Rheumatoid nodules are deeply seated firm masses that occur in patients with rheumatoid arthritis, particularly over bony prominences. A rare complication is the development of accelerated rheumatoid nodulosis, reported in some patients treated with methotrexate. This presentation is characterized by the rapid development of multiple nodules.
The term rheumatoid nodulosis has been proposed for the clinical presentation of multiple nodules on the hands and elbows, which can occur in patients with systemic lupus erythematosus who do not exhibit rheumatoid arthritis.
Pseudorheumatoid nodule: a term that has been applied to nodules in the subcutis that mimic rheumatoid nodules histologically but that develop as a reactive process in the skin. Originally, the term was considered synonymous with rheumatoid nodules in the subcutis. However, with the recognition of granuloma annulare, the nodules are now generally considered to represent a subcutaneous variant of granuloma annulare.
Rheumatoid nodule = رﺜواﻨﻴﺔ ﻋﻘﻴدﺔ

Histopathology .
Rheumatoid nodules occur in the subcutis and deep dermis. They exhibit one or several areas of fibrinoid degeneration of the collagen fibers. A dense infiltrate of inflammatory cells is present, including lymphocytes, plasma cells, and eosinophils. Histiocytes and their aggregates are a constant feature. Lymphoid aggregates and germinal centers may be found. In infiltrates there is often a preponderance of T-lymphocytes. Involvement of adjacent fat cells by a lymphocytic infiltrate leads to liquefaction of the adipose tissue. In the surrounding stroma, there is a proliferation of blood vessels associated with fibrosis. A sparse infiltrate of other inflammatory cells is associated with the histiocytes and surrounding stroma. Lymphocytic aggregates and germinal centers may be found.
not usually encountered. In perforating rheumatoid nodules, the central fibrinoid material connects to the skin surface.

*Pathogenesis.* Factors that have been implicated in the formation of rheumatoid nodules include trauma, vasculitis, and a specific T-cell-mediated immune reaction.
Differential Diagnosis. The principal differential diagnosis is subcutaneous granuloma annulare, which was discussed in the section on granuloma annulare. A distinction should be made from epithelioid sarcoma, which was also covered in that section. Nonabsorbable sutures or other foreign material may produce periarticular palisaded granulomas like those of rheumatoid nodule; in such instances, there should be a history of previous surgery or trauma, and birefringent material may be visible under polarized light. Rheumatic fever produces nodules (rheumatic nodules), especially over the elbows, knees, scalp, knuckles, ankles, and spine, which were confused with rheumatoid nodules in the early part of the 20th century.

Histologically, a rheumatic fever nodule is less likely to show central, homogeneous fibrinoid necrosis. A palisade of histiocytes is usually not as well developed, and fibrosis is minimal or absent. Rarely, an infectious process, such as cryptococcosis, can produce a deep, palisaded granuloma. It can be differentiated from rheumatoid nodule because the palisade surrounds primarily necrotic debris and organisms rather than fibrinoid material.