Response

Dear Editor:

In our opinion, Gallego and Aguilera have failed to correctly interpret the content of our article, in which we reported 2 cases of cardiac cephalgia. They accept that the first case fulfilled the diagnostic criteria required by the International Headache Society. We agree with them that the second case fails to comply strictly with these criteria, since no concomitant myocardial ischemia was documented. However, this does not mean that the patient did not have cardiac cephalgia. The clinical characteristics of the patient, with active ischemic heart disease and many vascular risk factors, and the characteristics of the headache were all compatible with this diagnosis. It is difficult to accept that the repeated and immediate response to the nitrates, which the patient reported spontaneously, was due to a placebo effect, as the authors state, because headache is the most common side effect of these drugs. The reason for not confirming the diagnosis was the very lack of awareness of this entity by the patient's physicians, who did not suspect the diagnosis while the patient was alive. In neurology, more specifically in the field of headaches, many diagnoses still depend on purely clinical criteria. Cardiology is a specialty that is much more advanced in the field of diagnostic confirmation by means of complementary tests. Howeres, in an elderly patient with multiple vascular risk factors with typically characteristic typical chest pain, would the authors make a clinicas diagnosis of angina even though no ECG had been done? We are sure they would. It is therefore important to remember that in many cases the clinical history itself, bearing very much in mind the particular characteristics of the patient, is still enough to give correct clinical diagnoses, as we believe was the case for our second patient and for whom the authors fail to offer an alternative diagnosis.

To conclude, as Gallego and Aguilera do that as a result of our article in which we present just two cases from two different hospitals that "cardiologists may start to receive in our offices patients with headache in order to rule out a possible ischemic heart disease and emergency departments may begin requesting electrocardiograms, enzyme determinations and cardiologic evaluations for all patients with this symptom" is unnecessarily alarmist. At no point in our manuscript do we state that this is a common entity, but rather completely the opposite. With a question mark at the end of the title, we comment on the possibility, which we feel sure is the case given the growing number of reports over the last 2 years, that the entity is underdiagnosed, as a result of lack of awareness and individualization until very recently. In the text we make it clear that "this entity should be suspected in the case of any de novo cephalgia beginning after age 50 in patients with vascular risk factors, in particular ischemic heart disease" and which responds to nitrates. Given that it is very unusual for primary headaches to start in a person above the age of 50 years, more so in a patient with atheromatosis, the authors can rest assured that by simply following the sensible recommendations of the International Headache Society, the offices of cardiologists will not become clogged by patients with headache, nor will emergency departments begin requesting complementary studies for *all* patents with headache. Ultimatery we would like to take this opportunity to remind everyone that, although cardiac cephalgia is a rare entity, its recognition is not trivial. The differential diagnosis with migraine is crucial to avoid the usual administration of vasoconstriction drugs. Once again, a correct clinical history is key to the diagnosis of these patients as, although migraine headache is very similar to that of cardiac cephalgia, migraine does not commence in persons over the age of 50 years, is exceptional in patients with atheromatosis and typically worsens with nitrates.

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