

급성 심근경색증에서 경색심근의 관류정도와 12유도 심전도상 R파, ST절, QRS평점과의 관계

안정천 · 김수미 · 황교승 · 이은미 · 송우혁 · 임도선
박창규 · 김영훈 · 서홍석 · 심완주 · 오동주 · 노영무

Significance of ST Segment, R Wave, Q Wave and QRS Score for Assessing Myocardial Perfusion in Acute Myocardial Infarction

Jeong Cheon Ahn, MD, Soo Mi Kim, MD, Kyo Seung Hwang, MD, Eun Mi Lee, MD,
Woo Hyuk Song, MD, Chang Gyu Park, MD, Young Hoonm Kim, MD, Hong Seog Seo, MD,
Wan Joo Shim, MD, Dong Joo Oh, MD and Young Moo Ro, M.D.

Department of Internal Medicine, College of Medicine, Korea University, Seoul, Korea

ABSTRACT

Background and Objectives : The restoration of infarct-related coronary artery (IRA) patency in acute myocardial infarction (AMI) linked to a significant improvement in survival. Because of microvascular and cellular injury, patent IRA does not always represent successful reperfusion. With progress of myocardial ischemia, standard 12 lead ECG shows evolutionary changes of ST-segment, R wave and Q wave. But their relations to myocardial perfusion were uncertain. **Methods** : Total 41 patients of the first anterior wall AMI were enrolled and serial ECGs were taken to measure sum of ST-segment elevation (ST), sum of Q wave (Q), sum of R wave (R), and QRS score (QRSs) proposed by Selvester in each patients before thrombolytic therapy (i), after coronary angiography at 90 minutes of thrombolytic therapy (a), and before discharge (d). Myocardial contrast echocardiography was performed within 10 days of AMI to estimate opacification score (OS) and opacification index (OI) in segments of LAD territory. We investigate the relation between evolution of ECG changes and perfusion status of infarcted myocardium. **Results** : 1) There was no relation between OI and ST, but R and QRSs showed significant relation with OI before discharge ($r=0.59$, -0.33 , $p<0.05$, respectively), post thrombolytic therapy ($r=0.51$, -0.61 , $p<0.05$), and baseline ECG ($r=0.53$, -0.51 , $p<0.05$). 2) The number of segments with OS (0.5) showed no significant relation to the degree of ST and Q, but number of segments with OS (0) showed significant relation to that of R and QRSs (r of R_i , R_a , R_d vs number of segments with OS (0) = -0.59 , -0.66 , -0.43 , $p<0.05$, QRS $_i$, QRS $_a$, QRS $_d$ vs number of segments with OS (0) = 0.58 , 0.58 , 0.57 , $p<0.05$). **Conclusion** : These findings suggest that the ECG changes of R wave and QRS scores could be useful markers of perfusion state in thrombolytic era. (Korean Circulation J 1998;28(10):1707-1716)

KEY WORDS : Acute myocardial infarction · Myocardial perfusion · ECG · Myocardial contrast-echocardiography.

: 1998 8 12
: 1998 11 19
: , 136 - 075 574
: (02) 920 - 5445 · : (02) 927 - 1478
E - mail : hhansin@unitel.co.kr

서론

가 .

대상 및 방법

가

연구 대상

1995 2 1997 8

가 .¹⁻⁷⁾

(anterior wall AMI)

2

41 .

nitroglycerin

30

가

가

12

2

(' No Reflow ' phenom -

0.1 mV

ST

enon)

8 - 10)

2

0.2 mV

ST

가

가

.¹¹⁾

가

,

W - P - W

,

,

(myocardial contrast echocardiogr -

,

aphy, MCE),

(magnetic resonance

imaging, MRI),

(positron emission tomography, PET)

.

가

가

관동맥 조영술 및 심근 조영 심초음파도 검사의 시행

12

ST

90

Seldinger

29

7 10

,

Q

, R 가

, TIMI

가

TIMI 2

.^{12 - 14)}

TIMI 3

가 TIMI 3 가

,

가

41

가

12

90

,

29

7 10

.

hexabrix

Sonicator(Heat system, U.S.A)

4

2

3

cc,

2 cc

Hewlett - Packard

가

Sonos 1500

12

가

gain

1/2 inch

가 (left anterior descending artery) (Fig. 1)

가 7 (Opacification Score, OS) 가 (Opacification Index, OI)

심전도 검사

20 12 ST (base - line ECG, i) 90 (Post - angiographic ECG, a) (Pre - discharge ECG, d)

ST (degree of ST elevation) (STi, STa, STd, mV), Q (depth of Q wave) (Qi, Qa, Qd, mV), R (height of R wave) (Ri, Ra, Rd, mV), Selvester QRS (QRSi, QRSa, QRSd)

ST V1 V6 PR segment J 0.06 Q R aVR

QRS Selvester¹⁶⁾ QRS (scoring system) V1 V6 R , Q , Q , R , S 13 (Table 1).

통계처리 SPSS program ± paired t - test, unpaired t - test, ANOVA, (correlation analysis), (regression analysis) p 0.05

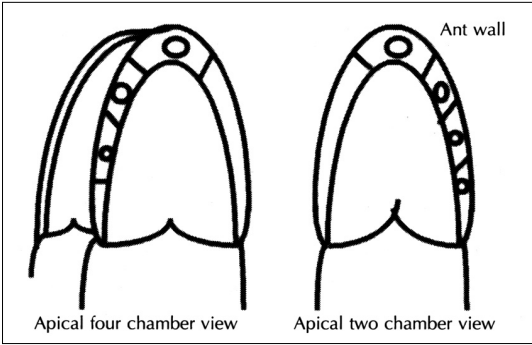


Fig. 1. Observed segments in LAD territory.

Table 1. QRS scoring system in Anterior wall acute myocardial infarction

V ₁ (2)	Any Q	** (1)	V ₄ (3)	Q 20ms	(1)	R/S 0.5	(2)
	Q or S 1.8mV	(1)		R/Q 0.5	(2)	R/S 1	(1)
V ₂ (1)	Any Q	(1)		R/Q 1	(1)	R 0.7mV	(1)
	R 10ms	(1)		Notched R	(1)		
	R 0.1mV	(1)	V ₅ (3)	Q 30ms	(1)	R/S 1	(2)
	R RV1mV	(1)		R/Q 1	(2)	R/S 2	(1)
V ₃ (1)	Any Q	(1)		R/Q 2	(1)	R 0.7mV	(1)
	R 20ms	(1)		Notched R	(1)		
	R 0.2mV	(1)	V ₆ (3)	Q 30ms(1)		R/S 1	(2)
				R/Q 1	(2)	R/S 3	(1)
				R/Q 3	(1)	R 0.6mV	(1)
				Notched R	(1)		

* : score limit for each lead, ** : score for each criteria

Total 13 points

결 과

대상환자의 특성

41 가 35
55
18 , 29 , 6 , 17
5.5±9.3 6
33 , 8
6 15
90
TIMI 3 34
, TIMI 2 2 , TIMI 1 1 , TIMI 0가 4
TIMI 2 7
TIMI 3
가
5.5±4.5
0.75±0.15

ST절의 상승 및 Q파크기의 합계와 경색심근의 관류 정도와의 관계

가 4.7±5.0 , 90
가 9.4±5.8 , 가 7.2
±2.1 . ST STi가 STa
STd (p=0.04, 0.032,
respe - ctively), STa STd
(STi : STa · STd=1.59±
1.07 mV : 0.819±0.715 mV : 0.64±0.39 mV). Q
(Qi) 2.18±
1.79 mV, 90 (Qa) 3.37±2.14
mV, (Qd) 3.59±2.10
mV Q 가 가 (p=
0.042, 0.04), Qa Qd
(Fig. 2).

ST, Q
(r of STi, STa,
STd vs OI = -0.35, -0.04, -0.07, p>0.05, r of
Qi, Qa, Qd vs OI=0.24, 0.02, -0.08, p>0.05,
respectively).

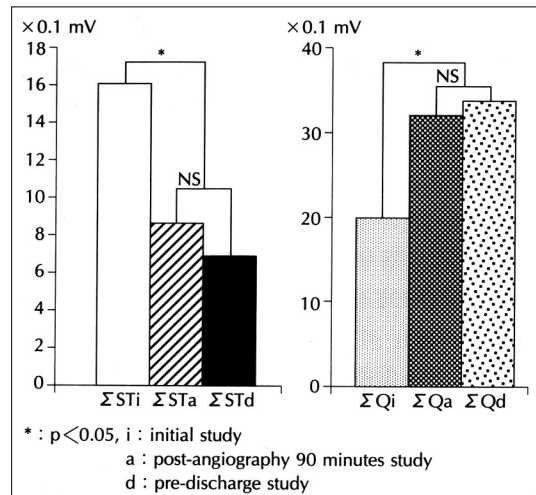


Fig. 2. Changes of ST and Q.

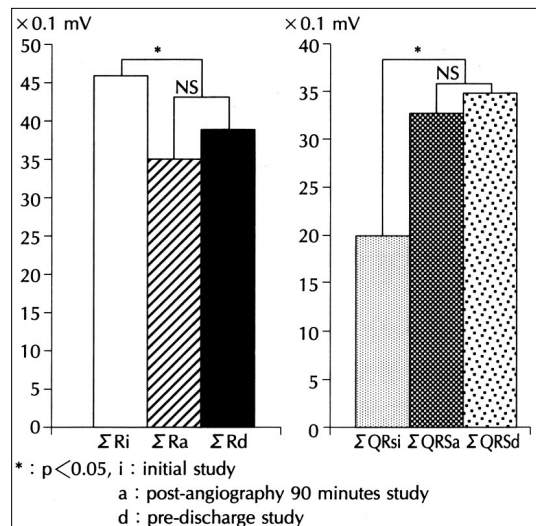
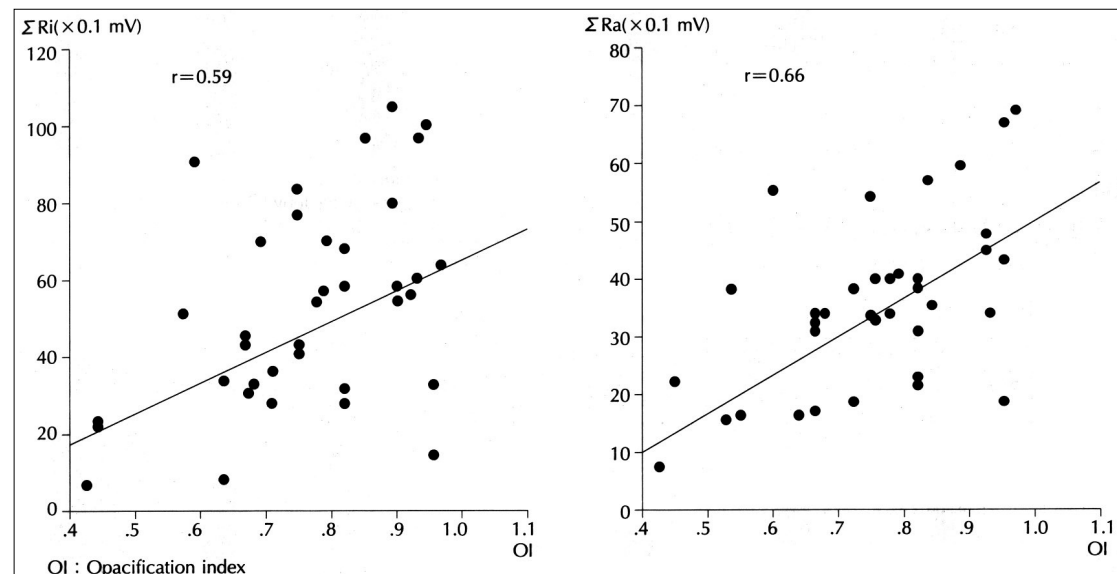


Fig. 3. Change of R and QRSs.

R파고의 감소 및 QRS 평점과 조영지수의 관계

R Ri : Ra : Rd=4.70±2.22 : 3.5
6±1.46 : 3.59±2.10 mV R
90
QRS (QRSi)
4.58±2.53, (QRsa) 6.0±2.26,
(QRsd) 6.36±2.42
QRS (p<0.05, Fig. 3).
R
QRS 가 R

	R	Ra	Rd	QRSi	QRSa	QRSd
OI	r= 0.53	0.51	0.59	- 0.51	- 0.61	- 0.33
No of OS(0)	- 0.59	- 0.66	- 0.43	0.58	0.58	0.57
No of OS(0.5)	NS	NS	NS	NS	NS	NS
OI : opacification index		i : initial study		OS : opacification score		
a : post-angiography 90 minutes study		QRS : QRS score		d : pre-discharge study		



QRS	Ri,	가 0	(A , n=7),
a, d	QRSi, a, d	가 0	(B , n=
R	가	QRS	(Table 2, Fig. 4).
			23), 3
			7
			(C , n=11)
			R
			QRS
R	QRS	가 0	.
	가 0.5		Fig. 5
가 0		R, QRS	
가			R
	가 0.5,		A
			C
			(5.8±3.2 mV vs 3.2±1.8 mV, p<0.
			01).
	가	(Table 2),	(4.7±1.6 mV vs 3.5±0.8
	가		mV, p<0.05),
		가	가
			(4.2±1.4 mV vs 3.0±2.1 mV, p>0.05).
			R
			A
			R
			,
조영점수에 따른 R파고의 총합과 QRS평점의 변화			5.8±3.2 mV, 4.6±1.7 mV, 4.2±1.5 mV
			, B
	가 0.5	90	C
			R
			(B : 5.1±1.5 mV vs 3.5±0.8 mV, p=

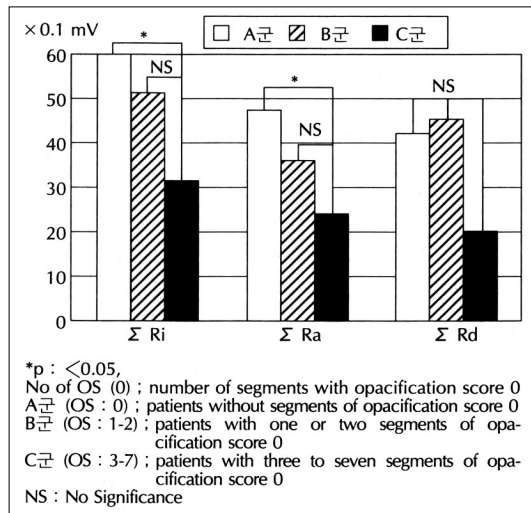


Fig. 5. Comparison of R between groups.

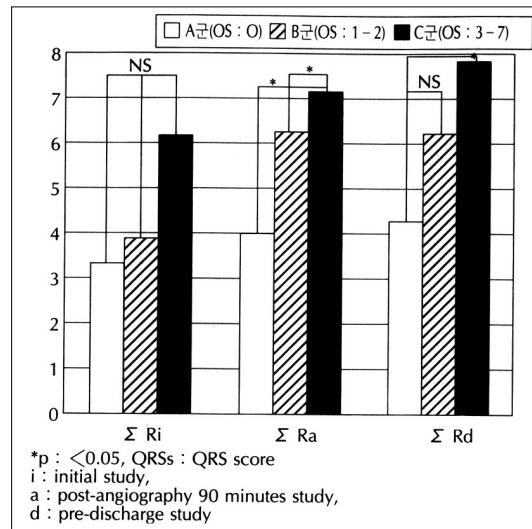


Fig. 7. Comparison of QRSs between groups.

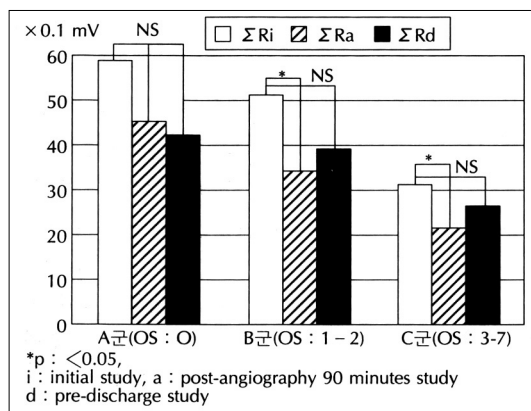


Fig. 6. Sequential changes of R within a specific group.

0.035, C : 3.2 ± 1.8 mV vs 2.3 ± 0.9 mV, $p=0.046$) (Fig. 6).

QRS 가 0
C A B
(C : B = 6.2 ± 1.1 : 3.5 ± 0.7 , $p=0.07$, C : A = 6.2 ± 1.1 : 3.3 ± 1.0 , $p=0.068$),
B A QRS 가
(C vs B = 7.3 ± 1.9 vs 6.3 ± 1.5 , $p=0.035$, C vs B = 7.3 ± 1.9 vs 4.0 ± 2.5 , $p=0.041$),
C 7.7 ± 2.0 A 4.4 ± 2.5 가
($p=0.021$) (Fig. 7).

QRS A
QRS

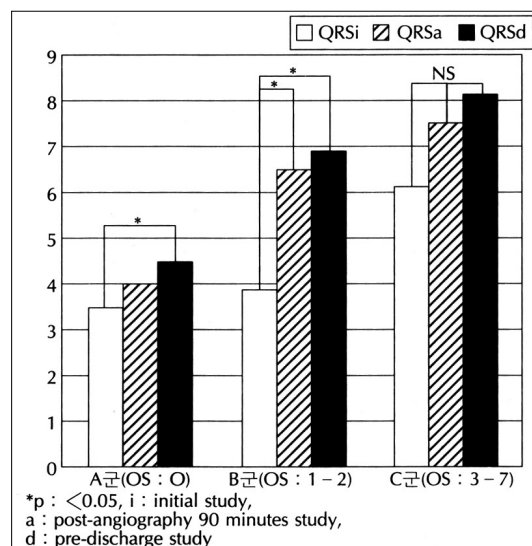


Fig. 8. Sequential changes of QRSs within a specific group.

(3.5 ± 2.0 vs 4.8 ± 2.3 , $p=0.03$), B
90
QRS 가 (3.9 ± 1.9 vs 6.5 ± 1.5, 6.8 ± 1.4, $p=0.05$). C
, QRS 6.1 ± 1.7, 7.5 ± 1.3, 8.1 ± 0.9 가 (Fig. 8).

ST절의 하강정도에 따른 심근관류정도의 비교
ST

33

ST 50%

(n=24)

(n=9)

50% ST 가

ST절 및 Q파의 변화와 관류지수와의 관계

(V1 - V6) ST

(0.79±0.13 vs 0.72±0.15, p=0.17).

(ST) ¹⁹⁾ ST

가

고 찰

가

5

13) Frits²⁰⁾ ST

24 48

ST

15)17) 가

2 ST

ST

(sensitivity)

(specificity)가

ST

ST

8-10) 가

가

(microvascular damage)

가

11) 가 TIMI 3

90

TIMI 2

가

TIMI 3

ST 90

ST

90

12-14) Selv -

ST 50%

ester QRS

가

18)

가 ST

가

ST

50%

1713

R QRS Q (Q), R (R)
Selvester QRS QRS scoring system
가 12 90
, 29 7 10
2 4
가 .
요 약
연구배경 :
가 positron emission tomography(PET)가
. 12
가 가 ST
Q , R , QRS (scoring system)
가 . 가
가 12
가
가
방 법 :
(anterior wall AMI)
TIMI 3 2
41
. 15 20
ST 가
(ECGi) 90
(ECGa),
(ECGd) V1 - V6
ST (ST), aVR
결 과 :
1) 41 55 ,
35 : 6 ECGi,
ECGa, ECGd 4.7 ± 5.0 , 9.4 ±
5.8 , 7.2 ± 3.1 5.5
± 4.5 , 0.75 ± 0.15
2) ST Q
가 R (Ri, Ra, Rd, vs
OI : r = 0.53, 0.51, 0.59, p < 0.05) QRS (QRSi,
QRSa, QRSd vs OI : r = - 0.51, - 0.61, - 0.33, p < 0.05)
3) 가 0 (No of OS(O))
QRS R (r of
QRSi, QRSa, QRSd vs No of OS(O) = 0.58, 0.58, 0.57,
p < 0.05 Ri, Ra, Rd vs No of OS(O) = - 0.59,
- 0.66, - 0.43, p < 0.05) 가 0.5
4) 6 33
ST 50% (n = 24)
(n = 9)
(0.79 ± 0.13 vs 0.72 ± 0.15, p = 0.17).
결 론 :
12
R QRS
중심 단어 :
REFERENCES
1) The I.S.A.M Study group. *A prospective trial of intravenous streptokinase in acute myocardial infarction (I.S.A.M).*

- N Engl J Med* 1986;314:1465-71.
- 2) Simons ML, Serruys PW, van der Brand M. *Early thrombolysis in acute myocardial infarction: Limitation of infarct size and improved survival.* *J Am Coll Cardiol* 1986;7:717-28.
 - 3) Kennedy JW, Ritche JL, Davis KB, Fritz JK. *Western Washington randomized trial of intracoronary streptokinase in acute myocardial infarction.* *N Engl J Med* 1983;309:1477-82.
 - 4) Gruppo Italiano per lo Studio della Streptokinasi nell'Infarto miocardico (GISSI). *Effectiveness of intravenous thrombolytic treatment in acute myocardial infarction.* *Lancet* 1986;1:397-401.
 - 5) ISIS-2 (Second International Study of Infarct Survival) Collaborative Group. *Randomized trial of intravenous streptokinase, oral aspirin, both or neither among 17,877 cases of suspected acute myocardial infarction: ISIS-2.* *Lancet* 1988;11:349-401.
 - 6) Res JCI, Simmons ML, van der Wall EE. *Long term improvement in global left ventricular function after early thrombolytic treatment in acute myocardial infarction.* *Br Heart J* 1986;56:414-21.
 - 7) Stacks RS, Philips HR III, Gierson DS. *Functional improvement of jeopardized myocardium following intracoronary streptokinase infusion in acute myocardial infarction.* *J Clin Invest* 1983;72:84-5.
 - 8) Erlebacher JA, Weiss JL, Weisfeldt ML, Bulkley MB. *Early dilatation of the infarcted segments in acute transmural myocardial infarction: Role of infarct expansion in acute ventricular enlargement.* *J Am Coll Cardiol* 1984;4:201-8.
 - 9) Hochman JS, Choo H. *Limitation of myocardial infarct expansion by reperfusion independent of myocardial salvage.* *Circulation* 1987;75:299-306.
 - 10) Ito H, Yu H, Tomook T, Masyuama T, Aburaua M, Sakai N, et al. *Incidence and time course of left ventricular dilatation in the early convalescent stage of reperfused anterior wall acute myocardial infarction.* *Am J Cardiol* 1994;73:539-43.
 - 11) Roval D, DeMaria AN, Batte LA. *Myocardial contrast-echo effect: The dilemma of coronary blood flow and volume.* *J Am Coll Cardiol* 1990;16:1252-7.
 - 12) Peter C, Peer G, Kari S, Flemming P, Jesper HS, Nancy BW, et al. *Effect of intravenous streptokinase on the relation between initial ST-predicted size and final QRS-estimated size of acute myocardial infarcts.* *J Am Coll Cardiol* 1990;16:1252-7.
 - 13) Rolf S, Rudget D, Thomas B, Karl W, Ulrich T. *Extent of early ST segment elevation resolution: A simple but predictor of outcome in patients with acute myocardial infarction.* *J Am Coll Cardiol* 1994;24:384-91.
 - 14) Dissman R, Goerke M, von Amelen H. *Prediction of early reperfusion and left ventricular damage by ST segment analysis during thrombolysis in acute myocardial infarction.* *Z Kardiologie* 1993;82:271-8.
 - 15) Hills LD, Former S, Braunwald E. *Risk stratification before thrombolytic therapy in patients with acute myocardial infarction.* *J Am Coll Cardiol* 1990;16:313-15.
 - 16) Selvester R, Wagner G, Hindman N. *The Selvester QRS scoring system for estimating myocardial infarct size. The development of and application of the system.* *Arch Intern Med* 1985;145:1877-1881.
 - 17) Michael HP, Gerard TW, Patricia AR, Arthur EW. *Natural history of left ventricular size and function after acute myocardial infarction.* *Circulation* 1990;82:484-94.
 - 18) Hindman NB, Schoken DD, Widman M. *Evaluation of a QRS scoring system for estimating myocardial infarct size. Specificity and method of application of the complete system.* *Am J Cardiol* 1985;55:1485-9.
 - 19) Scoroder R, Linderer T, Bruggman T. *Controversial indications, rationale for thrombolysis: Later than 4-6 hr from chest pain onset and in patients with smaller myocardial infarction.* *Eur Heart J* 1990;11:Suppl F:19-28.
 - 20) Frits WB, Paul GA, Volders MS, Frank V, Hei JW. *Development of ST segment elevation and Q and R wave changes in acute myocardial infarction and influence of thrombolytic therapy.* *Am J Cardiol* 1996;77:337-43.
 - 21) Chares F. *Electrocardiography.* In: Braunwald E, editors. *Heart Disease.* 5th ed. Saunders;1997. p.128-9.
 - 22) Kawasaki K, Kusachi S, Hina K, Yamasaki S, Kita T, Endo C, et al. *Q wave regression unrelated to patency of infarct related artery or left ventricular ejection fraction or volume after anterior wall acute myocardial infarction treated with or without reperfusion therapy.* *Am J Cardiol* 1995;76:14-20.
 - 23) Depasque NP, Burch GE, Phillips JH. *Electrocardiographic alterations associated with electrically silent areas of myocardium.* *Heart J* 1964;68:697-709.
 - 24) Haia R, Chiche P. *Transient abnormal Q waves in the course of ischemic heart disease.* *Chest* 1974;65:140-44.
 - 25) Bruken R, Tillisch J, Schweiger M, Child JS, Marshal R, Mandelkern M, et al. *Regional perfusion, glucose metabolism, and wall motion in patients with chronic electrocardiographic Q wave infarctions: Evidence for persistence of viable tissue in some infarct region by positron emission tomography.* *Circulation* 1986;73:951-63.
 - 26) Aland RF, Rafael FS, Simmon C, Lusin C, Eduardo de M, Robert, et al. *ST segment tracking for rapid determination of patency of the infarct-related artery in acute myocardial infarction.* *J Am Coll Cardiol* 1995;26:675-83.