effective alternatives, particularly in patients where phlebotomy is less feasible. In both siblings, ferritin levels declined substantially with deferasirox monotherapy. Third, interruption of treatment, as seen in the elder sibling, allows ferritin to rise again, underlining the importance of sustained long-term management. **Conclusion:** We report two siblings with homozygous HFE-related hereditary hemochromatosis and significant hyperferritinemia. Both responded favorably to deferasirox therapy with substantial reductions in ferritin levels. These findings emphasize the value of family screening, genetic testing, and consistent treatment in the management of hereditary hemochromatosis.

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Adult Hematology Abstract Categories

Lymphoma

PP 26

From CD5-Negative Indolent B-Cell LPD to Therapy-Related CLL/SLL with Unmutated IGHV After Breast Cancer: Rationale for BTK-Inhibitor–Based First-Line Therapy

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Introduction: Therapy-related chronic lymphocytic leukemia/small lymphocytic lymphoma (t-CLL/SLL) is uncommon compared with therapy-related AML/MDS. We report a breast-cancer survivor who evolved from a CD5-negative low-grade B-cell lymphoproliferative disorder (LPD) to classical CLL/SLL with **unmutated IGHV**, underscoring why targeted BTK inhibition may supersede chemo-immunotherapy in this setting. **Methods:** Single-patient case review of prospectively collected data. We extracted longitudinal clinical, imaging (PET-CT), bone-marrow histology, multiparameter flow cytometry, and cytogenetics (FISH, IGHV mutation testing). Treatment decisions were individualized by a multidisciplinary team. **Results:** A 1959-born woman had invasive ductal breast carcinoma (2009) treated with adriamycin–cyclophosphamide, weekly paclitaxel, and radiotherapy, achieving long-term remission. In 2018 bone marrow was normal; in 2019 splenectomy for progressive splenomegaly revealed florid follicular hyperplasia. Between 2020–2022, bone-marrow biopsies showed a **low-grade B-cell LPD** ($CD20^+$, **CD5–/CD23–/CD10–**), managed with **rituximab–bendamustine (8 cycles)**, yielding metabolic complete remission. In 2025 she re-presented with profound fatigue and anemia. Labs showed marked lymphocytosis (WBC 46×10^9/L), hemoglobin severely reduced, and PET-CT consistent with medullary disease. Bone marrow showed **40–50%** intertrabecular lymphoid infiltration. **Flow cytometry now demonstrated classical CLL/SLL** ($CD19^+$, $CD20^+$, **$CD5^+$, $CD23^+$**, κ-restriction). Molecular work-up: **IGHV unmutated**; FISH: **monoallelic del(13q)**; **del(17p)/del(11q) negative**. Given prior anthracycline exposure/radiation and the high-risk biology conferred by unmutated IGHV despite isolated 13q deletion, the tumor board selected **acalabrutinib plus rituximab** rather than re-exposure to chemo-immunotherapy. Transfusion support and infection prophylaxis accompanied therapy planning. **Discussion:** This case is notable for: (i) **Therapy-related CLL/SLL** emerging years after breast-cancer treatment—an under-recognized survivorship risk; (ii) **Phenotypic evolution** from an initially **CD5-negative** indolent B-cell LPD to **typical $CD5^+$/$CD23^+$ CLL/SLL**, highlighting clonal drift and the need for repeat immunophenotyping at relapse; (iii) **Risk adjudication** where **unmutated IGHV** outweighs the generally favorable isolated **13q deletion**, steering first-line choice away from bendamustine-rituximab toward **BTK-inhibitor–based therapy**; and (iv) pragmatic considerations in a previously anthracycline-exposed patient, favoring targeted agents for efficacy and tolerability. Educationally, the case adds to scarce real-world documentation of t-CLL, illustrates immunophenotypic switch over time, and provides a clear management rationale aligned with modern risk biology. **Conclusion:** In this therapy-related CLL/SLL with **unmutated IGHV** and prior breast-cancer treatment, **acalabrutinib + rituximab** was selected as the preferred front-line strategy over chemo-immunotherapy. The case emphasizes the importance of serial phenotyping and genomics to detect evolution and to personalize therapy in cancer survivorship.

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PP 27

ISOLATED SPLENIC RELAPSE IN CLASSICAL HODGKIN LYMPHOMA: A CHALLENGING CASE REQUIRING NOVEL THERAPEUTIC APPROACHES

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Case Report: A 63-year-old male initially presented in 2024 with splenomegaly and was diagnosed with classical Hodgkin lymphoma following tru-cut biopsy. Immunohistochemistry confirmed CD30+, PAX5+, and MUM1+ Reed-Sternberg cells with negative CD3, CD20, and LCA expression. Initial staging revealed isolated splenic involvement without mediastinal or peripheral lymph node involvement. The patient received standard ABVD chemotherapy (adriamycin, bleomycin, vinblastine, dacarbazine) with concurrent rituximab therapy. Treatment resulted in partial response with persistent residual splenic lesions despite completing the planned regimen. In June 2025, surveillance PET-CT demonstrated disease progression with a 5-cm splenic mass showing intense metabolic activity (SUVmax: 17.2) without involvement of other anatomical sites. Bone marrow biopsy revealed 50% cellularity with normal hematopoiesis, reticulin score 0/4, negative CD30, and sparse PAX5 positivity, confirming absence of bone marrow involvement. Repeat splenic tru-cut biopsy confirmed relapsed classical Hodgkin lymphoma with characteristic immunophenotype: CD30+, PAX5+, MUM1+, GATA3+ with negative CD3, CD20, and LCA, consistent with the

original diagnosis. Cardiac evaluation revealed preserved ejection fraction (65%) with mild left ventricular diastolic relaxation abnormality, indicating reasonable cardiac reserve but potential limitations for intensive chemotherapy regimens. Given the patient's age (63 years), cardiac status, and previous treatment exposure, he was deemed unsuitable for conventional high-dose salvage chemotherapy followed by ASCT. The isolated nature of splenic relapse and excellent performance status made him an ideal candidate for novel targeted approaches. Treatment planning focused on brentuximab vedotin-based combination therapy, specifically BV plus bendamustine, given the CD30+ phenotype and the patient's clinical profile. Alternative regimens including BV plus ICE or BV plus nivolumab were considered as backup options. The treatment strategy included 2-4 cycles of BV-based therapy with interim PET-CT response assessment. Achievement of PET-negative status would prompt consideration of ASCT consolidation if the patient's performance status improved, or continuation with BV maintenance or immunotherapy with nivolumab if transplant remained contraindicated. **Discussion:** This case illustrates several important aspects of relapsed Hodgkin lymphoma management. Isolated splenic relapse represents an uncommon pattern that may result from inadequate initial therapy or inherent disease biology. The patient's age and cardiac comorbidities precluded standard intensive salvage approaches, highlighting the need for effective, well-tolerated alternatives. Brentuximab vedotin, an anti-CD30 antibody-drug conjugate, has demonstrated significant efficacy in relapsed/refractory Hodgkin lymphoma, with response rates exceeding 70% in various combination regimens. The choice of BV plus bendamustine reflects a balance between efficacy and tolerability, particularly suitable for older patients. The isolated splenic presentation also raises consideration of surgical management. Splenectomy could be considered if systemic therapy fails, though the preference remains for systemic approaches given potential for occult disease. **Conclusion:** Isolated splenic relapse in classical Hodgkin lymphoma requires individualized treatment approaches, particularly in elderly patients. Brentuximab vedotin-based combinations offer effective alternatives to intensive chemotherapy, demonstrating the evolving landscape of lymphoma therapy toward more targeted, personalized treatment strategies.

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PP 28

SEQUENTIAL DEVELOPMENT OF DIFFUSE LARGE B-CELL LYMPHOMA FOLLOWING SUCCESSFUL HAIRY CELL LEUKEMIA TREATMENT: A CASE REPORT WITH COMPLETE REMISSION

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Case Report: A 53-year-old male from Samandağ presented in early 2024 with progressive anemia, fatigue, and splenomegaly. Laboratory evaluation revealed pancytopenia with atypical lymphoid cells on peripheral smear and mildly elevated LDH. Physical examination confirmed palpable splenomegaly without lymphadenopathy. Bone marrow biopsy performed on August 5, 2024, demonstrated classic hairy cell leukemia with characteristic immunophenotype: CD20+, CD103+, CD25+, Annexin A1+, TRAP+ with negative CD3, CD5, CD23, and CD34. Flow cytometry confirmed 8-10% clonal B-cell population with CD103+, CD25+, CD11c+ expression and aberrant kappa/lambda ratio, establishing HCL diagnosis. Treatment was initiated with rituximab plus cladribine combination therapy along with G-CSF support and prophylactic antifungal therapy. Post-treatment evaluation on September 17, 2024, demonstrated exceptional response with complete disappearance of all HCL-specific phenotypic markers (0% residual disease) and minimal CD20+ cells (1.8%) reflecting rituximab effect. Bone marrow biopsy confirmed morphologic remission. Imaging showed dramatic spleen size reduction from 22 cm to 14 cm with regression of retroperitoneal lymphadenopathy. Eight months later, in April-May 2025, the patient developed B-symptoms including persistent fever, weight loss, and dyspnea. HRCT and PET-CT revealed concerning new findings: left lower lobe pulmonary lesion with intense metabolic activity (SUVmax: 34.07), mediastinal involvement (SUVmax: 16.13), and new abdominal lymphadenopathy (SUVmax: 7-10). Lung biopsy performed on June 16, 2025, revealed diffuse large B-cell lymphoma with non-germinal center phenotype: CD20+, PAX5+, Bcl-6+, MUM1+ with extensive Bcl-2 expression (95%) and low c-Myc expression (10%), confirming systemic DLBCL diagnosis. Standard R-CHOP chemotherapy (six cycles) was administered from July through November 2025. The patient tolerated treatment well with only mild neutropenia as significant toxicity. Post-treatment PET-CT demonstrated complete metabolic remission with disappearance of all metabolically active lesions, achieving Deauville score $\leq$2. At current follow-up, the patient remains in complete remission from both malignancies with excellent performance status and no evidence of disease recurrence. **Discussion:** This case represents a rare scenario of sequential B-cell malignancies with successful treatment outcomes for both conditions. The eight-month interval between HCL remission and DLBCL development, combined with distinct immunophenotypes, suggests either treatment-related secondary malignancy or activation of a dormant malignant clone rather than clonal evolution. The non-germinal center DLBCL phenotype with high Bcl-2 expression indicates aggressive biology requiring prompt intervention. The excellent response to standard R-CHOP therapy demonstrates that DLBCL following HCL treatment responds comparably to de novo DLBCL, supporting conventional treatment approaches. This case emphasizes the critical importance of long-term surveillance in HCL patients, as secondary malignancies can develop despite achieving complete remission. The development of new constitutional symptoms or imaging abnormalities warrants thorough evaluation for secondary malignancies. **Conclusion:** Sequential development of DLBCL following successful HCL treatment represents a rare but treatable clinical scenario. Standard DLBCL therapy remains highly effective in this setting, achieving complete remission comparable to de novo cases. This case underscores the