Letters to the Editor

Elazir B. M. Di Piglia1,a, Claudia Renata R. Penna1,b, Jeferson Tobias1,c, Desirée Oliveira1,d, Edson Marchiori1,e

1. Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil.

a. https://orcid.org/0000-0003-3683-697X; b. https://orcid.org/0000-0002-9696-0449; c. https://orcid.org/0000-0001-8010-5846; d. https://orcid.org/0000-0003-0444-6539; e. https://orcid.org/0000-0001-8797-7380.

Correspondence: Dr. Edson Marchiori. Rua Thomaz Camero, 438, Valparaíso, Petrópolis, RJ, Brazil, 25685-120. Email: edmarchiori@gmail.com.

Received 22 October 2017. Accepted after revision 28 November 2017.

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).

REFERENCES
1. Miranda CLVM, Sousa CSM, Cordão NGNP, et al. Intestinal perforation: an unusual complication of barium enema. Radiol Bras. 2017;50:339–40.
2. Pessôa FMC, Bittencourt LK, Melo ASA. Ogilvie syndrome after use of vincristine: tomographic findings. Radiol Bras. 2017;50:273–4.
3. Niemeyer B, Correia RS, Salata TM, et al. Subcapsular splenic hematoma and spontaneous hemoperitoneum in a cocaine user. Radiol Bras. 2017;50:136–7.
4. 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.
5. Yigiter M, Yildiz A, Firinci B, et al. Annular pancreas in children: a decade of experience. Eurasian J Med. 2010;42:116–9.
6. Schmidt MK, Osvaldt AB, Fraga JCS, et al. Pâncreas anular – ressecção pancreática ou derivação duodenal. Rev Assoc Med Bras. 2004;50:74–8.
7. Sandrasegaran K, Patel A, Fogel EL, et al. Annular pancreas in adults. AJR Am J Roentgenol. 2009;193:455–60.
8. Türkvatan A, Erdem A, Türkoğlu MA, et al. Congenital variants and anomalies of the pancreas and pancreatic duct: imaging by magnetic resonance cholangiopancreatography and multidetector computed tomography. Korean J Radiol. 2013;14:905–13.
9. Nijs E, Callahan MJ, Taylor GA. Disorders of the pediatric pancreas: imaging features. Pediatr Radiol. 2005;35:358–73.

Elazir B. M. Di Pigliaa,b, Claudia Renata R. Pennaa,b, Jeferson Tobiasa,b, Desirée Oliveriab,c, Edson Marchioriab,c

1. Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil.

a. https://orcid.org/0000-0003-3683-697X; b. https://orcid.org/0000-0002-9696-0449; c. https://orcid.org/0000-0003-0444-6539; e. https://orcid.org/0000-0001-8797-7380.

Correspondence: Dr. Edson Marchiori. Rua Thomaz Camero, 438, Valparaíso, Petrópolis, RJ, Brazil, 25685-120. Email: edmarchiori@gmail.com.

Received 22 October 2017. Accepted after revision 28 November 2017.

http://dx.doi.org/10.1590/0100-3984.2017.0196

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

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.
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