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Letters to the Editor

Primary and Secondary Stabbing Headache: A Response

We appreciate the interest taken in our expert opinion on primary and secondary stabbing headache.[1] We agree that trigger points are associated with headache and that trigger point examination is an important part of the examination. Depending upon the clinical context, the presence of trigger points alone does not exclude the need for neuroimaging as trigger points can be an epiphenomenon of secondary headache etiologies. The case descriptions represent real time, brief vignettes. The relevant elements of the examination were provided by one of us (R.W.E.) and these patients had no reproduction of their attacks by palpation.

Our collective experience in trigger points includes one of us (R.W.E.) who has performed many thousands of trigger point injections for neck pain and headache in the last 33 years and has discussed trigger points in a number of his publications, including a detailed review of its history, dating back for centuries.[2] The other of us (M.S.R.) has led an expert consensus statement on trigger point injections.[3] We agree that the relationship of myofascial pain with headache disorders is an area in need of further study.[3,4] However, we are unaware of any literature reports of an isolated stabbing headache phenotype directly attributed to a myofascial cause. In fact, in the seminal textbook regarding myofascial pain and trigger points, primary stabbing headache is not even considered among headache disorders that may feature myofacsial trigger points, and other headache disorders featuring short paroxysms are also considered unlikely to be accompanied by myofascial trigger points.[5]

The high rates of other primary headache disorders, particularly migraine, in patients with stabbing headache as well as the variable and often dynamic location of attacks are not suggestive of a myofascial etiology in most patients, though spontaneous firing of peripheral trigeminal and cervical afferents may be contributory.[6,7] We are also unaware of any evidence that a lack of indomethacin responsiveness indicates an underlying secondary headache disorder may be present. In fact, secondary causes of another indomethacin-responsive headache disorder, hemicrania continua, may respond to indomethacin robustly,[8] and at a dose of indomethacin similar to those with primary hemicrania continua.[9]

The addition of pericranial tenderness to the criteria for stabbing headache in the International Classification of Headache Disorders[10] would require peer reviewed published evidence. If trigger points are felt to be important in the pathophysiology of primary stabbing headache, or if stabbing headache is felt to be secondary to a myofascial etiology directly, Dr. Sorrell may wish to report his clinical experience or perform a prospective study.

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