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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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

importance of continued surveillance in HCL survivors and demonstrates excellent outcomes with appropriate treatment of secondary lymphomas.

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PP 29

High FDG Uptake in Low-Grade Follicular Lymphoma: A Clinico-Radiologic Discordance Case

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Case Report: A 53-year-old female presented with a 2-month history of progressive, painless left axillary mass without B-symptoms (fever, night sweats, weight loss). Medical history was unremarkable without chronic diseases, previous malignancy, or family history of cancer. Physical examination revealed good general condition with stable vital signs. A 3-cm, rubbery, mobile lymph node was palpated in the left axilla without other palpable lymphadenopathy. Abdominal examination demonstrated mild hepatomegaly (2 cm below costal margin) without splenomegaly. Laboratory evaluation showed normal complete blood count (Hb: 12.5 g/dL, WBC: 6.3×10^9/L, PLT: 220×10^9/L) with mildly elevated LDH (270 U/L). Renal and hepatic function tests were normal, and viral serologies were negative. PET-CT imaging revealed significant findings: left axillary lymphadenopathy (30×22 mm) with SUVmax 9.12, mediastinal involvement in para-aortic and aortopulmonary regions (SUVmax: 5.89), bilateral apical pulmonary nodules (7.5 mm) with low FDG uptake, and a hypodense hepatic lesion (15×12 mm) with mild FDG uptake. No splenic involvement or bone metastases were detected. Excisional biopsy of the left axillary lymph node confirmed follicular lymphoma, grade 1-2 according to WHO 2016 criteria. Immunohistochemistry demonstrated CD20(+), CD23(+), with negative CD5 and cyclin D1, consistent with follicular lymphoma. Critically, Ki-67 proliferation index was only 10%, indicating low proliferative activity. Bone marrow examination showed normal hematopoiesis with reticulin grade 0/4, negative amyloid staining, and no evidence of lymphomatous infiltration. Based on Lugano criteria, the patient was staged as advanced disease (stage IIIA-IIIB) due to mediastinal involvement and hepatomegaly. Discussion: This case presents a striking clinico-radiologic discordance between low-grade histological features and high metabolic activity. The SUVmax of 9.12 is unusually high for grade 1-2 follicular lymphoma, typically associated with more aggressive histologies or transformed lymphomas. Several mechanisms may explain this phenomenon. First, inflammatory microenvironment within lymph nodes can increase FDG uptake independent of tumor grade. Second, early transformation to diffuse large B-cell lymphoma may be focal and missed on single biopsy sampling. Third, some low-grade lymphomas may exhibit metabolically active behavior without histological transformation. The management approach requires careful consideration. While current guidelines recommend "watch and wait" for asymptomatic, low tumor burden indolent FL, the high metabolic activity and advanced stage disease create uncertainty. Options include close surveillance with repeat biopsy if progression occurs, rituximab monotherapy, or combination therapy with R-CHOP or R-bendamustine for bulky/symptomatic disease. The hepatomegaly and mediastinal involvement, combined with high SUVmax, may favor earlier intervention despite the indolent histology and absence of B-symptoms. Conclusion: High FDG uptake in low-grade follicular lymphoma represents a rare clinico-radiologic discordance that challenges standard management algorithms. This case emphasizes the importance of integrating clinical, histological, and radiological findings in lymphoma management and suggests the need for individualized treatment approaches when conventional parameters conflict. Close monitoring with consideration for earlier intervention may be warranted in such cases.

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Indolent Follicular Lymphoma with "Hot" PET: A Clinic–Radiologic Mismatch That Challenges Early Treatment vs Watchful Waiting

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Introduction: Follicular lymphoma (FL) grade 1–2 typically behaves indolently and is often managed with watchful waiting when tumor burden is low. However, moderately high FDG uptake on PET-CT may suggest biological heterogeneity or incipient transformation despite low-grade histology, creating a management dilemma. We report a patient with biopsy-proven FL grade 1–2 and unexpectedly "hot" PET signals, illustrating decision points between immediate therapy and surveillance. **Methods:** Single-patient case report. We reviewed clinical data, laboratory tests, excisional lymph-node histology with immunohistochemistry (IHC), bone marrow (BM) evaluation, and whole-body PET-CT at diagnosis. Management decisions were based on symptoms, tumor burden, and longitudinal imaging. **Results:** A 53-year-old woman presented with a painless, mobile left axillary mass detected 2 months earlier. She denied fever, drenching night sweats, or weight loss. Physical exam revealed a ~3 cm left axillary node; no hepatosplenomegaly or other palpable lymphadenopathy. PET-CT demonstrated a **30 × 22 mm** left axillary node with **SUVmax 9.12**, additional mediastinal paraaortic/aortopulmonary nodes (**SUVmax 5.89**), and tiny bilateral apical lung nodules with low uptake. The liver contained a **15 × 12 mm** hypodense lesion with faint FDG avidity and mild hepatomegaly; spleen and adrenals were normal; bone involvement was absent. Excisional node biopsy showed **classical FL, grade 1–2**. IHC: **CD20+, CD23+, CD5−, Cyclin D1−; Ki-67 ≈10%**. BM aspirate/biopsy exhibited normal hematopoiesis with **no lymphoma infiltration** (reticulin 0/4; amyloid negative). Baseline blood counts and biochemistry were within