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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PP 30

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

reference limits except for a mildly elevated LDH. Composite staging favored **advanced-stage (IIIA–IIIB) FL** owing to mediastinal involvement and hepatomegaly, yet **clinical tumor burden was low**: solitary bulky node absent, no B symptoms, preserved counts, and no organ compromise. Given the discrepancy—**indolent histology with relatively high axillary SUV**—management options were discussed. Because transformation was not proven (low Ki-67, no high-grade features on biopsy, and no PET focus >10 with structural suspicion elsewhere), we selected **watchful waiting** with close clinical and PET/CT surveillance, reserving therapy for symptomatic progression, GELF high-tumor-burden criteria, rising SUVs or node growth, or any histologic evidence of transformation (repeat biopsy triggered by interval changes). Single-agent rituximab or R-based chemoimmunotherapy would be considered if progression occurs. **Discussion:** This case highlights a **clinic–radiologic mismatch**: low-grade FL with **SUVmax ~9** in the index node. While high SUVs in FL can raise concern for transformation, histology and low proliferation argued against immediate cytotoxic therapy. In asymptomatic, low-burden FL, **watch-and-wait remains appropriate**, provided that surveillance is disciplined and **re-biopsy is performed for PET-dominant changes** or clinical progression. Educationally, the case underscores the limits of relying on SUV alone, the centrality of tissue confirmation, and the value of individualized triggers for treatment versus observation. **Conclusion:** In FL grade 1–2 with "hot" PET but low clinical burden, **structured watchful waiting with planned re-biopsy on interval change** can safely balance overtreatment risks against the need to detect transformation early.

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PP 31

Mantle Cell Lymphoma Presenting with Gastrointestinal Bleeding in an Elderly Patient: A Case of Stage IV Disease Treated with Rituximab Monotherapy

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Case Report: An 85-year-old male presented with progressive fatigue and melena over several weeks. His medical history was notable for advanced age with overall frailty but no significant comorbidities. Physical examination revealed poor general condition with pallor and mild dehydration. No palpable lymphadenopathy, hepatomegaly, or splenomegaly was detected on initial examination. Laboratory evaluation demonstrated severe anemia (hemoglobin 8.1 g/dL, hematocrit 27%) with significant leukocytosis (20.9×10^9/L) and marked monocytosis (46%). Platelet count remained normal (181×10^9/L). Additional findings included hypoalbuminemia (28.5 g/L), elevated LDH (218 U/L), and moderate renal impairment (creatinine 1.23 mg/dL, eGFR 53 mL/min). Endoscopic evaluation revealed erosive pangastritis with antral and duodenal ulcers. Colonoscopy identified a 3.5-4 cm ulcerative, polypoid mass in the cecum with additional rectal involvement prompting biopsy. Histopathological examination of gastrointestinal biopsies confirmed mantle cell lymphoma with characteristic immunophenotype: CD20(+), Cyclin D1(+), SOX11(+), BCL2(+), and CD43(+) with negative CD3, CD5, and CD23. The Ki-67 proliferation index was 20%, indicating moderate proliferative activity. PET-CT staging revealed extensive disease with widespread lymphadenopathy involving cervical, axillary, mediastinal, retroperitoneal, and pelvic regions. Gastrointestinal involvement showed intense FDG uptake (SUVmax 12.1) in cecum and rectum. Diffuse hepatic and splenic involvement was present along with diffuse bone marrow uptake, establishing stage IV disease. Given the patient's advanced age (85 years), frailty, history of gastrointestinal ulceration, and moderate renal impairment, intensive chemotherapy regimens were deemed inappropriate. Treatment was initiated with rituximab monotherapy (626 mg every 28 days) with antiemetic prophylaxis. BTK inhibitor therapy was considered but deferred due to high bleeding risk given active gastrointestinal ulceration. Supportive care included proton pump inhibitor therapy and red blood cell transfusions as needed. The patient demonstrated good tolerance to rituximab therapy with early symptomatic improvement and stabilization of hematological parameters. **Discussion:** This case illustrates several important aspects of MCL management in elderly patients. The presentation with gastrointestinal bleeding and extensive disease is typical for MCL, which frequently involves the GI tract at diagnosis. The moderate Ki-67 proliferation index (20%) suggested less aggressive biology, supporting a less intensive treatment approach. The decision to use rituximab monotherapy reflects the growing recognition that treatment intensity must be individualized based on patient fitness and comorbidities. While intensive regimens like hyperCVAD or Nordic protocols achieve superior outcomes in younger patients, they carry prohibitive toxicity in frail elderly populations. Rituximab monotherapy has shown activity in MCL with response rates of 40-60% and manageable toxicity profiles, making it suitable for elderly, frail patients. The early tolerance and symptomatic improvement observed support this approach. **Conclusion:** MCL management in elderly, frail patients requires individualized treatment decisions balancing disease control with quality of life. Rituximab monotherapy represents a reasonable option for patients unsuitable for intensive chemotherapy, providing disease control with acceptable toxicity. This case demonstrates the feasibility of this approach in carefully selected patients.

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