Expert Opinion

Nummular Headache

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I initially saw the following patient and had no definite diagnosis which is not uncommon for me. I hope I am not alone. Several hours later, during lunch, I picked up a journal which had just come in the mail and turned to reference. [1] I had my diagnosis.

CLINICAL HISTORY

A 45-year-old woman presents with a 3 month history of a scalp pain. She describes a burning, stinging, itching, and sore pain of the mid-posterior frontal and anterior parietal scalp in an elliptical distribution extending across both sides with a diameter of about 5 cm. The pain is present intermittently daily lasting hours at a time with an intensity of 5/10. At times, the area is sensitive when she brushes her hair. Ibuprofen may reduce the discomfort. She has seen two dermatologists who found normal skin examinations. There is no history of migraine or other headaches. There is a past medical history of hypertension. Neurological examination was normal with no abnormality of scalp sensation.

Questions.—What is your diagnosis? Would you recommend any testing? What treatment would you recommend?

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EXPERT COMMENTARY

The patient is suffering from a chronic, fluctuating pain, confined within a small oval-shaped area of the head. These features qualify for a diagnosis of nummular headache (NH).[2-4]

NH is characterized by mild to moderate head pain exclusively felt in a rounded or elliptical area, typically 1 to 6 cm in diameter. Although any region of the head may be affected, the parietal area, particularly its most convex part (*tuber parietale*) is the common localization of NH. The symptomatic area is single and unilateral, neither changing in shape nor size with time. The pain is continous with fluctuations including lancinating exacerbations lasting from several seconds or minutes, up to a few hours. The temporal pattern is either chronic or remitting. Pseudoremissions may be observed when the pain reaches a very low grade or only discomfort in the affected area is reported. Either during symptomatic periods or interictally, the affected area may show a variable combination of hyposthesia, dysesthesia, paresthesia, or tenderness.

Nummular headache is a primary, benign disorder, but local structural lesions of the bone and scalp must be ruled out. The diagnosis work up should include a careful examination of the symptomatic area, with inspection and palpation on the skin, as well as sensory testing of the scalp. Moreover, blood work, ESR, a screening of immunological disorders, and X-ray and CT scan of the head are recommended. Nummular headache must also be distinguished from tender points of more extensive headaches. Although nummular headache may coexist with other primary headaches, it has an independent course.

Size and shape of the symptomatic area along with signs and symptoms of local sensory dysfunction suggest a neuralgia of a terminal branch of a pericranial nerve. However, several features militate against such a concept: on the one hand, anesthetic block of the symptomatic area has been performed in a few patients but it was of no avail; moreover, the particular topography observed in cases such as the one presented here—with an elliptical symptomatic area divided in half by the midline—is hardly consistent with a pericranial neuralgia. Nevertheless, it may be difficult for the patient to ascertain the topography of the symptoms when a cutaneous nerve emerging near the midline is affected.

At this stage of development, the source of NH is unclear. Therefore, we prefer to provisionally consider NH as an epicranial headache (*epicrania*). This concept[1,4,5] means that NH seems to be an "in situ" headache, the origin of the pain being within the epicranial tissues, that is, internal and external layers of the skull, and all the layers of the the scalp, including epicranial nerves and arteries.

In NH, treatment is generally needless. When necessary, most patients get relief with conventional analgesics. Some patients may need antineuralgic therapies, mostly gabapentin. In very rare instances the pain becomes annoying and refractory to the usual assortment of therapeutic alternatives generally used in other headaches, cranial neuralgias, and painful syndromes.

FOLLOW-UP

A MRI of the brain was normal. Blood work was normal including the following: an erythocyte sedimentation rate was 12 mm per hour; rheumatoid factor 11 IU per ml; ANA screen negative; serum protein electrophoresis was normal; serum immunofixation showed no monoclonal immunoglobin; Sjogren's antibodies A and B negative; Vitamin B12 level 743 pg per ml; and TSH 1.5. The patient was placed on gabapentin 100 mg po tid which she took prn with a reduction in the level of pain to a 2/10.

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