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

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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