Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Heart Attack?

John Cerf, DC

A nurse walked a 46-year-old male patient past the emergency department (ED) nurse's station. As they passed, I overheard the patient say he was embarrassed. He said it was his wife's idea for him to go to the hospital; his major complaint was just a feeling of anxiety in his chest. As a precaution, the nurse brought him to a room and attached the leads of the ECG to him. She hurried quickly out of the room to get the attending physician, as the man had ST elevation (as demonstrated on an ECG monitor); as it turned out, he was having an acute myocardial infarction. I guess my CPR teacher wasn't kidding when he said, "Don't write off chest pain because you think it may only be indigestion!" This observation gave me a healthy respect for chest symptoms, and increased my level of suspicion when taking a history that includes chest or cardiovascular symptoms.

On another day, while waiting to see a patient in the ED, the attending physician asked me to take a look at a 72-year-old woman. The doctor advised me that while a cardiologist had been called, he wanted me to see if there was a musculoskeletal component to her complaints that could be handled with chiropractic techniques. The woman gave me a history of sudden and severe lower back pain following bending earlier in the day. She added that her back pain was soon followed by nausea, sweating, trembling and faintness. She reported that her past medical history included "heart valve surgery and a couple of pre-strokes," and that she was taking antihypertension medications. Her lumbar radiographic examination was negative except for minor calcification of the abdominal aorta, without dilatation, and minor degenerative changes of the lumbar spine. Her electrocardiogram was within normal limits. Her laboratory findings failed to reveal any useful information. The physical examination was essentially normal, with the exception of lumbar paraspinal muscle spasm, verbalization of tenderness on palpation, and severe lumbar vertebral joint fixation on motion palpation.

My first impulse was to consider excusing myself from this case. While there was an obvious musculoskeletal component to the patient's complaints, her past cardiovascular history and current cardiovascular complaints were more urgent considerations. I left the room without offering any treatment. I wanted to discuss my thoughts with the attending physician. As I walked out of the room, I saw a cardiologist headed for the room with a serious look on his face.

I did not know this doctor, and I was concerned that he might think it odd that a chiropractor was consulting a patient whose main complaints did not seem to involve the back. I walked straight to the nurse's station, sat down, and starting working on my consultation report. After a few moments, I looked up to see the cardiologist peering down at me. I was expecting the worst when he inquired, "Well, what do you think?" I replied that due to the lack of objective findings, it appeared that she had a vasovagal reaction to the severe lower back pain. He agreed, saying, "She's all yours," and walked away.

Another attending physician called me in to see an obese 63-year-old man who had presented with chest pain. The man complained of pain in the left chest, left cervical, and left trapezius areas. He also complained of numb sensations that passed from his left upper trapezius to his left hand, with associated tingling in all of the fingers of his left hand. His history sounded much more like a heart attack than the above-described 46-year-old with "anxiety in his chest." The patient's ECG was

equivocal. His blood work showed high CPK consistent with muscle damage, possibly including heart muscle. His Troponin I, an enzyme more specific to heart muscle damage, was within normal ranges. His CPK, MB fraction, which is also more specific for heart muscle, was high. While it was unlikely that the patient was suffering a heart attack, the attending physician wanted more confirmation that the problem was of musculoskeletal origin before discharging the patient.

The patient denied any recent trauma or injury to his neck or left shoulder. He did mention that the tingling in his hand seemed to decrease when he raised his left hand over his head (positive Bakody's Sign). Left shoulder depression appeared to increase the tingling in his left hand. Palpation revealed cervical paraspinal and left upper trapezius muscle spasm. Motion palpation revealed severe vertebral joint fixation. The patient tolerated treatment with electrical muscle stimulation and supine cervical manipulation without complication. He advised that his left neck/upper trapezius/chest pain and the tingling in his left hand had decreased significantly following treatment. As there is no evidence that spinal manipulation can relieve the pain of a myocardial infarction, the attending physician considered the relief as confirmation that the pain was of musculoskeletal origin without cardiac involvement. The patient was discharged from the hospital, with instructions to follow up with the primary care physician and the chiropractor.

While I do not suspect that chiropractic will be written into the standard hospital protocols for working up chest pain, the above scenarios illustrate how a resourceful ED physician can use an "on-call" chiropractor to provide the best possible care for the patient. Using the chiropractor in the manner described above reflects well on the physician calling for the chiropractic consultation, the hospital's reputation for providing thorough service, and the chiropractic profession's reputation.

FEBRUARY 2004