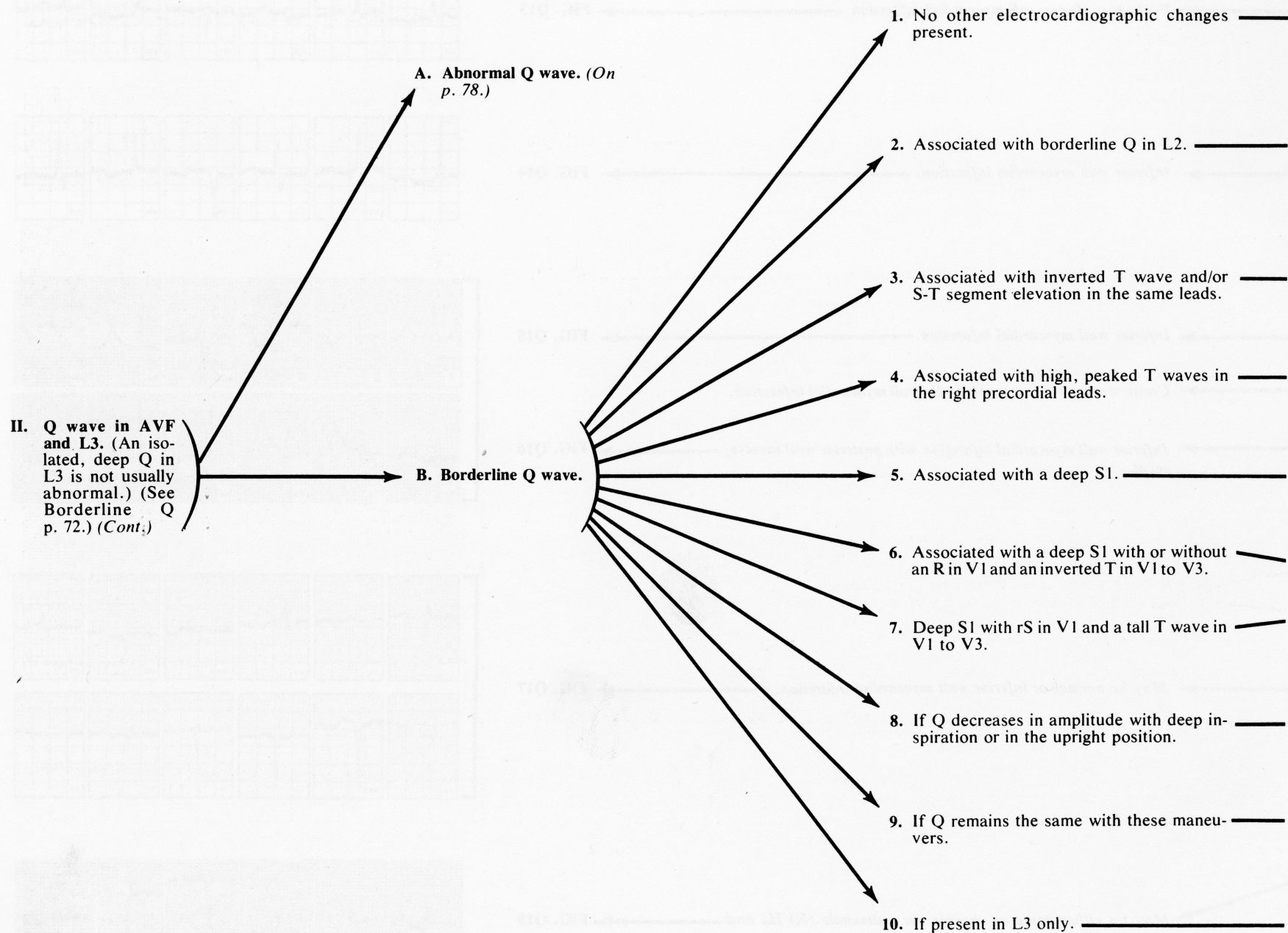




→ *Borderline electrocardiogram.* → FIG. Q19

→ *More likely abnormal and associated with an inferior wall myocardial infarction but still borderline.* → FIG. Q20

→ *Most likely inferior wall myocardial infarction.* → FIG. Q21

→ *More likely posterior wall myocardial infarction.*

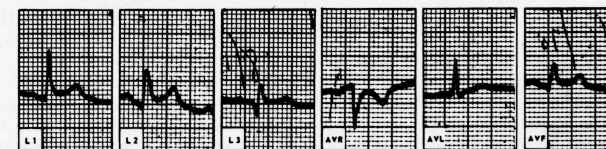
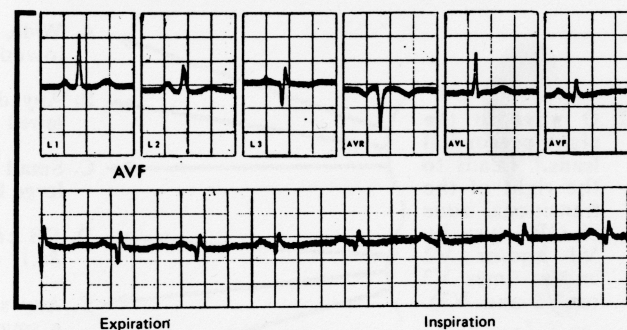
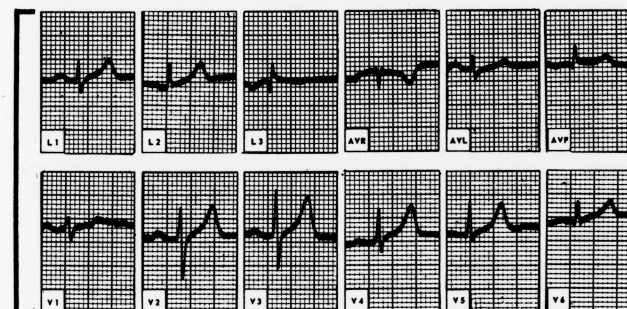
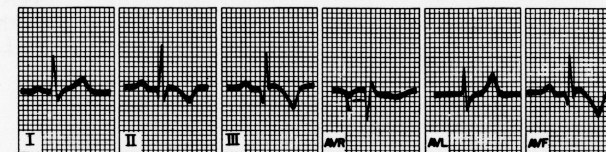
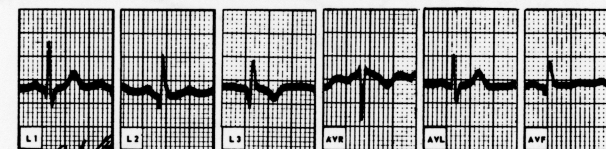
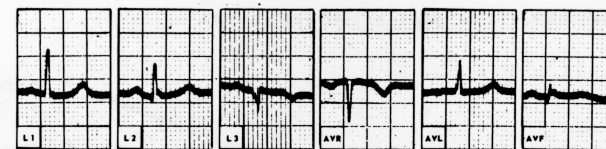
→ *Most likely normal.* → FIG. Q22

→ *(May be either acute or chronic cor pulmonale. Possible inferior wall myocardial infarction or borderline tracing.)*

→ *More likely to be normal.* → FIG. Q23

→ *Borderline electrocardiogram.*

→ *Normal.* → FIG. Q24



DIFFERENTIAL DIAGNOSIS OF Q WAVE (Cont.)

II. Q wave in AVF and L3. (An isolated, deep Q in L3 is not usually abnormal.) (See p. 72.) (Cont.)

A. Abnormal Q wave (On p. 78.)

B. Borderline Q wave. (On p. 80.)

C. QS complex in AVF. (Usually associated with a QS in L3. Rarely in L2.)

1. Associated with no other electrocardiographic changes.

2. Associated with an inverted T wave and/or S-T segment elevation in the same leads.

3. If, with deep inspiration or sitting, QS becomes Qr or QR.

4. If, with deep inspiration or sitting, QS becomes rS or R.

5. If, with deep inspiration, QS does not change.

III. Q wave in the right precordial leads.* Leads to the right of the transitional zone of QRS (usually V1 and/or V2 and at times V3 or V2 and V3).

A. Wide, deep Q wave followed by a small r.

B. Any deep Q wave followed by a large R.

C. Small q followed by a large R. (See p. 84.)

D. QS complex. (See p. 86.)

E. Any small q preceding a small r. (See p. 86.)

F. Failure of progression of r. (See p. 88.)

1. With no other associated electrocardiographic abnormality.

2. Associated with the right axis deviation in the frontal plane leads.

3. With a deeply inverted T wave with or without S-T segment elevation in the same leads.

*The Q wave in these leads can assume many different forms. The distinction between a normal, borderline and abnormal Q wave is not as clear-cut here as it is in other leads. At times these leads may have an initial positive deflection in the presence of infarction of the left ventricle. Therefore this section includes abnormalities of the QRS complex in the region where the normal evolution of r to R across the precordium does not take place.

Borderline electrocardiogram. If QS is notched or slurred this is probable but not diagnostic of inferior wall myocardial infarction.

FIG. Q25

Most likely inferior wall myocardial infarction.

Inferior wall myocardial infarction.

FIG. Q26

Probably normal.

FIG. Q27

Borderline electrocardiogram.

Usually anteroapical myocardial infarction.

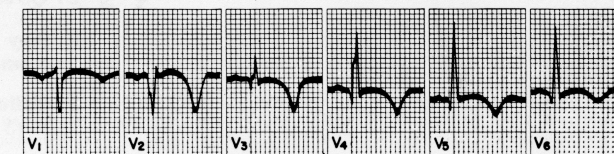
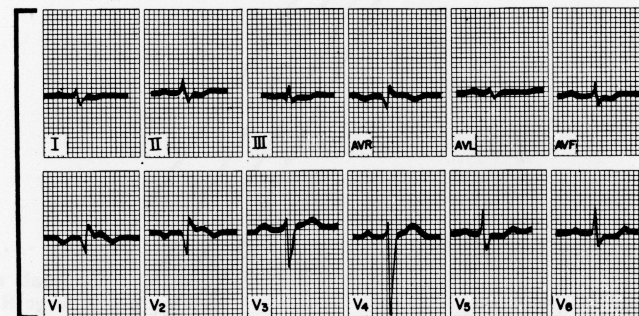
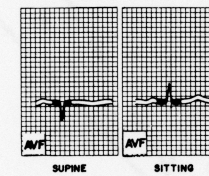
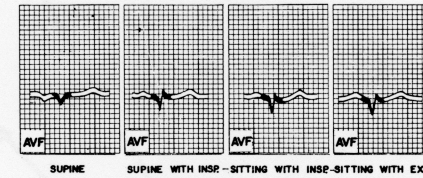
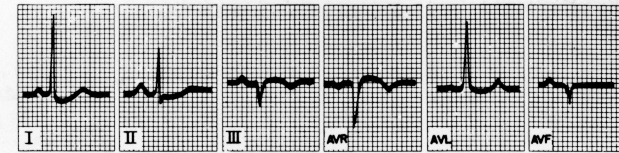
FIG. Q28

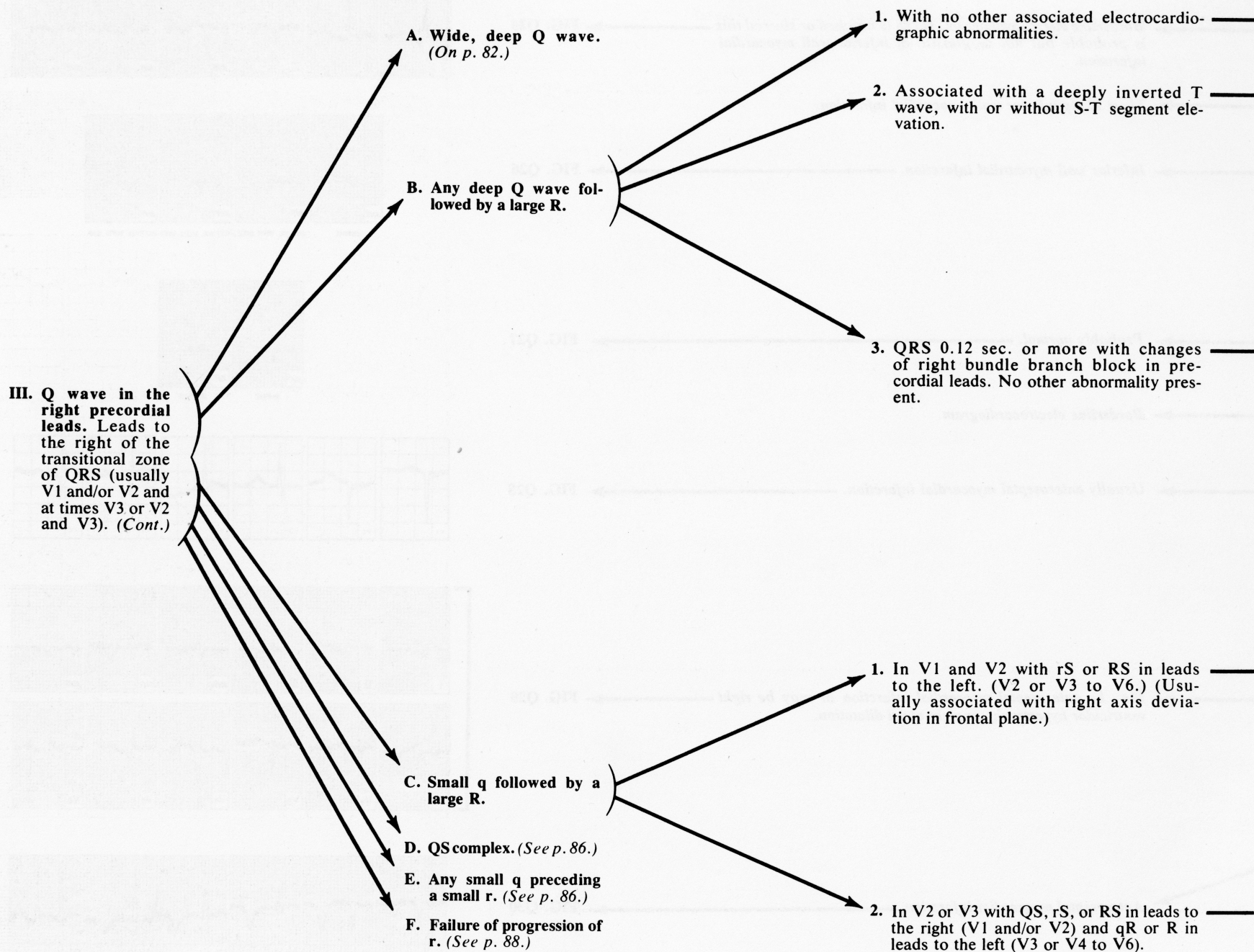
May be anteroapical myocardial infarction or may be right ventricular hypertrophy or right atrial dilatation.

FIG. Q29

Anteroapical myocardial infarction.

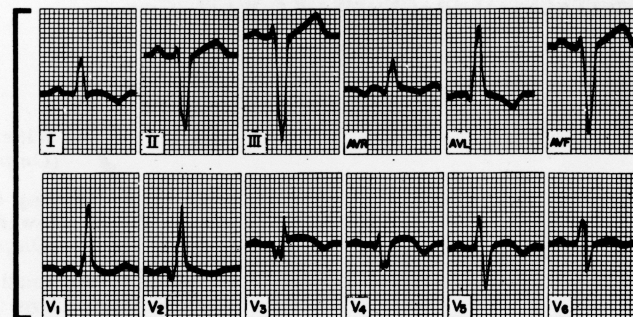
FIG. Q30



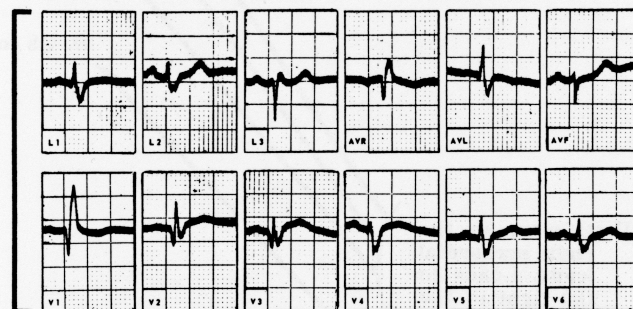


→ *Definitely abnormal electrocardiogram. Usually anteroseptal myocardial infarction.*

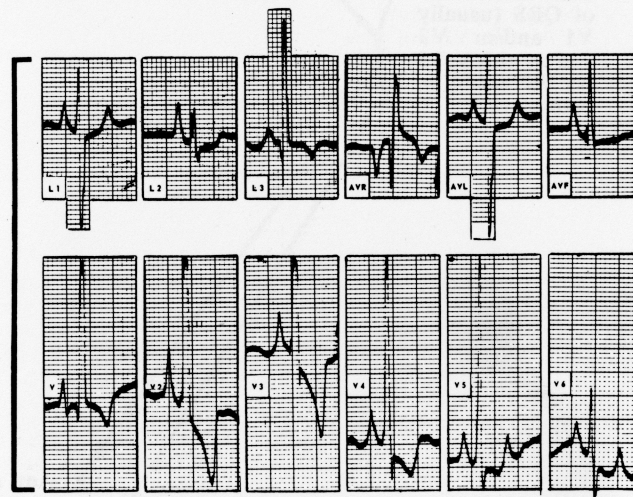
→ *Definitely anteroseptal myocardial infarction.* → FIG. Q31



→ *May be right bundle branch block alone with the initial r wave isoelectric, or may be right bundle branch block with an anteroseptal myocardial infarction.* → FIG. Q32



→ *Right ventricular hypertrophy.* → FIG. Q33



→ *Normal counterclockwise rotation of the heart.* → FIG. Q34



III. Q wave in the right precordial leads. Leads to the right of the transitional zone of QRS (usually V1 and/or V2 and at times V3 or V2 and V3). (Cont.)

A. Wide, deep Q wave.
(On p. 82.)

B. Any deep Q wave followed by a large R.
(On p. 84.)

C. Small q followed by a large R. (On p. 84).

D. QS complex.

1. With no other associated abnormal electrocardiographic findings.

2. With notching of the QS complex.

3. Associated with a deeply inverted T wave in V1, V2, and V3. With or without S-T segment elevation.

4. In V2 or V3 preceded by an rS or RS in V1 or V2.

E. Any small q preceding a small r.

F. Failure of progression of r. (See p. 88.)*

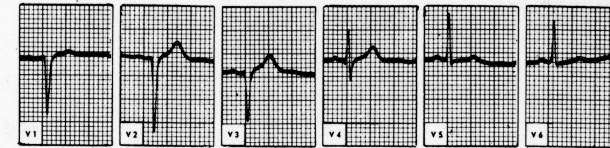
1. With no other electrocardiographic changes.

2. With inverted T wave in the same leads with or without S-T elevation.

*In the determination of abnormality of this finding, exploratory leads demonstrating an abnormal Q wave between, above, or below V1 through V4 lead positions may resolve the problem.

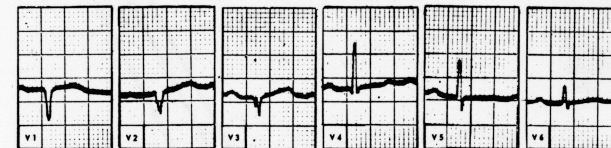
→ *Usually normal.*
Rarely evidence of an *anteroseptal myocardial infarct.*

→ FIG. Q35



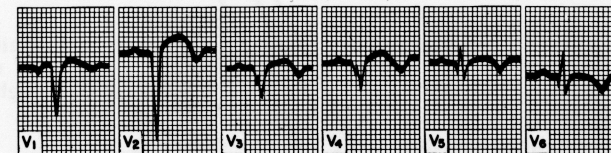
→ *Probably abnormal—anteroseptal infarct.*

→ FIG. Q36



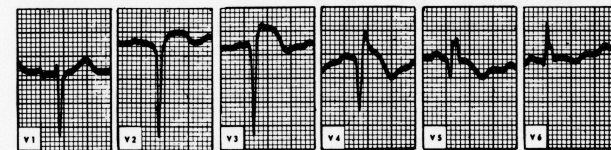
→ *Anteroseptal myocardial infarction.*

→ FIG. Q37



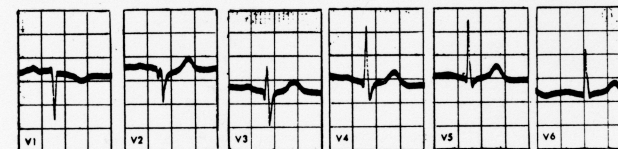
→ *Usually anteroseptal myocardial infarction.*
Further exploratory leads may be indicated to confirm this diagnosis.*

→ FIG. Q38



→ *Abnormal tracing—usually anteroseptal myocardial infarct (V3).*

→ FIG. Q39



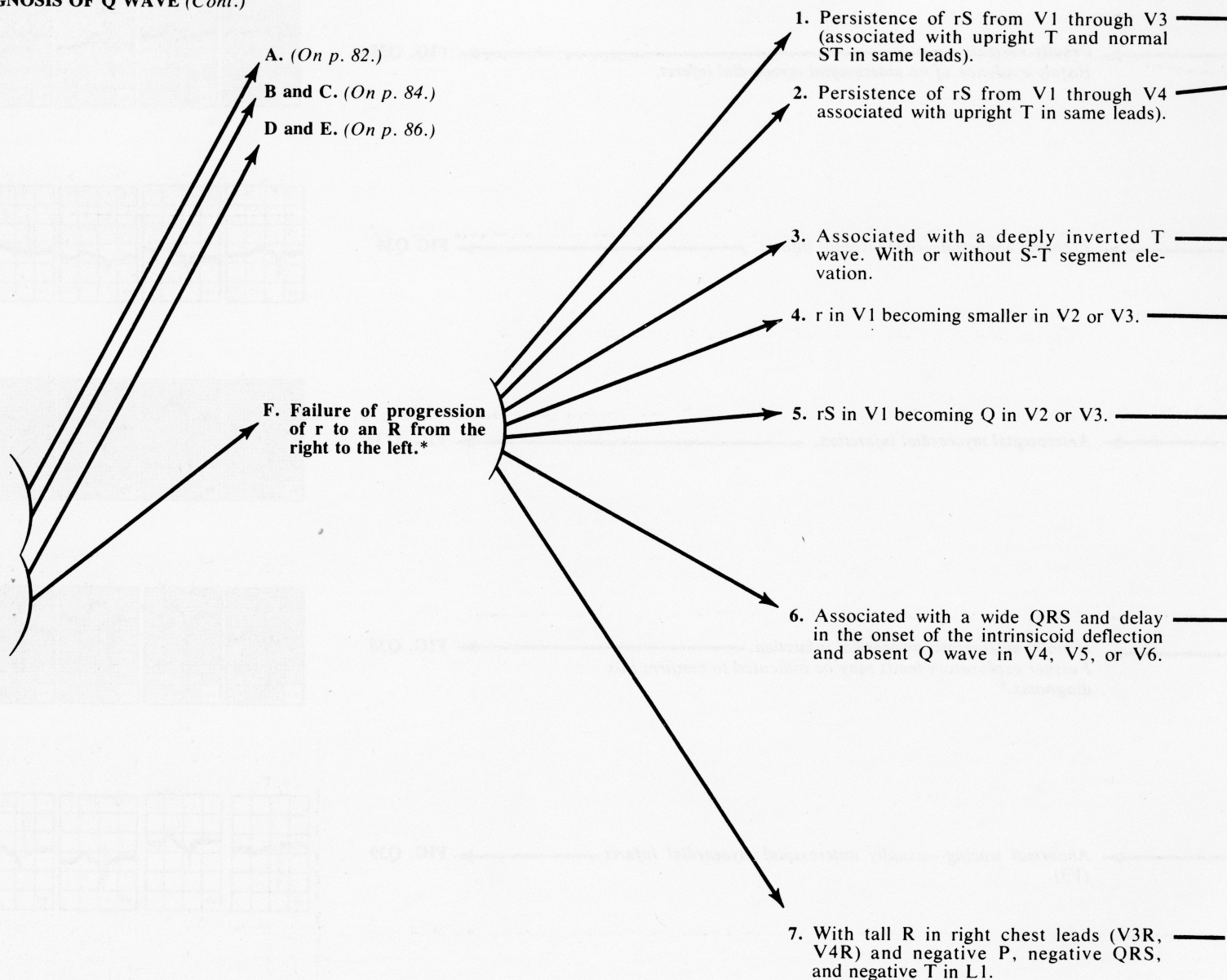
→ *Anteroseptal myocardial infarction.*

→ FIG. Q40



DIFFERENTIAL DIAGNOSIS OF Q WAVE (Cont.)

III. Q wave in the right precordial leads. Leads to the right of the transitional zone of QRS (usually V1 and/or V2 and at times V3 or V2 and V3). (Cont.)



*In the determination of abnormality of this finding, exploratory leads demonstrating an abnormal Q wave between, above or below V1 through V4 lead positions may resolve the problem.

→ Usually normal.

→ Usually normal. → FIG. Q41
Rarely anteroseptal myocardial infarction.

→ Usually anteroseptal myocardial infarction. → FIG. Q42

→ May be normal.
May be associated with anteroseptal myocardial infarction.

→ Anteroseptal myocardial infarction. (See Fig. Q30.) → FIG. Q43

→ Left bundle branch block. (Diagnosis based on left precordial leads.) → FIG. Q44

→ Dextrocardia. → FIG. Q45

