



## Letters to the Editor

## Secondary Cutis verticis gyrata in a Patient With Tuberous Sclerosis?☆



### ¿Cutis verticis gyrata secundaria en un paciente con esclerosis tuberosa?

Dear Editor,

We have read with interest the article published by Duménigo Arias et al. about a male patient with a giant cerebriform nevus of the scalp,<sup>1</sup> and we would like to make two brief comments.

Cutis verticis gyrata (CVG) is characterized by the presence of circumvolutions and deep grooves that imitate the cerebral surface; it is more frequent in men and is classified into primary or secondary types.<sup>2</sup> The secondary type is associated with systemic diseases such as acromegaly and tuberous sclerosis, inflammatory dermatosis such as psoriasis and eczema, and numerous skin tumors like plexiform neurofibroma, hamartoma, cylindroma, dermatofibroma, collagenoma, nevus lipomatosus, sebaceous nevus and congenital melanocytic nevus.<sup>3</sup>

Cerebriform intradermal nevus predominates in females and constitutes up to 12.5% of all CVG. Normally, it is a congenital, non-hyperpigmented, alopecic lesion located in the parietal-occipital region that grows rapidly between the ages of 5 and 10.<sup>4</sup> Part of its importance lies in the potential risk for developing melanoma (4.5%).<sup>5</sup> We believe that the cerebriform clinical morphology and the case history presented are compatible with the diagnosis of nevus, but a pathology study is necessary to exclude other causes of CVG, such as hamartomas or neurofibromas.

Furthermore, in one of the images of the patient provided by the authors, several skin lesions are observed on the forehead as well as multiple lesions on the nose and nasolabial folds, suggestive of fibrous plaque and angiofibromas, respectively. These are typical manifestations of tuberous sclerosis complex (TSC), which is a cause of CVG and is related with tumors like collagenomas, another possible cause.<sup>4,6,7</sup> It should also be noted that there has been a recent report of a giant congenital nevus of the scalp in a girl with TSC.<sup>8</sup>

In conclusion, we feel it is important to complete the clinical history and the physical examination of the patient with a

histopathology study of a cerebriform scalp tumor. This would allow us to know whether the patient has TSC and confirm the nature of the lesion originating the secondary CVG, and thus increase the value of this interesting case.

#### Conflict of Interest

We have received no grant support, nor have we made previous presentations at congresses. Both authors have contributed to the authorship of this manuscript.

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Elvira León-Muiños<sup>a</sup>, Benigno Monteagudo<sup>b,\*</sup>

<sup>a</sup>Centro de Salud de San Sadurniño, Área Sanitaria de Ferrol, SERGAS, San Sadurniño, A Coruña, Spain

<sup>b</sup>Servicio de Dermatología, Complejo Hospitalario Universitario de Ferrol, Área Sanitaria de Ferrol, SERGAS, Ferrol, A Coruña, Spain

\*Corresponding author.

E-mail address: [benigno.monteagudo.sanchez@sergas.es](mailto:benigno.monteagudo.sanchez@sergas.es) (B. Monteagudo).

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## Chronic Fistula After Laparoscopic Vertical Gastrectomy<sup>☆</sup>



### Fistula crónica tras gastrectomía vertical laparoscópica

Dear Editor

We have found interesting the recent article by Ferrer Márquez, in which the authors analyzed a patient with chronic fistula after vertical gastrectomy (VG) and a serious chronic postoperative leak.<sup>1</sup> However, we would like to comment on other considerable treatment methods.

At our high-volume university bariatric center, the leak rate is 2.7% for primary VG and around 7% for corrective VG as a second procedure.<sup>2,3</sup> We have made a special effort to implement a leak treatment algorithm based on our experience of more than 1100 cases, and we believe that leak treatment should be uniform and a combination of medical, radiological, endoscopic and surgical treatments. In our experience, we have obtained a primary cure rate of more than 85% of resistant leaks after VG, and almost 100% after surgical treatment.<sup>4</sup>

As described by Eisendrath et al., we believe that conservative medical/radiological treatment with drain placement and endoscopy should be the first step in the therapeutic algorithm. This method of treatment has successfully resolved 75% of leaks in these patients (overall success rate, including all patients, was 81%).<sup>5</sup> Self-expanding stent placement is a good option for reducing the need for revision surgery and for improving patient results.<sup>6</sup> Nonetheless, we have found no efficacy in using more than 2 attempts at stent placement. As for the radiological application of percutaneous glues, we have not found them to be useful, and the leak area can become even worse with their use as it can become a fibrous tissue that is difficult to heal. Thus, we believe that our success rate is related with the Roux-en-Y loop, which provides drainage proximal to the leak and resolves the eventual distal stenosis that favors chronic leakage.<sup>7</sup>

In our opinion, many medical and surgical modalities have been described for the treatment of stenosis after VG. These

include observation, endoscopic dilation, seromyotomy and wedge resection of the stomach sleeve included in the stenosis.<sup>8</sup>

The placement of a Roux-en-Y loop above the VG defect can be useful. We believe that when a proximal leak has persisted for more than 4 months, a Roux-en-Y loop should be inserted laparoscopically above the defect.<sup>5</sup> Baltasar et al. described the technique in open surgery.<sup>9</sup> Careful, extensive dissection of the proximal stomach, hiatus and mediastinal esophagus is essential to safely debride the defect and offer tissue quality that provides safe and effective suture of the small bowel loop over the stomach.<sup>5</sup> The conversion rate reaches 11.1% in some centers.<sup>10</sup> This technique should only be done when systemic signs of infection have completely disappeared, which is generally at least 3 months after the initial process.<sup>2</sup> Likewise, we do not believe that total gastrectomies are the only or best surgical option for managing leaks, as has been reported.<sup>2</sup>

We hope that these comments provide other relevant surgical options in addition to what was mentioned in the article by Ferrer Márquez et al.<sup>1</sup>

#### Conflict of Interests

The authors have no conflict of interests.

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