disk hernia without ponytail or medullary cone involvement.

The biochemical study carried out did not reveal any alterations in thyroid hormones, vitamin B_{12}, folic acid, long-chain fatty acids or immunoelectrophoresis. The CSF analysis showed leukocytosis with a clear mononuclear predominance and mild proteinorachia. The serological studies in blood and CSF were negative for syphilis and HIV, but positive for HTLV I-II (his spouse turned out to be seronegative).

In Europe and the United States, the cases reported correspond to immigrants from endemic areas or autochthonous populations that have travelled to these regions or have had sexual relations with people of such origin.[3] In Spain to date, 7 cases of HAM/TSP have been reported; two were in immigrants from endemic areas, four were Spaniards who had lived in these areas and exact information is not available for the other case.[7-10] The method of transmission is also unknown in our patient.

In recent years, the increase in migratory flows to Europe from endemic areas may bring about an increase in the incidence of infections by the HTLV-I virus in the decades to come, as well as of the other illnesses associated with it.

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Atypical migraine progressing from nummular headache to epicrania fugax

Un caso de cefalea atípica con evolución de cefalea numular a *epicrania fugax*

Sir,

Pareja et al[1] recently reported a new headache syndrome or variant called epicrania fugax. We present here a further case of headache with similar characteristics and a peculiar evolution.

Twenty-three year old female with no prior illnesses of interest with the exception of infrequent tension headache. For the last few months, she has presented shooting pain on a specific point of her scalp of less than 1 cm in diameter and located in the left parietal area. Said pain lasted between 2 and 3 seconds, was moderate-severe in intensity, and was sometimes followed by mild pain for several hours. This occurred 3 to 4 times a day without any trigger. Neurological examination was normal, except for the presence of a hypersensitive point in the area of the pain. Haemogram showed an MCV of 77 and the magnetic resonance of the head was normal. Two months following her first visit, the characteristics of the pain were similar; however, in a new examination 5 months later, she reported changes in the previous few weeks: the pain occurred once or twice a day; it always radiated to the ipsilateral eye, occasionally accompanied by tearing and rarely radiated to the left ear. She had no symptoms between paroxysms. The remaining characteristics were similar: stabbing-type pain, moderate to severe in intensity and lasting for 2 to 3 seconds. She followed several treatments (gabapentin, tramadol, vitamin complexes, flunarizine) with no clear response to any of them (slight temporary improvement with gabapentin and flunarizine).

Our patient is a young woman who debuted with stabbing, epicranial pain lasting very few seconds, at a single point on her scalp innervated by the first trigeminal branch, moderate-severe in intensity, with no other symptoms, which occurred several times per day. Between paroxysms, she began presenting mild pain in

the symptomatic area. This onset is compatible with nummular headache: pain in a confined parietal area, with stabbing exacerbations lasting for a few seconds and, between symptomatic periods, the possibility of altered sensitivity in the area affected.[2,3] However, over time, the pain radiated to one eye, sometimes accompanied by epiphora, which meets all the characteristics of epicrania fugax, which has been described as pain in a single location that, beginning in the temporal or posterior parietal area of the scalp, may radiate to the ipsilateral orbital region and the nose, with ipsilateral autonomic symptoms in some cases. The sequence lasts for 1-10 sec with 2 attacks per month and countless attacks per day.[1] The mean age at onset is 46 years and the female to male ratio is 9:1. Nummular headache and epicrania fugax share a common physiopathological basis, since they are considered primary headache of peripheral epicranial origin.[1,3] which might account for the overlap between both entities is the case we report. The differential diagnosis of our patient's headache must also be made with the so-called ultra short-lasting headaches.[1,2,4,5] It would be related to primary stabbing headache, which affects young people, is located in the temporal-orbital region, is accompanied by stabbing pain lasting for just a few seconds and recurs at least once a day. However, it generally affects multiple locations; spreading of the pain is very rare and it is never accompanied by autonomic symptoms.[1,3,4] In our case, the pain occurred exclusively on one point of the scalp, with hypersensitivity of the area and, over time, it radiated to the ipsilateral orbital region. Although it is similar to neuralgia of the first trigeminal branch, this location is rare; it presents trigger points from the second and third trigeminal branch in areas such as the chin and nasolabial sulcus and the attack tends to be shorter.[1,4] We were unable to classify it as SUNCT, since the duration is from 5-240 sec and it is located mainly in the orbital, supraorbital, or temporal area.[3]

In short, we present a case of atypical headache that, despite the fact that it debuted with characteristics of nummular headache, might be classified as epicrania fugax[6] headache.

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