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Letter to the Editor

Consider Electromog, Stress, and Sleeping Position as Alternative Causes for Headaches Attributed to Neck-Shoulder Smartphone Clamping

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Letter to the Editor

We read with interest the article by Prakash *et al.* regarding a case series of seven patients with headaches caused by frequently wedging a smartphone between the neck and shoulder ^[1]. The headaches were unilateral, temporally associated with the habit of clamping the phone between the neck and shoulder, and non-pulsating; they lacked migrainous or autonomic features and neurological abnormalities, were accompanied by tenderness and trigger points in the neck muscles, and responded to physiotherapy and the avoidance of the clamping posture ^[1]. While the study is insightful, it warrants further discussion.

A primary point is that alternative causes for the unilateral headaches were not adequately considered or ruled out ^[2]. Excessive exposure of the head to the smartphone's strong electromagnetic field was not taken into account. Given that electromagnetic fields are suspected of triggering migraines and other types of headaches ^[3], it is conceivable that the headaches in these seven patients - who were heavy smartphone users - were actually attributable to prolonged exposure to high field strength rather than solely to head posture. Tension-type headaches resulting from excessive stress were also overlooked. Since heavy smartphone users often exhibit elevated stress levels ^[4], it would have been beneficial to include an assessment of daily stress, using a standard stress scale, in the analysis. Applying such a scale would have helped determine the extent to which chronic stress contributed to the lateralized headaches, ensuring that chronic strain was not overlooked as a potential factor in the described problem. A third alternative cause of headache that was not considered is sleeping position. How many of the studied patients slept in a prone position, requiring them to turn their heads to the right or left? Taking the sleeping position into account in the analysis is crucial, as this posture is typically maintained for a significantly longer period than the position adopted when holding a smartphone against the ear during a call.

A second point is that it is difficult to understand why the neurological examination was described as unremarkable for all seven patients, given that the clinical assessment revealed muscular tenderness and sensitivity to pressure, and headaches could be triggered by manipulating trigger points. Since a neurological examination should also encompass a clinical assessment of muscle function and condition, particularly regarding the neck muscles, the findings for the patients examined should not have been categorically classified as unremarkable.

A third point is that the exact duration of daily smartphone use was not recorded ^[1]. Assuming that the headaches experienced by the seven patients were indeed attributable to the prolonged maintenance of a static, asymmetrical posture, the intensity and nature of the headaches could depend on the exact daily duration of this posture. Was there a positive correlation between the duration of smartphone use and the intensity of the headaches?

The fourth point is that clamping the telephone handset between the shoulder and neck was already common practice in the pre-smartphone era. However, headaches attributed to this practice were not reported during that time. This suggests that factors other than head posture contributed to the development of headaches in the seven patients presented.

The fifth point is that the cervical arteries were not examined to determine the presence of stenoses, occlusions, vasculitis, or large-vessel dissections. Since neck pain can also be caused by macroangiopathy, it would have been crucial to rule out damage to the cervical arteries as well.

The sixth point concerns the discrepancy observed in patients 4, 5, and 7, who experienced nearly constant headaches ^[1]. How can it be explained that the headaches in these three patients could nonetheless be triggered?

The seventh point is that the head is tilted toward the side where the smartphone is held even when the device is simply being held in the hand. This indicates that a lateralised posture is adopted even when the device is not clamped, without necessarily resulting in headaches.

Finally, it should be noted that both the VAS and HIT-6 scales have various drawbacks that limit their informative value. Disadvantages of the HIT-6 include its subjectivity and reliance on the patient's personal perception and recall, as well as its focus on general functional impairment and frequency rather than on specific patterns of pain intensity or precise triggers. Disadvantages of the VAS include the subjective interpretation of intensity levels; the fact that it measures only pain intensity while disregarding nausea, light sensitivity, or a pulsating quality; the requirement for good vision and the ability to map abstract pain onto a physical line; and the possibility that patients might mark the absolute maximum on the line at the very onset of a severe attack, even though the pain worsens as the attack progresses.

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