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\(^1,2\). 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\(^2,3\). 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\(^1,4,6\).

REFERENCES
1. Schenato LK, Gil T, Carvalho LA, et al. Cutis verticis gyrata primária essencial. J Pediatr. 2002;78:75–80.
2. Tucci A, Pezzani L, Scuvera G, et al. Is cutis verticis gyrata-intellectual disability syndrome an underdiagnosed condition? A case report and review of 62 cases. Am J Med Genet Part A. 2016;173(A):638–46.
3. Chang GY. Cutis verticis gyrata, underrecognized neurocutaneous syndrome. Neurology. 1996;47:573–5.
4. Garden JM, Robinson JK. Essential primary cutis verticis gyrata: treatment with the scalp reduction procedure. Arch Dermatol. 1984;120:1480–3.
5. Dumas P, Chardon VM, Balague T, et al. Cutis verticis gyrata primitif essentiel: cas clinique et revue de la littérature. Ann Chir Plast Esthet. 2009;55:243–8.
6. Wália B, Bhamali Anil. Cutis verticis gyrata. BJM Case Reports. 2011;10.1136.

Isa Félix Adôrno\(^1,\) Rômulo Florêncio Tristão Santos\(^1,2,\) Thiago Franchi Nunes\(^3,4,\) Gabriel Barbosa Sandim\(^3,4,\) Edson Marchiori\(^2,5,\) 1. Universidade Federal de Mato Grosso do Sul (UFMS), Campo Grande, MS, Brazil. 2. Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil. Correspondence: Dr. Thiago Franchi Nunes. Avenida Senator Filinto Müller, 355, Vila Ipiranga, Campo Grande, MS, Brazil, 79080-190, Email: thiaogfranchinunes@gmail.com.

Received 12 November 2017. Accepted after revision 11 December 2017. http://dx.doi.org/10.1590/0100-3984.2017.0218

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
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\(^5\). 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\(^1,11\).

REFERENCES

1. Moreira LBM, Pinheiro RA, Melo ASA, et al. Panniculite mesentérica: aspectos na tomografia computadorizada. Radiol Bras. 2001;34:135–40.
2. Bush BW, Hammar SP Jr, Rudolph RH. Sclerosing mesenteritis. Response to cyclophosphamide. Arch Intern Med. 1986;146:503–5.
3. Fujiyoshi F, Ichinari N, Kajiya Y, et al. Retractile mesenteritis: small-bowel radiography, CT, and MR imaging. AJR Am J Roentgenol. 1997;169:791–3.
4. Duest AL, Freund H, Rosenmann E, et al. Mesenteric panniculitis: review of the literature and presentation of cases. Surgery. 1977;81:203–11.
5. Hemaid A, Vanegas F, Alvarez OA, et al. Mesenteric lipodystrophy with fever of unknown origin and mesenteric calcifications. South Med J. 1999;92:513–6.
6. Queiroz RM, Sampaio FDC, Marques PE, et al. Pylephlebitis and septic thrombosis of the inferior mesenteric vein secondary to diverticulitis. Radiol Bras. 2018;51:336–7.
7. Niemeyer B, Correia RS, Salata TM, et al. Subcapsular splenic hematoma and spontaneous hemoperitoneum in a cocaine user. Radiol Bras. 2017;50:136–7.
8. Naves AA, D’Ippolito G, Souza LRMF, et al. What radiologists should know about tomographic evaluation of acute diverticulitis of the colon. Radiol Bras. 2017;50:126–31.
9. Daskalogiannaki M, Voloudaki A, Prassopoulos P, et al. CT evaluation of mesenteric panniculitis: prevalence and associated diseases. AJR Am J Roentgenol. 2000;174:427–31.
10. Akram S, Pardi DS, Schaffner JA, et al. Sclerosing mesenteritis: clinical features, treatment, and outcome in ninety-two patients. Clin Gastroenterol Hepatol. 2007;5:589–96.
11. Ege G, Akman H, Cakiroglu G. Mesenteric panniculitis associated with abdominal tuberculous lymphadenitis: a case report and review of the literature. Br J Radiol. 2002;75:378–80.

Tiago Kojun Tibana\(^*\), Rúmulo Florêncio Tristão Santos\(^*\), Denise Maria Rissato Camillo\(^*\), Edson Marchiori\(^*\), Thiago Franchi Nunes\(^*\)

1. Universidade Federal de Mato Grosso do Sul (UFMS), Campo Grande, MS, Brazil.
2. Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil.

Correspondence: Dr. Tiago Kojun Tibana. Avenida Senador Filinto Müller, 355, Vila Ipiranga. Campo Grande, MS, Brazil, 79080-190. Email: tiagotibana@hotmail.com.

http://dx.doi.org/10.1590/0100-3984.2017.0209