Vectorcardiographic Diagnosis and Electrocardiographic Correlation in Left Ventricular Asynergy Due to Coronary Artery Disease

I. Severe Asynergy of the Anterior and Apical Segments

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SUMMARY
The transverse plane QRS loop vectorcardiogram (VCG) was analyzed in 102 consecutive patients, angiographically proven to have coronary artery disease (CAD), whose right anterior oblique left ventriculogram showed severe asynergy (akinesis or marked hypokinesis) of the anterior and apical segments. Eighty-four of the 102 loops were considered to be diagnostic of severe asynergy because similar loops were not found in patients with CAD with less severe asynergy of either or both segments or in normal control subjects. Eighty-two of the 84 showed a uniformly abnormal pattern. Posterior vectors exhibited partial or complete clockwise “rotation” and were much more prominent than early anterior forces. In fact, the latter were often absent. In the other two VCGs, at least the early half of the loop displayed prominent anterior vectors.

The ECGs showed marked variability of the QRS in leads V₁-V₆. Abnormal Q waves were present in only 63 of the 102. The number of these leads showing abnormal Q waves varied from one to all of these positions.

Additional Indexing Words:
QRS pattern
Variability of electrocardiogram
Clockwise posterior forces
Transverse plane

In patients with coronary artery disease (CAD) a relationship has been demonstrated between abnormal Q waves in the electrocardiogram (ECG) and asynergy proven by ventriculography.¹ ² This correlation is not surprising since abnormal Q waves, indicative of myocardial infarction, might be expected to be associated with localized areas of diminished ventricular wall motion. Subsequent personal experience to be detailed below (table 1 and pp 472-473) indicated, however, that in the diagnosis of severe and extensive asynergy, abnormal Q waves are of limited value. Indeed, in many cases, there may be no abnormal Q waves at all. Since important physiological and therapeutic considerations are implicit in the diagnosis of severe and extensive asynergy, our attention turned to the potential use of the vectorcardiogram (VCG) in diagnosis.

The present report is specifically concerned with an appraisal of the value of the transverse plane VCG, as compared to the ECG, in the diagnosis of severe asynergy of the anterior and apical segments of the left ventricle in subjects with coronary artery disease.

Materials and Methods

Patient Population
The present report is based on VCG, ECG, and ventriculographic observations on 1004 consecutive patients proven by cinearteriography to have significant disease of one or more major coronary arteries. The ventriculograms of 102 of the 1004 patients showed severe asynergy of at least the anterior and apical segments (see below).

Patients with other significant causes of heart disease were excluded from this study. This excluded subgroup consisted of patients with 1) rheumatic heart disease, primary myocardial disease, hypertrophic subaortic stenosis, pulmonary embolism, primary pulmonary disease, and congenital heart disease; 2) blood pressure recordings above 160/90 or ven-
Abnormal Q waves were defined as being (a) QS or Q wave ≥ 0.04 sec and depth of Q wave > 25% of following R wave in V_7-V_4; (b) Q waves ≥ 0.04 sec and > 15% of total QRS amplitude in V_2 and V_4. Poor R wave progression was defined as R waves less than 2 mm in V_2 and/or less than 4 mm in V_4. Reversed R wave progression was defined as R in V_4 < R in V_2 and/or R in V_2 < R in V_4. The particular leads involved by abnormal Q waves under the column labeled “no. of precordial leads (V_7-V_4) in which present” also showed marked variation. Abnormal Q waves were absent in V_7-V_4 in 30 of the 84 patients with diagnostic VCGs (types A, B, C, E, and F). Twelve of the 30 showed poor R wave progression. Eleven others showed reversed R wave progression. The remaining seven are analyzed in the column labeled “VCG Types A-C.”

corciulographic evidence of more than 2+ mitral regurgitation (based on 1+ to 4+ grading) due to coronary artery disease; or 3) ECG evidence of classical left bundle branch block and Wolff-Parkinson-White syndrome. Presence of right bundle branch block, hemiblock, and/or perinfarction block did not exclude patients from this study. No patient was excluded because his VCG or ECG might be explained by left ventricular hypertrophy (LVH). None of the 102 loops resembled the usual pattern of LVH, however, occasionally in atypical LVH due to marked hypertension, severe aortic and/or mitral valve disease, and myopathy, the loops may resemble some of the VCGs here described for severe asynergy. Two ECGs of the 102 were consistent with LVH (table 1).

No patient was in the acute stages of a myocardial infarction. Five patients had had previous bypass coronary surgery and/or internal mammary implant. However, no one was included who had an aneurysmectomy. Most patients at the time of catheterization were free of obvious congestive heart failure, i.e., pulmonary edema, gross hepatomegaly, or peripheral edema.

Coronary Angiography and Ventriculography

Selective coronary cinearteriography was performed by either the Sones or Judkins technique. An arterial lesion was considered significant if 75% or more of the arterial lumen was obstructed.

Left ventriculography in the 30° right anterior oblique view was performed using a Siemens 10-5 inch or a General Electric 9-6 inch dual-field image-intensifier system. A power injection into the left ventricle utilizing 30-50 ml of contrast agent was made through a multiholed catheter passed retrograde across the aortic valve. Cine films were recorded at 60-100 frames/sec using 16 mm film and were analyzed by at least two observers who had no prior knowledge of the VCG and ECG.

The end-diastolic and end-systolic ventriculographic silhouettes were traced. The apex and the aortic valve were used as fixed reference points. The long axis (midaortic valve to apex) and transverse diameters were superimposed on both the end-diastolic and end-systolic silhouettes. The apical, anterior, inferior, and basal segments and their hemiaxes were identified (fig. 1). For the purpose of this study only the anterior and apical segments were analyzed.

In the normal subject, shortening (difference in end-diastolic and end-systolic hemiaxes) amounts to 30-50% for the anterior and periapical transverse hemiaxes and 20-30% for the basal transverse hemiaxes.
for the base-to-apex long axis. Akinosis of the anterior segment was defined as no shortening of its transverse hemi-
axes. Hypokinesis (impaired or diminished shortening) of the anterior segment was graded as marked (< 10% shorten-
ing of its transverse hemi-axes), moderate (10–19% shortening), or mild (20–29% shortening). Apical akinesis was de-
defined as no shortening of both its transverse hemi-axes and its long axis. Apical hypokinesis was graded as marked
(< 10% shortening of its transverse hemi-axes and 5% or less shortening of its long aaxis), moderate (10–19% of its transverse hemi-axes and 6–10% of its long axis) and mild
(20–29% shortening of its transverse hemi-axes and 11–15% of its long axis). If various parts of a segment showed
different degrees of asynergy, the grade of the entire seg-
ment was the average change in multiple plotted hemi-axes
of that segment.

For the purpose of this study both akinesis and marked
hypokinesis were considered to be severe asynergy. The 102
patients here reported showed severe asynergy of the anterior and apical segments: 1) in 60, both segments were
akinetic; 2) in 30, one segment was akinetic (usually the
apex) and the other segment showed marked hypokinesis; 3) in
the remaining 12, both segments showed marked hypokinesis. Since paradoxical ventricular motion, present
in 18 of the 102, was found in all three groups (including
those with and without ST-segment elevation), no attempt
will be made to differentiate those with and without
dyskinesis.

Vectorcardiography and Electrocardiography

A vectorcardiogram and a standard 12-lead electrocar-
diogram were recorded at the same time. The vectorcar-
diogram was obtained in the supine position in all three
planar projections by the Frank lead reference system.9
Electrodes were placed at the fourth interspace, as
suggested by Langner et al.9 for the supine position. Vec-
torcardiograms were recorded with a Hart Electronics
instrument, model PV-3. The amplifiers were set at a high
frequency response of 200 to 300 Hz and a low frequency
of 0.1 Hz. Since extreme range may introduce artifact, all
VCGs were recorded in the above frequency range.
Emphasis is placed on the high frequency response of the
VCG amplifiers. A high frequency response of 100 Hz or less
(generally the upper frequency response of conventional
ECG amplifiers) may distort the planar phase relationships
as well as decrease the magnitude of the deflections of the
QRS loop herein described.

For the purpose of this report the transverse plane QRS
loop was chosen for analysis. A study was made of 1) planar
phase relationships, i.e., direction of “rotation,” contour,
the presence and location of crossovers, and the relative
location of the efferent as compared with the afferent limb
of the loop, and 2) quantitative criteria, i.e., the location of
a particularly timed vector. Abnormalities of both of these
parameters have been previously described in loops
associated with myocardial infarction.11–14

The loops and vector notations are presented and dis-
cussed in the standard manner.15 The loops’ rightward,
leftward, anterior, and posterior deviations are indicated by
the symbols X, X+, Z, and Z+ respectively. Dash intervals
of 2 msec duration are represented by “teardrops” whose
blurry end indicates its leading edge.

In some of the photographs the P and T as well as the
QRS vectors are shown. Since P and T may obscure the early
part of the QRS, the initial portion of the QRS, with at least
the T loop eliminated, is also shown beneath its correspond-
ing complete loop. This was done to delineate the entire
QRS clearly.

Results — Vectorcardiography

I. Planar phase relationships

Among the 102 patients who had severe asynergy of
at least the anterior and apical segments of the left
ventricle, 96 showed one of six markedly abnormal
transverse plane QRS patterns designated types A–F
(figs. 2–9).

In types A–E the efferent and/or afferent limb of
the posterior vectors displayed abnormal clockwise
direction. Posterior forces were much more prominent
than the early anterior vectors; in fact the latter were
often absent. In type F early anterior forces were
prominent.

In the remaining six, designated Miscellaneous
group, the QRS loop was normal in two and showed
minor abnormalities in four (fig. 10).

![Figure 2](image-url)

Examples of loops designated as type A1. (In this and all following
figures, the order of loops discussed will be from left to right.)

Posterior vectors (1) are considered to be mostly or completely
clockwise because (a) their efferent limb is predominantly or en-
tirely more rightward than their afferent limb and (b) their efferent
limb is partly or completely convex (bowed) in a rightward
direction and (2) are predominantly or entirely to the right (X > X+
or X+ absent). The third and fourth loops are considered to be mostly
clockwise because they show a crossover at their distal portions (1a
above). Note variation in location of initial vectors; in some loops
they are anterior and in others posterior.
Type A

In 54 patients, both the efferent and afferent limbs of the posterior forces were mostly or completely clockwise. In seven, this posterior portion of the loop was predominantly or entirely to the right \( [\text{type A1 (fig. 2)}] \). In 14, the posterior portion of the loop was deviated approximately equally to the right and left \( [\text{type A2 (fig. 3)}] \), and in 33, posterior vectors showed a predominantly or an entirely leftward orientation \( [\text{type A3 (fig. 4)}] \).

Type B

In nine, the efferent limb of the posterior forces was counterclockwise but the afferent limb was clockwise. In all nine, these vectors had a predominantly or entirely leftward orientation \( (\text{fig. 5}) \).

Type C

In ten, posterior forces formed a figure-of-eight pattern of which at least the early part of the efferent limb was counterclockwise and at least the early part of the afferent limb clockwise. In all ten, both limbs of these posterior vectors were predominantly or entirely to the left \( (\text{fig. 6}) \).

Type D

In 12, at least the early part of the efferent limb of posterior forces was clockwise but the afferent limb was counterclockwise. In all 12 both limbs were predominantly or entirely to the left \( (\text{fig. 7}) \).

Type E

In nine, showing right bundle branch block (RBBB), the terminal anterior and rightward forces of RBBB were preceded by posterior vectors of which at least the efferent limb was mostly or completely clockwise \( (\text{fig. 8}) \).

In the nine cases of type E, the loop was deviated posteriorly \( (Z^+) \) 0.76, 0.66, 0.45, 0.33, 0.30 (3 cases), 0.25, and, 0.22 mV, respectively. By contrast, \( Z^+ \) in types A–D had a mean of 1.07 mV with a sd of 0.4 mV, the range varying from 0.53 to 2.00 mV. This less marked posterior deviation in type E may be due to the fact that RBBB, in itself, may bring even the midportion of the loop to a more anterior or less posterior position.\(^{17}\)

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**Figure 3**

Examples of loops designated as type A2. Posterior vectors (1) are considered to be mostly or completely clockwise because (a) their efferent limb is predominantly or entirely to the right of their afferent limb \( (X = X^+) \). The last loop \( (\text{fig. 1a above}) \) is considered to be mostly clockwise because it shows a crossover at its distal portion. In addition, this loop is so narrow that, varying with normal respiration, the two limbs become almost completely superimposed in some cycles. Again note variation in location of initial vectors.

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**Figure 4**

Examples of loops designated as type A3. Posterior vectors (1) are considered to be mostly or completely clockwise because (a) their afferent limb is predominantly or entirely more leftward and/or less posterior than their efferent limb \( (X^+ > X \text{ or } X \text{ absent}) \). The last loop \( (\text{fig. 1a above}) \) is considered to be mostly clockwise for reasons stated in 1a. Again note variation in location of initial vectors.
Examples of loops designated as type B. Posterior vectors’ (1) efferent limb is considered to be counterclockwise because it is convex (bowed) in a leftward and/or anterior direction, (2) afferent limb is considered to be clockwise because it is convex (bowed) in a leftward and/or anterior direction, and (3) both limbs are predominantly or entirely to the left (X^+ > X or X absent). In all examples excepting the last, the afferent limb is almost entirely or entirely more leftward than the efferent limb. The last loop is considered to be a variant of type B. In contrast to the first three loops, its two limbs cross over at their proximal part so that a good portion of the efferent limb is more leftward than the afferent limb; nevertheless, a part of the latter is convex in a leftward direction as in the other three loops. Again note variation in location of initial vectors; in the third loop the initial forces are briefly posterior, then anterior.

Type F

In two cases at least the early half of the QRS loop was deviated anteriorly and the entire loop was predominantly or entirely rightward (fig. 9).

Miscellaneous Group

Among the remaining six of the 102, the QRS loop was normal in two and showed RBBB without any other abnormality in one. The other three showed minimal QRS changes (fig. 10).

Differential Diagnosis

Types A, B, C, E, and F loops were not found in the other 902 patients, angiographically proven to have coronary artery disease, but who had less than severe asynergy of the anterior and/or apical segments. Moreover, these five types of loops, as well as type D loops, were not found in a group of 600 normal control subjects, including 80 who had undergone cardiac catheterization with coronary angiography and ventriculography.

In four subjects with severe asynergy of the apex but moderate hypokinesis of the anterior segment, the pattern of the loop simulated type A in three and type C in the fourth (fig. 11). In these four patients, however, Z^+ was less than 0.5 mV (0.43, 0.40, and 0.35 mV in the three exceptions and 0.3 mV in the other). By contrast, the smallest Z^+ value found in type A was 0.67 mV and in type C, 0.53 and 0.63 mV, respectively. In all other loops in group A-D, Z^+ was 0.7 mV or greater (also see type E under Results). Other more subtle differences between the first three of the above four loops and type A loops are illustrated in figure 11.

In 30 patients with severe asynergy of the apex but moderate hypokinesis of the anterior segment, the VCGs were similar in all respects (including the value of Z^+) to type D loops.

As might be expected the VCG patterns found in the Miscellaneous group were frequently found in cases associated with mild hypokinesis or no asynergy at all of the anterior and/or apical segments.

II. Quantitative Criteria

The most useful and established quantitative criteria for diagnosing anterior infarction are: (A) for anteroinferior or posterior infarction, a posterior location of the 0.02 sec vector13,14 and (B) for anterolateral infarction a duration of initial rightward
forces greater than 0.022 second. The application of these two criteria to the 102 cases of severe anterior and apical asynery showed that 30 loops fulfilled both criteria A and B, 36 only A, 17 only B, and 19 loops fulfilled neither criteria. Criterion A, the more sensitive of the two criteria, was also fulfilled by 65 of the 902 patients who had less or no asynery of either both the anterior and apical segments than the 102. Among the 84 loops that were considered diagnostic according to abnormalities in planar phase relationships (types A, B, C, E, and F loops), 29 fulfilled both criteria A and B, 26 only A, 16 only B, and 13 loops neither criteria.

Results — Electrocardiography

Since a relationship between abnormal Q waves and asynery has been demonstrated,1 2 the QRS in the left precordial leads V5-V6 was analyzed in the 102 cases with severe asynery of the anterior and apical segments. Table 1 gives a detailed analysis of the ECG findings and correlates them with the VCG.

Figure 12 shows two pairs of ECGs; the first pair is associated with VCG type A and the second pair with VCG type B abnormality. The first example of each pair shows in one or more left precordial leads an ini-

tial r or R followed by an S wave; the second example of each pair shows normal Q waves in these leads. These four examples emphasize that clockwise “rotation” of posterior forces, as is present in these A and B loops, which corresponds to one or more precordial Q or S waves, is a very important clue to the diagnosis of severe anterior and apical asynery. There were many other examples in which the significance of a downward deflection (S wave) in one or more left precordial leads was similarly masked by an initial r or R wave; yet the VCG was usually diagnostic and uniform in exhibiting clockwise “rotation” of the posterior part of the loop (table 1).

Discussion

This report demonstrates the value of the VCG in the diagnosis of severe asynery of the anterior and apical segments of the left ventricle in patients with coronary artery disease. Diagnostic loops were found
in 84 of the 102 patients. Types A, B, C, and E VCGs, 82 of the 84, showed a uniformly abnormal pattern. Posterior vectors were much more prominent than early anterior forces and exhibited partial or complete clockwise "rotation." In the other two VCGs, type F, at least the early half of the loop displayed prominent anterior vectors.

The ECGs showed marked variability of the QRS in leads V2-V6. Abnormal Q waves were present in 63 of the 102. However, the number of these leads showing abnormal Q waves varied from one to all of these positions. Less definite electrocardiographic evidence of myocardial infarction (poor R wave or reversed R wave progression) was present in 26 other patients. In the remaining 13, the ECGs were not at all suggestive of infarction. These results are at variance with the findings of Miller et al. who noted that "the quantity of dyssnergy was directly related to the precordial extent of pathologic Q waves."2

Since 96 of the 102 cases of severe asynergy here described were associated with marked changes in the transverse plane QRS loop (Types A–F), it is not unexpected that these changes would be associated with myocardial infarction. Indeed, in our experience and that of others,11-14 VCG patterns similar to these have been proven, at autopsy or at heart surgery, to be associated with infarction of the anterior wall.

Although not defined in such detail as in the present report, many abnormalities in planar phase relationships (morphologic changes) described here as associated with asynery have been described previously in various types of anterior infarction. These abnormalities have been characterized by phrases similar to some of those used here such as "figure-of-eight," "complete clockwise rotation," the "effenter limb may be clockwise but the rest of the loop counterclockwise," etc.11-14

For the most part, however, it has become common practice to emphasize or even to require a particularly timed vector to be in a certain position (quantitative criteria) in order to make the diagnosis of infarction.

The results of this study show that quantitative criteria for (A) antero-septal or localized anterior and for (B) antero-lateral infarction were as sensitive as certain abnormalities in planar phase relationships in diagnosing 102 cases of severe anterior and apical asynergy. Eighty-three of the 102 loops satisfied either or both quantitative criteria; 84 showed specific abnormalities in planar phase relationships. However, quantitative criteria were not specific. Thirty-six of the 83 VCGs fulfilled only criterion A. This criterion was also met by loops associated with less asynergy. By contrast the morphologic abnormalities found in the 84 were specific because they were not found in loops associated with less asynergy. This experience emphasizes that although quantitative criteria are useful in defining the total pattern of the loop, it is most important to analyze these other morphologic features of the VCG in order to make the specific diagnosis of severe anterior and apical asynergy.

Lichtlen and Albert described the VCG in 33 aneurysms proven by ventriculography and involving various parts of the anterior cardiac silhouette.15 Since only cases with "lack of any systolic inward movement, rather showing an outward paradoxical motion" were included, their cases are not entirely comparable to those in the present study. Among the 33, they showed VCGs similar to some type A1 loops (loops #1, #2, and #3 in fig. 2) associated with extensive

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Two unusual loops were designated type F because (1) at least the early half of the QRS is anterior and (2) the entire loop is hardly or not at all deviated to the left (X' minimal or absent). In the first VCG the early half of the loop, except for a crossover, is clockwise. Variations in "rotation" in the late part of the QRS may be due to the rightward and anterior appendage of RBBB that is also present. In the second VCG, all of the loop is clearly clockwise.

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aneurysm involving the antero-basal, anterior, and apical segments. In the present series, by contrast, the transverse plane VCG was not reliable in the diagnosis of severe asynergy of the antero-basal segment.

Type D and the Miscellaneous type loops were found among the 102 patients with severe anterior and apical asynergy; type D loops were also associated with somewhat less asynergy and the Miscellaneous type loops with little or no asynergy.

This overlap may conceivably be explained by...
ischemia. Observations at autopsy and at heart surgery in many of these patients tend to support this hypothesis. In contrast with A, B, C, E, and F loops, type D VCGs were associated with less extensive infarction of a zone corresponding to the anterior and apical segments, and the Miscellaneous type loops with little or no infarction. Nevertheless, the correlation of the VCG patterns here described with the specific location and cubic volume of infarcted muscle — and with the extent to which ischemia, rather than infarction, may play a role in severe anterior and apical asynergy — remain to be determined.

This study demonstrates the sensitivity and specificity of morphologic changes in the VCG loop in the diagnosis of severe anterior and apical asynergy. By contrast, quantitative (location of a particularly timed vector) criteria for infarction, though sensitive in defining other aspects of the loop, fell short of being specific for the diagnosis of severe anterior and apical asynergy. The results emphasize the importance of a "total pattern" approach in interpreting the VCG. In addition, a prospective series of patients is needed to confirm the results of this retrospective study.

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ECGs of four patients with severe asynergy of the anterior and apical segments. The first pair is associated with VCG type A1 abnormality (fig. 2, loops §3 and §1 respectively) and the second pair with VCG type B abnormality (fig. 5, loops §2 and §1 respectively). In ECG §1 (top tracings) there is reversed R wave progression in the left precordial leads (RS'R' in V4) and in ECG §3 the QRS is within normal limits; in neither case would one suspect the extent and severity of the asynergy that is present and also suggested by their counterparts ECGs §2 and §4. In both ECG §1 and §3 the masking effect of an initial R wave is associated with initial leftward and anterior vectors (see also text). The standard in the first ECG applies to the other three tracings.
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