the second cycle of Hyper-CVAD therapy (Methotrexate 1000 mg/m^2/day, Cytarabine 2 × 3000 mg/m^2/day for 2 days, Prednisolone 2 × 25 mg/m^2/day for 3 days) was initiated. On the 4th day of treatment, the creatinine level was found to be 3.96 mg/dL. At the beginning of the treatment, the patient's creatinine level was 0.77 mg/dL. The patient was consulted with Nephrology, and acute renal failure due to toxic nephropathy was considered. Emergency dialysis was not deemed necessary. Hydration and symptomatic treatment were recommended for follow-up. On the 6th day of treatment, the patient developed a fever above 38°C. Considering the presence of neutropenia, Cefoperazone & Sulbactam treatment was initiated upon the recommendation of the Infectious Diseases Department. On the 8th day of treatment, the patient experienced a sudden speech disorder accompanied by dizziness. Brain CT and Diffusion MRI showed no signs of bleeding or ischemia. No findings suggestive of ALL involvement were observed in the contrast-enhanced Brain MRI. The CSF cytology was normal. Due to suspicion of ALL involvement, a dose of intrathecal Methotrexate 12 mg and Cytarabine 100 mg was administered. Neurology consultation suggested the possibility of an atypical epileptic seizure. Antiepileptic treatment was initiated. As the creatinine level decreased to 1.96 mg/dL and no other pathological condition explaining the existing neurological findings was identified, CNS involvement of ALL was considered, and Radiotherapy (RT) was planned. Consultation with Radiation Oncology led to the initiation of CNS radiotherapy, with a total of 4 RT sessions administered. On the 10th day of treatment, Filgrastim (G-CSF) was started for the patient who was in absolute neutropenia. On the 11th day of treatment, erythematous rashes developed on the extremities and genital area, along with vesicular rash lesions on the back. The patient was consulted with Dermatology, and considering the possibility of Toxic Epidermal Necrolysis (TEN), a skin biopsy was performed. The biopsy result confirmed TEN. The patient was started on pulse prednisolone 1000 mg for 3 days. Along with steroids, plasmapheresis (1:1) was administered. On the 13th day of treatment, the patient developed a fever over 38°C, and based on the recommendations of the Infectious Diseases Department, the cefoperazone & sulbactam treatment was discontinued. As the creatinine level decreased to 1.1 mg/dL, Colistin and Imipenem were started. The patient's total bilirubin level increased to 7.68 mg/dL (with a predominance of direct bilirubin) compared to the previous day's total bilirubin level of 1.96 mg/dL. Due to the lack of significant improvement in skin lesions, a second session of plasmapheresis (1:1) was performed on the 15th day of treatment. On the 16th day of treatment, the patient's total bilirubin level increased to 17 mg/dL. Concurrently, the patient developed hypernatremia (Na: 166 mmoL/L), and emergency hemodialysis was planned upon the recommendation of Nephrology. A 2-hour hemodialysis session was performed. At the end of dialysis, the patient experienced respiratory arrest. The patient was electively intubated and transferred to the intensive care unit. Despite high-dose positive inotropic support, the patient developed cardiac arrest and died on the 17th day of treatment due to multiorgan failure. **Conclusion:** Stevens-Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN) are clinical conditions with high morbidity and mortality, often triggered by medications. The most common culprits include sulfonamides, anticonvulsants, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), and beta-lactam antibiotics. Clinically, SJS/TEN presents with fever, along with skin and mucosal membrane lesions. When vesicular lesions cover less than 10% of the body surface, it is considered SJS; when over 30%, it is classified as TEN, and if between 10%–30%, it is considered SJS/TEN overlap syndrome. In our first case, the involvement was between 10%–30%, leading to the diagnosis of SJS/TEN Overlap Syndrome. In the second case, as the lesions involved more than 30% of the body surface, the diagnosis of TEN was made. Methotrexate, widely used in various diseases, is associated with side effects such as nephrotoxicity, hepatotoxicity, bone marrow toxicity, and mucositis. Dermatological side effects, including urticaria, maculopapular rashes, mucositis, erythema, TEN, SJS, and psoriatic rashes, have also been reported. Methotrexate-induced SJS/TEN in the literature is attributed to direct cellular toxicity, hypersensitivity, or drug interactions, such as with NSAIDs. There is ongoing debate about whether the resulting epidermal necrolysis is due to dose-dependent toxicity or an allergic reaction. In our two cases, high-dose methotrexate was administered due to primary hematologic malignancies. Adequate doses of folic acid were provided 24 hours after Methotrexate administration. Both cases initially developed nephrotoxicity following methotrexate use, subsequently leading to skin involvement. Early treatment strategies, including steroids, Intravenous Immunoglobulin (IVIG), and supportive care as recommended in the literature, were implemented. However, both patients developed complications related to absolute neutropenia due to high-dose chemotherapy combined with methotrexate. SCORTEN scores were determined to be very high, at 5 or above. Unfortunately, both of our cases were lost due to the development of multi-organ failure. In conclusion, patients undergoing high-dose methotrexate therapy require close monitoring for nephrotoxicity and skin reactions to mitigate potentially fatal outcomes.

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PP 17_ Case report

RITUXIMAB WITH INVOLVED FIELD IRRADIATION FOR EARLY-STAGE DIFFUSE LARGE CELL LYMPHOMA

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Objective: Efficacy and safety of Involved Field (IF) radiotherapy in combination for anti-CD20 antibody Rituximab (MabThera) and Involved field Radiotherapy for early-stage Diffuse Large Cell lymphoma (DLBCL) in a prospective, single-arm

multicenter study. **Methodology:** Forty-five stage I–II FL patients received 8 cycles of Rituximab (375 mg/m^2) and IF irradiation (30/40 Gy). Progression-Free Survival (PFS) 1-year from treatment start is the primary endpoint. Secondary endpoints were complete response rates, toxicity, quality of life with protocol defined visits up to month 15. **Results:** For the primary endpoint, PFS at 1-year was 85% for the intention-to-treat set. Long-term data were captured in selected sites and evaluated as post hoc analysis in the Per Protocol (PP) set: PFS was 78% at 1-year with a median follow-up of 15 months, respectively. There were 17/45 recurrences in the PP set, of which 14 were outside the radiation volume only. There were 9 serious adverse events (3 related to the therapy) during the first 15 months. **Conclusion:** IF radiotherapy combined with Rituximab is well tolerated and highly efficient with low rates of recurrence in the first years in early-stage DLBCL. The efficacy is comparable with more aggressive therapy approaches without compromising the quality of life and maintains for an extended follow-up of more than 3 years.

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Adult Hematology Abstract Categories

T-Cell Lymphoma

PP 18_Case report

CASES OF PRIMARY CUTANEOUS ANAPLASTIC LARGE CELL LYMPHOMA TREATED WITH SYSTEMIC OR LOCAL THERAPY

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Introduction: Primary Cutaneous Anaplastic Large Cell Lymphoma (PC-ALCL) is a CD30+ peripheral T-cell lymphoproliferative disorder without systemic involvement. It accounts for approximately 8% of cutaneous lymphoma cases. Most patients with PC-ALCL present with slow-growing, solitary or grouped skin nodules, and in some cases, regional lymph node involvement is observed. **Case-1:** A 61-year-old male patient presented to our clinic with swelling and edema of the right lower lip, along with a 57 cm draining ulcerative skin lesion in the suprasternal region. The patient had previously received six cycles of treatment for T-cell lymphoma at an outside center. A PET-CT scan identified a soft tissue lesion in the skin/subcutaneous tissue at the level of the right thyroid lobe and isthmus, measuring 57*15*52 mm, with a maximum SUV of 34. Biopsies taken from the lower lip and suprasternal skin were reported as primary cutaneous anaplastic large cell lymphoma. CD30 expression was found to be 95%. The patient was started on brentuximab vedotin along with the GDP protocol. After two cycles of treatment, improvement in the skin lesions was observed. **Case-2:** A 61-year-old male patient presented to our clinic with a complaint of a lesion on the anterior surface of the right tibia, measuring approximately 10*10 cm. The biopsy taken from the lesion was reported as CD30+ primary cutaneous anaplastic large cell lymphoma. A PET-CT scan revealed moderately hypermetabolic lymph nodes with thick cortices in the right iliac and inguinal lymphatic chains. Radiotherapy was applied to the area of the primary lesion and the regional lymph nodes, and improvement in the skin lesions was observed with treatment. **Discussion:** We aimed to discuss the outcomes of applying localized radiotherapy or systemic treatment to two patients with PC-ALCL who presented to our clinic: one with a relapse and the other with a new diagnosis. Brentuximab vedotin is effective in this disease. Since disease control could not be fully achieved with localized radiotherapy alone, we believe that the combination of systemic therapy and radiotherapy may be an important treatment option for these patients. Further large-scale case series are needed to guide treatment.

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Adult Hematology Abstract Categories

Myelodysplastic Neoplasms

PP 19_Case report

CLINICAL PRESENTATION AND OUTCOMES OF PATIENTS WITH MYELODYSPLASTIC SYNDROME INTRODUCTION

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Objective: Myelodysplastic Syndrome (MDS) is a clonal hematopoietic disorder that is characterized by dysplasia along with anaemia, thrombocytopenia or neutropenia and a risk of progression to Acute Myeloid Leukaemia (AML). In the United States, the yearly incidence of MDS is approximately 4 per 100 000 people, notably higher among older population rising tenfold by the age of eighty (80) years. Prognostic systems, such as the revised International Prognostic Scoring System (IPSS-R), offer rationally accurate estimates of survival at the population level. The goals of treatment in individuals having lower-risk MDS includes improving quality of life and minimizing Red Blood Cells (RBCs) and platelet transfusions. Therapeutic goals in patients having Higher-Risk MDS (HR-MDS), include decreasing the risk of transformation to AML and increasing survival. Haematopoietic Cell Transplantation (HCT) has the potential to cure MDS, but less than 10% of affected people undergo this treatment. Improvements in the understanding of MDS has resulted in newer management strategies for these patients. As a result, the treatment landscape for MDS patients is changing. All these advancements are expected to improve the survival rate of patients suffering from MDS. There is limited data on presentation and outcomes of MDS