

## Phalangeal Nodule in A 50-Year-Old Woman

Mounia Bennani\*, Jihane Ziani, Sara Elloudi, Zakia Douhi, Hanane Baybay, Fatima Zahra Mernissi

Departement of dermatologie, Hassan II hospital Univesity of Fes, Morocco.

\*Corresponding author: Mounia Bennani, Departement of dermatologie, Hassan II hospital Univesity of Fes, Morocco. Email: mouniaabennani24@gmail.com

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50-year-old patient, with no pathological history, no particular medication. Admitted in dermatology consultation, for a small nodule of 1 cm of firm consistency, asymptomatic, sitting opposite the inter phalangeal joint of the third finger of the right hand (Figure 1 (A, B)), in dermoscopy we found on a whitish background, points and tortuous vessels without lipid deposition at the vitropressure, the rest of the somatic examination was without particularity, the interrogation found the notion of arthralgia of inflammatory appearance evolving for 2 years under several analgesics without clear improvement without associated joint deformation

### Quel est votre diagnostic

**Nodule Rhumatoïde:** Rheumatoid nodules are the most common extra articular manifestation of RA [1], their physiopathology is not elucidated yet, the one clear modifiable risk factor is smoking [2]. The prevalence is estimated at 10%, although the 10-year occurrence rate in any single individual may be as high as 30% over 10 years [3]. These nodules are usually encountered on extensor surfaces and areas of pressure or repetitive trauma, most notably the olecranon and dorsal aspect of the hand (Fig. 1). However, they can develop on any tendon/ligament-like

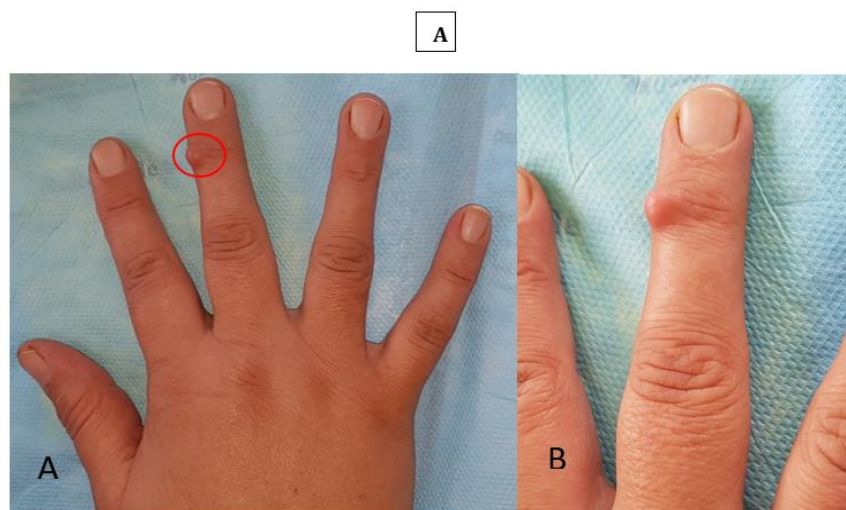
structures such as the Achilles tendon and vocal cords. In bedbound patients, these nodules can also be seen on the occiput and ischium.

Diagnosis is usually determined clinically. When seen in early or aggressive disease and located on extensor or pressure point surfaces, the differential is usually limited (1) Most patients with rheumatoid nodules have positive RF factor [4].

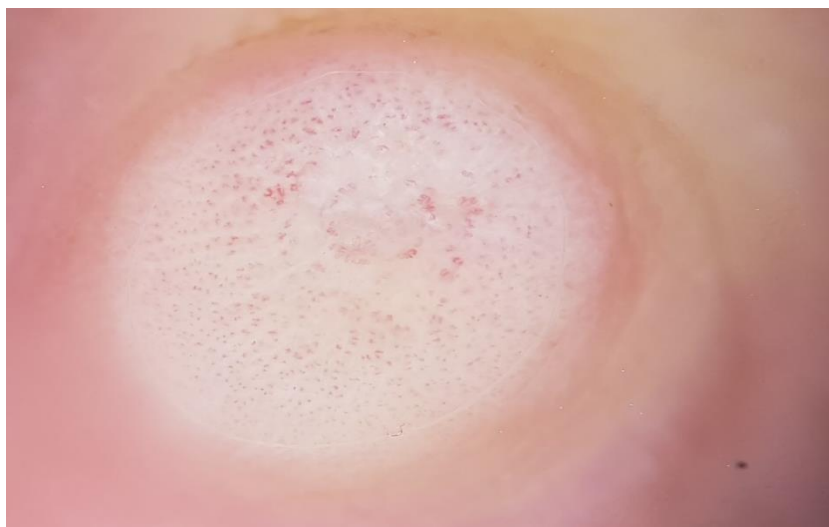
Frequently, nodules are asymptomatic, present no major clinical problems, and require no specific therapy [1] Several small studies demonstrate that local injection of glucocorticoids can reduce the size of rheumatoid nodules [5,6] Surgical excision is generally avoided unless the rheumatoid nodule is causing severe pain, nerve compression, skin ulceration, or recurrent infections [7].

For our patient in front of the Clinical aspect and the interrogation, we asked for the dosage of the rheumatoid factor which had returned positive, then the patient was referred to rheumatology where the diagnosis of rheumatoid arthritis was confirmed and the patient was put under treatment level 1 for his polyarthritis with therapeutic abstention for the rheumatoid nodule after consertation with our patient.

Figure 1



**Figure 2**



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