

SIGNIFICANCE OF THE “FORGOTTEN” aVR LEAD - 2008

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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 >5 mm (RV outflow tract) and a Q/R ratio in aVR \leq 1: Q \leq than R wave constitutes a RVE criterion (5).**

References

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