

TABLE 1. Occurrence of partial biopsies according to discipline. (Values in parentheses are percentages)

	1983	1986	1988
Dermatologists	22 (45)	29 (39)	12 (18)
General surgeons	9 (4)	5 (3)	3 (1)
Plastic surgeons	0 (0)	0 (0)	0 (0)
General practitioners	2 (9)	4 (10)	1 (3)
Total	33 (10)	38 (10)	16 (4)

630 by a surgeon, 151 by a plastic surgeon, 190 by a dermatologist, and 26 by specialists in other disciplines.

General and plastic surgeons performed partial biopsies only in a small percentage of the cases (1983, 3%; 1986, 2%; 1988, 1%) whereas dermatologists performed many. Far fewer incisional and punch biopsies were performed by dermatologists in 1988 than in 1983 and 1986 (1983, 45%; 1986, 39%; 1988, 18%) (Table 1).

The number of partial biopsies dropped sharply after the consensus meeting. In both 1983 and 1986, 11 dermatologists had performed an incisional biopsy on a suspected case of melanoma; in 1988, there were only two.

The comparison between dermatologists and non-dermatologists has only a limited value because the referral pattern is different.

We conclude that the primary approach of the clinicians, especially the dermatologists, with respect to cutaneous melanoma has improved appreciably after the consensus meeting held in 1984.

## CASE REPORTS

### **Cutis verticis gyrata**

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*History.* A 25-year-old man presented with a swelling in the occipital region which he had since birth. The lesion neither itched nor bled, but was occasionally inflamed. Recently the patient had noticed bald patches developing in the affected region. There was no family history of any skin abnormalities.

*Examination.* The occipital region showed gyrus-like elevations of soft consistency. The skinfolds did not disappear when traction was applied to the surrounding healthy skin. The skin colour had not changed and there were no signs of inflammation. The growth of the hair was very thin in the affected region, especially in the grooves.

Neurological and ophthalmological examinations showed no abnormalities.



FIGURE 1. Cutis verticis gyrata.

*Histology and electron microscopy.* The epidermis was orthokeratotic and there was marked thickening of the papillary reticular dermis with cell poor and rich areas. Fairly fibroblast-rich fasciculi were shown extending in the subcutis. Electron microscopy revealed fibroblasts in the cell-rich areas and no naevus cells were seen.

*Comment.* Cutis verticis gyrata is a morphological description and not a disease entity. The lesion is mainly localized to the hairy scalp, particularly in the occipital region, and comprises skin folds and grooves resembling the gyri of the human cerebrum. The condition is usually asymptomatic but accumulation of material in the grooves may cause complaints about a foetid odour, burning sensation, pruritus or irritation. A primary and a secondary form can be distinguished. The former is often found in association with mental deficiency, epilepsy, cerebral palsy, cranial anomalies (microcephaly), ophthalmological abnormalities (cataract, strabismus) or a combination of these. As in our patient, the condition is rarely encountered in otherwise normal, healthy persons.

The secondary form results from inflammation, trauma or due to a melanocytic naevus. It is also seen in association with neurofibromata, tuberous sclerosis, acromegaly and leukaemia. There is sometimes familial occurrence of cutis verticis gyrata based on an autosomal recessive transmission. Treatment consists of surgical excision.

#### REFERENCES

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