biopsy performed on July 17, 2025, confirmed diffuse large B-cell lymphoma with germinal center phenotype. Immunohistochemistry showed CD20(+), Bcl-2(+), Bcl-6 (+), MUM-1(+) with high proliferation index (Ki-67: 80%) and elevated c-Myc expression (60%). CD10 and CD5 were negative. The clinical constellation of findings confirmed Richter transformation with splenic DLBCL complicated by spontaneous splenic hemorrhage and hemoperitoneum, representing a medical emergency. **Discussion:** This case demonstrates an exceptionally rare presentation of Richter transformation. While most Richter transformations present with rapidly enlarging lymph nodes, isolated splenic involvement is uncommon. The extremely high SUVmax (32.82) indicated aggressive disease with high metabolic activity, consistent with high-grade DLBCL. The development of spontaneous splenic hematoma likely resulted from tumor infiltration weakening the splenic capsule and parenchyma, combined with underlying thrombocytopenia and coagulopathy. The resulting hemoperitoneum represents a life-threatening complication requiring urgent intervention. The coagulopathy and cytopenias observed may reflect both disease progression and splenic sequestration. The concurrent thyroid abnormalities warrant investigation for secondary malignancies or treatment-related complications. Management challenges include balancing the need for immediate treatment of aggressive lymphoma against the risk of exacerbating bleeding complications. Careful coordination between hematology, surgery, and radiology teams is essential for optimal outcomes. **Conclusion:** Richter transformation can present with rare but life-threatening complications including spontaneous splenic hemorrhage. High clinical suspicion, urgent imaging, and multidisciplinary management are crucial for patients with CLL developing new abdominal symptoms. This case underscores the importance of recognizing atypical presentations of Richter transformation to ensure prompt diagnosis and appropriate intervention.

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Adult Hematology Abstract Categories

Chronic Myeloproliferative Diseases

PP 23

CD56-Negative Conjunctival Solitary Extramedullary Plasmacytoma with Bence–Jones Lambda: Organ-Sparing Therapy and Durable Remission in a Young Adult

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Introduction: Solitary extramedullary plasmacytoma (EMP) accounts for a small fraction of plasma-cell neoplasms and rarely involves the conjunctiva. Distinguishing localized EMP from ocular adnexal lymphomas and reactive plasmacytosis is crucial, as management and prognosis differ substantially. We report a CD56-negative, lambda-restricted conjunctival EMP in a 27-year-old male with baseline Bence–Jones proteinuria, successfully treated with organ-sparing surgery plus orbital radiotherapy (RT) and maintained in remission at one year. **Methods:** This single-patient case review used prospectively recorded clinical data. Diagnostic workflow comprised ophthalmologic examination, complete blood count and chemistry, serum protein electrophoresis (SPEP) with immunofixation, 24-hour urine immunofixation, bone marrow aspirate/biopsy with immunohistochemistry (IHC), whole-body PET/CT, and brain/orbital MRI as indicated. Response was assessed clinically, biochemically (paraprotein clearance), and radiologically. **Results:** A painless, 1.5-cm vascular conjunctival mass was excised. Histology showed dense plasmacytic infiltration. IHC: CD38+, CD138+, lambda light-chain restriction, CD56−; B- and T-cell markers were non-diagnostic for lymphoma. SPEP showed no serum M-spike, while urine immunofixation revealed monoclonal lambda (Bence–Jones) positivity. Bone marrow morphology and flow cytometry demonstrated normal hematopoiesis without clonal plasma cells. PET/CT showed avid uptake confined to the conjunctival lesion; minor uptakes in stomach/sacrum lacked structural correlates. CRAB criteria were absent. Definitive local therapy consisted of adjuvant orbital RT (40 Gy in 20 fractions) after complete excision. Treatment was well tolerated. At 3 months, urine monoclonal lambda resolved; at 12 months, there was no local recurrence or new systemic disease clinically or on surveillance imaging/labs. **Discussion:** Key learning points include: (i) Localization and phenotype—conjunctival EMP is exceptional; CD56 negativity, while not universal, may be more frequent in extramedullary disease and can correlate with reduced bone tropism, supporting a truly localized process. (ii) Diagnostic clarity—lambda