



Month September Year 2009

<b>EKG</b>	<b>#1</b>	<b>#2</b>	<b>#3</b>
<b>Clinical info.</b>	<b>45 yo F with CP radiating to left arm</b>	<b>84 yo F with history of CHF and HTN having respiratory distress</b>	<b>59 yo M with left arm and leg numbness</b>
<b>Rate</b>	<b>87</b>	<b>79</b>	<b>87</b>
<b>Rhythm</b>	<b>SR</b>	<b>SR</b>	<b>SR</b>
<b>ST Elevation?</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>
<b>Leads</b>	<b>V1-V3</b>	<b>V1-V4</b>	<b>V1-V3</b>
<b>Location (if STEMI)</b>	<b>Anteroseptal</b>	<b>Anteroseptal</b>	<b>Anteroseptal</b>
<b>Arteries (if STEMI)</b>	<b>LAD</b>	<b>LAD</b>	<b>LAD</b>
<b>Imposter(s)?</b>	<b>Yes</b>	<b>Yes</b>	<b>None</b>
<b>List imposter(s)</b>	<b>LBBB</b>	<b>LBBB</b>	
<b>Other information</b>	<p>Even without an old ECG for comparison, always be vigilant for a LBBB alone as the first sign of acute infarct. Although the ST elevations are convex, they are &gt; 2mm in 3 contiguous leads and associated with reciprocal ST depressions.</p>	<p>Note the evolving “tomb stone” appearance of the ST elevations in V1. When present, this is almost always associated with STEMI.</p>	<p>Although the ST elevations are subtle, the presence of reciprocal ST depressions are an important sign that this is the real deal.</p>