Peripheral T-cell lymphomas are a group of heterogeneous disorders and according to WHO classification, are categorized into nodal and extranodal forms. NK/T-cell lymphoma, nasal type, is a subtype of extranodal peripheral T-cell lymphoma and commonly presents as a midfacial destructive lesion. This disorder is more prevalent in Asia and South America and has a strong association with Epstein Barr Virus infection. Invasion of vessel walls by lymphoid cells, which is known as angiocentricity, is characteristic of nasal type NK/T-cell lymphoma. The tumor cells express CD2 and CD56 antigens; but not CD3. The nasal cavity is the mostly frequently affected site. Other commonly affected sites include palate and upper airways. On cross sectional imaging, the nasal involvement is seen as a diffuse sheet-like mucosal thickening along the nasal turbinates and septum or as a destructive midline mass (Figs.1,2).

The latter form was previously described as a lethal midline granuloma or polymorphic reticulosis. The mass frequently extends into subcutaneous tissues of nasal ala and buccinator space (Fig.3).

T-cell lymphoma, compared to B-cell lymphoma, has an aggressive course and poor prognosis. The median survival was reported to be 12 months, even in patients showing a localised disease. Extranodal NK/T-cell lymphoma is sensitive to both chemo- and radiotherapy. Methotrexate and anthracycline based chemotherapy regimen (SMILE protocol) with infield radiotherapy is the recommended protocol for treatment of NK/T-cell lymphoma.