OS was ~50% in patients <50 years and 25% in those ≥50 years. In chemotherapy treated patients, 5-year EFS was 18.9%; CIR was 46.7% and NRM 34.4%. Univariate analysis linked older age, thrombocytopenia, high blast count, elevated C-reactive protein (CRP), hypoalbuminemia, and FLT3 mutation to worse OS. Persistent MRD after induction I also predicted poor outcomes. In multivariate models, FLT3-ITD (HR = 2.51), older age (HR = 1.03), and hypoalbuminemia (HR = 0.58) were independently associated with worse OS. FLT3-ITD and elevated CRP remained significant for EFS. **Discussion and conclusion:** This study reveals notably poor outcomes in a cohort of NPM1-mutated AML patients treated in the Brazilian public system, particularly among those with FLT3-ITD and older age. High early mortality, limited access to FLT3 inhibitors, and delayed implementation of MRD-guided post-remission strategies likely contributed. These findings reinforce the need to improve access to molecular diagnostics, targeted therapies, and allogeneic transplantation across all treatment phases.

https://doi.org/10.1016/j.htct.2025.104635

ID - 3096

PRIMARY UTERINE CERVICAL MYELOID SARCOMA AS THE INITIAL PRESENTATION OF ACUTE MYELOID LEUKEMIA WITH MONOCYTIC DIFFERENTIATION: A RARE CASE REPORT

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Introduction: Myeloid sarcoma (also known as granulocytic sarcoma or chloroma) is a rare extramedullary manifestation of acute myeloid leukemia (AML). Presentation as a gynecologic mass is exceptionally uncommon and often leads to diagnostic delay and suboptimal initial management. We report a case of AML with monocytic differentiation initially presenting as a cervical tumor, misinterpreted as undifferentiated carcinoma, later confirmed as myeloid sarcoma. **Case report:** A 37-year-old woman, G2P2, previously healthy, had a two-year history of abnormal uterine bleeding and dyspareunia under routine gynecologic follow-up. In February 2023, she developed abdominal pain, dizziness and vaginal bleeding. A cervical mass was detected, and biopsy suggested undifferentiated carcinoma. She was referred for oncologic assessment in March. Staging revealed multiple lytic bone lesions, in the spine and pelvis, and lymphadenopathy in pelvic, inguinal and abdominal chains, raising suspicion of metastatic disease. A cervical biopsy was performed. Initial immunohistochemistry of the cervical lesion showed diffuse positivity for LCA and negativity for cytokeratin and p40, raising suspicion for a hematolymphoid neoplasm. Concurrently, the presence of circulating atypical cells in peripheral blood during early hospitalization prompted hematologic evaluation. Bone marrow aspirate revealed 68% pleomorphic blasts and flow cytometry identified a population of myeloid blasts with monocytic differentiation (CD64++, CD4+, HLA-DR+, CD33++, CD36+, CD14−, CD11b+). Molecular testing for BCR-ABL, FLT3-ITD/TKD, NPM1, and RUNX1-RUNX1T1 mutations was negative. Induction chemotherapy with 7+3 (cytarabine and daunorubicin) was initiated in April. The clinical course was complicated by febrile neutropenia, mucositis and probable invasive fungal pneumonia, managed with liposomal amphotericin B, resulting in initial improvement. In mid-May, the patient developed persistent bone pain and headache. Imaging demonstrated new osteolytic lesions and findings suggestive of central nervous system involvement. Cerebrospinal fluid analysis confirmed leukemic infiltration, with 1.2% of atypical cells exhibiting the same immunophenotypic profile as the diagnostic marrow blasts. Given refractoriness to initial therapy, reinduction was undertaken with the MITO-FLAG protocol (mitoxantrone, fludarabine, high-dose cytarabine). The subsequent course was marked by prolonged aplasia, septic shock of undetermined origin and multiorgan failure, culminating in death on day +19 post-reinduction. **Conclusion:** The absence of recurrent mutations and the rapid clinical deterioration highlight the aggressive nature of AML with monocytic differentiation, particularly when associated with extramedullary involvement. In this case, disease progression occurred despite induction chemotherapy, with leukemic infiltration of the bone marrow, central nervous system and skeleton, further complicated by severe infectious events. Given its capacity to mimic solid tumors, myeloid sarcoma should be included in the differential diagnosis of neoplastic lesions with atypical features, even in the absence of circulating blasts. This is especially relevant in uncommon anatomical sites such as the uterine cervix. Early recognition may significantly impact therapeutic decisions. Ultimately, this case reinforces the importance of maintaining high clinical suspicion and ensuring early hematologic evaluation in patients with unusual tumor presentations.

https://doi.org/10.1016/j.htct.2025.104636

ID - 2613

PROGRESSÃO DE SÍNDROME MIELODISPLÁSICA PARA NEOPLASIA DE CÉLULAS DENDRÍTICAS PLASMOCITOIDES BLÁSTICAS COM MANIFESTAÇÕES IMUNOLÓGICAS GRAVES

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