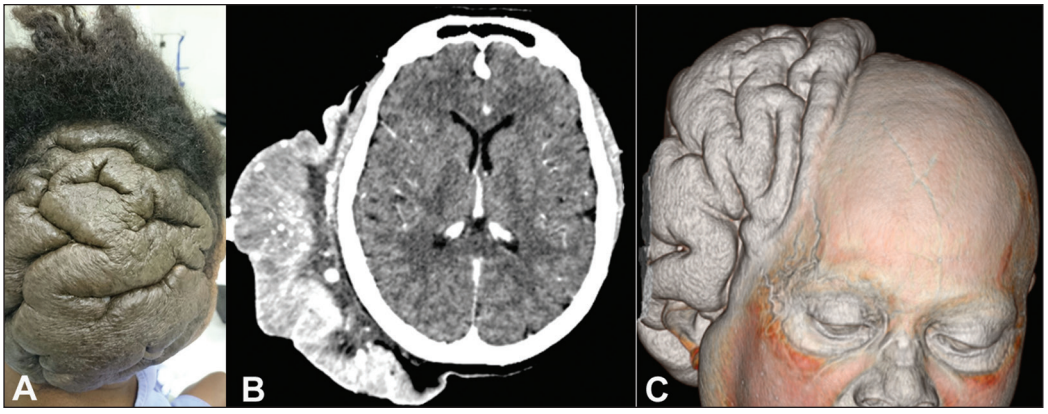

Figure 1. A: Photograph of the occipital region, showing a cerebriform cutaneous mass. **B:** Contrast-enhanced axial computed tomography of the skull, showing a lesion involving the subcutaneous tissue of the right parieto-occipital region, with no signs of communication with the brain. **C:** Three-dimensional reconstruction providing a better view of the lesion and of its relationship with the cranial vault.

view of the lesion and of its relationship with the cranial vault (Figure 1C). Collectively, those findings were consistent with a diagnosis of cutis verticis gyrata (CVG). Local scalp hygiene resulted in clinical improvement. The patient was discharged to outpatient treatment by the dermatology department of our institution.

CVG is a disease characterized by excessive growth of the skin of the scalp, resulting in the formation of sulci and gyri that resemble those of the cerebral cortex. The etiology of CVG is unknown. It is categorized as primary essential, primary non-essential, or secondary[1,2].

The primary non-essential form, which accounts for 0.5% of cases, is associated with neurological manifestations such as microcephaly, intellectual disability, cerebral palsy, and epilepsy, as well as ophthalmological manifestations such as cataracts and blindness[1,3]. The primary essential form is not associated with neurological or ophthalmological alterations, presenting only as scalp folds, which mimic the cerebral gyri, and predominantly affects men; it typically appears during or after puberty, 90% of patients being diagnosed after 30 years of age[1,3,4].

The secondary form, which can occur at any age, affects men and women with similar frequency; the clinical presentation varies depending on the underlying cause, such causes including cerebriform intradermal nevus, inflammatory dermatoses, endocrine diseases, and genetic syndromes[2,5]. Typically, the scalp folds and furrows seen in CVG show a disordered pattern, with an asymmetric distribution.

An appropriate investigation includes histopathological analysis to determine the etiology. Although the affected area is asymptomatic, there can be accumulation of secretions, causing odor and itching; therefore, good scalp hygiene is important for symptom relief. When secondary to other etiologies, CVG usually regresses after treatment of the underlying disease, although surgical excision may be necessary in this or any of the forms of presentation[1,4,6].

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Mesenteric panniculitis in a patient with rheumatoid arthritis

Dear Editor,

A 63-year-old man presented with a four-month history of intermittent pain in the upper abdomen, progressively increasing in intensity, together with asthenia, nausea, and weight loss of 10 kg. He had been under treatment for rheumatoid arthritis (with methotrexate and prednisone) for seven years. Physical examination showed pain on deep palpation, together with a partially mobile, fibroelastic mass, in the left upper quadrant of the abdomen. Laboratory tests showed no significant changes, except for a slightly elevated erythrocyte sedimentation rate. Tumor markers were within the limits of normality. Computed tomography (CT) of the abdomen showed an expansile heterogeneous mass, with predominantly fat density, encompassing lymph nodes and containing ectatic vascular structures (Figure 1). Based on the clinical reports and the CT findings, the working diagnosis was mesenteric panniculitis. We chose to test our hypothesis by adjusting the dose of prednisone. The patient progressed satisfactorily, evolving to complete resolution of the symptoms.

Mesenteric panniculitis is a rare disease of as yet unknown etiology, characterized by chronic nonspecific inflammation involving the adipose tissue of the mesentery. It is most common in men between the fifth and sixth decades of life. It has been linked to a variety of conditions, such as infections, trauma, surgery, pancreatitis, mesenteric ischemia, and autoimmune disorders[1–3]. The symptoms of mesenteric panniculitis can be progressive, intermittent, or absent. Symptomatic patients can

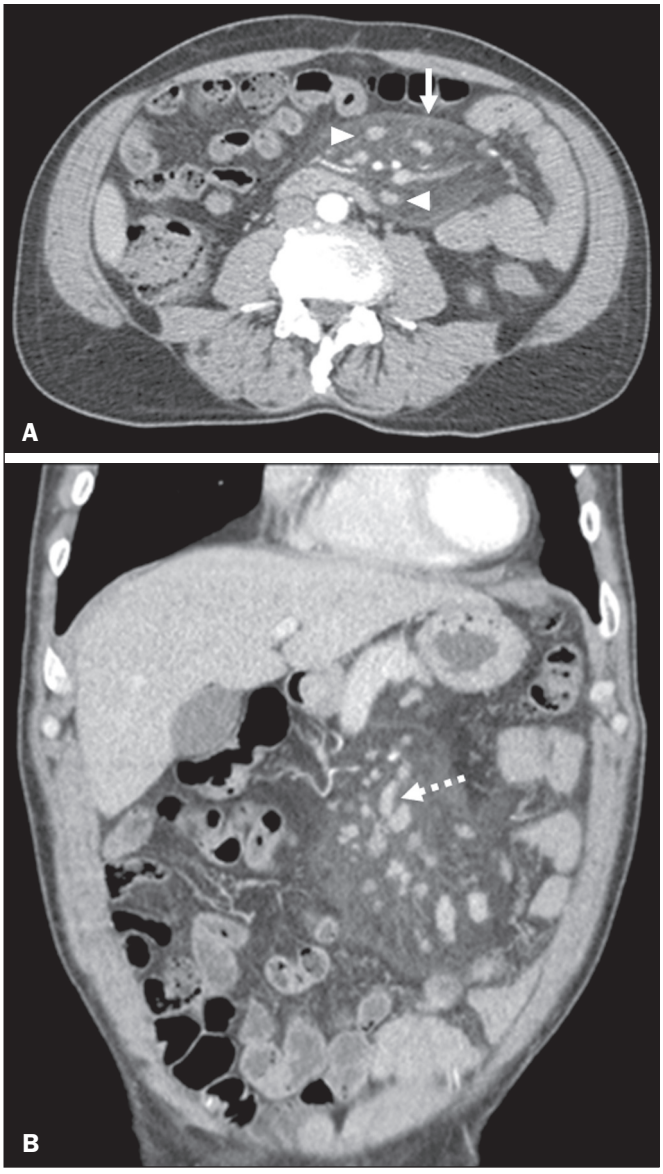

Figure 1. Axial and coronal CT (**A** and **B**, respectively) showing a heterogeneous expansile formation, with predominantly fat density, containing lymph nodes (arrowhead) and ectatic vascular structures (dotted arrow), partially delimited by a tumor pseudocapsule and extending from the root of the mesentery to the left iliac fossa.

present with a palpable abdominal mass and nonspecific systemic manifestations, including abdominal pain, loss of appetite, asthenia, weight loss, and intestinal disorders of varying duration. Laboratory test results are nonspecific, including leukocytosis, anemia, and elevation of the erythrocyte sedimentation rate[1,4,5].

In a variety of acute abdominal conditions, CT has been used as a diagnostic tool, as well as in the evaluation of treatment efficacy[5–8]. The CT findings depend on the stage of the disease and on whether the predominant component is inflammatory, fibrous, or adipose[3]. Mesenteric panniculitis usually presents as a heterogeneous mass with an adipose component, its density slightly increased by the local inflammatory process, together with linear bands of soft-tissue density (tumor pseudocapsule, detected in up to 50% of cases), as well as lymph node enlargement and mesenteric vascular ectasia[9]. Although the definitive diagnosis is established through laparoscopic biopsy[5], that is not always necessary. Recent studies have shown that mesenteric panniculitis can be diagnosed on the basis of CT characteristics[10,11].

There are as yet no treatments for mesenteric panniculitis that are considered totally efficacious[1]. The disease tends to resolve spontaneously. Pharmacological treatment is reserved for symptomatic cases and includes the use of corticosteroids, thalidomide, cyclophosphamide, progesterone, colchicine, and azathioprine. Surgical resection is limited to cases of intestinal obstruction and other complications, such as ischemia or high suspicion of malignancy[1,11].

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