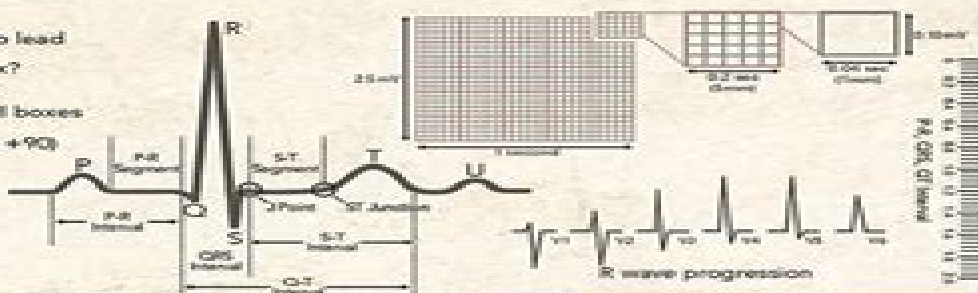


ECG INTERPRETATION GUIDE FOR PRIMARY CARE

OVERVIEW

- Rate**
 - Count large boxes within the N-N' intervals
 - Count QRS complexes in recorded 2.5 sec limb lead
- Rhythm**
 - Are P waves present before each QRS complex?
 - Are QRS complexes preceded by a P wave?
 - Do P waves appear uniform within each lead?
 - N-N' interval does not vary more than 3-4 small boxes
- Axis**
 - If I and aVF are both positive, axis is WNL (0 to +90)
- Hypertrophy**
 - Are P waves tall or wide?
 - Large R wave in V1
 - S wave in V1 + R wave in V5 or V6 > 35mm
- QRS Complexes (wide or tight)?**
 - If wide, consider bundle branch block
- Ischemia, Injury & Infarct**
 - ST elevation or depression?
 - Is R wave progression normal (V1-V6)?
 - Are T waves peaked, flattened or inverted?



- RATE**

*Normal = 60 to 100 bpm

 - Count large boxes between QRS complexes (N-N')

300	150	100	75	60	50	45	37
1	2	3	4	5	6	7	8

 - 1500 (small boxes per minute) divided by # of small boxes between N-N' interval
 - Count QRS complexes in single lead I, II, III, aVL, aVR or aVF:
2 to 4 = 60-100 bpm 4 to 5 = 100 bpm

2. RHYTHM

- Are P waves present before each QRS complex?
- Are QRS complexes preceded by a P wave?
- Is the P wave upright in I and inverted in aVR?
- N-N' interval does not vary more than 3 small boxes
- Measure PR interval N = 0.12-0.20 (3-5 small boxes)
- Measure QRS interval N = 0.06-0.10 (1.5-2.5 small boxes)
- Measure QT interval N = 0.31-0.41 (M) and 0.34-0.44 (F)
- Calculate QTc N = <0.45 (M) and <0.46 (F)

3. AXIS

*WNL = I & aVF (+), QRS (+) in I, II, III and aVF

- Look for most isoelectric ECG lead (I, II, III, aVR, aVL & aVF)
- Using the axis wheel, find the corresponding lead at a right angle to the most isoelectric lead:
 - If QRS is upright, read axis directly (towards arrow)
 - If QRS is inverted, read axis 180° away

- Right Axis Deviation (> +120) think L posterior hemiblock**
 I. QRS in lead I (-) & in aVF (+)
Left Axis Deviation (> -45) think L anterior hemiblock
 I. QRS in lead I (+) & leads II, III & aVF (-)



4. HYPERTROPHY

Right Atrial Enlargement (Mountain)

- Tall (>2.5mm), narrow P waves in leads I, II and aVF

Left Atrial Enlargement (Camel)

- Wide (>3mm) and notched P waves in one or more leads (I, II & aVL)
- Notched P wave in any lead with 2 peaks ≥0.04 seconds apart
- Negative deflection of P wave in V1 > 1mm

Right Ventricular Hypertrophy

- RAD ≥ +90° *Unless concurrent L/VH is also present
- R wave > S wave magnitude in V1 (R:S > 1 in V1) - or -
- R wave magnitude in V1 + S wave magnitude in V6 ≥ 11mm
- Deep S waves may be present in V5-V6, I & aVL
- rsR' pattern may be present in V1

Left Ventricular Hypertrophy (Sokolow-Lyon)

- S wave in V1 or V2 + R wave in V5 or V6 ≥ 35mm
- R wave in V5 or V6 ≥ 26mm
- R wave in aVL ≥ 13mm

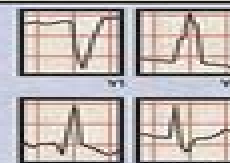
5. BUNDLE BRANCH BLOCKS

Left Bundle Branch Block

- QRS duration is >0.12 sec
- Monophasic R waves in leads I, aVL & V6
- QRS is most negative in V1-V3

Right Bundle Branch Block

- QRS duration is >0.12 sec
- rsR' pattern in V1-V2
- Broad S waves in leads I, aVL & V6
- T wave inversion in V1-V3 is secondary to conduction deficit



6. ISCHEMIA, INJURY & INFARCT

Ischemia (ST depression) or Injury (ST elevation)

- Locate nadir (bottom of S wave)
- Measure 2 small boxes over (0.08 seconds)
- Follow straight up to ST segment and compare to point on the isoelectric line. Elevation (≥1mm) or Depression (≤1mm)

T wave morphology

- T waves in same direction as R wave. If inverted rule out injury, infarct or hypertrophy
- T wave <5mm in limb leads and <10mm in precordial leads
- T wave late rise morphology

Significant Q wave (Infarct)

- >1mm wide or ≥ 1/4 of the total vertical magnitude of the QRS complex
- A QS complex is always significant except in lead aVR

Quick Guide To Community Care

M Carnoy



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