**CASE REPORT**

A 77-year-old male patient born in Itaperuna, State of Rio de Janeiro, came to our service complaining of dizziness, discomfort, headache, and vomiting that had persisted for 30 days. He had no sinonasal symptoms. The patient underwent routine examination. Skull CT scans were ordered because of the symptoms he manifested, and a tumor with soft-tissue density measuring 19 x 20 x 30 mm was seen in the left posterior ethmoidal cells, in addition to erosion of the lamina papyracea (Figure 1). A rigid 0° scope was used to biopsy the patient. The tumor was removed and sent to the surgeon felt the tumor could be easily resected. The tumor was removed and sent to the pathologist for analysis. The report came back categorizing it as lymphoproliferative disease, and immunohistochemistry found it to be an aggressive, CD 20-positive (marker for B-cells), and immunophenotyping differentiates primary nasal lymphoma - derived from T-cells - from B-cell nasopharyngeal lymphoma (69%)4,5.

According to the Ann Arbor staging system (also used for HL), our patient was on stage IEA, as only one extranodal structure was involved (ethmoid sinus) and he had no B symptoms, thus excluding other possible primary involvement sites5. Treatment is based on surgery, systemic chemotherapy, and localized radiotherapy, and patient mean survival is five years. Regional and distal metastases are rare5.

**CONCLUSION**

Lymphomas are the most frequent non-epithelial malignant tumors of the nose, and must be included in the differential diagnosis of paranasal sinus neoplasms. Proper workup and definitive diagnosis are fundamental for the early introduction of treatment and improved survival of NHL patients.