and reliable diagnosis of MPN. Few lines can be included regarding the need of further studies with larger cohort from multi centers Use of high throughput sequencing techniques for identifying mutations located anywhere else in these genes Shouldn't it be 4?

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PP 24_Case report

A CASE OF THROMBOCYTOSIS AND HEMOTHORAX IN A PATIENT WITH ITP FOLLOWING ROMIPLOSTIM USE

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Introduction: Immune Thrombocytopenia (ITP) is an autoimmune disease characterized by isolated thrombocytopenia and normal to large platelets in the peripheral blood smear. It is an autoimmune disorder that leads to peripheral platelet destruction and decreased platelet production. Romiplostim, a peptide-antibody fusion product, is a thrombopoietin receptor agonist indicated for use in patients with ITP. Romiplostim is indicated for patients with ITP who have had an inadequate response to first-line therapy. Side effects of the drug include increased bone marrow reticulin, reversal of severe thrombocytopenia, thrombocytosis and increased immunoblast proliferation. In this case report, we present a patient with ITP refractory to first-line therapies who was admitted to the intensive care unit for thrombocytosis and haemothorax after a single dose of Romiplostim. **Case:** A 34-year-old female patient, who had been followed in the hematology clinic for ITP for approximately 5-years, was admitted to the clinic because of deep thrombocytopenia and deep anaemia due to menometrorrhagia. On admission, the platelet count was 2000 ($10^3/\mu L$) and the hemoglobin level was 5.4 g/dL, and she was taking eltrombopag 75 mg at the time of admission. He was tachycardic and hypotensive and was given erythrocyte suspension. Clinical and radiological examination revealed no bleeding foci other than menstrual and oral mucosal bleeding. The patient was treated with steroids, IVIG and rituximab during the follow-up period in the clinic. Despite the treatments given, bleeding control could not be achieved and a single dose of 2 mcg/kg Romiplostim was administered to the patient in the 2^{nd} week of hospitalization. The patient's platelet count began to rise rapidly on the 3^{rd} day after treatment and was measured at 1,650,000 ($10^3/\mu L$) on the 5^{th} day. At the same time, the patient developed dyspnea and a chest scan was performed, which revealed a hemothorax. The patient was admitted to intensive care. Drainage was performed with a chest tube. Acquired von Willebrand Factor (vWF) deficiency due to thrombocytosis was considered as the cause of the hemorrhage. The vWF level in the blood was found to be low. The thrombocytosis was controlled by platelet apheresis. After clinical improvement, platelet levels were normalized, and the patient was discharged. **Conclusion:** Romiplostim is a generally well tolerated agent. Current evidence suggests that it increases platelet counts, reduces bleeding, reduces the need for rescue therapy, reduces the amount of corticosteroids required, improves quality of life and, in isolated cases, is associated with remission of ITP. However, it should be used with caution as serious side effects include increased bone marrow reticulin, reversal of severe thrombocytopenia, thrombocytosis and increased immunoblastic proliferation

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Adult Hematology Abstract Categories

Multiple Myeloma

PP 25_Case report

IMPACT OF LENALIDOMIDE MAINTENANCE DOSAGE ON SURVIVAL OUTCOMES IN MULTIPLE MYELOMA

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Objective: This study aimed to assess the impact of lenalidomide maintenance dosing on clinical outcomes and the development of lenalidomide refractoriness in Multiple Myeloma (MM) patients who received maintenance therapy following Autologous Stem Cell Transplantation (ASCT) at our institution. **Methodology:** A retrospective analysis was conducted on 82 MM patients who underwent lenalidomide maintenance therapy on a 21/28-day cycle post-ASCT. Low-dose maintenance was defined as a dose below the maximum allowable level, determined by the patient's Glomerular Filtration Rate (GFR) and hematologic parameters at initiation. The Maximum Tolerable Dose (MTD) was defined as the highest dose a patient could tolerate based on these criteria. **Results:** In the overall cohort, median PFS was 56.0-months (95% CI: 40.15–71.85) and median OS was not reached. However, 88.3% of patients were alive at 60-months and 68.2% at 120-months. A response of ≥ VGPR was observed in 91% of patients receiving low-dose maintenance therapy, compared to 73.3% in those receiving treatment at the maximum tolerated dose ($p = 0.005$). While the median PFS was 56.0-months (95% CI 47.06–64.93) in those receiving low-dose maintenance; the median PFS was 33-months (95% CI 23.36–42.63) in those receiving maintenance at the MTD ($p = 0.166$). Dose reductions during maintenance therapy due to adverse effects were reported in 17 patients (20.7%). Of these, 11 patients (16.9%) were initially on low-dose maintenance, while 6 patients (40%) were on the MTD ($p = 0.42$). The median duration of maintenance therapy was 21 months (6–34) for patients on low-dose maintenance and 11 months (4–24) for those on the MTD ($p = 0.114$). Second-line treatment was administered to 40 patients (48.7%) who experienced progression. The median PFS2 was 25.36-months (95% CI 9.24–41.48), and the median OS2 was 73.23-months (95% CI 42.50–103.95). Median PFS2 was 25.43-months (95% CI 0.20–50.66) and the survival rate was 70% at 60-months in those receiving lenalidomide-based second line therapy, while median PFS2 was 25.36-months (95% CI 6.30–44.42) and the survival rate was 53.8% at 60-months in those receiving lenalidomide free