A 44-year-old male cigarette smoker with an elevated serum cholesterol level and a family history of coronary artery disease experienced nocturnal chest pain. The following day he went to see a cardiologist. Five years earlier, this cardiologist had evaluated the patient for chest pain with an electrocardiogram (ECG) and blood tests and told him he was okay. The cardiologist scheduled the patient for a future stress test, but this time did not do an ECG, even at the patient’s request.

The patient had more chest pain that night and the following day went to a chiropractor who gave him an “adjustment” and recorded an ECG (Figure 1), which the chiropractor interpreted as normal. The next day the patient had worse and more prolonged chest pain and went to the hospital, where an ECG showed an acute anterolateral myocardial infarct (Figure 2). The serum creatine kinase peaked at 3148 U/L (reference, 24–200) with an MB fraction of 130.4 (reference, 0–44). The serum troponin I peaked at 41.50 ng/mL (reference, 0–0.60).

Cardiac angiography revealed marked hypokinesis of the distal one-half of the anterolateral wall of the left ventricle with an akinetic apex and a left ventricular ejection fraction of 45% (reference, ≥55%). Coronary arteriography showed a normal left main artery; subtotal occlusion of the left anterior descending artery distal to the first septal perforating branch with TIMI grade 1 flow and distal disease; 80% narrowing of the proximal portion of the right artery with a 50% narrowing in its middle portion; and only minimal irregularities in the left circumflex artery. Three days after angiography, the patient underwent a coronary arterial bypass operation with the left internal mammary artery anastomosed to the proximal portion of the left anterior descending artery, and reversed saphenous vein grafts anastomosed to the distal left anterior descending and the distal right arteries.

As described by Wellens and his associates, terminal T-wave inversion in the anterior precordial leads, as seen in Figure 1, predicts critical narrowing high in the left anterior descending coronary artery, the so-called Wellens warning.

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typical preinfarction angina was not recognized as such by the cardiologist or the chiropractor. The typical Wellens warning on the ECG was not recognized because the cardiologist did not record an ECG despite the patient’s urging, and the chiropractor did not understand the pattern. Not surprisingly, both were subsequently sued.