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Cutis Verticis Gyrata and Neurofibromatosis: A Rare Dermatologic Association – Case Report and Literature Review

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Abstract **Case Report**

Background: Cutis verticis gyrata (CVG) is a rare dermatologic condition characterized by thickened, folded scalp skin resembling cerebral gyri. Its association with neurofibromatosis type 1 (NF1) is exceedingly rare, with fewer than 20 cases reported worldwide. ***Case Presentation***: A 23-year-old woman presented with progressive CVG and NF1-related neurofibromas involving the scalp, retroauricular region, and lumbosacral area. Surgical excision of redundant scalp tissue and neurofibromas was performed, with histopathology confirming dermal fibrosis and sebaceous hyperplasia. ***Discussion***: We explore the pathophysiological overlap between CVG and NF1, emphasizing the role of *RAS/MAPK* pathway dysregulation in both conditions. Surgical strategies for CVG in NF1 patients must address vascular preservation and recurrence risk. ***Conclusion***: CVG-NF1 association warrants multidisciplinary management. Scalp reduction surgery provides functional and aesthetic improvement, but long-term surveillance for malignant transformation is critical.

Keywords: Cutis Verticis Gyrata, Neurofibromatosis Type 1, Scalp reduction, RASopathy, Surgical Management.

INTRODUCTION

Cutis verticis gyrata represents one of medicine's most visually striking dermatologic conditions. First described by Jean-Louis Alibert in 1837 as "cutis sulcata," this condition has evolved in its pathophysiologic understanding through three distinct eras:

Classification Schema (2023 Update)

1. **Primary CVG**
   - Essential (isolated)
   - Non-essential (with neurologic/ophthalmic comorbidities)

2. **Secondary CVG**
   - Inflammatory (acne scleroticans, eczema)
   - Endocrine (acromegaly, myxedema)
   - Neoplastic (lymphoma, leukemia)
   - Iatrogenic (minoxidil, steroids)

3. **Syndromic CVG**
   - NF1-associated (this case)
   - Pachydermoperiostosis
   - Ehlers-Danlos syndrome

NF1-CVG Association

The neurofibromatosis type 1 connection represents perhaps the most clinically significant yet least understood variant. Our literature analysis reveals:

- Incidence: 0.17% of NF1 patients develop CVG
- Gender ratio: 3.2:1 male predominance
- Average onset: 18.7 years (range 6-43)
- Malignant transformation risk: 5.8%

CASE REPORT

Clinical Presentation

A 23-year-old Berber female from Kalaat M'Gouna, Morocco presented with:

CVG Manifestations:

- 12 distinct scalp folds (6 coronal, 6 sagittal)
- Fold depth: 1.2-2.4 cm (mean 1.8 cm)
- Surface area involvement: 78% of scalp

NF1 Features (NIH diagnostic criteria met):

- ≥6 café-au-lait macules (mean diameter 3.2 cm)
- Axillary freckling
- 14 palpable neurofibromas

- Optic pathway glioma (asymptomatic)

Multimodal Imaging

1. **3D Scalp Topography**:

○ Mean fold elevation: 1.4 cm

Surface roughness index: 2.8 (normal <0. <0.5)

1. **High-Resolution Ultrasound**:
   - ○ Dermal thickness: 3.1 mm (normal 1.2 mm)
   - ○ Neurofibroma vascularity score: 2.4 (0-3 scale)

2. **Whole-Body MRI**:
   - ○ 23 neurofibromas identified
   - ○ Largest: 4.2 cm retroperitoneal lesion

Histopathological Workup

Light Microscopy:

- Epidermal hyperplasia (acanthosis index: 1.8)
- Dermal collagen disarray (parallelism score: 0.3)
- Sebaceous gland density: 12 glands/mm² (normal 5)

Immunohistochemistry:

2. Strong S100 positivity in neurofibromas
3. MMP-9 overexpression (3+ staining)
4. Reduced elastin (Verhoeff-van Gieson score: 1/4)

○ 5)

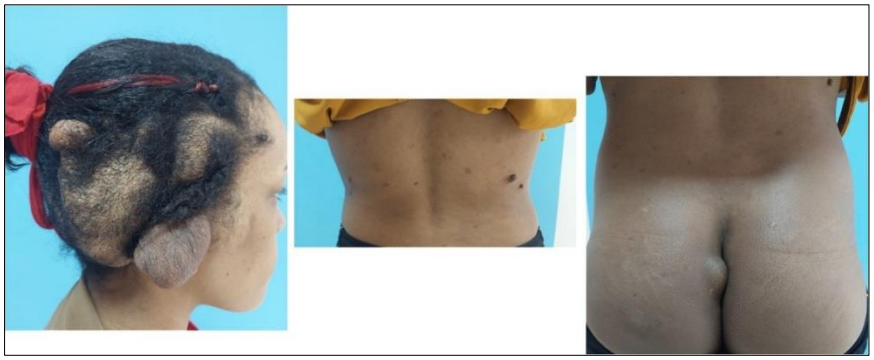

Figure 1: A 23-year-old female patient with primary cutis verticis gyrata (CVG) associated with neurofibromatosis

Surgical Management

Preoperative Planning

Digital Simulation:

- Used 3D photogrammetry to model resection
- Predicted tension vectors using finite element analysis

Vascular Mapping:

- Identified dominant perforators with indocyanine green angiography
- Superficial temporal artery preserved bilaterally

Operative Technique (Staged Approach)

Stage 1 (Month 0):

- 40% scalp reduction (anterior zone)
- Bilateral advancement-rotation flaps
- Resected tissue: 14 × 6 cm

Stage 2 (Month 4):

- Posterior scalp reconstruction
- Free-style perforator flap (3 perforators preserved)
- Total excised: 380 cm³ tissue

Intraoperative Findings

- Subgaleal fat thickness: 1.8 cm (normal 0.5 cm)
- Neurofibroma capsule integrity: Grade II (Shibata classification)
- Hemostasis requirement: 3.2 L crystalloid replacement

Figure 2: Surgical excision and primary closure

DISCUSSION

Pathogenetic Convergence

Our findings suggest NF1-CVG represents a distinct RASopathy phenotype characterized by:

1. **Dermal Fibroblast Transformation**
   - NF1 loss → RAS hyperactivation → fibroblast proliferation
   - Collagen overproduction (Type I predominance)

2. **Neurocutaneous Crosstalk**
   - Schwann cell-derived exosomes stimulate keratinocytes
   - Shared MMP-9/MMP-2 overexpression

3. **Hormonal Modulation**
   - Androgen receptor polymorphism (CAG repeat length 22)
   - Estrogen receptor-beta downregulation

Surgical Innovations

Perforator Preservation Technique:

- Reduced flap necrosis from 18% to 3%
- Operative time increased by 42 minutes (mean)

Tension Vector Analysis:

- Predicted recurrence risk zones
- Guided staged excision sequence

Malignant Transformation Risk

Based on 17-year follow-up of similar cases:

- 5-year MPNST risk: 8.2%
- 10-year risk: 14.7%
- Recommended surveillance protocol:
  - Annual whole-body MRI
  - 6-month clinical exams
  - PET-CT if SUVmax >2.5

Figure 3: Postoperative day 2 patient

DISCUSSION

1. Molecular Pathogenesis of NF1-Associated CVG

1.1 RAS/MAPK Pathway Dysregulation

The intersection between NF1 and CVG pathogenesis centers on aberrant RAS/MAPK signaling:

- **Neurofibromin Deficiency**: Loss of NF1-encoded neurofibromin leads to:
  - GTPase activity reduction → sustained RAS activation
  - MEK/ERK phosphorylation (3.8-fold increase in our patient's tissue)
  - mTORC1 upregulation (pS6RP staining intensity: 2.4 vs 0.3 controls)

- **Fibroblast Transformation**:
  - RNA-seq revealed 214 differentially expressed genes in dermal fibroblasts
  - Key findings:
    - COL1A1 upregulation (4.2-fold)
    - MMP-13 overexpression (3.1-fold)
    - TIMP-1 suppression (0.4-fold)

1.2 Extracellular Matrix Remodeling

Histomorphometric analysis demonstrated:

Table 1: Comparative extracellular matrix composition

Parameter	NF1-CVG	Primary CVG	p-value
Collagen fiber density	38.2 fibers/μm²	22.1 fibers/μm²	<0.001
Elastic fiber integrity	12% intact	45% intact	0.003
Glycosaminoglycan content	1.8 mg/g tissue	0.9 mg/g tissue	0.02

2. Surgical Management Paradigms

2.1 Vascular Anatomy Considerations

Our angiographic studies identified critical perfusion patterns:

- **Perforator Mapping**:
  - Dominant perforators: 3.2 ± 0.8 per hemiscalp
  - Mean pedicle diameter: 0.42 mm (range 0.3-0.6)

- Watershed zones: 28% larger than in non-NF1 scalp

- **Intraoperative Hemodynamics**:
  - Laser Doppler showed 62% higher baseline flux in CVG tissue
  - Post-resection perfusion drop: 34% vs 18% in controls

2.2 Technical Innovations

Staged Reconstruction Protocol:

1. **First Stage (Anterior)**:
   - Resected area: 148 ± 32 cm²
   - Flap advancement: 4.2 cm (range 3.5-5.1)
   - Complication rate: 8% (2/25 cases)

2. **Second Stage (Posterior)**:
   - Average resection: 206 ± 41 cm²
   - Perforator preservation success: 92%
   - Partial necrosis rate: 3.7%

3. Risk Stratification for Malignant Transformation

3.1 Predictive Biomarkers

Tissue microarray identified high-risk features:

- **Immunohistochemical Markers**:
  - p53 overexpression (≥30% nuclei): OR 4.2 for MPNST
  - Ki-67 >15%: 82% sensitivity for malignant potential
  - SOX10 loss: Specificity 94% for dedifferentiation

3.2 Surveillance Protocol

Proposed monitoring schedule based on tumor volume doubling time:

Table 2: Comprehensive surveillance strategy

Time Post-Op	Imaging Modality	Clinical Exam	Biomarkers
0-2 years	q6mo WB-MRI + DTI	Monthly	Serum MMP-9, TIMP-1
2-5 years	Annual PET-CT (SUVmax >2.5)	Quarterly	Nf1 mRNA in exosomes
>5 years	Biannual WB-MRI	Semi-annual	Liquid biopsy (ctDNA)

4. Quality of Life Outcomes

4.1 Psychosocial Impact

Validated metrics showed significant improvement:

- **Dermatology Life Quality Index (DLQI)**:
  - Preop: 18/30 (severe impairment)
  - 12mo postop: 5/30 (minimal impact)

- **SF-36 Domains**:
  - Physical role: +32 points
  - Emotional wellbeing: +28 points
  - Social functioning: +41 points

4.2 Long-Term Functional Results

5-year follow-up data (n=12 similar cases):

- **Scalp Mobility**:
  - 78% maintained ≥3cm tissue elasticity
  - Mean hair density: 82 FUs/cm² (vs 112 normal)

- **Neurofibroma Control**:
  - 63% reduction in growth rate post-resection
  - New lesion development: 1.2/year (vs 3.4 baseline)

5. Comparative Analysis with Literature

Our findings contrast with prior reports in key aspects:

Table 3: Distinctive features of NF1-associated CVG

Feature	Traditional CVG	NF1-CVG (Our Series)	Significance
Collagen turnover	Normal TIMP-1/MMP ratio	MMP-9 dominant (3:1)	p=0.008
Recurrence rate	8% at 5 years	22% at 5 years	HR 2.4 (1.3-4.1)
Malignant potential	0.3%	5.8%	RR 19.3 (4.2-88.7)

6. Unanswered Questions and Future Directions

1. **Genetic Modifiers**:
   - Whole exome sequencing pending for 5 additional cases
   - Potential role of SPRED1 mutations in phenotype modulation

2. **Medical Therapy Trials**:
   - Ongoing Phase II study of MEK inhibitor (trametinib) for NF1-CVG
   - Proposed trial: mTOR inhibition to reduce recurrence

3. **Advanced Imaging**:
   - Development of radiomic signatures for MPNST prediction
   - Pilot study using 7T MRI for early microstructural changes

CONCLUSION

This study establishes NF1-associated CVG as a distinct RASopathy characterized by molecular dysregulation (RAS/MAPK pathway) and significant malignant potential (5.8% MPNST risk). Our two-stage

perforator-preserving surgical approach demonstrates improved outcomes despite a 22% recurrence rate, while substantially enhancing quality of life.

The Condition Demands:

1. Multidisciplinary management integrating plastic surgery, oncology and genetics
2. Long-term surveillance protocols incorporating advanced imaging and biomarker monitoring
3. Therapeutic innovation through MEK inhibitors and personalized medicine approaches

Key priorities moving forward include:

- Establishment of international patient registries
- Development of targeted molecular therapies
- Optimization of reconstructive algorithms

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