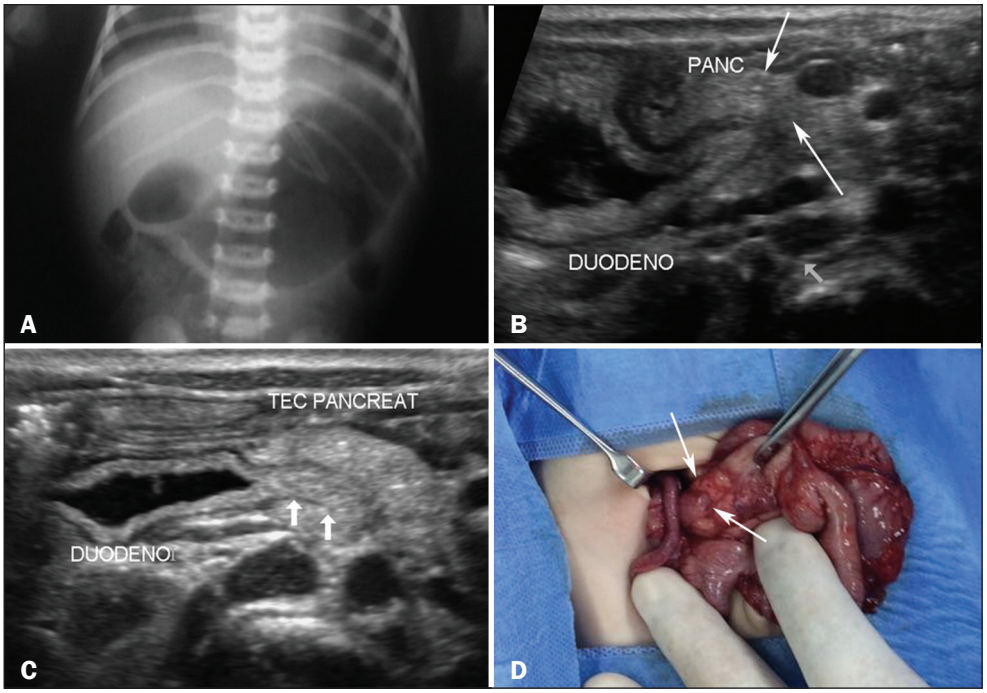

Figure 1. A: X-ray of the abdomen, showing gas distention of the stomach and duodenum, with little gas seen distally, characterizing the double-bubble sign. **B,C:** Ultrasound of the abdomen, showing pancreatic tissue (arrowheads in **B**) partially surrounding the duodenum (arrows in **C**). **D:** Photograph, obtained during laparotomy, confirming the presence of the pancreatic tissue (arrows) surrounding the duodenum.

the more caudal portion of the pancreatic head and the uncinate process, and the dorsal bud develops into the body and tail of the pancreas[6]. An annular pancreas is due to failure of the ventral bud to rotate, resulting in incarceration of the duodenum[7]. In general, an annular pancreas is symptomatic in children, especially in the neonatal period[5], the main symptoms being bilious vomiting and abdominal distention[6]. In adults, it is typically asymptomatic and is diagnosed as an incidental finding[5,8].

An abdominal X-ray of a patient with an annular pancreas will show the double-bubble sign, indicative of duodenal obstruction. Ultrasound, which is the first-line examination in the investigation of abdominal pain in children, reveals a fluid-distended duodenum and can identify the second duodenal portion incarcerated by pancreatic tissue. On computed tomography, pancreatic tissue surrounding the duodenum can also be seen[9]. In most cases, endoscopy is also performed. However, it should be borne in mind that even if the radiological and endoscopic findings both suggest an annular pancreas, the definitive diagnosis is established only during surgery. In patients with symptoms of obstruction, laparotomy can reveal a band of pancreatic tissue surrounding the second portion of the duodenum, supporting the diagnostic hypothesis, which can be confirmed by examining the resected specimen[6].

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Primary essential cutis verticis gyrata

Dear Editor,

A 53-year-old woman was admitted to the emergency room with a three-day history of self-reported fever and diffuse headache. She reported no history of surgical interventions. On physical examination, her overall health status was satisfactory. However, a cutaneous mass, rich in sulci but without secretions, was observed in the right parietal region (Figure 1A). Computed tomography of the skull showed right-sided cutaneous thickening in the parietal, temporal, and occipital regions, with diffuse microcalcifications, mimicking the appearance of cerebral gyri. The cranial vault and cerebral parenchyma were unaffected (Figure 1B). Three-dimensional reconstruction provided a better

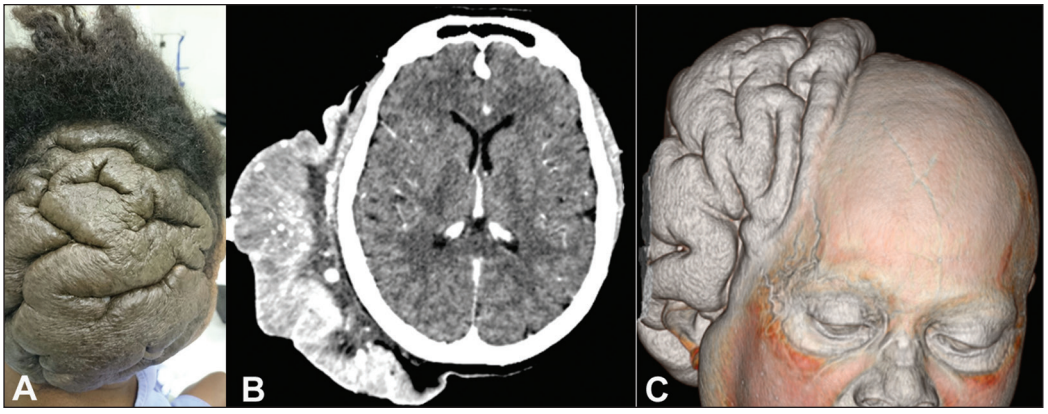

Figure 1. A: Photograph of the occipital region, showing a cerebriform cutaneous mass. **B:** Contrast-enhanced axial computed tomography of the skull, showing a lesion involving the subcutaneous tissue of the right parieto-occipital region, with no signs of communication with the brain. **C:** Three-dimensional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