studies were inconclusive, yet clinical and imaging findings confirmed active disease. **Methods:** A comprehensive diagnostic evaluation was performed, including hematology and biochemistry profiles, serum protein electrophoresis, serum and urine immunofixation, serum free light chain (sFLC) quantification, bone marrow aspiration and biopsy with immunohistochemistry, and 18F-FDG PET-CT imaging. **Results:** Gülüşen Kellesibüyük, a 75-year-old female, presented with fatigue, anemia, and back pain. Laboratory evaluation revealed hemoglobin of 9.7 g/dL, elevated inflammatory markers, and preserved renal and calcium levels. Serum protein electrophoresis demonstrated no monoclonal spike. Immunofixation of urine identified monoclonal kappa light chains. sFLC testing showed markedly increased kappa levels (121–270 mg/L) with a pathological κ/λ ratio between 3.9 and 4.2. Bone marrow aspirates revealed only 2–3% plasma cells with polytypic staining, and biopsies were normocellular without evidence of clonal infiltration. Despite these inconclusive marrow results, PET-CT demonstrated a metabolically active lytic lesion in the L4 vertebra (SUVmax 11.4) and multiple punctate cranial lytic lesions. The combination of anemia, abnormal light chain ratio, and PET-CT–confirmed bone lesions established the diagnosis of active LCMM. **Discussion:** This case emphasizes the diagnostic complexity of LCMM, where reliance solely on serum electrophoresis or marrow histology may be misleading. The absence of an M spike, coupled with non-diagnostic marrow sampling, initially obscured the diagnosis. However, integration of sFLC analysis, urine immunofixation, and advanced imaging confirmed the presence of active myeloma. Elderly, transplant-ineligible patients such as this one benefit from modern therapeutic approaches that combine efficacy with tolerability. Triplet regimens including daratumumab with lenalidomide and dexamethasone or reduced-intensity bortezomib-based protocols are recommended as first-line options. For patients with limited access to hospital care, oral regimens may be considered, though efficacy is comparatively lower, Türkiye. **Conclusion:** The case of demonstrates that light-chain multiple myeloma can be present despite normal serum electrophoresis and non-clonal marrow findings. Comprehensive evaluation with free light chain assays, urine studies, and PET-CT is essential to avoid underdiagnosis. This case highlights the importance of applying full diagnostic criteria to detect atypical myeloma presentations early, ensuring timely initiation of therapy and improved patient outcomes.

https://doi.org/10.1016/j.htct.2025.106174

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Early-Stage Nodular Lymphocyte-Predominant Hodgkin Lymphoma (NLPHL) in a Young Woman: A Rare Subtype Managed Without Chemotherapy

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Introduction: Nodular lymphocyte-predominant Hodgkin lymphoma (NLPHL) is a rare subtype of Hodgkin lymphoma, comprising approximately 5–7% of cases. Unlike classical HL, NLPHL is characterized by CD20-positive "popcorn" cells (LP cells), lacks Epstein-Barr virus association, and tends to follow an indolent course. Accurate diagnosis is critical, as the therapeutic approach differs substantially. We report an early-stage NLPHL case in a young woman managed successfully without chemotherapy, emphasizing the value of histopathological precision and risk-adapted therapy. **Methods:** A 33-year-old woman presented with a painless cervical swelling. Physical examination revealed enlarged left cervical and supraclavicular lymph nodes. She had no B symptoms such as fever, night sweats, or weight loss. Blood counts and biochemistry were within normal limits. An excisional biopsy of a lymph node was performed, followed by immunohistochemistry and whole-body 18F-FDG PET-CT for staging. Bone marrow aspiration and biopsy were also conducted to rule out marrow involvement. **Results:** Histopathological examination demonstrated nodular architecture containing scattered lymphocyte-predominant (LP) cells. Immunophenotyping revealed strong CD20 and Pax5 expression, with negativity for CD3 and CD15. CD21 staining highlighted an expanded follicular dendritic cell meshwork, confirming the diagnosis of NLPHL. PET-CT showed FDG-avid lymph nodes localized to the left cervical and supraclavicular regions, with a maximum SUV of 27.9. No pathological uptake was seen in the mediastinum, abdomen, bones, or spleen. Bone marrow biopsy was normocellular without evidence of infiltration. The disease was staged as Stage IA (non-bulky), CD20-positive NLPHL. The patient was treated with rituximab monotherapy (375 mg/m^2 weekly for 4 doses), followed by involved-field radiotherapy (30 Gy) to the involved nodal regions. Given her age and reproductive status, fertility preservation was discussed before initiating treatment. The plan aimed to minimize long-term toxicity while maintaining curative potential. **Discussion:** This case illustrates several important themes. First, accurate histological subtyping allowed for a deviation from standard chemotherapy-based HL protocols. Second, the use of rituximab and radiotherapy alone is an emerging and evidence-supported strategy for early-stage NLPHL, particularly in CD20-positive, non-bulky cases. Third, the patient's demographic—young and female—makes chemotherapy-free management especially attractive given concerns about fertility and late effects. Finally, the case has strong educational value, highlighting the need to distinguish NLPHL from classical HL and indolent B-cell lymphomas, both histologically and metabolically. **Conclusion:** This case demonstrates how a rare Hodgkin lymphoma subtype can be successfully managed with a chemotherapy-free, targeted approach. It reinforces the importance of accurate subtyping and risk-adapted treatment in delivering personalized care, especially in young patients where fertility and quality of life are key considerations

https://doi.org/10.1016/j.htct.2025.106175