

Clinical Setting: 70 y M with VF arrest, s/p ROSC in the field. Unresponsive.

HR - 62

BP - 98/55

RR - 22

SpO2 - 98% on NRB

Temp - 96.9 F

This is a case of **Anterior STEMI**.

There is a normal rate, but undetermined rhythm - I don't see any p-waves and suspect accelerated intraventricular rhythm. There is ST elevation in V2-V4, with TWI's in I and aVL. There are not any obvious reciprocal depressions. This is consistent with an anterior STEMI. With any VF or VT arrest, you should scrutinize the ECG for signs of OMI, as these presenting rhythms increase the likelihood ratio for OMI/ACS and are more likely to benefit from emergent catheterization compared to all comers in cardiac arrest. At present, it doesn't seem like all VT/VF should be getting emergent cath, but this is still being studied.

This patient ended up having severe LAD disease, severe RCA in-stent thrombosis, and required multiple angioplasties and 2 stents. Post-cath actually had a pretty good ECHO, 55% EF, no RWMA's, though his EKG showed q-waves inferiorly and anteriorly indicating some component of transmural completed infarct.

This EKG isn't one of the more subtle ones you will see, but ECG reading is a numbers game, all about pattern recognition. The more pathology you see, the better you are!