SHORT REPORTS

Rheumatoid nodule of pharynx

We wish to report a case of a rheumatoid nodule in the pharynx. On reviewing the literature the only similar case was that mentioned but not reported in full by Gardner in 1968.[1] Indeed, the only other example of a rheumatoid nodule in the upper alimentary tract was described in the tongue.[2]

Case report

The patient was a 48-year-old woman with a five-year history of seropositive rheumatoid arthritis who had been treated with prednisolone and non-steroid anti-inflammatory agents. She complained of anorexia, dysphagia, and progressive weight loss. There were classical joint changes of rheumatoid arthritis in hands, wrists, elbows, and knees with rheumatoid nodules affecting the extensor aspects of both arms and over the cervical and lumbar spine. There were small areas of skin infarction overlying the nodules of the arms. Barium swallow disclosed a rounded lesion posteriorly in the pharynx at the level of C3-4 (see figure). Oesophagoscopy failed to show the rounded lesion. Nevertheless, some thickening of the mucosa was seen at this site and a biopsy was taken.

Barium swallow showing filling defect in pharynx.

Microscopy of the fragments received showed stratified squamous epithelium overlying vascular connective tissue, in which there were several nodules with necrotic fibrinoid centres. The nodules were bounded by foamy macrophages and elongated cells which showed palisading, while occasional Touton-type giant cells were present. The appearances were those of typical rheumatoid nodules.

Discussion

Nodules at a variety of sites may cause unusual symptoms in patients with rheumatoid arthritis. We cannot prove with certainty that this patient's dysphagia with consequent weight loss was due to the presence of these rheumatoid nodules, but the evidence in favour of such an explanation is strong.

The case serves as a caution to physicians to remember the ubiquitous nodule.

[1] Gardner, D L, Clinicopathological Conference, Royal Postgraduate Medical School, London, 1968.
[2] Raven, R W, *et al*, *Annals of Rheumatic Diseases*, 1948, **7**, 63.

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Gout with normal serum urate concentration

The absolute diagnosis of gout depends on the detection of urate crystals in the affected joint. It is still widely held that a hyperuricaemia above 0·42 mmol/l (7 mg/100 ml) for men and 0·36 mmol/l (6 mg/100 ml) for premenopausal women is an essential element in the diagnosis.[1] The purpose of this paper, however, while presenting no new findings,[2-4] is to draw attention to four patients with gout whose serum urate concentrations were well within normal limits.

Case reports

Case 1—A 59-year-old man presented with a painful right wrist, which was aspirated. Abundant crystals were seen inside leucocytes and identified by compensated polarised light microscopy as monosodium urate monohydrate. His serum urate was 0·31 mmol/l (5·2 mg/100 ml). Ten years previously he had had an acutely painful great toe and his serum urate concentration had been 0·3 mmol/l (4·4 mg/100 ml). During two subsequent similar attacks the concentrations had been 0·45 and 0·48 mmol/l (7·6 and 8·0 mg/100 ml) respectively.

Case 2—A 66-year-old man presented with exquisitely tender inflammation of the great toe joint that had developed two days after a minor injury to the foot. His serum urate was 0·35 mmol/l (5·9 mg/100 ml). The symptoms responded rapidly to phenylbutazone. He subsequently had an identical attack, which responded promptly to colchicine; the serum urate was not estimated on that occasion.

Case 3—A 65-year-old man had had episodic pain in the left forefoot for 10 years. He presented with swelling of the whole forefoot and exquisite tenderness of the first metatarsaophalangeal joint. He described the previous attacks as identical, although less severe. His serum urate was 0·29 mmol/l (4·8 mg/100 ml) but rose progressively over seven weeks to 0·49 mmol/l (8·2 mg/100 ml). He was then started on allopurinol and colchicine. Colchicine was stopped because of diarrhoea and he promptly developed identical acute podagra, this time with a serum urate concentration of 0·36 mmol/l (6·0 mg/100 ml).

Case 4—A 77-year-old man had had a painful swelling of his left little finger three years previously that discharged white material before healing. He now had a painful, tense swelling of the left fifth distal interphalangeal joint. Purulent material was aspirated but was sterile on culture. Polarised light microscopy, however, showed abundant intracellular and extracellular urate crystals. The serum urate was 0·34 mmol/l (5·7 mg/100 ml). One month later it was 0·39 mmol/l (6·6 mg/100 ml).

Comment

The problem of diagnosing an acutely inflamed joint if gout is suspected is complicated when the patient is already receiving allopurinol or a uricosuric drug. None of these patients was taking any drug. We reviewed the case notes of 57 patients with gout seen since