A prominent R wave in V1 but not in V2 is a specific sign of a large lateral infarction: Algerian study

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Introduction and Objectives: In the absence of right ventricular hypertrophy or bundle-branch block, a prominent R wave in V1 or V2 is considered to reflect a lateral myocardial infarction. We investigated the differences in infarct location and size between patients with prominent R wave in V1 and those with prominent R wave in V2.

Methods: We studied 50 patients with a previous first infarction involving left ventricular inferior and/ or lateral wall at myocardial scintigraphy

Results: A prominent R wave in V1 was present in 8 patients (16%), in V2 in 23 (46%). At myocardial scintigraphy, the infarction involved the inferior wall in 11 patients (22%), the lateral wall in 6 (12%), and both walls in 33 patients (66%). The sensitivity of a prominent R wave in V1 in detecting a lateral infarction was low (17.9%), while the specificity was high (90.9%). The sensitivity and specificity of a prominent R wave in V2 were 46.2% and 54.5%, respectively. In patients with a prominent R wave in V1, infarct size and lateral extent were greater than in patients without this pattern (P<0.005 and <0.01 respectively). In patients with a prominent R wave in V2, infarct size, lateral extent were not different from patients without this pattern.

Conclusions: Only a prominent R wave in V1 is a specific sign of large lateral infarction.

Bioresorbable everolimus eluting stents in acute coronary syndromes. Preliminary implantation data and follow up of 40 patients

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Between February 2013 and October 2014, 105 patients aged 64.2 (25-94) underwent coronary artery stenting with at least one Absorb Biovascular Scaffold (BVS).

Of these procedures 40 were realized in the setting of acute coronary syndromes (15 ST elevation myocardial Infarction – STEMI – and 25 non STEMI). 42 BVS have been implanted through a radial approach on the culprit lesion under angiographic control alone. Left anterior descending artery was involved in 19, the right coronary artery in 14 and the left circumflex in 7 patients. 18 patients had multivessel disease and underwent a second staged procedure before discharge with BVS or metallic drug eluting stents implantation.

In hospital stay was event free for all 40 patients. All were discharged under conventional dual antiplatelet therapy.

Out hospital follow up (11.2 months –2-22): no clinical event occurred. One patient experienced 70% restenosis proximal to the stent and underwent new stenting with metallic drug eluting stent (TLR: 2.5%).

Conclusions: at that time our preliminary data confirm the safety at mid term of the BVS device in acute coronary syndromes.