included—279 with DLBCL and 22 with PMBCL. The overall frequency of CD30 positivity was 19.6%, with 19% in DLBCL and 27.3% in PMBCL. Among CD30+ cases, nodal biopsies were significantly more frequent (62.7%) than extranodal (37.3%), compared to 47.5% and 52.5% respectively in CD30-negative cases (p = 0.036). No significant associations were observed between ExpCD30 and NCCN-IPI risk category, or between ExpCD30 and cell of origin. ExpCD30 was not significantly associated with OS (p = 0.22) or PFS (p = 0.42). In multivariate models, the only independent predictor of worse outcomes was the presence of ≥ 4 NCCN-IPI risk factors, associated with poorer OS (HR 3.15, 95% CI: 1.99–5.01, p < 0.001) and PFS (HR 2.90, 95% CI: 1.90–4.42, p < 0.001). In the DLBCL subgroup, ExpCD30 was not significantly associated with GC vs. non-GC classification such as NCCN-IPI score. ExpCD30 did not impact OS (p = 0.35) or PFS (p = 0.70). Once again, having ≥ 4 NCCN- IPI risk factors remained the only significant prognostic factor in the multivariate analysis. Due to the small number of cases (n = 22), we were unable to conduct detailed statistical analyses in the PMBCL subgroup. **Discussion and conclusion:** Our cohort represents the third largest sample among previously published studies and is the first in Brazil and Latin America to evaluate CD30 expression in these specific lymphoma subtypes. Our findings are consistent with most of the studies published in the international literature. CD30 positivity was observed in approximately one-fifth of cases, more frequently in nodal biopsies, but showed no significant association with major prognostic factors or survival outcomes.

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CHARACTERISTICS AND TREATMENT PATTERNS OF PATIENTS WITH MANTLE CELL LYMPHOMA IN BRAZIL: A REAL-WORLD STUDY

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Introduction: Mantle cell lymphoma (MCL) is a non-Hodgkin lymphoma with an adverse prognosis, caused by an accumulation of malignant B-cells originating from the mantle zone of lymph nodes. There is limited evidence exploring patients (pts) with MCL and their treatment in Brazil. **Objectives:** This study aimed to describe the demographics, clinical characteristics and treatment patterns of pts with MCL across Brazil. **Material and methods:** Data were drawn from the Adelphi MCL Disease Specific Programme™, a cross-sectional survey with retrospective data collection from March-October 2022 in 8 countries including Brazil. Hematologists/hem-oncologists provided demographics, clinical characteristics and treatment data for six consecutively consulting pts with MCL in a 1:2 ratio of first-line (1L) to pre-treated (2L+), with ≥two of the 2L+ pts having received a Bruton's tyrosine kinase inhibitor (BTKi). All analyses were descriptive. **Results:** 37 physicians provided data on 244 pts with MCL in Brazil. Most physicians (85%, n = 29/34, known setting) practiced in a specialist center, and 12% (n = 4/34, known setting) in a university setting. Of the pts, 75% (n = 183/244) were male with median age (interquartile range) 65.0 (55.0-71.0) years and 19% (n = 46/244) had a caregiver. Most were covered by private healthcare plans (72%, n = 176/244), with 19% (n = 47/244) covered by the public healthcare system. Most pts had classical MCL (61%, n = 148/244), 12% (n = 30/244) blastoid/pleomorphic disease and one fifth indolent disease (22%, n = 53/244) as recorded by the treating physician. At diagnosis, 30%/35%/31% of pts had an ECOG performance status of 0/1/≥2. Using a simplified MCL international prognostic index (sMIPI) proxy, 55% (n = 101/182) were classed as low risk, 29% (n = 53/182) intermediate risk and 15% (n = 18/182) high risk at data collection. Overall, 50% received a BTKi, and 98% of 1L and 90% of 2L therapies were initiated post-2014 and post-2020, respectively. Stem cell transplant was received by 9% (n = 23/244) at 1L and by 2% (n = 3/160) at 2L. At 1L, 62% (n = 151/244) received chemoimmunotherapy (CIT), and 17% (n = 42/244) received a BTKi (monotherapy or combination), with R-CHOP the most common CIT (37%, n = 90/244) and ibrutinib the most common BTKi (12%, n = 29/244). Overall response rate (ORR) at 1L was 60% (n = 25/42) and 72% (n = 109/151) for BTKi-based treatment and CIT respectively, with a complete response rate (CRR) of 40% (n = 17/42) and 50% (n = 75/151) respectively. At 2L, 58% (n = 92/160) received a BTKi-based treatment (n = 67/92 ibrutinib, n = 25/92 acalabrutinib) and 15% (n = 24/160) received CIT with R-CHOP (n = 7/24) being the most common CIT. ORR was 53% (n = 49/92) for BTKi-based treatment and 75% (n = 18/24) for CIT, with 21% (n = 19/92) and 46% (n = 11/24) CRR, respectively. Unacceptable tolerability was reported as the reason for treatment cessation for one pt (n = 1/176) at 1L and 17% (n = 10/59) at 2L. **Discussion and conclusion:** Conclusions: Most pts were elderly males and classified as low risk or intermediate risk using a sMIPI proxy. Though one-fifth of pts were reported to have indolent disease at diagnosis, one-third had an ECOG score of ≥2 during treatment, indicating functional decline. Although our study set a quota for 2L+ pts treated with BTKi, observation of BTKi use in 1L was unexpected since BTKi was not approved in the 1L setting at data collection in Brazil; this could suggest unmet need for targeted treatment in the first-line setting at data collection.

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DESAFIO DIAGNÓSTICO EM LINFOMA PLASMABLÁSTICO: RELATO DE CASO EM PACIENTE IMUNOCOMPETENTE

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