SIGNIFICANCE OF THE "FORGOTTEN" aVR LEAD

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1) ST segment elevation in aVR suggests left coronary artery trunk obstruction (1).
2) ST segment depression in DI, DII and V4 through V6, in association with elevation in aVR, identifies patients with three-vessel or left coronary artery trunk obstruction (2).
3) ST segment depression in aVR and right precordial leads are observed in acute pericarditis. In acute pericarditis, ST segment elevation with a superior concavity is observed in several leads; mainly in precordial leads with reciprocal alterations (depression) only in aVR (3).
4) In intoxication with tricyclic antidepressants, prominent R wave is observed in aVR (4).
5) In supraventricular tachycardia with narrow QRS: ST elevation in aVR suggests Wolff-Parkinson-White syndrome (4).
6) Prominent final R wave in aVR (aVR sign) is observed in ECG type 1 pattern of Brugada syndrome (5). Prominent R wave in this lead is associated to a greater tendency to arrhythmic events (6).
7) Prominent final R wave in aVR is characteristic of ECDs, and useful for the differential diagnosis with LAFB (7).
8) Transient ST segment elevation in aVR has been described in Tako-Tsubo heart disease (8).
9) A positive T wave in aVR is an important sign of ectopic right atrial rhythm (9).
10) **The aVR lead faces the basal, infundibular, RVOT or crista supraventricularis regions. An R wave in aVR >(RV outflow tract) and a Q/R ratio in aVR≤1: Q≤than R wave constitutes a RVE criterion** (5).

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