was begun, but again progression was observed leading to a therapy change to Bortezomib and dexamethasone (May). At that time, the cutaneous lesions occupied an area of 12 × 7 cm on the thoracic wall and 10 × 8 cm on the right temporal region (irradiated with response). Two months later, he exhibited an increasing creatinine; an ultrasound revealed a 20 cm mass involving the right kidney, running along the ureter to the right iliac fossa. Palliative treatment with continuous cyclophosphamide, dexamethasone and clarithromycin was started. The patient died a month later.

OR55
Nonsecretory multiple myeloma presenting with extensive extramedullary plasmacytoma
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A 31 year old Malay lady presented in June 2011 with chronic back pain, bilateral breast lumps and constitutional symptoms. Clinical examination revealed multiple breast lumps of varying sizes without skin changes. She also had proptosis of the right eye but extraocular muscle movements were normal. Computed tomography scan showed multiple enhancing nodules in both breasts, chest and abdominal walls, left renal pelvis mass and inguinal lymphadenopathy. There were extensive lytic osseous lesions involving entire vertebrae, pelvic bone, sternum, both humeral heads and multiple ribs. Some were associated with soft tissue components and abundant paraspinus masses with intraspinal extension. There was a homogeneously enhancing mass at the retroorbital extraconal of the right orbit with linear calcification. She also had anaemia with renal impairment. Histopathological examination of breast lump biopsy confirmed plasmacytoma. Bone marrow studies showed multiple myeloma. However, no monoclonal gammapathy was found in the serum or urine. β2-microglobulin was 2.78 μg/mL. Cytogenetic analysis showed hypertriploidy. She was treated with bortezomib, cyclophosphamide, dexamethasone with zoledronic acid. In view of intraspinal extension, intraheal methotrexate, cytarabine and hydrocortisone were administered. Treatment was complicated by haemorrhagic cystitis following fourth cycle. Therefore, treatment was changed to bortezomib, dexamethasone and thalidomide. She also had radiotherapy 20 Gy in 5 fractions to the paraspinal mass. Clinical and radiological assessment after three cycles of chemotherapy showed very good partial response. She was planned for reassessment after eight cycles. Long-term plan for her is autologous peripheral blood stem cell transplantation (PBSCT). In this case, we would like to highlight the extensiveness of non-secretary multiple myeloma in our patient with a rare initial presentation. We would like to discuss on the maintenance therapy following PBSCT and the salvage therapy options if the disease relapses or progresses.

OR56
The differential diagnosis: multiple myeloma or Waldenström’s macroglobulinemia?
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Patient N., 55 y.o., female. Complaints of bone pain since summer 2011. Later acute back pain appeared. X-ray revealed the compressive fracture of L2. Patient was referred to the National Cancer Institute. Multiple osteolytic destructions with destruction of cortical layer could be observed on CT-scans, compressive fracture of L2, pathological fractures of 8–9 ribs. Blood count revealed leucopenia of grade 2 and thrombocytopenia of grade 1. According to Bone marrow aspirate test results there were 10% of plasmocytes, 20% of lymphocytes. Histology and immunohistochemistry of bone marrow biopsy concluded that focal involvement of bone marrow with B-cell small cell lymphoma with plasmocytic differentiation took place (CD3+; CD20+; CD38+; CD138+; CD56−). Immunophenotype of bone marrow aspirate revealed 72% of clonal cells with phenotype as follows: CD45−; CD19−; CD38+; CD138+; CD56+/−. The immunofixation of proteins in blood and urine revealed monoclonal paraprotein IgM-kappa in the serum in γ-zone; BJ-protein class Kappa in urine. BJ-protein concentration was 0.018 g/l (0.03 g/day) and serum M-protein − 2.01 g/l. What is the diagnosis: Multiple myeloma (MM) M IIIA stage (Durie–Salmon), ISS I or Waldenström’s macroglobulinemia? Immunoglobulin (Ig) M myeloma is a MM displaying clinical and pathologic features of both MM and Waldenström’s macroglobulinemia (WM). The clinical differentiation of MM from WM is straightforward. When a patient presents with features typical of MM and an IgM component, a diagnosis of IgM-MM is made. The distinction between IgM-MM and WM is based on the pure plasma cell morphology in myeloma and presence of lytic bone lesions in myeloma.


OR57
Coincidence of multiple myeloma and non-Hodgkin’s lymphoma in female
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Patient D., female, 58 years old had complaints on increase of the temperature to 39ºC, weakness, weight loss