

1 **ECG analysis in patients with acute coronary syndrome undergoing**
2 **invasive management: rationale and design of the electrocardiography sub-**
3 **study of the MATRIX trial**

4
5 Felice Gragnano, MD,^{a*} Vanessa Spedicato, MD,^{a*} Enrico Frigoli, MD,^b Giuseppe Gargiulo, MD,
6 PhD,^{a,c} Dario Di Maio, MD^d, Fabio Fimiani, MD,^d Vincenzo Fioretti, MD,^c Claudia Annoiato, MD,^d
7 Michele Cimmino, MD,^e Fabrizio Esposito, MD,^c Salvatore Chianese, MD,^c Martina Scalise, MD,^c
8 Luigi Fimiani, MD,^e Michele Franzese, MD,^c Emanuele Monda, MD,^d Alessandra Schiavo, MD,^d
9 Arturo Cesaro, MD,^d Alfonso De Michele, MD,^d Renato Scalise, MD,^e Alessandro Caracciolo, MD,^e
10 Giuseppe Andò, MD, PhD,^e Eugenio Stabile, MD, PhD,^c Stephan Windecker, MD, PhD,^a Paolo
11 Calabrò, MD, PhD,^d Marco Valgimigli, MD, PhD^a

12 * These authors contributed equally

13

14 ^a Swiss Cardiovascular Center, Inselspital Bern, University of Bern, Bern, Switzerland

15 ^b Clinical Trials Unit, University of Bern, Bern, Switzerland

16 ^c Division of Cardiology, Department of Advanced Biomedical Sciences, University of Naples

17 Federico II, Naples, Italy

18 ^d Division of Cardiology, A.O.R.N. "Sant'Anna e San Sebastiano", Caserta, Italy; Division of

19 Cardiology, Department of Translational Medical Sciences, University of Campania "Luigi

20 Vanvitelli", Naples, Italy

21 ^e Azienda Ospedaliera Policlinico "Gaetano Martino", University of Messina, Messina, Italy

22

23 **Short title: ECG-MATRIX sub-study**

24 **Word count (including main text, tables and figures): 5,491**

25 **Abstract word count: 237**

26

27

1 **Corresponding author:**

2 Prof. Marco Valgimigli,

3 Department of Cardiology, Bern University Hospital,

4 University of Bern,

5 Freiburgstrasse 8, 3010 Bern, Switzerland;

6 Email: marco.valgimigli@insel.ch

7 Tel. +41 31 632 21 11

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

1 **Abstract**

2 **Background.** The twelve-lead electrocardiogram (ECG) has become an essential tool for the
3 diagnosis, risk stratification, and management of patients with acute coronary syndromes (ACS).
4 However, several areas of residual controversies or gaps in evidence exist. Among them, P-wave
5 abnormalities identifying atrial ischemia/infarction are largely neglected in clinical practice, and their
6 diagnostic and prognostic implications remain elusive; the value of ECG to identify the culprit lesion
7 has been investigated, but validated criteria indicating the presence of coronary occlusion in patients
8 without ST-elevation are lacking; finally, which criteria among the multiple proposed, better define
9 pathological Q-waves or success of revascularisation deserve further investigations

10 **Methods.** The Minimizing Adverse hemorrhagic events via TRansradial access site and systemic
11 Implementation of AngioX (MATRIX) trial was designed to test the impact of bleeding avoidance
12 strategies on ischemic and bleeding outcomes across the whole spectrum of patients with ACS
13 receiving invasive management. The ECG-MATRIX is a pre-specified sub-study of the MATRIX
14 programme which aims at analyzing the clinical value of ECG metrics in 4,516 ACS patients (with
15 and without ST-segment elevation in 2,212 and 2,304 cases, respectively) with matched pre and post-
16 treatment ECGs.

17 **Conclusions.** This study represents a unique opportunity to further investigate the role of ECGs in the
18 diagnosis and risk stratification of ACS patients with or without ST-segment deviation, as well as to
19 assess whether the radial approach and bivalirudin may affect post-treatment ECG metrics and patterns
20 in a large contemporary ACS population.

21

22

23 **Keywords:** ECG, acute coronary syndromes, myocardial infarction, atrial infarction, radial access,
24 percutaneous coronary intervention

25

26

27

28

1 **Introduction**

2 The twelve-lead standard trans-thoracic electrocardiogram (ECG) remains a fundamental instrument
3 for the diagnosis, risk stratification, and treatment of patients with suspected or confirmed acute
4 coronary syndrome (ACS)[1–3]. Matched pre and post-treatment ECGs analysis provides additional
5 information on the success (or failure) of epicardial flow restoration, as well as microvascular
6 reperfusion, and risk stratification for short- and long-term outcomes[4–6]. Numerous studies have
7 investigated the diagnostic and prognostic role of ECG in patients with ACS undergoing invasive
8 management (**supplementary appendix, Table S1**)[4–12]. However, several issues remain unclear.
9 Among them, P-wave abnormalities identifying atrial ischemia/infarction are largely neglected in
10 clinical practice, as their diagnostic and prognostic implications remain elusive[13–17]. Numerous
11 studies have assessed the value of specific ECG patterns/algorithms to identify culprit lesion, but they
12 suffer from multiple limitations, and their usefulness needs to be reassessed[18–25]. Validated criteria
13 indicating the presence of coronary occlusion in patients without ST-elevation are lacking and would
14 carry major implications for practice[26–30]. Further questions regarding the impact of access site
15 and/or antithrombotic regimens on atrial and ventricular ischemia assessed by ECG analysis remain
16 poorly investigated and would deserve further attention.

17 The Minimizing Adverse Haemorrhagic Events by Transradial Access Site and Systemic
18 Implementation of Angiox (MATRIX) was a programme of three nested, randomised, multicentre
19 trials[31–34] assessing the comparative safety and effectiveness of radial versus femoral access and
20 bivalirudin versus unfractionated heparin (with optional glycoprotein IIb/IIIa inhibitors) in 8,404
21 patients with ACS (with or without ST-segment deviation) undergoing invasive management. Within
22 the programme, an electrocardiography sub-study (ECG-MATRIX) was pre-specified in the trial
23 protocol (available online at
24 https://nejm.org/doi/full/10.1056/NEJMoa1507854#article_supplementary_material)[32] and designed
25 in accordance with previously proposed criteria for conducting an ECG sub-study nested within
26 prospective trials in patients with coronary artery disease[35].

1 In this paper, we intend to highlight the remaining areas of controversies surrounding the role of the
2 ECG in the management of ACS patients coupled with the rationale for and design of the ECG-
3 MATRIX.

4

5 **Role of P-wave morphology for the diagnosis of atrial infarction and prediction of** 6 **supraventricular arrhythmias and outcomes**

7 Since its first description in 1925[36], atrial infarction remains an elusive entity and a potentially
8 unrecognized cause of atrial dysfunction and supraventricular arrhythmias[37,38]. Major concepts
9 about the clinical presentation of the disease have been previously reviewed[12,14](search strategy
10 detailed in **supplementary appendix**). Atrial infarction can occur in up to 30% of patients with
11 concomitant ventricular infarction[16,17], while it has been rarely reported as isolated
12 findings[12,39,40]. The majority of atrial infarctions occur as a consequence of atherosclerotic
13 coronary disease, as the result of occlusion of atrial coronary branches, and are either thrombotic or
14 percutaneous coronary intervention (PCI) related. As atrial branches typically arise from proximal
15 right and/or left circumflex coronary arteries, their involvement is generally associated with coronary
16 lesions jeopardizing a large ventricular mass[12,37]. Accidental atrial branch occlusion during elective
17 PCI is a neglected but relatively frequent cause of ischemic atrial damage[37], associated with peri-
18 procedural myocardial infarction (MI), atrial arrhythmias, and intra-atrial conduction delay[37].
19 Although challenging, the diagnosis of atrial ischemia/infarction can be made via the assessment of
20 suspected ECG alterations, including abnormal P-wave morphology (i.e., notched shape, 'M' or 'W'
21 pattern), prolonged P-wave duration (i.e., inter-atrial block), PR-segment deviation, or new-onset atrial
22 arrhythmias (i.e., atrial premature beats, atrial fibrillation)[12,13,15,41,42]. Moreover, the ECG
23 confers the possibility of defining atrial injury localization, showing a relatively high incidence of
24 right (81-98%) as compared to left (2-19%) or bi-atrial (19-24%) involvement[14,15]. To date, the
25 definition remains the main issue in diagnosing atrial infarction at ECG because of the lack of
26 universally accepted criteria. Burch suggested that any PR-deviation (even a fraction of a millimeter)
27 should be considered as potentially suspicious for atrial infarction, although this approach may lack
28 adequate accuracy[14,42]. The criteria currently used, were proposed by Liu et al. in 1961 and based

1 on a small case series (**Figure 1**)[13], and have never been prospectively validated in large cohorts.
2 Moreover, their usefulness in clinical practice has been recently largely questioned[16,17]. Among
3 224 ST-segment elevation myocardial infarction (STEMI) patients who underwent retrospective
4 assessment, none met the major criteria proposed by Liu. However, the presence of PR-displacement
5 in any leads was common (31% of cases) and independently predicted a 30-day, as well as 1-year
6 mortality (adjusted odds ratio 6.22; 95% confidence interval [CI] 2.33-18.64)[17]. In the setting of a
7 case-control sub-analysis of the APEX-AMI, which included 630 patients with or without new-onset
8 atrial fibrillation, the presence of abnormal P-wave morphology was significantly associated with new
9 atrial fibrillation (adjusted odds ratio, 1.68; 95% CI 1.03-2.73), and was independently associated with
10 mortality at 90-day follow-up in the overall (adjusted hazard rate, 1.90; 95% CI 1.04 to 3.46) and new-
11 onset atrial fibrillation (adjusted hazard rate, 2.43; 95% CI 1.22 to 4.84) cohorts. The current evidence
12 is mainly derived from retrospective and modestly sized STEMI studies. The evidence on patients
13 with NSTEMI-ACS remains very limited, and few studies have assessed P-wave morphology in
14 association with angiographic data in order to corroborate the occurrence of atrial infarction[12,43]. In
15 addition, none of the previous studies investigated the possible differential impact of measuring PR-
16 displacement at atrial J-point versus maximum point of deviation, the clinical meaning of PR-segment
17 slope (horizontal, slight, marked down- and up-slope), and concordance/discordance between P-wave
18 and PR-deviation polarity, or the prognostic implications of P-wave/PR-segment abnormalities
19 resolution (or persistence) after PCI. Moreover, prior studies focused on P-wave morphology either
20 mainly or exclusively in isolation from other ECG changes. Therefore, it remains unclear whether P-
21 wave/PR-segment morphology truly predicts outcomes, including mortality, independently from other
22 concomitant ECG changes and/or extent of ventricular ischemia. Finally, no study has assessed the
23 association between ECG pattern of atrial infarction and subsequent stroke risk. The **supplementary**
24 **appendix** provides detailed descriptions of how ECG metrics are centrally assessed.

25

26 **The prognostic role of Q-wave regression and the issue of a standardized definition**

27 The presence of Q-waves in patients with ACS has more than a mere descriptive or
28 electrocardiographic meaning, as it entails relevant information regarding the pathophysiology,

1 anatomy, and prognosis[44–46]. Although over the last decades, the diagnostic importance of Q-wave
2 infarction has been overshadowed by a more recent definition centered on ST-segment deviation[47],
3 this entity still to date has a remarkable value[7,48,49]. Approximately 30% of ACS patients have new
4 pathological Q-waves as marker for advanced stages in infarct evolution, more extended and less
5 reversible injury, as well as a worse prognosis[7,45,46,49–52]. A variety of definitions for
6 pathological Q-waves have been previously published (**Table 1**)[53–58]. Earlier studies defined a Q-
7 wave as *pathological* if lasting more than 40 ms with an amplitude of more than 25% of the
8 corresponding R-wave[53,54]. Over the years, the criteria for pathological Q-waves have been
9 redefined from classic[53,54] to the most recent definition reported in the 2018 Universal Definition
10 of MI[47]. The criteria for defining pathological Q-wave (or Q-wave equivalent) have been mainly
11 derived from patients without acute myocardial ischemia[59,60], thus raising potential issues
12 regarding the appropriateness of their use in ACS. Moreover, considering the relevant differences
13 among various criteria, it is not uncommon that Q-waves can be defined as pathological by some
14 definitions, but not by others. As a consequence, patients can be diagnosed as having (or not)
15 pathological Q-waves based on which definition is used. Several studies compared previously
16 published criteria to assess their diagnostic and prognostic implications[61–64]. In a large population
17 study, Q-waves classification based on the Third Universal Definition of MI did not provide
18 advantages compared to simple ≥ 40 ms Q-wave criteria with respect to predicting the risk of
19 cardiovascular death[63]. In 184 STEMI patients treated with primary PCI, Delewi et al. showed that,
20 among previously proposed Q-wave definitions, classic criteria for Q-wave had the best correlation
21 with infarct size as determined by cardiac magnetic resonance[62]. In agreement with other
22 studies[61,65], these findings suggested high specificity (due to a more strict definition) of classic
23 criteria as opposed to high false positivity of the more recently proposed criteria for detecting
24 myocardial injury. A drawback in using overly stringent (and less sensitive) criteria means risking
25 missing out on clinically relevant information; this is especially so in high-risk patients such as those
26 with ACS. To date, it is largely unclear, although potentially relevant for clinical practice, whether the
27 classic or more recent Q-wave criteria better predict clinical outcomes in ACS patients, pointing to the
28 importance of a contemporary reappraisal of this topic.

1 Another matter of controversy is whether dynamic Q-wave changes between pre and post-treatment
2 ECGs (either new development, worsening, or regression) can predict clinical outcomes[48,62,66,67].
3 Q-wave appearance can be transient and due to ischemic conduction delay in *vital* (electrically
4 inactive) myocardium rather than irreversible *necrosis*; thus, their resolution might be a marker of
5 effective myocardial salvage in patients who are readily reperfused[67–69]. On the other hand, their
6 appearance after PCI and/or persistence at discharge might imply more severe ischemic injury and
7 failed reperfusion. As compared with Q-wave persistence, Q-wave regression has been associated with
8 better myocardial recovery and larger improvement in left ventricular function at cardiac magnetic
9 resonance and perfusion SPECT, suggesting potential clinical relevance[62,70]. However, results from
10 imaging and clinical studies actually diverge. The HORIZONS-AMI, evaluating 1,084 STEMI
11 patients with Q-waves on their presenting ECG, failed to show any significant differences in terms of
12 cardiac death (5.1 vs. 9.2%; P=0.10) and all-cause death (2.9% vs. 5.6%; P=0.052), between patients
13 with resolved versus persistent Q-waves at discharge, even though the percentage of events was
14 numerically halved in the former[7]. To note in this study, the definition of pathological Q-waves was
15 based on Selvester QRS criteria[7]. Thus, the contemporary prognostic value of Q-wave development,
16 worsening, or regression after treatment, as well as their definition, remains a topic worth investigating
17 further.

18

19 **ST-deviation and resolution in STEMI and NSTEMI-ACS settings**

20 Due to its high specificity, low cost, and near-universal availability, ST-segment deviation plays a
21 central role in the management of patients with suspected ACS[71–74]. The mechanism of regional
22 ST-deviation after occlusion of a coronary artery has been widely studied and is related to regional
23 loss of function of ion channels generating electrical gradients[75]. The characteristic changes of ST-
24 segments on the standard twelve-lead ECG during ischemia and after reperfusion (either by
25 thrombolysis or PCI) have made the analysis of ST an indispensable tool, not only to diagnose ACS
26 but also to localize the occluded coronary artery, detect the site of occlusion (proximal versus distal),
27 predict outcomes, and evaluate treatment success/failure[4,23,25,76,77]. Moreover, the use of
28 additional right precordial leads (especially V4R) is of valid help in diagnosing right ventricular

1 involvement and carries relevant implications in clinical decision-making[78,79]. Since right
2 precordial leads were not recorded for the purpose of the MATRIX trial, we will investigate the
3 usefulness of standard 12-lead ECGs in identifying the site of culprit lesion in a large and
4 contemporary cohort of patients who underwent routine coronary angiography.

5 The clinical relevance of ischemic ST-segment changes has been extensively investigated in the
6 STEMI population[6,76,80–85]. The early resolution of ST-deviation (ST-segment recovery) as well
7 as post-treatment residual ST-deviation have been repeatedly shown to carry independent prognostic
8 implications after infarction, well beyond post-treatment angiographic data[6,76,80–84,86,87].

9 Whether access site and pharmacologic regimen can impact on ST-segment recovery remains unclear.
10 Radial access has been shown to reduce ischemic and bleeding events and mortality as compared to
11 femoral access[33,34,88–91]. In addition, some authors advocated increasing time to reperfusion by
12 radial access due to technical challenges and higher crossover rates, especially in the case of STEMI
13 and non-experienced operators[92,93]. Actually, no large study compared the impact of radial versus
14 femoral access on myocardial reperfusion based on ECGs analysis. Previous studies reported a
15 comparable effect of bivalirudin and unfractionated heparin plus GPI on ST-resolution and residual
16 ST-deviation after PCI[81,94,95]. However, an adequately powered comparison of bivalirudin versus
17 heparin (with or without GPI) on ECG measures of myocardial perfusion had not been previously
18 published. Moreover, no large study prospectively evaluated the possible differential impact of
19 different bivalirudin regimens (either full versus low dose or prolonged versus short-term infusion) on
20 ST-resolution. Among different studies, numerous measurement methods have been proposed, mainly
21 differing for the number of ECGs (index and post-treatment[96], or post-treatment only), number of
22 leads (all leads, selected leads according to MI location, or single worst lead), ST-deviation direction
23 (ST-elevation only, or combined ST-elevation and depression), quantification of ST-recovery (% of
24 resolution, absolute resolution, or residual ST-deviation), speed of ST-recovery, and cut-off/s
25 used[6,76,80–84,97]. In this context, comparative studies aiming at establishing the *gold standard*
26 method for calculating ST-segment resolution/persistence provided controversial results. Buller[6] and
27 Verouden[97] and colleagues came up with conflicting conclusions, reporting that residual ST-
28 elevation measured in the most affected lead on post-treatment ECG only[6] and the sum of ST-

1 deviation resolution (at a 50% cut-off) on pre and post-treatment ECG[97] were the best independent
2 predictor of mortality, respectively. Although several hypotheses have been put forth to explain
3 differences in results (i.e., timing for ECGs recording, randomized versus real-world study, statistical
4 approach), the puzzle remains unsolved. Further investigation of which ST-recovery measurement
5 methods can better predict outcomes in a contemporary setting of STEMI treated by default primary
6 PCI and potent P2Y12 inhibitors, and with limited use of GPI, is actually of critical importance.
7 Finally, whether combining additional signs of ischemia resolution (i.e., Q-wave disappearance, QRS
8 and T-peak to T-end interval narrowing) might implement the ability to predict successful reperfusion
9 and outcomes remains yet to be determined.

10 The presence of ST-depression on admission ECG among NSTEMI-ACS patients is currently used to
11 identify patients at higher risk for events, and who may benefit from an early invasive strategy[72,98–
12 100]. Data from large trials showed the relevant predictive role of ST-depression on admission for
13 death and recurrent MI[101–103], which suggested a positive correlation between the severity of ST-
14 depression and outcomes[101–103]. However, discordant data have also been reported. In the Global
15 Registry of Acute Coronary Events (GRACE) and Canadian ACS Registry registries[104,105], the
16 quantitative assessment of ST-depression failed to show an incremental predictive value for clinical
17 outcomes as compared to the simple qualitative evaluation (presence or absence) of ST-
18 depression[104,105]. Also, the value of post-treatment ST-depression resolution in patients with
19 NSTEMI-ACS remains under-investigated and less well defined by specific criteria compared with
20 STEMI[106,107], and clear cut-off value, as well as the point for the correct assessment (J-point vs. 60
21 ms after J point), remain unclear. Thus, considering current limitations, the prognostic role of ST-
22 segment deviation and resolution in the NSTEMI-ACS patients should be better clarified.

23

24 **Role of ECG in identifying culprit lesion location and patency among ACS patients**

25 Numerous ECG criteria/algorithms aimed at predicting culprit lesion location (and their potential
26 prognostic implications) have been previously published[18–22,108–111] and reviewed[4,5,112,113].
27 However, in a recent validation cohort study, their performance was poor, suggesting a lack of
28 generalizability in current practice[114]. Prior studies attempting to correlate ECG patterns with the

1 culprit lesions location entail several limitations. First, they often implemented a retrospective design
2 and the inclusion of a modest number of patients (often less than a hundred) that were additionally
3 grouped per vessel (i.e., RCA versus LCX) or site (proximal versus distal) of occlusion[4,5,18,23,25].
4 Moreover, their execution largely predated the modern primary PCI era where immediate angiography
5 provides greater reliability for culprit lesion identification[23,25]. Finally, previous analyses mainly
6 focused on selected ACS populations, such as those with single-vessel disease and inferior or anterior
7 locations, excluding those with multi-vessel disease [18–20, 23,25,108,109].
8 While most analyses focused so far on the degree of ST-deviation for the identification of culprit
9 lesion location, no large study clarified whether measuring it at the J-point or more downstream (i.e.,
10 20, 60 or 80 ms after the J-point), may impact ECG prediction compatibility[115,116]. Moreover,
11 dynamic changes in the QRS complexes, ST-segments, and T-waves often occur during culprit
12 occlusion. Whether the combination of multiple ECG parameters (i.e., QRS duration and morphology,
13 axis orientation, T-wave characteristics) in a more comprehensive ECG algorithm/score can improve
14 the reliability of currently used criteria for localizing culprit remains to be determined. Finally, no
15 prior study has assessed the capability of ECG in identifying culprit lesion patency and conversely its
16 role on ECG alterations and outcomes in STEMI patients.

17

18 **Total occlusion of the culprit artery in NSTEMI-ACS**

19 The presence of a total occlusion of culprit coronary artery is usually associated with ST-elevation on
20 ECG in ACS patients, and requires immediate coronary angiography and revascularization. However,
21 a considerable proportion of acute coronary occlusion may be missed if the ECG is assessed only for
22 ST-elevation in contiguous leads, fulfilling diagnostic criteria for STEMI[26,28,117–119]. Indeed, a
23 subset of NSTEMI-ACS patients (approximating at ¼ of cases) presents a total culprit vessel occlusion
24 (Thrombolysis in Myocardial Infarction [TIMI] flow grade 0/1) at coronary angiography, without any
25 evidence of classic STEMI pattern[26–28,120–122]. In more than 70% of these cases, either the right
26 coronary or left circumflex artery are involved, with a predominant infero-lateral and posterior infarct
27 distribution[26–28,121]. As proof of concept, occlusion of the left circumflex is underreported in
28 studies recruiting STEMI (only 15% of cases)[26], a possible consequence of the silent nature of

1 perfused territory on standard twelve-lead ECG[26,27]. These patients with ‘missed STEMI’ and total
2 occlusion of the culprit artery almost systematically received delayed invasive treatment, being
3 referred to the catheterization laboratory 24-48 hours after initial presentation[26–28,123]. This point
4 poses relevant concerns due to the established detrimental impact of culprit occlusion on outcomes and
5 potential benefit from earlier reperfusion. The TRITON–TIMI 38 (Trial to Assess Improvement in
6 Therapeutic Outcomes by Optimizing Platelet Inhibition with Prasugrel-Thrombolysis In Myocardial
7 Infarction 38) enrolled 13,608 ACS patients, of whom 1,198 or 8.8% presented with anterior ST-
8 depression[27]. Of those, 314 or 26.2% had an occluded culprit at coronary angiography (performed at
9 a median time from ECG of 29.4 h), with a left circumflex involvement in half of the cases. At 30-day
10 follow-up, the rate of death and MI was significantly higher among patients with an occluded artery as
11 compared with those with a patent culprit artery, suggesting the relevant prognostic value of this factor
12 and the inadequate management of these patients[27]. Confirming these data, a recent meta-analysis of
13 40,777 subjects estimated that NSTEMI-ACS patients with total occlusion of culprit artery are at a higher
14 risk of both major adverse cardiac events and all-cause mortality at short (risk ratio [RR] 1.41; CI
15 1.17-1.70; P = 0.0003 and RR 1.67; CI 1.31-2.13; P < 0.0001, respectively) and long-term (RR 1.32;
16 CI 1.11-1.56; P = 0.001 and RR 1.42; CI 1.08-1.86; P = 0.01, respectively) follow-up[28].
17 Therefore, patients presenting with NSTEMI-ACS with an occluded culprit vessel on coronary
18 angiography represent a high-risk subset whose identification remains challenging, and for whom
19 current guidelines do not provide specific recommendations[72,98]. Although several ECG criteria,
20 based on the magnitude and location of ST-depression, pathological Q-waves, and R/S ratio in leads
21 V1-V2 have been proposed, results from previous studies conflict and are not validated in the large
22 NSTEMI-ACS population, making their practical values unclear[26,28,117,121,124–126]. The
23 recognition of subtle ECG findings suggesting the presence and location of ongoing ischemia and
24 possible coronary occlusion (including a distinct ST-elevation in aVR or minor [non-diagnostic] ST-
25 elevation in other leads, T-wave width/morphology following ST-depression [i.e., de Winter’s sign],
26 U-wave polarity [positive vs. negative]) may be of value in patients presenting with NSTEMI-ACS.

1 To date, implementing the correct and timely identification of acute coronary occlusion in the NSTEMI-
2 ACS setting by specific ECG patterns/algorithms could be crucial to facilitate earlier revascularization
3 (following a “STEMI-like pathway”) and improve patients’ prognosis in contemporary practice.
4

5 **The prognostic role of T-wave morphologies and indices in ACS**

6 Although numerous studies have so far investigated and reviewed the role of T-wave abnormalities in
7 ACS[3,11], their prognostic significance remains a matter of contention[127–129]. In large ACS
8 studies, patients with isolated T-wave inversion (TWI) had similar cardiovascular outcomes and extent
9 of coronary lesions compared with those presenting normal ECG[128,130]. In line with these reports,
10 a recent sub-analysis of GRACE and Canadian ACS registries evaluating 7,201 NSTEMI-ACS
11 patients[131], TWI was a marker of high-risk profile (i.e., elderly, multiple cardiovascular risk factors)
12 but not an independent predictor of adverse outcomes[131]. On the other hand, other studies identified
13 specific T-wave abnormalities, as defined by Wellens[132] and de Winter[133], which are associated
14 with critical stenosis/occlusion of the proximal LAD and carry adverse prognostic implications if not
15 promptly invasively managed[127,132]. Moreover, Jacobsen et al. demonstrated that patients with
16 diffuse T-wave abnormalities had significantly worse outcomes[134] and benefited from an early
17 invasive as compared with a conservative strategy[135]. Methodological issues, low number of
18 patients undergoing coronary angiography, and considerable heterogeneity among populations might
19 have partially obscured the potential adverse prognostic impact of T-wave abnormalities in previous
20 studies. Further investigations regarding different aspects of T-wave abnormalities, including type,
21 location (anterior vs. non-anterior), extent (number of leads), and dynamics (pre and post-
22 revascularization changes) are necessary to shed light on this persistently ambiguous sign.
23 An additional T-wave-derived parameter, the T-peak to T-end interval (Tp-e), has been recently
24 proposed as a potential outcomes predictor in patients with ACS. Tp-e prolongation marks an
25 increased ventricular repolarization dispersion, the final substrate for ventricular arrhythmias and
26 sudden cardiac death in ischemic heart disease[136]. Erikssen et al.[136], evaluating 1,384 ACS
27 patients referred to coronary angiography, showing that prolonged Tp-e (relative risk 1.5, 95% CI 1.3
28 to 1.7) and heart rate-corrected Tp-e (relative risk 1.6; 95% CI 1.4 to 1.9) were strongly associated

1 with an increased risk of death, particularly for fatal arrhythmias. Initial evidence warrants further
2 investigations to elucidate the relationship between prolonged Tp-e with clinical, angiographic, and
3 outcome data in the whole ACS population, also to clarify which measurement method (tangent versus
4 tail method) should be used, and which is the prognostic impact of Tp-e interval changes from
5 admission to serial follow-up ECGs.

6

7 **Materials and methods**

8 *Study design and population*

9 Between October 11, 2011, and November 7, 2014, the MATRIX trial (NCT01433627) enrolled 8,404
10 patients with an ACS (both STEMI and NSTEMI-ACS) for whom invasive management was
11 planned[32–34]. Detailed rationale, design, and results have been previously reported[32–34,137]. Per
12 study protocol, standard twelve-lead ECGs (paper speed of 25 mm/s, calibrated at 1 mm = 0.1 mV)
13 were recorded in all patients, and classified as: (a) index ECG, before coronary angiography (at the
14 time of qualification for the inclusion in the trial); (b) post-procedural ECG, after the index coronary
15 angiography and/or PCI; (c) predischARGE ECG, during the hospital stay or at the time of discharge.
16 The ECG-MATRIX is a predefined sub-study of the MATRIX aimed at investigating the role of pre
17 and post-procedural ECG features to predict outcomes as well as angiographic findings in ACS
18 patients receiving invasive management. Moreover, the study sought to evaluate the impact of the
19 access site and/or pharmacological regimens on ECG patterns after PCI to gain further insight into the
20 comparative effectiveness on ECG parameters of procedural success of the two randomly allocated
21 intervention. This sub-study is being executed in accordance to previously proposed criteria for
22 conducting ECG sub-study which is nested within prospective trials in patients with coronary artery
23 disease[35]. Eligible patients for the sub-study were all participants in the trial. Since there was no
24 predefined fee for participating in the ECG-MATRIX sub-study, each site was originally invited to
25 participate on a voluntary basis. A total of 39 centers recruiting 6,764 patients declared their interest in
26 participating. After excluding patients in whom ECGs were not available for central analysis, 4,516
27 patients (2,212 or 49% STEMI, and 2,304 or 51% NSTEMI-ACS), which accounts for 53.7% of the

1 study population, of whom 4,022 patients have matched pre and post-treatment ECGs (1,999 or 49.7%
2 STEMI, and 2,023 or 50.3% NSTEMI-ACS), are eligible for the study.

3 From January to August 2018, all collected ECGs were anonymously catalogued, assessed for quality,
4 and digitized for central analysis with a final sampling rate of 500 samples/sec, in accordance with
5 current standards for adult ECGs[138]. The final version of the study design and methods were
6 defined in September 2018. ECG analysis started in October 2018 and is projected to reach completion
7 by Q2 2020. As per June 2, 2019, matched pre and post-treatment ECGs from 644 patients have been
8 analyzed.

9

10 *Methods for ECG analysis*

11 Central ECG analysis is performed at the Department of Cardiology, Inselspital, University of Bern,
12 Switzerland, by 13 fully trained cardiologists who are blinded to the original randomization scheme
13 and clinical outcomes (**Table 2**). To avoid inter-reader variability, all matched (index and post-
14 treatment) ECGs for each individual patient are measured by a single assessor. The average time for
15 central reading of a single ECG approximates to 45 minutes. All measurements are performed in a
16 computer environment using professional computer software (EP Calipers®,
17 www.epstudiossoftware.com/about-ep-calipers/). The software allows manual (operator-interactive)
18 measurements of digital ECG images (in high-resolution) using electronic calipers set manually by the
19 operators. This method has been selected for the present ECG sub-study, as it previously showed high
20 accuracy and reproducibility, limiting operator variability, and allowing to work on a large number of
21 ECG recordings easily[139,140].

22

23 *Inter-reader agreement assessment*

24 Previous studies underscored the importance of minimizing inter-reader differences in ECG analysis
25 and interpretation within and across ECG core laboratories, considering the relevant clinical
26 implications that this entails [141–143]. Moreover, inter-reader agreement analysis for ECG metrics
27 such as P-wave or PR-deviation measurements is rarely reported in the literature. Pearson correlation
28 and Bland-Altman plot analysis between the reference reader and reader 1 for PR-segment depression

1 (at J-point and maximum point of deviation) are shown in **figure 2**, and detailed methods and results
2 for all readers and metrics are shown in the **supplementary appendix**. Our findings demonstrate a
3 high inter-reader agreement among readers in all the investigated ECG metrics (in line with previous
4 results reported in the literature)[141–143] and support the accuracy of ECG analysis.

5 **ECG-MATRIX pre-specified sub-analyses**

6 For the purpose of this study, the following sub-analyses are pre-specified:

- 7 - atrial infarction sub-analysis, to assess the prognostic significance of ECG signs suggestive for
8 atrial infarction on admission and their resolution after PCI;
- 9 - Q-wave sub-analysis, to compare the prognostic impact of pathological Q-waves defined
10 according to the 2018 Universal MI definition with the previously reported definitions, and to
11 assess the prognostic value of Q-wave resolution after PCI;
- 12 - ECG value for predicting coronary flow and anatomical characteristics in STEMI patients;
- 13 - ECG value for predicting culprit vessel occlusion on coronary angiography in NSTEMI-ACS;
- 14 - T-wave pattern sub-analysis, to evaluate the prognostic relevance of T-wave metrics, and their
15 dynamic changes on serial ECGs.

16

17 The complete list of pre-specified sub-analyses is reported in the **supplementary appendix**.

18

19 **Conclusions**

20 The MATRIX trial was designed to test the impact of bleeding avoidance strategies, radial access and
21 bivalirudin in comparison with femoral access and unfractionated heparin with optional GPI
22 respectively, on ischemic and bleeding outcomes in patients with ACS undergoing invasive
23 management.

24 This will represent the largest contemporary study analyzing the role of ECG for the diagnosis and risk
25 stratification of ACS patients with or without ST-segment deviation, concurrently exploring atrial and
26 ventricular ischemia on matched pre and post-treatment ECGs. The ECG-MATRIX will attempt to
27 answer some outstanding questions regarding specific ECG parameters in the diagnosis and

1 management of ACS patients as well as reassessing the role of known ECG metrics in contemporary
2 practice consisting of early invasive management.

3

4 **Declaration of Conflicting Interests**

5 Dr. Valgimigli reports grants from The Medicines Company, grants from Terumo, during the conduct
6 of the study; grants and personal fees from AstraZeneca, personal fees and nonfinancial support from
7 The Medicines Company, personal fees from Terumo, St Jude Vascular, Alvimedica, Abbott Vascular,
8 and Correvio, outside the submitted work.

9 Dr. Windecker has received research and educational grants to the institution from Abbott, Amgen,
10 Bayer, BMS, Boston Scientific, Biotronik, CSL Behring, Edwards Lifesciences, Medtronic, Polares
11 and Sinomed.

12 Dr. Andò reports non-financial support from Terumo, during the conduct of the study; personal fees
13 from Daiichi Sankyo, personal fees and non-financial support from Bayer, non-financial support from
14 Boeringer-Ingelheim, personal fees from AstraZeneca, personal fees from Menarini, personal fees
15 from Chiesi, personal fees from Pfizer, personal fees from Biosensors, outside the submitted work.

16 Other Authors declare that there is no conflict of interest.

17

18 **Funding**

19 The trial was sponsored by GISE (non-profit organization), which received grant support from The
20 Medicines Company and TERUMO. The current analysis did not receive any direct or indirect
21 funding.

22

23 **Acknowledgments**

24 The authors would like to thank Francesca Agricola, Federica Massaro, Fabrizia Terracciano, and
25 Raffaella Antonia Vitale for their valuable time effort and support for the project.

26

27

28

1 **References**

- 2 [1] Birnbaum Y, Nikus K, Kligfield P, Fiol M, Barrabés JA, Sionis A, et al. The Role of the ECG
3 in Diagnosis, Risk Estimation, and Catheterization Laboratory Activation in Patients with
4 Acute Coronary Syndromes: A Consensus Document. *Ann Noninvasive Electrocardiol*
5 2014;19:412–25. doi:10.1111/anec.12196.
- 6 [2] Birnbaum Y, Wilson JM, Fiol M, de Luna AB, Eskola M, Nikus K. ECG Diagnosis and
7 Classification of Acute Coronary Syndromes. *Ann Noninvasive Electrocardiol* 2014;19:4–14.
8 doi:10.1111/anec.12130.
- 9 [3] Nikus K, Pahlm O, Wagner G, Birnbaum Y, Cinca J, Clemmensen P, et al.
10 Electrocardiographic classification of acute coronary syndromes: a review by a committee of
11 the International Society for Holter and Non-Invasive Electrocardiology. *J Electrocardiol*
12 2010;43:91–103. doi:10.1016/j.jelectrocard.2009.07.009.
- 13 [4] Zimetbaum PJ, Josephson ME. Use of the Electrocardiogram in Acute Myocardial Infarction.
14 *N Engl J Med* 2003;348:933–40. doi:10.1056/NEJMra022700.
- 15 [5] Birnbaum Y, Drew BJ. The electrocardiogram in ST elevation acute myocardial infarction:
16 Correlation with coronary anatomy and prognosis. *Postgrad Med J* 2003;79:490–504.
17 doi:10.1136/pmj.79.935.490.
- 18 [6] Buller CE, Fu Y, Mahaffey KW, Todaro TG, Adams P, Westerhout CM, et al. ST-segment
19 recovery and outcome after primary percutaneous coronary intervention for ST-elevation
20 myocardial infarction: Insights from the assessment of pexelizumab in acute myocardial
21 infarction (APEX-AMI) trial. *Circulation* 2008;118:1335–46.
22 doi:10.1161/CIRCULATIONAHA.108.767772.
- 23 [7] Kosmidou I, Redfors B, Crowley A, Gersh B, Chen S, Dizon JM, et al. Prognostic implications
24 of Q waves at presentation in patients with ST-segment elevation myocardial infarction
25 undergoing primary percutaneous coronary intervention: An analysis of the HORIZONS-AMI
26 study. *Clin Cardiol* 2017;40:982–7. doi:10.1002/clc.22751.
- 27 [8] Alherbish A, Westerhout CM, Fu Y, White HD, Granger CB, Wagner G, et al. The forgotten
28 lead: Does aVR ST-deviation add insight into the outcomes of ST-elevation myocardial

- 1 infarction patients? *Am Heart J* 2013;166:333–9. doi:10.1016/j.ahj.2013.05.018.
- 2 [9] Schröder R. Prognostic Impact of Early ST-Segment Resolution in Acute ST-Elevation
3 Myocardial Infarction. *Circulation* 2004;110. doi:10.1161/01.CIR.0000147778.05979.E6.
- 4 [10] Tierala I, Nikus KC, Sclarovsky S, Syväne M, Eskola M. Predicting the culprit artery in acute
5 ST-elevation myocardial infarction and introducing a new algorithm to predict infarct-related
6 artery in inferior ST-elevation myocardial infarction: correlation with coronary anatomy in the
7 HAAMU Trial. *J Electrocardiol* 2009;42:120–7. doi:10.1016/j.jelectrocard.2008.12.009.
- 8 [11] de Luna AB, Zareba W, Fiol M, Nikus K, Birnbaum Y, Baranowski R, et al. Negative T Wave
9 in Ischemic Heart Disease: A Consensus Article. *Ann Noninvasive Electrocardiol*
10 2014;19:426–41. doi:10.1111/anec.12193.
- 11 [12] Lu MLR, De Venecia T, Patnaik S, Figueredo VM. Atrial myocardial infarction: A tale of the
12 forgotten chamber. *Int J Cardiol* 2016;202:904–9. doi:10.1016/j.ijcard.2015.10.070.
- 13 [13] Liu CK, Greenspan G, Piccirillo RT. Atrial infarction of the heart. *Circulation* 1961;23:331–8.
14 doi:10.1161/01.CIR.23.3.331.
- 15 [14] Gardin JM, Singer DH. Atrial Infarction: Importance, Diagnosis, and Localization. *Arch Intern*
16 *Med* 1981;141:1345–8. doi:10.1001/archinte.1981.00340100101021.
- 17 [15] Hellerstein HK. Atrial infarction with diagnostic electrocardiographic findings. *Am Heart J*
18 1948;36:422–30. doi:10.1016/0002-8703(48)90338-X.
- 19 [16] van Diepen S, Siha H, Fu Y, Westerhout CM, Lopes RD, Granger CB, et al. Do baseline atrial
20 electrocardiographic and infarction patterns predict new-onset atrial fibrillation after ST-
21 elevation myocardial infarction? Insights from the Assessment of Pexelizumab in Acute
22 Myocardial Infarction Trial. *J Electrocardiol* 2010;43:351–8.
23 doi:10.1016/j.jelectrocard.2010.04.001.
- 24 [17] Lu MLR, Nwakile C, Bhalla V, De Venecia T, Shah M, Figueredo VM. Prognostic
25 significance of abnormal P wave morphology and PR-segment displacement after ST-elevation
26 myocardial infarction. *Int J Cardiol* 2015;197:216–21. doi:10.1016/j.ijcard.2015.06.055.
- 27 [18] Verouden NJ, Barwari K, Koch KT, Henriques JP, Baan J, Van Der Schaaf RJ, et al.
28 Distinguishing the right coronary artery from the left circumflex coronary artery as the infarct-

- 1 related artery in patients undergoing primary percutaneous coronary intervention for acute
2 inferior myocardial infarction. *Europace* 2009;11:1517–21. doi:10.1093/europace/eup234.
- 3 [19] Engelen DJ, Gorgels AP, Cheriex EC, De Muinck ED, Oude Ophuis AJ, Dassen WR, et al.
4 Value of the electrocardiogram in localizing the occlusion site in the left anterior descending
5 coronary artery in acute anterior myocardial infarction. *J Am Coll Cardiol* 1999;34:389–95.
6 doi:10.1016/S0735-1097(99)00197-7.
- 7 [20] Zimetbaum PJ, Krishnan S, Gold A, Carrozza JP, Josephson ME. Usefulness of ST-segment
8 elevation in lead III exceeding that of lead II for identifying the location of the totally occluded
9 coronary artery in inferior wall myocardial infarction. *Am J Cardiol* 1998;81:918–9.
- 10 [21] Braat SH, Gorgels APM, Bar FW, Wellens HJJ. Value of the ST-T segment in lead V4R in
11 inferior wall acute myocardial infarction to predict the site of coronary arterial occlusion. *Am J*
12 *Cardiol* 1988;62:140–2. doi:10.1016/0002-9149(88)91380-X.
- 13 [22] Braat SH, Brugada P, den Dulk K, van Ommen V, Wellens HJJ. Value of lead V4R for
14 recognition of the infarct coronary artery in acute inferior myocardial infarction. *Am J Cardiol*
15 1984;53:1538–41. doi:10.1016/0002-9149(84)90575-7.
- 16 [23] Fiol M, Carrillo AA, Cygankiewicz I, Ayestarán J, Caldés O, Feral V, et al. New criteria based
17 on ST changes in 12-lead surface ECG to detect proximal versus distal right coronary artery
18 occlusion in a case of acute inferoposterior myocardial infarction. *Ann Noninvasive*
19 *Electrocardiol* 2004;9:383–8. doi:10.1111/j.1542-474X.2004.94585.x.
- 20 [24] Fiol M, Carrillo A, Cygankiewicz I, Velasco J, Riera M, Bayés-Genis A, et al. A New
21 Electrocardiographic Algorithm to Locate the Occlusion in Left Anterior Descending Coronary
22 Artery. *Clin Cardiol* 2009;32:E1–6. doi:10.1002/clc.20347.
- 23 [25] Fiol M, Cygankiewicz I, Carrillo A, Bayés-Genis A, Santoyo O, Gómez A, et al. Value of
24 electrocardiographic algorithm based on “ups and downs” of ST in assessment of a culprit
25 artery in evolving inferior wall acute myocardial infarction. *Am J Cardiol* 2004;94:709–14.
26 doi:10.1016/j.amjcard.2004.05.053.
- 27 [26] Krishnaswamy A, Lincoff AM, Menon V. Magnitude and consequences of missing the acute
28 infarct-related circumflex artery. *Am Heart J* 2009;158:706–12. doi:10.1016/j.ahj.2009.08.024.

- 1 [27] Pride YB, Tung P, Mohanavelu S, Zorkun C, Wiviott SD, Antman EM, et al. Angiographic and
2 Clinical Outcomes Among Patients With Acute Coronary Syndromes Presenting With Isolated
3 Anterior ST-Segment Depression. *JACC Cardiovasc Interv* 2010;3:806–11.
4 doi:10.1016/j.jcin.2010.05.012.
- 5 [28] Khan AR, Golwala H, Tripathi A, Bin Abdulhak AA, Bavishi C, Riaz H, et al. Impact of total
6 occlusion of culprit artery in acute non-ST elevation myocardial infarction: a systematic review
7 and meta-analysis. *Eur Heart J* 2017;38:3082–9. doi:10.1093/eurheartj/ehx418.
- 8 [29] Birnbaum Y, Atar S. Electrocardiogram risk stratification of non–ST-elevation acute coronary
9 syndromes. *J Electrocardiol* 2006;39:S57–61. doi:10.1016/j.jelectrocard.2006.05.029.
- 10 [30] Birnbaum Y, Zhou S, Wagner GS. New considerations of ST segment “elevation” and
11 “depression” and accompanying T wave configuration in acute coronary syndromes. *J*
12 *Electrocardiol* 2011;44:1–6. doi:10.1016/j.jelectrocard.2010.11.001.
- 13 [31] Valgimigli M, Gagnor A, Calabrò P, Rubartelli P, Garducci S, Andò G, et al. Design and
14 rationale for the minimizing adverse haemorrhagic events by transradial access site and
15 systemic implementation of angioX program. *Am Heart J* 2014;168:838–45.
16 doi:10.1016/j.ahj.2014.08.013.
- 17 [32] Valgimigli M, Frigoli E, Leonardi S, Rothenbühler M, Gagnor A, Calabrò P, et al. Bivalirudin
18 or Unfractionated Heparin in Acute Coronary Syndromes. *N Engl J Med* 2015;373:997–1009.
19 doi:10.1056/NEJMoa1507854.
- 20 [33] Valgimigli M, Gagnor A, Calabrò P, Frigoli E, Leonardi S, Zaro T, et al. Radial versus femoral
21 access in patients with acute coronary syndromes undergoing invasive management: A
22 randomised multicentre trial. *Lancet* 2015;385:2465–76. doi:10.1016/S0140-6736(15)60292-6.
- 23 [34] Valgimigli M, Frigoli E, Leonardi S, Vranckx P, Rothenbühler M, Tebaldi M, et al. Radial
24 versus femoral access and bivalirudin versus unfractionated heparin in invasively managed
25 patients with acute coronary syndrome (MATRIX): final 1-year results of a multicentre,
26 randomised controlled trial. *Lancet* 2018;392:835–48. doi:10.1016/S0140-6736(18)31714-8.
- 27 [35] Sgarbossa EB, Pinski SL, Barbagelata A, Goodman SG, Natale A, Gates KB, et al. ECG
28 subanalyses in clinical trials: An investigator’s perspective. *J Electrocardiol* 1999;32:114–21.

- 1 doi:10.1016/S0022-0736(99)90060-2.
- 2 [36] A. Clerc RL. Infarctus auriculaire: tachyarrhythmia terminale. Bull Mem Soc Med Hop Paris
3 1925;41:1603–1607.
- 4 [37] Álvarez-García J, Vives-Borrás M, Gomis P, Ordoñez-Llanos J, Ferrero-Gregori A, Serra-
5 Peñaranda A, et al. Electrophysiological Effects of Selective Atrial Coronary Artery Occlusion
6 in Humans. *Circulation* 2016;133:2235–42. doi:10.1161/CIRCULATIONAHA.116.021700.
- 7 [38] Nielsen FE, Andersen HH, Gram-Hansen P, Sørensen HT, Klausen IC. The relationship
8 between ECG signs of atrial infarction and the development of supraventricular arrhythmias in
9 patients with acute myocardial infarction. *Am Heart J* 1992;123:69–72. doi:10.1016/0002-
10 8703(92)90748-K.
- 11 [39] Wong AK, Marais HJ, Jutzy K, Capestany GA, Marais GE. Isolated atrial infarction in a
12 patients with single vessel disease of the sinus node artery. *Chest* 1991;100:255–6.
13 doi:10.1378/chest.100.1.255.
- 14 [40] Andò G, Gaspardone A, Proietti I. Acute thrombosis of the sinus node artery: arrhythmological
15 implications. *Heart* 2003;89:E5.
- 16 [41] Sivertssen E, Hoel B, Bay G, Jørgensen L. Electrocardiographic atrial complex and acute atrial
17 myocardial infarction. *Am J Cardiol* 1973;31:450–6. doi:10.1016/0002-9149(73)90293-2.
- 18 [42] Burch GE. Of the P-R segment depression and atrial infarction. *Am Heart J* 1976;91:129–30.
19 doi:10.1016/S0002-8703(76)80445-0.
- 20 [43] Abellás-Sequeiros RA, Raposeiras-Roubín S, Abu-Assi E, González-Salvado V, Iglesias-
21 Álvarez D, Redondo-Diéguez A, et al. Mehran contrast nephropathy risk score: Is it still useful
22 10 years later? *J Cardiol* 2016;67:262–7. doi:10.1016/j.jjcc.2015.05.007.
- 23 [44] Bayés de Luna A, Wagner G, Birnbaum Y, Nikus K, Fiol M, Gorgels A, et al. A New
24 Terminology for Left Ventricular Walls and Location of Myocardial Infarcts That Present Q
25 Wave Based on the Standard of Cardiac Magnetic Resonance Imaging. *Circulation*
26 2006;114:1755–60. doi:10.1161/CIRCULATIONAHA.106.624924.
- 27 [45] Kaul P, Fu Y, Westerhout CM, Granger CB, Armstrong PW. Relative Prognostic Value of
28 Baseline Q Wave and Time from Symptom Onset Among Men and Women With ST-Elevation

- 1 Myocardial Infarction Undergoing Percutaneous Coronary Intervention. *Am J Cardiol*
2 2012;110:1555–60. doi:10.1016/j.amjcard.2012.07.020.
- 3 [46] Kholaf N, Zheng Y, Jagasia P, Himmelmann A, James SK, Steg PG, et al. Baseline Q Waves
4 and Time From Symptom Onset to ST-segment Elevation Myocardial Infarction: Insights From
5 PLATO on the Influence of Sex. *Am J Med* 2015;128:914.e11-914.e19.
6 doi:10.1016/j.amjmed.2015.03.005.
- 7 [47] Thygesen K, Alpert JS, Jaffe AS, Chaitman BR, Bax JJ, Morrow DA, et al. Fourth Universal
8 Definition of Myocardial Infarction (2018). *Circulation* 2018;138.
9 doi:10.1161/CIR.0000000000000617.
- 10 [48] Abdel-Razek O, Parfrey BP, Connors SP. Disappearance of pathologic anteroseptal Q waves
11 after reperfusion with percutaneous coronary intervention (PCI) in a 61 year old female: A case
12 report. *J Electrocardiol* 2017;50:949–51. doi:10.1016/j.jelectrocard.2017.06.002.
- 13 [49] Zheng Y, Bainey KR, Tyrrell BD, Brass N, Armstrong PW, Welsh RC. Relationships Between
14 Baseline Q Waves, Time From Symptom Onset, and Clinical Outcomes in ST-Segment-
15 Elevation Myocardial Infarction Patients: Insights From the Vital Heart Response Registry.
16 *Circ Cardiovasc Interv* 2017;10:e005399. doi:10.1161/CIRCINTERVENTIONS.117.005399.
- 17 [50] Wong CK, Gao W, Raffel OC, French JK, Stewart RA, White HD. Initial Q waves
18 accompanying ST-segment elevation at presentation of acute myocardial infarction and 30-day
19 mortality in patients given streptokinase therapy: an analysis from HERO-2. *Lancet*
20 2006;367:2061–7. doi:10.1016/S0140-6736(06)68929-0.
- 21 [51] Andrews J, French JK, Manda SOM, White HD. New Q waves on the presenting
22 electrocardiogram independently predict increased cardiac mortality following a first ST-
23 elevation myocardial infarction. *Eur Heart J* 2000;21:647–53. doi:10.1053/euhj.1999.1908.
- 24 [52] Siha H, Das D, Fu Y, Zheng Y, Westerhout CM, Storey RF, et al. Baseline Q waves as a
25 prognostic modulator in patients with ST-segment elevation: Insights from the PLATO trial.
26 *Cmaj* 2012;184:1135–42. doi:10.1503/cmaj.111683.
- 27 [53] Maisel AS, Ahnve S, Gilpin E, Henning H, Goldberger AL, Collins D, et al. Prognosis after
28 extension of myocardial infarct: The role of Q wave or non-Q wave infarction. *Circulation*

- 1 1985;71:211–7. doi:10.1016/j.micpro.2009.10.002.
- 2 [54] Williams RA, Cohn PF, Vokonas PS, Young E, Herman M V, Gorlin R. Electrocardiographic,
3 arteriographic and ventriculographic correlations in transmural myocardial infarction. *Am J*
4 *Cardiol* 1973;31:595–9. doi: 10.1016/0002-9149(73)90328-7
- 5 [55] Antman EM, McCabe CH, Gurfinkel EP, Turpie AGG, Bernink PJLM, Salein D, et al.
6 Enoxaparin prevents death and cardiac ischemic events in unstable angina/non-Q-wave
7 myocardial infarction: Results of the thrombolysis in myocardial infarction (TIMI) 11B trial.
8 *Circulation* 1999;100:1593–601. doi:10.1161/01.CIR.100.15.1593.
- 9 [56] Loring Z, Chelliah S, Selvester RH, Wagner G, Strauss DG. A detailed guide for quantification
10 of myocardial scar with the Selvester QRS score in the presence of electrocardiogram
11 confounders. *J Electrocardiol* 2011;44:544–54. doi:10.1016/j.jelectrocard.2011.06.008.
- 12 [57] Prineas RJ, Crow RS, Zhang Z-M. *The Minnesota Code Manual of Electrocardiographic*
13 *Findings*. London: Springer London; 2010. doi:10.1007/978-1-84882-778-3.
- 14 [58] Antman E, Bassand JP, Klein W, Ohman M, Lopez Sendon JL, Rydén L, et al. Myocardial
15 infarction redefined - A consensus document of The Joint European Society of
16 Cardiology/American College of Cardiology Committee for the redefinition of myocardial
17 infarction. *J Am Coll Cardiol* 2000;36:959–69. doi:10.1016/S0735-1097(00)00804-4.
- 18 [59] Anderson WD, Wagner NB, Lee KL, White RD, Yuschak J, Behar VS, et al. Evaluation of a
19 QRS scoring system for estimating myocardial infarct size. VI: Identification of screening
20 criteria for non-acute myocardial infarcts. *Am J Cardiol* 1988;61:729–33. doi:10.1016/0002-
21 9149(88)91056-9.
- 22 [60] Armstrong PW, Fu Y, Westerhout CM, Hudson MP, Mahaffey KW, White HD, et al. Baseline
23 Q-Wave Surpasses Time From Symptom Onset as a Prognostic Marker in ST-Segment
24 Elevation Myocardial Infarction Patients Treated With Primary Percutaneous Coronary
25 Intervention. *J Am Coll Cardiol* 2009;53:1503–9. doi:10.1016/j.jacc.2009.01.046.
- 26 [61] Jensen JK, Øvrehus K, Møldrup M, Mickley H, Højlund-Carlson PF. Redefinition of the Q
27 wave - Is there a clinical problem? *Am J Cardiol* 2006;97:974–6.
28 doi:10.1016/j.amjcard.2005.10.042.

- 1 [62] Delewi R, Ijff G, Van De Hoef TP, Hirsch A, Robbers LF, Nijveldt R, et al. Pathological Q
2 waves in myocardial infarction in patients treated by primary PCI. *JACC Cardiovasc Imaging*
3 2013;6:324–31. doi:10.1016/j.jcmg.2012.08.018.
- 4 [63] Perino AC, Soofi M, Singh N, Aggarwal S, Froelicher V. The long-term prognostic value of
5 the Q wave criteria for prior myocardial infarction recommended in the universal definition of
6 myocardial infarction. *J Electrocardiol* 2015;48:798–802.
7 doi:10.1016/j.jelectrocard.2015.07.004.
- 8 [64] Zhang Z, Prineas RJ, Eaton CB. Evaluation and Comparison of the Minnesota Code and
9 Novacode for Electrocardiographic Q-ST Wave Abnormalities for the Independent Prediction
10 of Incident Coronary Heart Disease and Total Mortality (from the Women’s Health Initiative).
11 *Am J Cardiol* 2010;106:18-25.e2. doi:10.1016/j.amjcard.2010.02.007.
- 12 [65] Nadour W, Doyle M, Williams RB, Rayarao G, Grant SB, Thompson D V., et al. Does the
13 presence of Q waves on the EKG accurately predict prior myocardial infarction when
14 compared to cardiac magnetic resonance using late gadolinium enhancement? A cross-
15 population study of noninfarct vs infarct patients. *Heart Rhythm* 2014;11:2018–26.
16 doi:10.1016/j.hrthm.2014.07.025.
- 17 [66] Kosmidou I, Redfors B, McAndrew T, Embacher M, Mehran R, Dizon JM, et al. Worsening
18 atrioventricular conduction after hospital discharge in patients with ST-segment elevation
19 myocardial infarction undergoing primary percutaneous coronary intervention. *Coron Artery*
20 *Dis* 2017;28:550–6. doi:10.1097/MCA.0000000000000525.
- 21 [67] Haiat R, Chiche P. Transient abnormal Q waves in the course of ischemic heart disease. *Chest*
22 1974;65:140–4. doi: 10.1378/chest.65.2.140
- 23 [68] Durrer D, van Dam RT, Freud GE, Janse MJ, Meijler FL, Arzbaecher RC. Total excitation of
24 the isolated human heart. *Circulation* 1970;41:899–912. doi:10.1161/01.CIR.41.6.899.
- 25 [69] Bar FW, Vermeer F, de Zwaan C, Ramentol M, Bratt S, Simoons ML, et al. Value of
26 admission electrocardiogram in predicting outcome of thrombolytic therapy in acute
27 myocardial infarction. A randomized trial conducted by the netherlands interuniversity
28 cardiology institute. *Am J Cardiol* 1987;59:6–13. doi:10.1016/S0002-9149(87)80060-7.

- 1 [70] Voon W. Q-wave regression after acute myocardial infarction assessed by TI-201 myocardial
2 perfusion SPECT. *J Nucl Cardiol* 2004;11:165–70. doi:10.1016/j.nuclcard.2003.10.009.
- 3 [71] Ibanez B, James S, Agewall S, Antunes MJ, Bucciarelli-Ducci C, Bueno H, et al. 2017 ESC
4 Guidelines for the management of acute myocardial infarction in patients presenting with ST-
5 segment elevation: the task force for the management of acute myocardial infarction in patients
6 presenting with ST-segment elevation of the European Socie. *Eur Heart J* 2018;39:119–77.
7 doi:10.1093/eurheartj/ehx393.
- 8 [72] Roffi M, Patrono C, Collet JP, Mueller C, Valgimigli M, Andreotti F, et al. 2015 ESC
9 Guidelines for the management of acute coronary syndromes in patients presenting without
10 persistent st-segment elevation: Task force for the management of acute coronary syndromes in
11 patients presenting without persistent ST-segment elevation of . *Eur Heart J* 2016;37:267–315.
12 doi:10.1093/eurheartj/ehv320.
- 13 [73] Calabrò P, Gragnano F, Di Maio M, Patti G, Antonucci E, Cirillo P, et al. Epidemiology and
14 Management of Patients With Acute Coronary Syndromes in Contemporary Real-World
15 Practice: Evolving Trends From the EYESHOT Study to the START-ANTIPLATELET
16 Registry. *Angiology* 2018;69:795–802. doi:10.1177/0003319718760917.
- 17 [74] Sardu C, Barbieri M, Balestrieri ML, Siniscalchi M, Paolisso P, Calabrò P, et al. Thrombus
18 aspiration in hyperglycemic ST-elevation myocardial infarction (STEMI) patients: clinical
19 outcomes at 1-year follow-up. *Cardiovasc Diabetol* 2018;17:152. doi:10.1186/s12933-018-
20 0795-8.
- 21 [75] Di Diego JM, Antzelevitch C. Acute myocardial ischemia: cellular mechanisms underlying ST
22 segment elevation. *J Electrocardiol* n.d.;47:486–90. doi:10.1016/j.jelectrocard.2014.02.005.
- 23 [76] Schröder K, Wegscheider K, Zeymer U, Tebbe U, Schröder R. Extent of ST-segment deviation
24 in a single electrocardiogram lead 90 min after thrombolysis as a predictor of medium-term
25 mortality in acute myocardial infarction. *Lancet* 2001;358:1479–86. doi:10.1016/S0140-
26 6736(01)06577-1.
- 27 [77] Armstrong PW, Siha H, Fu Y, Westerhout CM, Steg PG, James SK, et al. ST-elevation acute
28 coronary syndromes in the platelet inhibition and patient outcomes (PLATO) trial: Insights

- 1 from the ECG substudy. *Circulation* 2012;125:514–21.
2 doi:10.1161/CIRCULATIONAHA.111.047530.
- 3 [78] Braat SH, Brugada P, de Zwaan C, Coenegracht JM, Wellens HJ. Value of electrocardiogram
4 in diagnosing right ventricular involvement in patients with an acute inferior wall myocardial
5 infarction. *Heart* 1983;49:368–72. doi:10.1136/hrt.49.4.368.
- 6 [79] Grothoff M, Elpert C, Hoffmann J, Zachrau J, Lehmkuhl L, de Waha S, et al. Right Ventricular
7 Injury in ST-Elevation Myocardial Infarction. *Circ Cardiovasc Imaging* 2012;5:60–8.
8 doi:10.1161/CIRCIMAGING.111.967810.
- 9 [80] McLaughlin MG, Stone GW, Aymong E, Gardner G, Mehran R, Lansky AJ, et al. Prognostic
10 utility of comparative methods for assessment of ST-segment resolution after primary
11 angioplasty for acute myocardial infarction. *J Am Coll Cardiol* 2004;44:1215–23.
12 doi:10.1016/j.jacc.2004.06.053.
- 13 [81] Farkouh ME, Reiffel J, Dressler O, Nikolsky E, Parise H, Cristea E, et al. Relationship between
14 ST-segment recovery and clinical outcomes after primary percutaneous coronary intervention:
15 The HORIZONS-AMI ECG substudy report. *Circ Cardiovasc Interv* 2013;6:216–23.
16 doi:10.1161/CIRCINTERVENTIONS.112.000142.
- 17 [82] Sejersten M, Valeur N, Grande P, Nielsen TT, Clemmensen P. Long-Term Prognostic Value of
18 ST-Segment Resolution in Patients Treated With Fibrinolysis or Primary Percutaneous
19 Coronary Intervention. Results From the DANAMI-2 (DANish trial in Acute Myocardial
20 Infarction-2). *J Am Coll Cardiol* 2009;54:1763–9. doi:10.1016/j.jacc.2009.03.084.
- 21 [83] Kuijt WJ, Green CL, Verouden NJW, Haeck JDE, Tzivoni D, Koch KT, et al. What is the best
22 ST-segment recovery parameter to predict clinical outcome and myocardial infarct size?
23 Amplitude, speed, and completeness of ST-segment recovery after primary percutaneous
24 coronary intervention for ST-segment elevation myocardial infarcti. *J Electrocardiol*
25 2017;50:952–9. doi:10.1016/j.jelectrocard.2017.04.009.
- 26 [84] Andrews J, Straznicky IT, French JK, Green CL, Maas AC, Lund M, et al. ST-Segment
27 recovery adds to the assessment of TIMI 2 and 3 flow in predicting infarct wall motion after
28 thrombolytic therapy. *Circulation* 2000;101:2138–43. doi: 10.1161/01.CIR.101.18.2138.

- 1 [85] Sejersten M, Ripa RS, Maynard C, Wagner GS, Andersen HR, Grande P, et al. Usefulness of
2 quantitative baseline ST-segment elevation for predicting outcomes after primary coronary
3 angioplasty or fibrinolysis (results from the DANAMI-2 trial). *Am J Cardiol* 2006;97:611–6.
4 doi:10.1016/j.amjcard.2005.09.099.
- 5 [86] Dawkins K, Busk M, Sorensen J, Mortensen LS, Maynard C, Stinnett SS, et al. Association
6 between ST segment Resolution following Fibrinolytic therapy or Intracoronary stenting, and
7 Reinfarction in the same myocardial region in the DANAMI-2 study population. *Cardiovasc*
8 *Revascularization Med* 2011;12:75–81. doi:10.1016/j.carrev.2010.04.003.
- 9 [87] Zeymer U, Huber K, Fu Y, Ross A, Granger C, Goldstein P, et al. Impact of TIMI 3 patency
10 before primary percutaneous coronary intervention for ST-elevation myocardial infarction on
11 clinical outcome: results from the ASSENT-4 PCI study. *Eur Hear J Acute Cardiovasc Care*
12 2012;1:136–42. doi:10.1177/2048872612447069.
- 13 [88] Andò G, Gragnano F, Calabrò P, Valgimigli M. Radial vs femoral access for the prevention of
14 acute kidney injury (AKI) after coronary angiography or intervention: A systematic review and
15 meta-analysis. *Catheter Cardiovasc Interv* 2018. doi:10.1002/ccd.27903.
- 16 [89] Gragnano F, Manavifar N, Valgimigli M. A call for action in bleeding prevention. *Aging*
17 (Albany NY) 2019;11:287–8. doi:10.18632/aging.101745.
- 18 [90] Gargiulo G, Carrara G, Frigoli E, Leonardi S, Vranckx P, Campo G, et al. Post-Procedural
19 Bivalirudin Infusion at Full or Low Regimen in Patients With Acute Coronary Syndrome. *J*
20 *Am Coll Cardiol* 2019;73:758–74. doi:10.1016/j.jacc.2018.12.023.
- 21 [91] Cesaro A, Moscarella E, Gragnano F, Perrotta R, Diana V, Pariggiano I, et al. Transradial
22 access versus transfemoral access: a comparison of outcomes and efficacy in reducing
23 hemorrhagic events. *Expert Rev Cardiovasc Ther* 2019;17:435–47.
24 doi:10.1080/14779072.2019.1627873.
- 25 [92] Blake SR, Shahzad A, Aggarwal SK, Kumar A, Khan A, Stables RH. Radial versus femoral
26 vascular access in ST-elevation myocardial infarction: Are the results of femoral operators
27 unfairly represented in observational research? *Am Heart J* 2019;210:81–7.
28 doi:10.1016/j.ahj.2018.12.009.

- 1 [93] Bianchi R, D'Acerno L, Crisci M, Tartaglione D, Cappelli Bigazzi M, Canonico M, et al.
2 From Femoral to Radial Approach in Coronary Intervention: Review of the Literature and 6
3 Years Single-Center Experience. *Angiology* 2017;68:281–7. doi:10.1177/0003319716656714.
- 4 [94] van't Hof A, Giannini F, ten Berg J, Tolsma R, Clemmensen P, Bernstein D, et al. ST-segment
5 resolution with bivalirudin versus heparin and routine glycoprotein IIb/IIIa inhibitors started in
6 the ambulance in ST-segment elevation myocardial infarction patients transported for primary
7 percutaneous coronary intervention: The EUROMAX ST-s. *Eur Hear J Acute Cardiovasc Care*
8 2017;6:404–11. doi:10.1177/2048872615598633.
- 9 [95] Cortese B, Limbruno U, Severi S, De Matteis S, Diehl L, Pitì A. Effect of Prolonged
10 Bivalirudin Infusion on ST-Segment Resolution Following Primary Percutaneous Coronary
11 Intervention (from the PROBI VIRI 2 Study). *Am J Cardiol* 2011;108:1220–4.
12 doi:10.1016/j.amjcard.2011.06.033.
- 13 [96] Gorgels APM. ST-elevation and non-ST-elevation acute coronary syndromes: Should the
14 guidelines be changed? *J Electrocardiol* 2013;46:318–23.
15 doi:10.1016/j.jelectrocard.2013.04.005.
- 16 [97] Verouden NJW, Haeck JDE, Kuijt WJ, van Geloven N, Koch KT, Henriques JPS, et al.
17 Prediction of 1-Year Mortality With Different Measures of ST-Segment Recovery in All-
18 Comers After Primary Percutaneous Coronary Intervention for Acute Myocardial Infarction.
19 *Circ Cardiovasc Qual Outcomes* 2010;3:522–9. doi:10.1161/CIRCOUTCOMES.109.923797.
- 20 [98] Neumann F-J, Sousa-Uva M, Ahlsson A, Alfonso F, Banning AP, Benedetto U, et al. 2018
21 ESC/EACTS Guidelines on myocardial revascularization. *Eur Heart J* 2018.
22 doi:10.1093/eurheartj/ehy394.
- 23 [99] Mehta SR, Granger CB, Boden WE, Steg PG, Bassand J-P, Faxon DP, et al. Early versus
24 Delayed Invasive Intervention in Acute Coronary Syndromes. *N Engl J Med* 2009;360:2165–
25 75. doi:10.1056/NEJMoa0807986.
- 26 [100] Jobs A, Mehta SR, Montalescot G, Vicaut E, van't Hof AWJ, Badings EA, et al. Optimal
27 timing of an invasive strategy in patients with non-ST-elevation acute coronary syndrome: a
28 meta-analysis of randomised trials. *Lancet* 2017;390:737–46. doi:10.1016/S0140-

- 1 6736(17)31490-3.
- 2 [101] Holmvang L, Clemmensen P, Lindahl B, Lagerqvist B, Venge P, Wagner G, et al. Quantitative
3 analysis of the admission electrocardiogram identifies patients with unstable coronary artery
4 disease who benefit the most from early invasive treatment. *J Am Coll Cardiol* 2003;41:905–
5 15. doi:10.1016/S0735-1097(02)02970-4.
- 6 [102] Westerhout CM, Fu Y, Lauer MS, James S, Armstrong PW, Al-Hattab E, et al. Short- and
7 Long-Term Risk Stratification in Acute Coronary Syndromes. The Added Value of
8 Quantitative ST-Segment Depression and Multiple Biomarkers. *J Am Coll Cardiol*
9 2006;48:939–47. doi:10.1016/j.jacc.2006.04.085.
- 10 [103] Armstrong PW, Westerhout CM, Fu Y, Harrington RA, Storey RF, Katus H, et al. Quantitative
11 ST-depression in Acute Coronary Syndromes: the PLATO Electrocardiographic Substudy. *Am*
12 *J Med* 2013;126:723-729.e1. doi:10.1016/j.amjmed.2013.01.038.
- 13 [104] Yan RT, Yan AT, Granger CB, Lopez-Sendon J, Brieger D, Kennelly B, et al. Usefulness of
14 Quantitative Versus Qualitative ST-Segment Depression for Risk Stratification of Non-ST
15 Elevation Acute Coronary Syndromes in Contemporary Clinical Practice. *Am J Cardiol*
16 2008;101:919–24. doi:10.1016/j.amjcard.2007.11.041.
- 17 [105] Yan AT, Yan RT, Tan M, Chow C-M, Fitchett DH, Georgescu AA, et al. ST-segment
18 depression in non-ST elevation acute coronary syndromes: Quantitative analysis may not
19 provide incremental prognostic value beyond comprehensive risk stratification. *Am Heart J*
20 2006;152:270–6. doi:10.1016/j.ahj.2005.12.003.
- 21 [106] Willich SN, Stone PH, Muller JE, Tofler GH, Crowder J, Parker C, et al. High-risk subgroups
22 of patients with non-Q wave myocardial infarction based on direction and severity of ST
23 segment deviation. *Am Heart J* 1987;114:1110–9.
- 24 [107] Bayturan O, Bilge AR, Seküri C, Utük O, Tikiz H, Eser E, et al. The effect of tirofiban on ST
25 segment resolution in patients with non-ST elevated myocardial infarction. *Jpn Heart J*
26 2004;45:913–20. doi: 10.1536/jhj.45.913.
- 27 [108] Kosuge M, Kimura K, Ishikawa T, Hongo Y, Mochida Y, Sugiyama M, et al. New
28 electrocardiographic criteria for predicting the site of coronary artery occlusion in inferior wall

- 1 acute myocardial infarction. *Am J Cardiol* 1998;82:1318–22. doi: 10.1016/s0002-
2 9149(98)00634-1
- 3 [109] Wong TW, Huang XH, Liu W, Ng K, Ng KS. New electrocardiographic criteria for identifying
4 the culprit artery in inferior wall acute myocardial infarction—usefulness of T-wave amplitude
5 ratio in leads II/III and T-wave polarity in the right V5 lead. *Am J Cardiol* 2004;94:1168–71.
6 doi:10.1016/j.amjcard.2004.07.086.
- 7 [110] Rokos IC, Farkouh ME, Reiffel J, Dressler O, Mehran R, Stone GW. Correlation between
8 index electrocardiographic patterns and pre-intervention angiographic findings: Insights from
9 the HORIZONS-AMI trial. *Catheter Cardiovasc Interv* 2012;79:1092–8.
10 doi:10.1002/ccd.23262.
- 11 [111] Bayés de Luna A, Fiol-Sala M. Where Is the Culprit Lesion? *Circulation* 2016;134:1507–9.
12 doi:10.1161/CIRCULATIONAHA.116.024761.
- 13 [112] Fiol-Sala M, Bayés de Luna A. Acute Coronary Syndrome. *Circulation* 2017;136:691–3.
14 doi:10.1161/CIRCULATIONAHA.117.028832.
- 15 [113] Birnbaum Y, Bayés de Luna A, Fiol M, Nikus K, Macfarlane P, Gorgels A, et al. Common
16 pitfalls in the interpretation of electrocardiograms from patients with acute coronary syndromes
17 with narrow QRS: a consensus report. *J Electrocardiol* 2012;45:463–75.
18 doi:10.1016/j.jelectrocard.2012.06.011.
- 19 [114] Eerdekens R, Chavez JF, Fox JM, Flaherty JD, Dekker LRC, Johnson NP. Predicting the
20 infarct-related artery in STEMI from the surface ECG: Independent validation of proposed
21 criteria. *EuroIntervention* 2017;13:953–61. doi:10.4244/EIJ-D-17-00345.
- 22 [115] Ruiz-Mateos B, García-Borbolla R, Almendro-Delia M, Seoane-García T, García del Río M,
23 Cortes-Cortes FJ, et al. Localization of the culprit artery in inferior myocardial infarction:
24 Influence of the point of measurement of ST segment. *J Electrocardiol* 2019;53:8–12.
25 doi:10.1016/j.jelectrocard.2018.12.010.
- 26 [116] Vaturi MD M, Birnbaum MD Y. The use of the electrocardiogram to identify epicardial
27 coronary and tissue reperfusion in acute myocardial infarction. *J Thromb Thrombolysis*
28 2000;10:5–14. doi:10.1023/A:101876250.

- 1 [117] Boden WE, Spodick DH. Diagnostic significance of precordial ST-segment depression. *Am J*
2 *Cardiol* 1989;63:358–61. doi: 10.1016/0002-9149(89)90346-9.
- 3 [118] Gorgels APM, Engelen DJM, Wellens HJJ. Lead aVR, a mostly ignored but very valuable lead
4 in clinical electrocardiography**Editorials published in the *Journal of the American College of*
5 *Cardiology* reflect the views of the authors and do not necessarily represent the views of
6 JACC or the American. *J Am Coll Cardiol* 2001;38:1355–6. doi:10.1016/S0735-
7 1097(01)01564-9.
- 8 [119] Gorgels APM, Vos MA, Mulleneers R, de Zwaan C, Bär FWHM, Wellens HJJ. Value of the
9 electrocardiogram in diagnosing the number of severely narrowed coronary arteries in rest
10 angina pectoris. *Am J Cardiol* 1993;72:999–1003. doi:10.1016/0002-9149(93)90852-4.
- 11 [120] Kim MC, Ahn Y, Rhew SH, Jeong MH, Kim JH, Hong YJ, et al. Impact of Total Occlusion of
12 an Infarct-Related Artery on Long-Term Mortality in Acute Non-ST-Elevation Myocardial
13 Infarction Patients Who Underwent Early Percutaneous Coronary Intervention. *Int Heart J*
14 2012;53:160–4. doi:10.1536/ihj.53.160.
- 15 [121] Warren J, Mehran R, Yu J, Xu K, Bertrand ME, Cox DA, et al. Incidence and Impact of
16 Totally Occluded Culprit Coronary Arteries in Patients Presenting With Non–ST-Segment
17 Elevation Myocardial Infarction. *Am J Cardiol* 2015;115:428–33.
18 doi:10.1016/j.amjcard.2014.11.023.
- 19 [122] Nikus KC, Eskola MJ, Niemelä KO, Sclarovsky S. How to use ECG for decision support in the
20 catheterization laboratory. *J Electrocardiol* 2004;37:247–55.
21 doi:10.1016/j.jelectrocard.2004.07.011.
- 22 [123] Giacoppo D, Madhavan M V., Baber U, Warren J, Bansilal S, Witzenbichler B, et al. Impact of
23 contrast-induced acute kidney injury after percutaneous coronary intervention on short- and
24 long-term outcomes: Pooled analysis from the HORIZONS-AMI and ACUTY trials. *Circ*
25 *Cardiovasc Interv* 2015;8:e002475. doi:10.1161/CIRCINTERVENTIONS.114.002475.
- 26 [124] Shah A, Wagner GS, Green CL, Crater SW, Sawchak ST, Wildermann NM, et al.
27 Electrocardiographic differentiation of the ST-segment depression of acute myocardial injury
28 due to the left circumflex artery occlusion from that of myocardial ischemia of nonocclusive

- 1 etiologies. *Am J Cardiol* 1997;80:512–3. doi: 10.1016/s0002-9149(97)00406-2.
- 2 [125] Casas RE, Marriott HJ., Glancy DL. Value of Leads V7–V9 in Diagnosing Posterior Wall
3 Acute Myocardial Infarction and Other Causes of Tall R Waves in V1–V2. *Am J Cardiol*
4 1997;80:508–9. doi:10.1016/S0002-9149(97)00404-9.
- 5 [126] Kanemoto N, Wang Y, Fukushi H, Ibukiyama C, Takeuchi T, Sato T, et al.
6 Electrocardiographic characteristics of patients with left circumflex-related myocardial
7 infarction in the acute phase without tented T waves or definite ST elevation. *J Cardiol*
8 1995;26:149–58.
- 9 [127] Haines DE, Raabe DS, Gundel WD, Wackers FJT. Anatomic and prognostic significance of
10 new T-wave inversion in unstable angina. *Am J Cardiol* 1983;52:14–8.
11 doi:10.1007/s002380050259.
- 12 [128] Savonitto S, Ardissino D, Granger CB, Morando G, Prando MD, Mafriaci A, et al. Prognostic
13 value of the admission electrocardiogram in acute coronary syndromes. *J Am Med Assoc*
14 1999;281:707–13. doi:10.1001/jama.281.8.707.
- 15 [129] Herz I, Birnbaum Y, Zlotikamien B, Strasberg B, Sclarovsky S, Chetrit A, et al. The prognostic
16 implications of negative T waves in the leads with ST segment elevation on admission in acute
17 myocardial infarction. *Cardiology* 1999;92:121–7. doi:10.1159/000006959.
- 18 [130] Diderholm E, Andrén B, Frostfeldt G, Genberg M, Jernberg T, Lagerqvist B, et al. ST
19 depression in ECG at entry indicates severe coronary lesions and large benefits of an early
20 invasive treatment strategy in unstable coronary artery disease; the FRISC II ECG substudy.
21 *Eur Heart J* 2002;23:41–9. doi:10.1053/euhj.2001.2694.
- 22 [131] Sarak B, Goodman SG, Yan RT, Tan MK, Steg PG, Tan NS, et al. Prognostic value of
23 dynamic electrocardiographic T wave changes in non-ST elevation acute coronary syndrome.
24 *Heart* 2016;102:1396–402. doi:10.1136/heartjnl-2015-309161.
- 25 [132] de Zwaan C, Bär FWHM, Wellens HJJ. Characteristic electrocardiographic pattern indicating a
26 critical stenosis high in left anterior descending coronary artery in patients admitted because of
27 impending myocardial infarction. *Am Heart J* 1982;103:730–6. doi:10.1016/0002-
28 8703(82)90480-X.

- 1 [133] de Winter RJ, Verouden NJW, Wellens HJJ, Wilde AAM. A New ECG Sign of Proximal LAD
2 Occlusion. *N Engl J Med* 2008;359:2071–3. doi:10.1056/NEJMc0804737.
- 3 [134] Jacobsen MD, Wagner GS, Holmvang L, Macfarlane PW, Näslund U, Grande P, et al. Clinical
4 significance of abnormal T waves in patients with non-ST-segment elevation acute coronary
5 syndromes. *Am J Cardiol* 2001;88:1225–9. doi:10.1016/S0002-9149(01)02081-1.
- 6 [135] Jacobsen MD, Wagner GS, Holmvang L, Kontny F, Wallentin L, Husted S, et al. Quantitative
7 T-wave analysis predicts 1 year prognosis and benefit from early invasive treatment in the
8 FRISC II study population. *Eur Heart J* 2005;26:112–8. doi:10.1093/eurheartj/ehi026.
- 9 [136] Erikssen G, Liestøl K, Gullestad L, Haugaa KH, Bendz B, Amlie JP. The terminal part of the
10 QT interval (T peak to T end): A predictor of mortality after acute myocardial infarction. *Ann
11 Noninvasive Electrocardiol* 2012;17:85–94. doi:10.1111/j.1542-474X.2012.00493.x.
- 12 [137] Gargiulo G, Carrara G, Frigoli E, Vranckx P, Leonardi S, Ciociano N, et al. Bivalirudin or
13 Heparin in Patients Undergoing Invasive Management of Acute Coronary Syndromes. *J Am
14 Coll Cardiol* 2018;71:1231–42. doi:10.1016/j.jacc.2018.01.033.
- 15 [138] Kligfield P, Gettes LS, Bailey JJ, Childers R, Deal BJ, Hancock EW, et al. Recommendations
16 for the Standardization and Interpretation of the Electrocardiogram. *Circulation*
17 2007;115:1306–24. doi:10.1161/CIRCULATIONAHA.106.180200.
- 18 [139] Dilaveris P, Batchvarov V, Gialafos J, Malik M. Comparison of different methods for manual P
19 wave duration measurement in 12-lead electrocardiograms. *PACE - Pacing Clin Electrophysiol*
20 1999;22:1532–8. doi:10.1111/j.1540-8159.1999.tb00358.x.
- 21 [140] Andrikopoulos GK, Dilaveris PE, Richter DJ, Gialafos EJ, Synetos AG, Gialafos JE. Increased
22 variance of P wave duration on the electrocardiogram distinguishes patients with idiopathic
23 paroxysmal atrial fibrillation. *PACE - Pacing Clin Electrophysiol* 2000;23:1127–32.
24 doi:10.1111/j.1540-8159.2000.tb00913.x.
- 25 [141] Dianati Maleki N, Stocke K, Zheng Y, Westerhout CM, Fu Y, Chaitman BR, et al. An
26 assessment of ST-segment measurement variability between two core electrocardiogram
27 laboratories. *J Electrocardiol* 2014;47:38–44. doi:10.1016/j.jelectrocard.2013.10.005.
- 28 [142] Tjandrawidjaja MC, Fu Y, Al-Khalidi H, Todaro TG, Adams P, Van de Werf F, et al. Failure

1 of investigator adherence to electrocardiographic entry criteria is frequent and influences
2 clinical outcomes: lessons from APEX-AMI. *Eur Heart J* 2007;28:2850–7.
3 doi:10.1093/eurheartj/ehm453.

4 [143] Murray A, McLaughlin NB, Campbell RW. Measuring QT dispersion: man versus machine.
5 *Heart* 1997;77:539–42. doi:10.1136/hrt.77.6.539.

6 [144] Krone RJ, Friedman E, Thanavaro S, Miller JP, Kleiger RE, Oliver GC. Long-term prognosis
7 after first Q-wave (transmural) or non-Q-wave (nontransmural) myocardial infarction: Analysis
8 of 593 patients. *Am J Cardiol* 1983;52:234–9. doi:10.1016/0002-9149(83)90114-5.

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

1 **Figure legends**

2 **Figure 1.** Diagnostic criteria for atrial infarction proposed by Liu et al. [13], Hellerstein [15], and
3 Sivertssen et al. [41].

4 **Figure 2.** Pearson correlation and Bland-Altman plot analysis for PR-segment depression from the
5 reference (ref.) reader and reader 1.

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

1 **Table 1.** Multiple definitions of pathological Q-waves classification

Classic criteria [53,54,144]	Q-wave with a duration ≥ 40 ms and/or a depth $\geq 25\%$ of the R-wave in the same lead or the presence of a Q-wave equivalent
TIMI criteria [55]	Q-wave ≥ 30 ms in 2 contiguous leads, any Q- or R-wave ≤ 10 ms and ≤ 1 mm in lead V2, and R-wave ≥ 40 ms in V1
Selvester QRS Scoring System [56]	Q-wave duration ≥ 30 ms in leads I, II, aVL, aVF, V5, V6, or ≥ 20 ms in V4, or any Q-wave in V1, V2, V3 R-wave duration ≥ 40 ms in V1, or ≥ 50 ms in V2, or ≤ 30 ms in V3 R/Q ratio ≤ 1 in leads I, aVL, aVF R/S ratio ≥ 1 in lead V1 R/S ratio ≥ 1.5 in lead V2 R/Q or R/S ratio ≤ 0.5 in lead V4 R/Q or R/S ratio ≤ 1 in leads V5, V6
Selvester QRS Screening Criteria [59,60]	Q-wave ≥ 30 ms in aVF R-wave ≤ 1 mm and/or ≤ 10 ms in V2 R-wave ≥ 40 ms in V1 Additional criteria: Q-wave ≥ 40 ms in leads I and aVL Q-wave ≥ 40 ms in ≥ 2 leads of V4, V5, or V6 Any Q-wave in V2
Minnesota Code Manual [57]	Major Q-waves: Q-wave ≥ 50 ms in any leads; Q-wave ≥ 40 ms in any leads other than aVF and III; Q-wave ≥ 30 ms with R/Q < 3 in leads V2-V6, I, or II; QS-wave in lead V4 or V5; or an initial R wave in leads V1-V5 and flag QS in the next leads V2-V6 Moderate Q-waves: Q-wave ≥ 40 ms in lead aVF or III; Q wave ≥ 30 ms V2-V6, I, or II; Q-wave ≥ 20 msec and R/Q < 3 in leads V2-V6, I, or II; or QS-wave in leads V3, I, or II Minor Q-waves: Q-wave ≥ 30 ms in leads aVL, aVF, or III; Q-wave ≥ 20 ms and R/Q < 5 in leads V2-V6, I, or II; or QS in leads aVF, III, or V2
2000 ESC/ACC Consensus [58]	Any Q-wave in leads V1 through V3, Q-wave ≥ 30 ms in leads I, II, aVL, aVF, V4, V5, V6 The Q-wave changes must be present in any two contiguous leads, and be ≥ 1 mm in depth
2018 Fourth Universal Definition of MI [47]	Any Q-wave in leads V2-V3 ≥ 20 ms or QS complex in leads V2-V3 Q-wave ≥ 30 ms and ≥ 1 mm deep or QS complex in leads I, II, aVL, aVF or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF; V7-V9) R-wave ≥ 40 ms in V1-V2 and R/S ≥ 1 with a concordant positive T-wave in the absence of a conduction defect

2
3
4
5
6
7
8

1 **Table 2.** ECG metrics and patterns analyzed in the ECG-MATRIX

Heart rhythm	<ul style="list-style-type: none"> - Heart rate - Rhythm definition - Rhythm disturbance (supra-ventricular and ventricular arrhythmias) - Premature ectopic beats (atrial and ventricular)
Frontal plane QRS axis	<ul style="list-style-type: none"> - Normal axis orientation - Left or right axis deviation
Atrial depolarization	<ul style="list-style-type: none"> - P-wave voltage - P-wave duration - P-wave dispersion - P-wave time-to-peak (atrial intrinsicoid deflection) - P-peak to P-end interval - P-wave peak-to-end interval - P-wave morphology (i.e., irregular, M- / W-shaped) - P-wave terminal force in V1 - Left atrial enlargement - Right atrial enlargement - Interatrial block
Atrial repolarization	<ul style="list-style-type: none"> - PR-deviation at atrial J-point (elevation and/or depression) - Maximum PR-deviation (elevation and/or depression) - \sum PR-deviation at atrial J-point (elevation and/or depression) - \sum Maximum PR-deviation (elevation and/or depression) - PR-deviation resolution at atrial J-point (elevation and/or depression) - Maximum PR-deviation resolution (elevation and/or depression) - PR-segment deviation slope (flat, slightly/markedly down-sloping or up-sloping) - P-wave / PR-segment junction shape distinguishing a smooth-angled versus a sharp-angled - P-wave polarity / PR-deviation concordance (or discordance)
Atrioventricular conduction	<ul style="list-style-type: none"> - PR-interval duration - Time relation between P-wave / QRS complex - Atrioventricular block - Wolf-Parkinson-White pattern
Ventricular depolarization	<ul style="list-style-type: none"> - Q-, R-, S-, R'-, S'- (individual) waves voltage - Q-, R-, S-, R'-, S'- (individual) waves duration - R-wave time-to-peak (ventricular intrinsicoid deflection); - Peak-to-peak QRS complex amplitude - Net QRS complex deflection - QRS complex duration - QRS complex dispersion - Complete/incomplete right/left bundle branch block - Left anterior/posterior fascicular block - Bifascicular block
Ventricular repolarization	<ul style="list-style-type: none"> - ST-segment deviation at J-point (elevation and/or depression) - ST-segment deviation 60 ms after the J-point (elevation and/or depression) - \sum ST-segment deviation at J-point (elevation and/or depression) - \sum ST-segment deviation 60 ms after the J-point (elevation and/or depression) - ST-segment resolution at J-point (elevation and/or depression) - ST-segment resolution 60 ms after the J-point (elevation and/or depression) - Non-persistent ST-segment elevation - Dynamic ST-segment shifts

	<ul style="list-style-type: none"> - T-wave amplitude - Peak-to-peak T-wave amplitude - Net T-wave deflection - T-wave duration - T-wave morphology (i.e., biphasic, hyper-acute) - T-wave time-to-peak (T-wave intrinsicoid deflection) - Tp-e interval with tail method (with and without Bazett's correction) - Tp-e interval with tangent method (with and without Bazett's correction) - Tp-e interval dispersion - JT-interval with tail method (with and without Bazett's correction) - JT-interval with tangent method (with and without Bazett's correction) - JT-interval dispersion - JT-interval prolongation index - QT-interval with tail method (with and without Bazett's correction) - QT-interval with tangent method (with and without Bazett's correction) - QT-interval dispersion - QT-interval prolongation index
Additional metrics (including scores or patterns)	<ul style="list-style-type: none"> - Wellens' pattern - De Winter's pattern - Sgarbossa's criteria for left bundle branch block - Smiths' criteria for left bundle branch block - Anderson-Wilkins acuteness score - Left ventricular hypertrophy - Right ventricular hypertrophy - Index of Cardiac Electrophysiological Balance (iCEB) - ECG-based Regional Restitution Instability Index (R2I2) - Mechanical systole duration by Waller's formula