

AWMI WITH QRBBB

08-06-2005 04:32:35 PM COPY

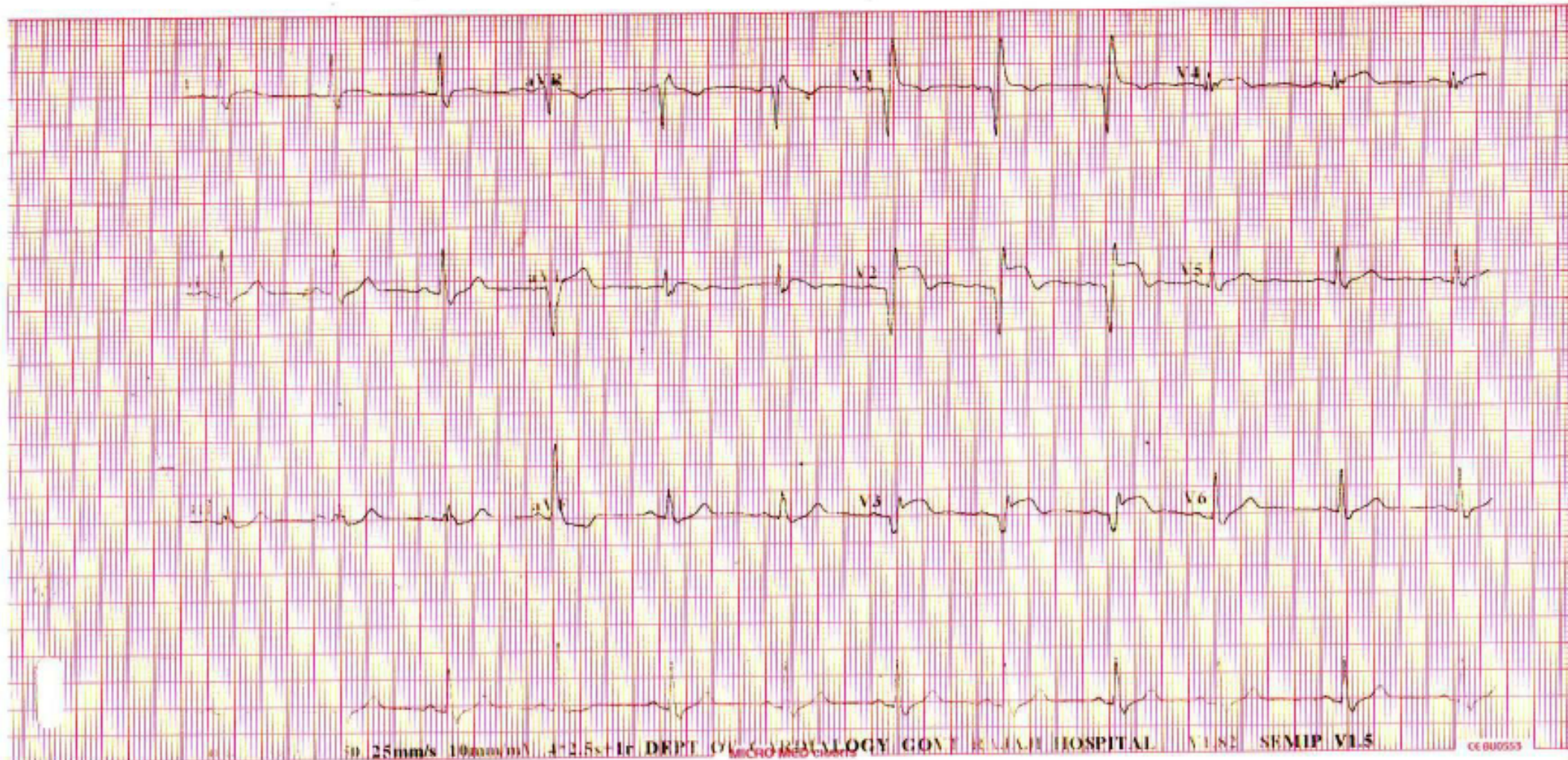
ID : 14743
Name :
Age : Years Gender : Male
Height : cm Weight : kg

HR : 70 BPM
P Dur : 115 ms
PR int : 166 ms
QRS Dur : 134 ms
QT/QTc int : 380/411 ms

RV5+SV1 amp : 1.599 mV
RV6/SV2 amp : 0.883/0.887 mV

Report continued by:

↓
↓



POST THROMBOLYSIS

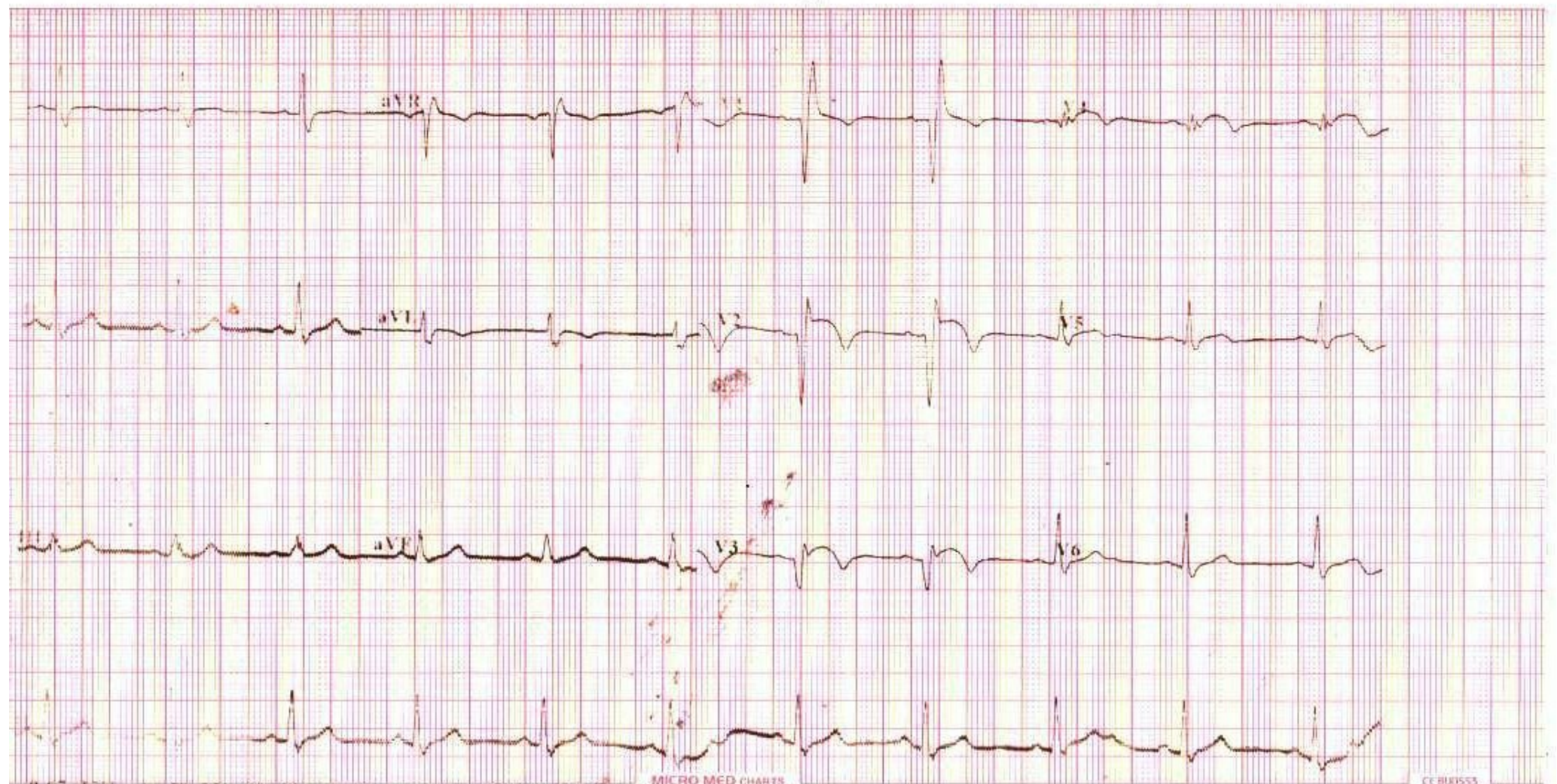
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HR : 64 BPM
 P Dur : 102 ms
 PR int : 156 ms
 QRS Dur : 128 ms
 QT/QTc int : 368/381 ms

Gender : Male
 Weight : kg

RV5+SV1 amp : 1.948 mV
 RV6/SV2 amp : 0.972/1.334 mV

Report completed by:



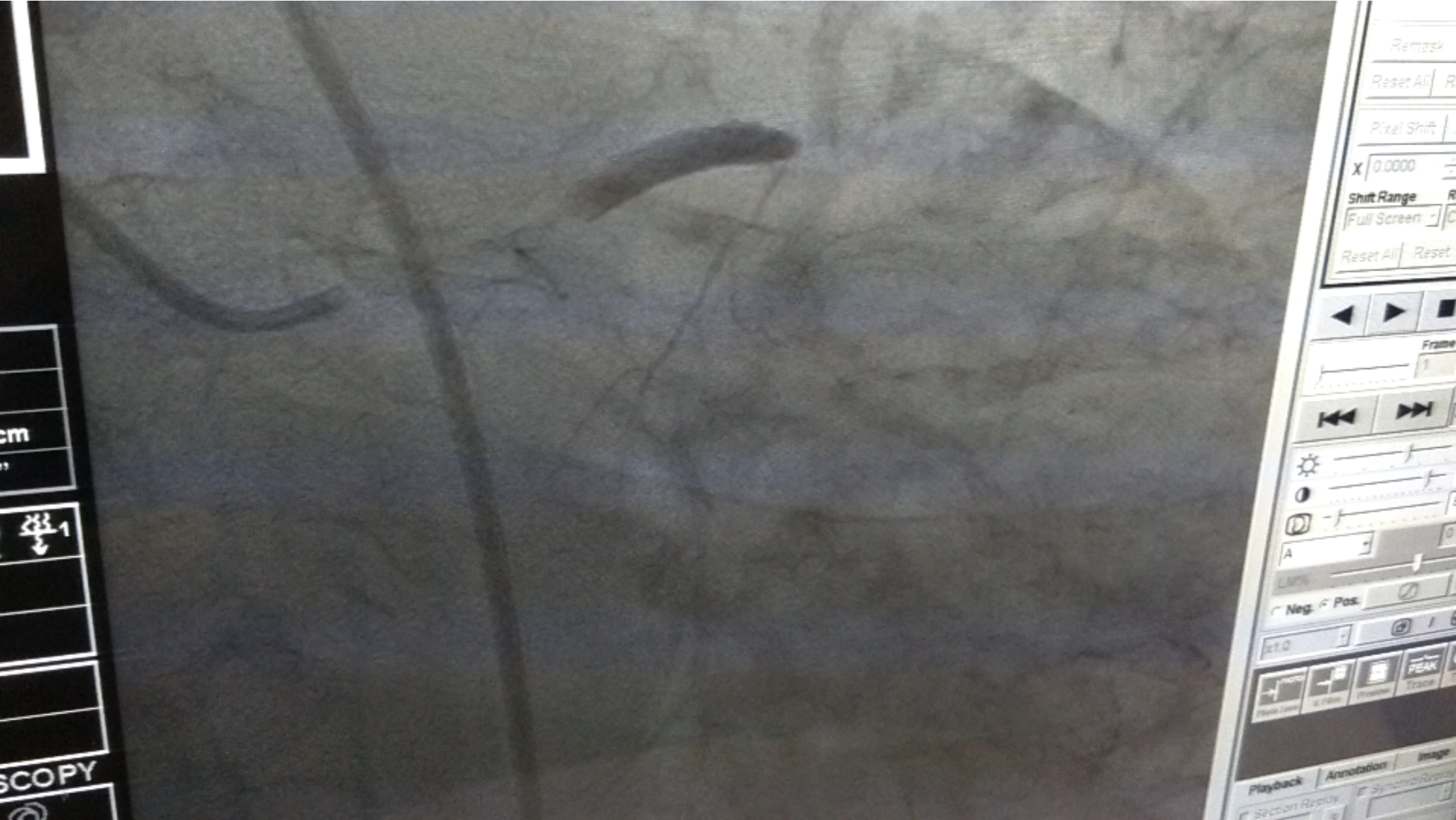




Table 1 STEMI: correlations between the ECG abnormalities, the injured myocardial

a Most prominent pattern of ST elevation in precordial leads I and aVL* (anteroseptal zone)

<i>Occluded artery</i>	<i>Injured myocardial area (see Figure 7)</i>	<i>Leads with ST changes</i>
1. LAD occlusion proximal to D ₁ and S ₁	Extensive anteroseptal zone (especially 1, 2, 7, 8, 13, 14, 16, and 17 segments)	<ul style="list-style-type: none">• ST↑ in V₁ to V₄₋₅ and aVR• ST↓ in II, III, aAVF, and often V₅₋₆
2. LAD occlusion proximal to D ₁ but distal to S ₁	Anteroseptal or extensive anterior (especially 1, 7, 13, 14, 16, and 17 segments)	<ul style="list-style-type: none">• ST↑ in V₂ to V₅₋₆, I, VL• ST ↓ in II, III, and aVF
3. LAD occlusion distal to D ₁ and S ₁	Apical (especially 13, 14, 15, 16, 17, and part of 7 and 8 segments)	<ul style="list-style-type: none">• ST↑ in V₂ to V₄₋₅• ST↑ or = in II, III, and aVF <p>If LAD is short less evident changes</p>

Table 1 (Continued)

a Most prominent pattern of ST elevation in precordial leads I and aVL* (anteroseptal zone)

<i>Occluded artery</i>	<i>Injured myocardial area (see Figure 7)</i>	<i>Leads with ST changes</i>
4. LAD occlusion proximal to S ₁ but distal to D ₁	Anteroseptal (especially 2, 8, 13, 14, 15, 16, and 17 segments)	<ul style="list-style-type: none">• ST↑ in V₁ to V₄, V₅, and aVR• ST↑ or = in II, III, and aVR• ST↓ in V₆
5. LAD subocclusion including D ₁ but not S ₁ , or selective D ₁ occlusion	Anterolateral limited (especially 7, 13, 12, and part of 1 and 16 segments)	<ul style="list-style-type: none">• ST↑ in I, aVL, and sometimes V₂–V_{5–6}• ST↓ in II, III, aVF (III > II)
6. LAD subocclusion including S ₁ but not D ₁ , or selective S ₁ occlusion	Septal (especially 2, 8, and sometimes part of 1, 3, 9, 14 segments)	<ul style="list-style-type: none">• ST↑ in V_{1–2}, aVR• ST↓ in I, II, III, aVF, V₆ (II > III)

l area, and the place of coronary occlusion.

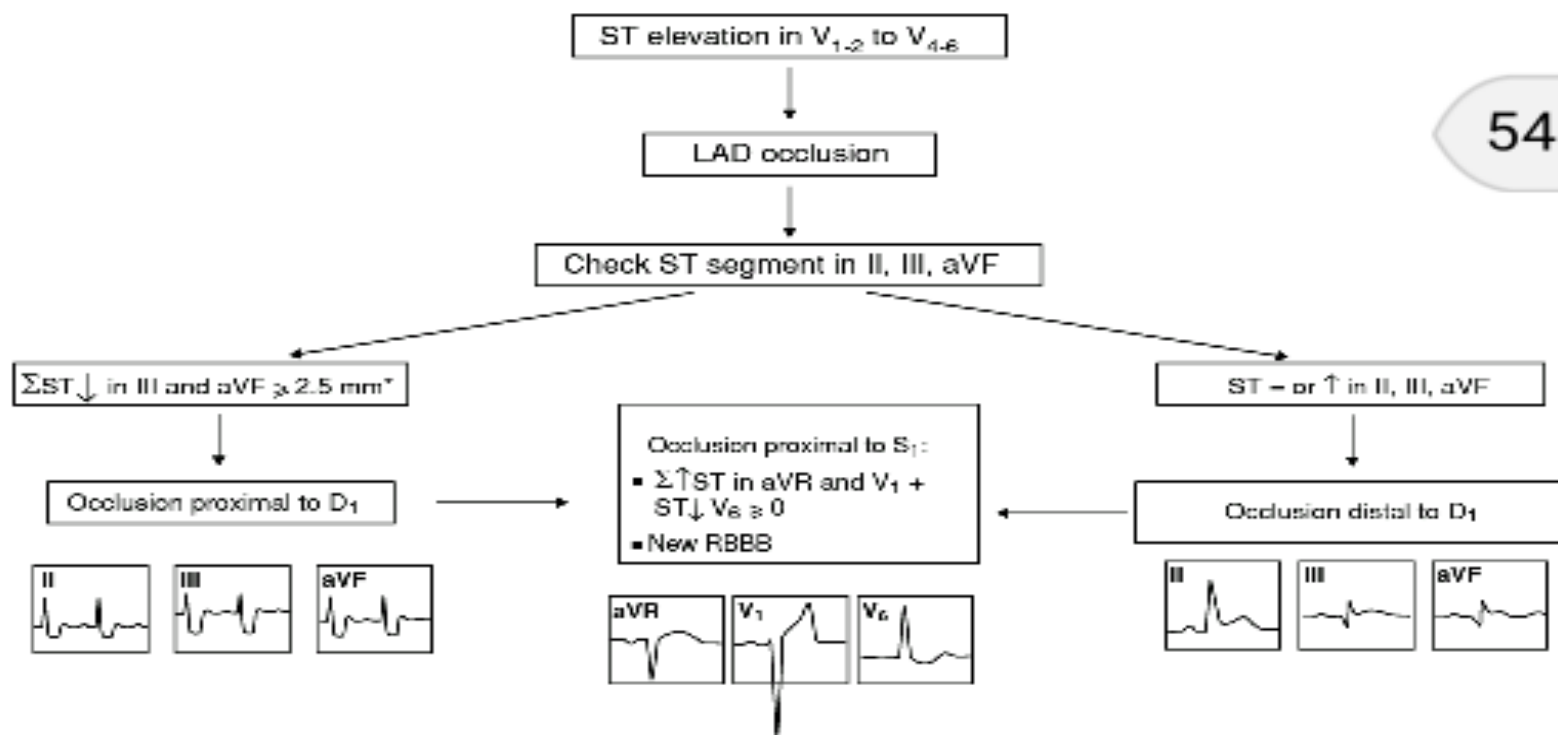
b Most prominent pattern of ST elevation in inferior and/or lateral leads[†] (inferolateral zone)

<i>Occluded artery (RCA vs LCX)</i>	<i>Injured myocardial wall (see Figure 7)</i>	<i>Leads with ST changes</i>
7. RCA occlusion proximal to the RV branches	Same as type 8 plus injury of RV	<ul style="list-style-type: none"> • ST↑ in II, III, and aVF with III > II • ST↓ in I, aVL • ST↑ in V₄R with T+ • ST isoelectric or elevated in V₁
8. RCA occlusion distal to the RV branches	Inferior wall and/or the inferior part of the septum (especially 3, 4, 9, 10, 14, and 15 segments)	<ul style="list-style-type: none"> • ST↑ in II, III, and aVF with III > II • ST↓ in I and aVL • ST↓ in V₁₋₃ but if affected zone is very small, almost no ST↓ in V₁₋₂
9. Very dominant RCA occlusion	Great part of inferolateral zone (especially 3, 4, 5, 9, 10, 11, 14, 15, 16, and 17 segments). Injury of RV if RCA is proximally occluded	<ul style="list-style-type: none"> • ST↑ in II, III, aVF with III > II • ST↓ in V₁₋₃ < ST ↑ in II, III, aVF. If the RCA is proximally occluded ST in V₁₋₃ is = or ↑ • ST↓ in I and aVL with VL > V₁ • ST ↑ in V₅₋₆ ≥ 2 mm

(Continued)

b Most prominent pattern of ST elevation in inferior and/or lateral leads[†] (inferolateral zone)

<i>Occluded artery (RCA vs LCX)</i>	<i>Injured myocardial wall (see Figure 7)</i>	<i>Leads with ST changes</i>
10. LCX occlusion proximal to first OM branches	Lateral wall and inferior wall, especially the inferobasal segment (especially 4, 5, 6, 10, 11, 12 segments)	<ul style="list-style-type: none"> • ST↓ in V₁₋₃ (mirror image) greater than ST↑ in inferior leads • ST↑ in II, III, aVF (II > III) • Usually, ST↑ in V₅₋₆ • ST↑ in I, VL (I > VL)
11. First OM occlusion	Lateral wall (especially 6, 12, and 16 segments)	<ul style="list-style-type: none"> • Often ST ↑ in I, aVL, V₅₋₆ and/or in II, III, aVF. Usually slight • Often slight ST ↓ in V₁₋₃
12. Very dominant LCX occlusion	Great part of inferolateral zone (especially 3, 4, 5, 6, 9, 10, 11, 12, 15 and 16 segments)	<ul style="list-style-type: none"> • ST ↑ in II, III, aVF (II ≥ III) often greater than ST ↓ in V₁₋₃ • The ST may be depressed in aVL but usually not in I • ST elevation in V₅₋₆ is sometimes very evident



*Cases with ST depression < 2.5 mm are difficult to classify in respect to D₁, but if $\Sigma \text{ST} \uparrow \text{aVR and } V_1 + \text{ST} \downarrow V_6 < 0$, are usually distal to S

The algorithm to localize the site of LAD occlusion in the case of STEMI with predominant ST elevation in the precordial leads (see text).

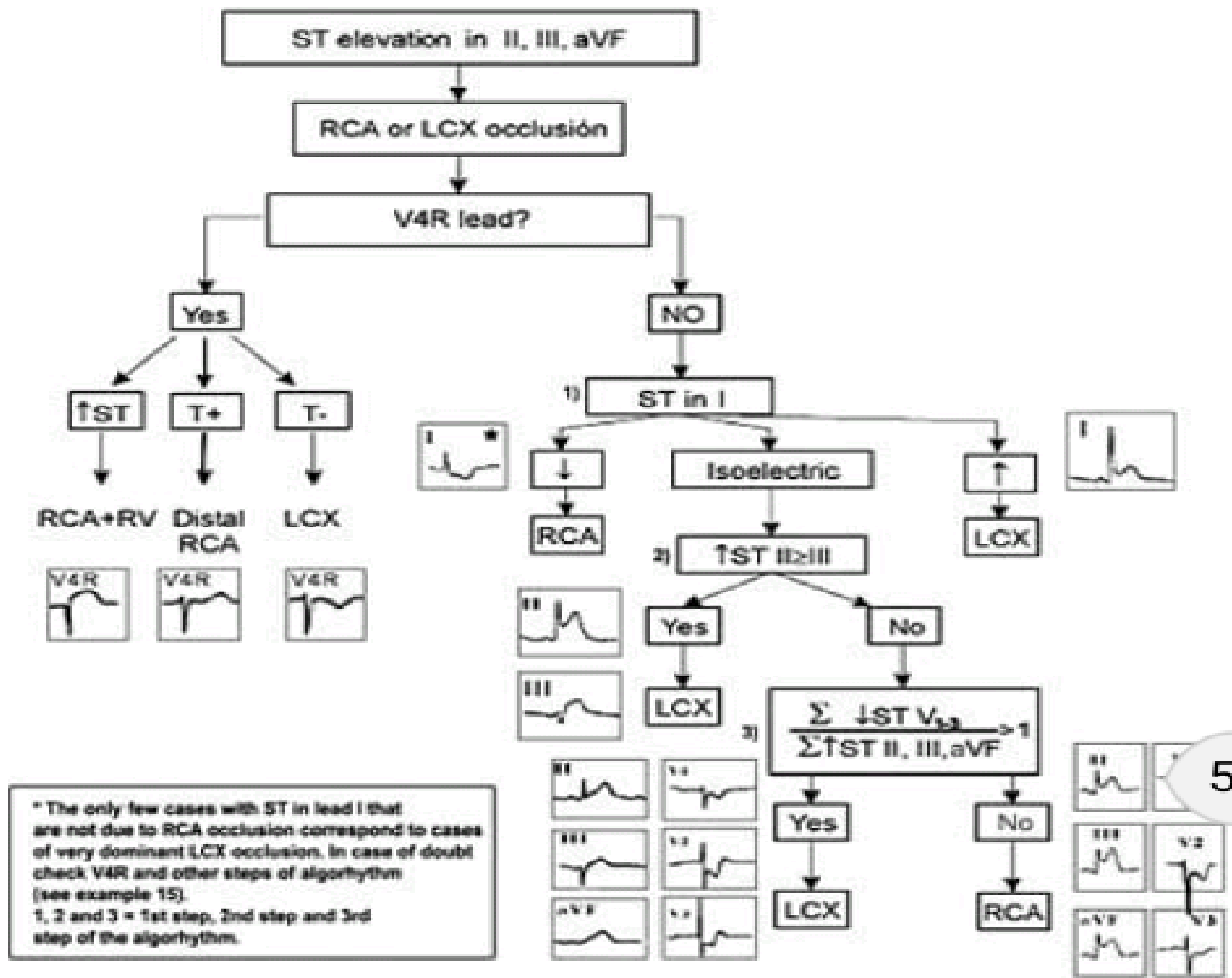


Figure 37 The algorithm to identify the occluded artery (RCA vs LCX) in the case of STEMI with ST elevation in the inferior leads (see text).