suggestive of NHL. Immunohistochemical study of both samples revealed: Ki67+ (80%), CD45+, PAX-5+, diffuse staining for CD20+, BCL-6+, CD79a+, CD30+, with negativity for epithelial and mesenchymal lineage markers. 18-FDG-PETCT revealed involvement of lymph nodes, bones, liver, kidney, thyroid, breasts and bulky in the female genital tract. Diagnosis of DLBCL sarcomatoid variant was established and therapy was scheduled with 6 x R-CHOP, 3 cycles of 3 g/m^2 methotrexate for CNS prophylaxis and uterine cervix radiotherapy depending on residual uptake on PET-CT after chemotherapy. She is currently after 1st. R-CHOP cycle. **Discussion:** Sarcomatoid variant of DLBCL is rare and already recognized as a morphological variant of DLBCL NOS by WHO-2016 Classification. The explanation for the occurrence of fusiform neoplastic cells remains unclear, but it is believed that tumor stromal fibrosis can justify deformation of the cell membrane of neoplastic cells, giving the sarcomatoid aspect. Its clinical significance, as well as prognostic impact, have not been established, nor has there been any definition of the need for therapy different from conventional treatment based on anthracyclines (R-CHOP). **Conclusion:** We described a case of uterine cervix sarcomatoid DLBCL, a rare entity that establishes a differential diagnosis with sarcomas of the female genital tract. Although it is an isolated case, our patient had multivisceral involvement and high-risk IPI, leading us to infer that this morphological variant may be related to greater biological aggressiveness, high tumor burden and poor outcomes, but this needs to be validated with description of other cases and cases series.

https://doi.org/10.1016/j.htct.2021.10.174

SARS-COV-2 INDUCED REMISSION OF DIFFUSE LARGE B-CELL LYMPHOMA: A CASE REPORT

AA Paz, XPH Condori, AA Hofmann, T Soares, V Predebon, VR Siqueira, F Dortzbacher, ET Calvache, CF Gomes, JP Portich, AS Ribeiro

Hospital de Clínicas de Porto Alegre (HCPA), Porto Alegre, RS, Brazil

Introduction: Diffuse Large B-cell lymphoma (DLBCL) is the most common non-Hodgkin lymphoma, which accounts for approximately 30% of all non-Hodgkin lymphoma cases. Spontaneous remission of DLBCL is exceedingly rare, with only a handful of case reports that describe the phenomenon present in the literature. Specialists are investigating similar cases to find out whether the SARS-CoV-2 infection triggered an antitumor immune response, as has been described with other infections in the context of high-grade non-Hodgkin lymphoma. We report one case of an elderly woman with EBV positive DLBCL diagnosed with PCR-positive SARS-CoV-2 pneumonia in the course of the disease and their outcomes. Case report: A 81 years-old woman, was referred to the consult ambulatory of intern medicine with progressive cervical, axillary and inguinal lymphadenopathy with local pain, fever and weight loss. The biopsy of an axillary lymph node demonstrated diffuse atypical lymphoid infiltrate. Immunohistochemistry stains showed positive CD20, CD30, Bcl-2 and MUM-1. It was negative for CD3, CD10, Bcl-6, c-Myc and CMV. The Ki-67 proliferation index was 80%. Epstein-Barr virus (EBV) stain were positive. These findings were consistent with DLBCL, EBV positive, clinical Stage IIIB and R-IPI 4 (poor prognosis and high risk). Since PET-CT was unavailable, thorax and abdomen computed tomographies were performed and revealed enlarged lymph node on pulmonary hilum, pathological lymph node enlargement in the axillary and supraclavicular chains bilaterally and peri aortocaval adenomegaly, extending along the bilateral femoral iliac vessels (larger lymph nodes of 2.5cm). She was treated with 4 cycles of R-CVP (rituximab with cyclophosphamide, vincristine and prednisone). When an interim PET-CT was performed, disease progression was revealed (Lugano score 5). Therefore, considering patient age and clinical status, treatment scheme was changed to R-mini-CHOP (rituximab with reduced doses of cyclophosphamide, doxorubicin, vincristine and prednisone), achieving partial response after 4 cycles (Lugano score 4). A month after this evaluation, she was admitted to the Emergency Department with diarrhea, fever and was diagnosed with PCR-positive SARS-CoV-2 pneumonia. After 6-days hospitalization with no significant ventilatory impairment, she was discharged. No corticosteroid or immunochemotherapy was administered. Two months later, she had no palpable lymphadenopathy and a PET/CT scan revealed widespread resolution of the lymphadenopathy and reduced metabolic uptake throughout (Lugano score 1). After a 7-months follow-up, the patient still has no clinical relapse. **Discussion:** The putative mechanisms of action include cross-reactivity of pathogen-specic T cells with tumour antigens and natural killer cell activation by inammatory cytokines produced in response to infection. It is important to consider that the more cases of SARS-CoV-2 infection in patients with non-Hodgkin lymphoma, the more likely it is to analyze lymphoma remissions and demonstrate the exact mechanism of pathogen-specific T cells with tumor antigens. **Conclusion:** Because spontaneous remission of DLBCL associated with SARS-CoV-2 infection is a new event, careful investigation of these cases is important, because the information gained may lead to new therapeutic targets or treatment strategies for future patients.

https://doi.org/10.1016/j.htct.2021.10.175

SCIMITAR SYNDROME IN A PATIENT WITH NON-HODGKIN'S LYMPHOMA: A RARE CASE REPORT IN THE BRAZILIAN AMAZON

KOR Borges [a], AFR Nascimento [b], AMC Sousa [b], CEB Mesquita [b], AF Ribeiro [b], GMRE Almeida [c], BVRE Almeida [c], KFM Penalber [a], CB Junior [a], P Pezente [a]

[a] *Oncológica Tapajós, Santarém, PA, Brazil*
[b] *Universidade do Estado do Pará (UEPA), Belém, PA, Brazil*
[c] *IMEPAC Centro Universitário, Araguari, MG, Brazil*

Non-Hodgkin's Lymphoma is a neoplasm that originates from mutations in the lymphatic tissue in the B and T progenitor cells, whose clinical manifestation is characterized by the enlargement of lymph nodes and general systemic symptoms. Otherwise, scimitar syndrome (SS) is a rare variant of a group of congenital cardiovascular disorders known as partial anomalous pulmonary venous return, in which the pulmonary venous flow ends in the right atrium rather than the left atrium. This report describes a 60-year-old patient, born in Santarém (PA), who was diagnosed with diffuse large-cell non-Hodgkin's Lymphoma with immunophenotype B, with a germinal center type IIIB pattern - CD20, CD10, BCL2 and BCL6 positively diffuse and Kl -67 positive around 60 to 70%. After diagnosis, she received systemic infusion chemotherapy with R-CHOP (Rituximab, Cyclophosphamide, Doxorubicin, Vincristine and Prednisone) according to current guidelines. During the tomographic scan, the diagnosis of associated Scimitar Syndrome was made. Radiographic findings such as hypoplastic right lung, anomalous pulmonary venous drainage through the inferior vena cava, anomalous pulmonary irrigation through a branch of the descending aorta, dextrocardia (deviation of the heart to the right side of the body) characterize the Scimitar Syndrome, have been described in the literature and identified in the referred clinical case. The absence of identifiable symptoms in the clinical history attributed to the syndrome may justify its identification by an incidental radiological finding in an imaging scan of Non-Hodgkin's Lymphoma. After the diagnosis of lymphoma, according to current guidelines, he completed the proposed chemotherapy regimen with a complete response and remains in outpatient follow-up. Furthermore, the association of the syndrome with the occurrence of malignant neoplasms gives scientific relevance and rare character to the aforementioned case report.

https://doi.org/10.1016/j.htct.2021.10.176

SEGUNDA NEOPLASIA PRIMÁRIA CONCOMITANTE: UM ALERTA AOS ONCOHEMATOLOGISTAS

MP Borim

Grupo Oncomed, ONCOMED BH e Instituto Orizonti, Belo Horizonte, MG, Brasil

Relato de caso: ZS, 69 anos, feminino, hipertensa controlada, fumante passiva por mais de 20 anos, em janeiro/21 submetida a procedimento dentário de simples complexidade percebendo após o mesmo aumento de glândula submandibular esquerda. Sem resolução às medidas suportivas, realizou biópsia de massa endurada submandibular e de linfonodo discretamente aumentado em cadeia cervical anterior ipsilateral. Anatomopatológico com imuno-histoquímica de glândula submandibular sem anormalidades; linfonodo cervical: Linfoma Difuso de células B com padrão de células de centro não germinativo (CD20 positivo / BCL2 com positividade irregular/ BCL6 positivo / MUM1 positivo em 30-40% das células analisadas / Ki67 positivo em 80 a 90%). FISH para mutação no gene c-MYC negativa. PET CT - aumento do metabolismo glicolítico em lesão pulmonar lobulada circunjacente à bifurcação de brônquio subsegmentar lateral do lobo médio (medindo 22,2 x 15,0 mm e SUV máximo = 8,37) e em lesão hipodensa em face ântero medial de terço superior de baço (medindo 7,8 mm e SUV máximo = 4,54), sugestivas de acometimento pela neoplasia linfoproliferativa. ESTADIO IV-A. Tratada com R-CHOP, recebeu 3 ciclos e repetiu PET CT – aumento do metabolismo glicolítico em lesão lobulada no segmento lateral do lobo médio, inalterada em relação ao estudo prévio. Não se identifica a lesão hipodensa previamente hipermetabólica na face ântero medial do terço superior do baço, visibilizada no último controle. Optou-se assim por biopsiar a lesão pulmonar - punção aspirativa guiada: anatomopatológico e imuno-histoquímica compatíveis com adenocarcinoma primário pulmonar. Realizada cirurgia robótica, com intenção curativa, junho/2021; exame da peça cirúrgica confirmou adenocarcinoma de padrão acinar e lepídico moderamente diferenciado, 2,5 cm, margens cirúrgicas livres. Quinze linfonodos avaliados, todos negativos para metástases. Após a intervenção Robótica a paciente prosseguiu com mais 3 ciclos de R-CHOP, finalizando o tratamento do linfoma.

https://doi.org/10.1016/j.htct.2021.10.177

SÍNDROME DE SÉZARY: RELATO DE CASO

KA Rabelo [a], VEG Silva [a], JF Almeida [a], KG Pereira [a], MIC Nogueres [a], SMM Barbalho [a], IR Daloy [a], MA Souza [a], TSN Machado [b]

[a] *Universidade Vale do Rio Doce (Univale), Governador Valadares, MG, Brasil*
[b] *Hospital Municipal de Governador Valadares (HMGV), Governador Valadares, MG, Brasil*

Introdução: As formas mais comuns de Linfoma Cutâneo de Células T (LCCT) são a síndrome de Sézary (SS) e a micose fungóide (MF), que representam cerca de 50% dos LCCT primários e acomentem geralmente a população idosa, do sexo masculino. Assim, as lesões iniciais de MF podem se apresentar como manchas eczematosas com bordas bem definidas em regiões não expostas ao sol. Já o estadiamento da SS/MF é avaliado pela análise de pele (T), linfonodos (N), envolvimento de órgãos viscerais (M) e sangue (B), uma vez que, no estágio "T"o envolvimento de sangue depende de sua carga tumoral além de serem avaliados os tipos de lesões cutâneas e sua extensão. Desse modo, pacientes com SS dependem da presença e implicação visceral e nodal, mas podem ser considerados portadores de estágio IVA1, IVA2 e IVB. **Relato de caso:** Paciente A.M.V.M., sexo feminino, 65 anos de idade, comparece ao Núcleo de Especialistas em Oncologia (NEO), a procura de atendimento hematológico devido a lesões pelo corpo há cerca de um ano, se encontra em estadiamento 4B e portava consigo estudo de imuno-histoquímica com biopsia de pele compatível a MF, imunofenotipagem evidenciando SS, além de informar tratamento prévio com fototerapia simples. Nos exames laboratoriais apresentou um quadro de leucocitose em torno de 14.000/mm^3 e neutropenia, diante disso, foi orientada quanto a necessidade de realização