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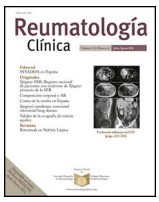

Images in Clinical Rheumatology

Another Gouty Tophus? The Many Faces of the Enchondroma☆

¿Otro tofo gotoso? Las múltiples caras del encondroma

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Primary bone tumors of the hands are rare (2%–5%), the most common of them is the enchondroma.[1,2] Enchondromas usually develop in the second decade of life, but can occur at any age. In all, 50% are located in the proximal phalanges, followed in frequency by the metacarpal bones and middle phalanges. Patients usually remain asymptomatic, although, on occasion, there may be an enlargement or deformity of the fingers, pain and pathological fractures secondary to the expansion and remodeling of the lesion. The development of multiple enchondromas is known as Ollier disease.[3,4]

The patient was an 82-year-old man diagnosed with gout. He presented with a tumor-like lesion on the second phalanx of the third finger of the left hand that had developed months earlier (Fig. 1A and B). Since a gouty tophus at that site is rare, he underwent plain radiography (Fig. 1C and D), which showed an expansile lytic lesion. The findings in magnetic resonance imaging (MRI) were suggestive of malignancy (Fig. 2A–C). Ultimately, biopsy was performed, leading to a diagnosis of enchondroma (Fig. 2D).

The differential diagnosis of a lesion affecting the hand like the one we present includes, in addition to intraosseous gouty tophus (reported in up to 13.3% of patients with advanced gouty arthropathy)[5,6] and enchondroma, other bone tumors such as chondrosarcoma,[7] low-grade chondroblastoma, myxoid fibroma, epidermoid cysts, nonossifying fibromas, fibrous dysplasia and giant cell tumor.[8] Other conditions to be ruled out would be bone infarction, brown tumors associated with hyperparathyroidism,[9] xanthomas, rheumatoid nodules and sarcoid granulomas[10] and those related to infections (syphilis, *Borrelia*, mycobacteria).[8]

In radiographs, enchondromas are characterized as round, well-defined lesions with central radiolucency in the diaphysis or the metaphysis. It may have a lobulated contour, punctate calcifications and even endosteal scalloping, cortical thinning and pathological fractures in the case of substantial enlargement.[2]

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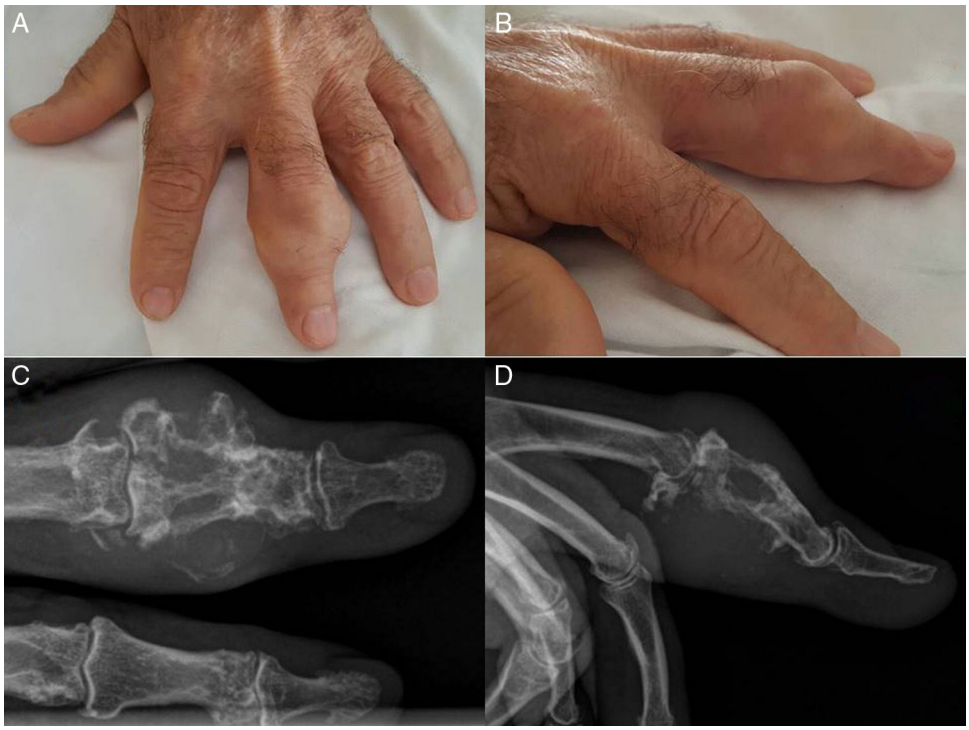

Fig. 1. (A and B) Multilobulated tumor in the second phalange of the third finger of the left hand. (C and D) Anteroposterior and lateral radiographs of the third finger of the left hand, showing a large expansile lytic lesion, that undergoes inflation, deflation and destroys the cortical.

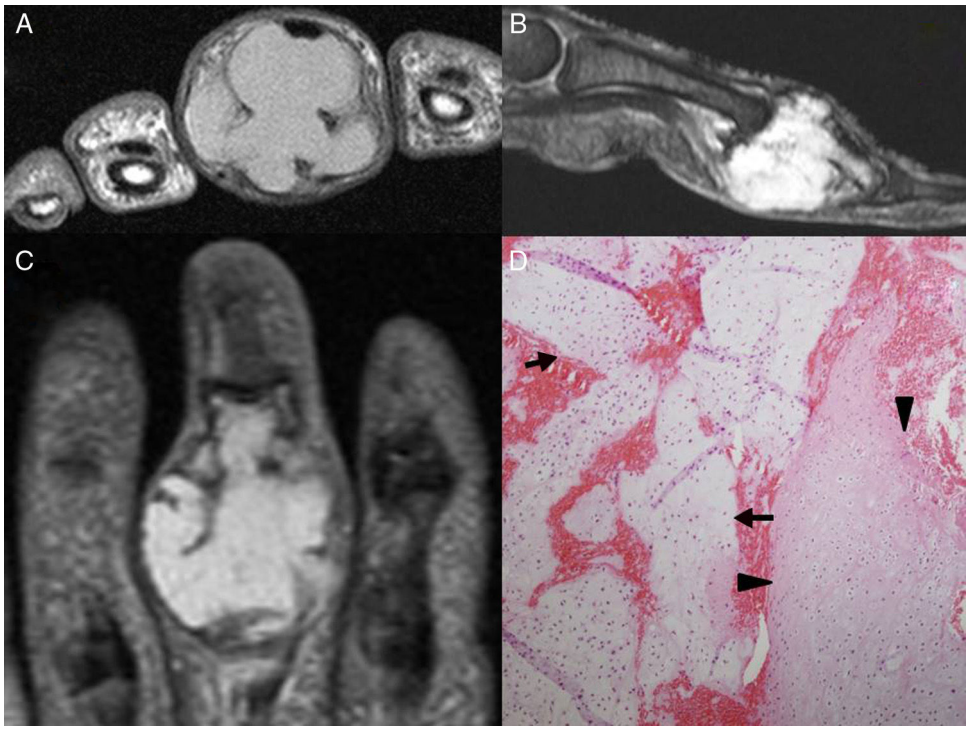

Fig. 2. (A–C) Magnetic resonance images; multilobulated expansile lesion, with endosteal scalloping and substantial cortical thinning, which is hypointense in T1 (axial plane) and hyperintense in the T2-weighted sequence with fat suppression (sagittal plane) and in a short tau inversion recovery (STIR) sequence (coronal plane). (D) Biopsy of the tumor showing mature hyaline cartilage (arrows), with areas of myxoid degeneration (arrowheads), compatible with enchondroma.

Ethical Disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality of data. The authors declare that no patient data appear in this article.

Right to privacy and informed consent. The authors declare that no patient data appear in this article.

Conflicts of Interest

The authors declare they have no conflicts of interest.

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