Ann's Finger Bump

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Meet Ann

- Ann is a 54-year-old Caucasian female who presents with a nodule on her finger and a groove in her fingernail
- The lesion is occasionally tender but not pruritic, and there is no discharge from the lesion
- Ann has no personal or family history of skin problems
- She is otherwise healthy but feels she may have some mild arthritis starting up

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What is your diagnosis?

a) Milia cyst
b) Digital mucous cyst
c) Branchial cleft cyst
d) Epidermoid cyst
e) Cystic basal cell carcinoma

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See page 2 for the answer to last month's case

Here is the answer to last month's case

Meet Xavier

- A 46-year-old, healthy male presents with complaints of recurrent tenderness of the right ear of one year's duration
- Examination reveals an indurated, pearly papule on the apical helix of the right ear, measuring 4 mm in diameter

What is your diagnosis?

a) Spitz nevus
b) Nevus sebaceous
c) Campbell de Morgan spot (cherry angioma)
d) Chondrodermatitis nodularis helicis

Answer: D

Chondrodermatitis nodularis helicis (CNH) **(answer d)** is a common, benign, painful disorder of the external ear. It is characterized by tender, single or multiple papulonodules on the helix or antihelix of the ear. These lesions often display ulceration of the surface.

The majority of reported cases occur in middle-aged or older Caucasian males, often with a history of chronic sun exposure and actinic damage. Nonetheless, CNH occurs in all races and affects both sexes. The papulonodules are raised and indurated on palpation. There may be an associated eschar or surface ulceration. Lesions may range in size from several millimeters to 2 cm in diameter. The apex of the helix is the most common location.

A skin biopsy may be required to rule out the possibility of skin cancer, such as basal or squamous cell carcinoma, as well as keratoacanthoma.

Pathology reveals acellular degeneration of collagen with fibrin deposition. Often, there is associated ulceration of the epidermis. Larger lesions may display cartilage degeneration as well. The most accepted and plausible hypothesis identifies mechanical pressure or trauma resulting in microvascular injury of the underlying tissue as the cause of these nodules. There may also be an association with connective tissue disorders, including lupus erythematosus as well as thyroid illness.

Pressure relieving prosthetic devices may be tried, but they are often unsuccessful. Medical management includes topical steroid creams, triamcinolone injection, as well as cryotherapy. Ulcers may be treated with topical antibiotics. Surgery remains the best option. Local wedge excision, curettage, and laser ablation may bring significant relief with a low recurrence rate and a satisfactory cosmetic result.

Simon Lee, MD, FRCPC

cme

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to our winner for the month of June 2012

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