The Kinetocardiogram

III. The Distribution of Forces Over the Anterior Chest

By E. E. Eddleman, Jr., M.D., and Kathryn Willis, M.D.

The distribution of the various motions of the anterior chest wall during the cardiac cycle has been studied, with particular reference to their magnitude in normal subjects. A few recordings of the posterior chest wall motions are included. Analysis of the type of distribution and localization of certain motions suggest their origin in terms of response of the chest wall to cardiac forces.

In preceding communications, a simple method of recording precordial movements was presented, as well as an analysis of the three types of patterns found in normal young adults. The present report presents an analysis of the distribution of various motions and magnitude of force over the entire anterior chest wall.

Method

The method of recording the movements over the chest, and estimating their magnitude, has been presented previously. Records for this study were obtained from approximately 20 normal type I adult males. The amplitudes of the various movements have been estimated in 12 of these individuals. A few observations which have been made on both the anterior and posterior surfaces of the chest with the subject either lying on his right side or sitting. The motion of the posterior chest wall was studied in a few subjects, with the subject lying prone. Records were obtained from the right parasternal region in all intercostal spaces and designated as KV₁, first, second and third intercostal spaces, etc.: whereas tracings for the left parasternal space were designated as KV₃, first, second, third, fourth intercostal spaces, etc. The tracings from the left mid-clavicular line were designated as KV₄, first, second, third, fourth, and fifth intercostal spaces; while records from the midclavicular line on the right side of the chest were designated as KV₅ in the first, second, third, etc., intercostal spaces. Records obtained halfway between the left midclavicular line (KV₄) and the parasternal regions (KV₁) were designated as KV₃, second, third, etc., intercostal spaces; and the comparable portion of the right side of the chest were designated as KV₅₁, first, second, third, etc., intercostal spaces. Records from the anterior axillary lines are designated KV₁ and KV₅₁, with the intercostal space, and, similarly, the mid-axillary line is designated as KV₆ (left chest) and KV₅₂ (right chest). Records were also obtained in the subclavicular region in the midclavicular line. All intercostal spaces were not explored in every subject; however, in the majority of subjects records were made from all areas.

Results

Patterns from the Right Side of the Chest. Figure 1 is presented to furnish a guide to nomenclature which has been previously discussed. Figure 2 contains records obtained from KV₅₁ in the fifth intercostal space and in KV₅₂ in the second intercostal space. Note that the record lacks much of the detail of those obtained from the left anterior precordium. There are two significant features that should be pointed out: (1) There is a pronounced inward movement (I₁–E₁) immediately before and during the early part of rapid ejection (as determined by the carotid upstroke). (2) The outward movement during systole (E₁–E₂), which parallels the IJ upstroke of the displacement ballistocardiogram, is especially prominent. The peak of the movement (E₂) in records from the right upper chest usually precedes the J peak in the ballistocardiogram .01 to .02 second, while it usually follows the J peak in KV₅₁ records, and in records from the left upper chest. Most of the records from the right anterior chest are similar in this general type pattern. The initial inward motion associated with ejection (I₁–E₁), how-

From the Department of Medicine, Medical College of Alabama, Birmingham, Ala.

Dr. Eddleman is a Research Fellow of the National Heart Institute, National Institutes of Health, U. S. Public Health Service.

This investigation was supported by a research grant [H-689(C)] from the National Heart Institute, National Institutes of Health, U. S. Public Health Service.
ever, is most pronounced in the region paralleling the lower portion of the sternum, and becomes much smaller in the upper chest, while the reverse is true with the outward motion \((E_2-E_3)\) that parallels the \(IJ\) upstroke. (In figure 2 note that the diastolic movements are not prominent in any of these records obtained from the right side of the chest.)

**Pattern of Records from the Left Anterior Side of the Chest.** Figure 3 contains records from the left anterior chest at \(KV_3\) in the third intercostal space. In contrast to the movements on the right side of the chest the outward systolic movement \((E_4-E_5)\), which parallels the IJK wave in the ballistocardiograph, is small or absent. Conversely, the diastolic waves have become more prominent, especially the outward movement \((D_1-D_2)\) which parallels the MN upstroke in the ballistocardiogram. The inward motion during early ejection \((I_1-E_1\) on the right and \(I_1-E_4\) on the left) is similar in magnitude to that noted on the right chest, and is deepest in the lower parasternal area, and almost absent in the upper chest. Records from the lateral subclavicular area on both sides of the chest (fig. 4) resemble a mixed arterial and venous pulse tracing. It is probable that the pattern is, therefore, a transmitted pulse from the subclavian vessels. Thus records from the left chest have more prominent diastolic movements, while the records from the right chest have more prominent systolic movements.

**Records Obtained with the Patient Lying on the Right Side and in the Sitting Positions.** Although the records obtained with the patient lying on the right side are somewhat poor in quality, because the patient is usually unable to remain sufficiently quiet, there are several significant features. The anterior records with

---

**Fig. 1.** The nomenclature for the kinetocardiograms is represented in a schematic drawing of records taken from \(KV_1\) on the right side of the chest and \(KV_4\) on the left side of the chest. The nomenclature is based upon a modified division of the cardiac cycle. All points between the onset of the P wave and the QRS complex in the electrocardiogram are assumed to be due to atrial contraction and the letter A is used to indicate the points occurring in this period. Although the isometric contraction phase technically begins with the onset of the first heart sound and ends with the beginning of ejection, the phase of protosystole as discussed in the preceding communication is included in this period. The motions which begin after the onset of the QRS complex in the electrocardiogram are presumed to be ventricular in origin since they occur in patients with auricular fibrillation and in complete heart block. The letter I is used to indicate this isometric contraction period. The letter E is used to indicate the period during ejection while the movements during diastole are indicated by the letter D. Note that the odd subscript numerals are all located in the valleys while the even subscript numerals are all located on the peaks of the various movements. Note also that the point \(I_3\) in \(KV_1\) on the right side of the chest occurs approximately at the same time as \(I_3\) on the left side of the chest, since \(I_2\) was the next definable point after \(I_1\) on the right side of the chest. Thus the motion \(I_3\) to \(I_4\) is absent on the right side of the chest. 
patient lying on the right side are, in general, similar to the records obtained with the patient supine, although they are altered somewhat in amplitude. Motions of the posterior chest during protosystole and early isometric contraction, however, were opposite in direction to those obtained on the anterior chest (fig. 5). The records from the comparable positions in the sitting position, the record from KV₂ was identical to that obtained supine. The records directly opposite on the posterior chest revealed the same observations as obtained with the subject lying on the right side (fig. 6).

*Records with the Patient Prone.* A surprising finding was that with the patient prone, the records obtained from the posterior region in exactly the same position are completely altered from those of the posterior chest with the patient lying on the right side or sitting (fig. 5). The records resemble those made from the anterior chest in type II subjects. It is possible that the effect of gravity and the inability of the anterior chest wall to move with that posture produce the altered response, and the records become incomparable with the movements on the anterior surface of the chest supine.

![Fig. 2. Records from KV₃R in the fifth intercostal space and KV₃R in the second intercostal space. Note that the outward movement E₁-E₂, which parallels the IJ wave of the ballistocardiogram, is much more prominent in the upper right anterior chest wall than in the lower right chest. The inward motion, which begins just before carotid ejection, is more pronounced in the inferior region of the right anterior chest than in the upper portions of the anterior chest. In both records, the movements occurring during diastole are relatively small in amplitude.](http://circ.ahajournals.org/)

from the back reveal that the inward motion associated with ejection (I₁-E₁) is similar to that noted over the anterior surface. The movement (E₁-E₂) which parallels the I-J wave of the ballistocardiograph is somewhat pronounced in records from the left posterior chest. The inward movement of the anterior surface of the chest during early isometric relaxation (E₁-D₁), followed by the outward movement (D₁-D₂), are noted on the posterior aspect of the chest to be in the opposite direction (fig. 5).
Amplitude of Response. The most significant aspect of this study was the distribution of the forces in regard to the amplitude of the various movements. Figure 7 contains the mean amplitude of the outward motion (I₁-₁₄) associated with the apical thrust, plotted in the various positions on the chest wall. Note that the force is maximal in the region of the point of maximal impulse and KV₃, and diminishes circumferentially in all directions, being absent over most of the right chest and on the upper left anterior chest. This movement is thus a localized movement to the region of the palpable apex thrust.

Figure 8 represents the mean amplitudes of the inward motion associated with ejection (Iₕ-Eₙ). Although the initial inward movement recorded from the right side of the chest is probably not related to ejection, the total inward movements, Iₕ-E₁ on the right and Iₕ-E₁ on the left, were measured. Note that the greatest magnitude of motion is noted in the lower parasternal area. This inward motion is symmetric in magnitude, being similar over the right and left chest, with a decrease in amplitude the further laterally the records are taken. Also, it is of note that this inward motion is very small or absent in the upper chest, and, occasionally, an outward motion may be detected.

Figure 9 is the representation of the mean amplitude of the wave (E₁-E₂) which parallels the IJ upstroke on the ballistocardiogram. The maximal amplitude is distributed over the right anterior chest, and extends down into the KV₃ᵣ and KV₄ᵣ areas in the fourth and fifth intercostal spaces. The area of maximal outward motion is noted in KV₃ᵣ in the second intercostal space (fig. 9). This outward motion E₁-E₂ is also fairly marked in the right parasternal area in the fourth, third, and second intercostal spaces. Only very small E₁-E₂ motions are noted over the left anterior chest and, when occurring, are of greater amplitude.
in the upper portion of the chest in the region of the second intercostal space. The outward motion \((E_{t}-E_{s})\), which begins with or just before the phase of protodiastole, is equally distributed over the lower left and right chest relaxation, is most prominent in the left lower parasternal region (fig. 11). This motion is somewhat localized, with an average amplitude of approximately 50 to 70 microns in the left parasternal region, falling off fairly rapidly to 25 microns in KV₁ and around 19 microns in KV₅. Although D₁-D₂ is present both in the right chest and in the left chest, the localiza-

in the parasternal regions, as is the distribution of the inward movement \((E_{t}-D_{t})\) that parallels the LM downstroke of the ballistocardiogram (fig. 10).

The outward motion \((D_{t}-D_{s})\) which parallels the MN upstroke in the ballistocardiogram, and which occurs during the phase of isometric

![Fig. 5. Composite figure of records obtained in the KV₁ position with the subject supine, from the posterior aspect of the left chest with the subject lying on the right side, and from the posterior aspect of the left chest with the subject prone. It was possible to superimpose these records, since they were of approximately the same cycle length. The movements from the posterior chest (with the patient lying on the right side), which occur during the isometric contraction period and the isometric diastolic period, were of opposite directions to the movements from the anterior chest (supine). Note that the record from approximately the same position on the posterior aspect of the chest is entirely changed when the patient is prone. However, the movements during the isometric contraction period are still opposite in direction to those noted on the anterior surface, while the marked outward movement \((D_{t}-D_{s})\) in diastole is now in the same direction as that obtained supine.

![Fig. 6. Record of the anterior KV₂ and opposite position, posteriorly, obtained from a subject in the sitting position. Note again, as in figure 5, that the movements on the posterior aspect of the chest are, in general, opposite in direction to those on the anterior side. It is important that the movement \((D_{t}-D_{s})\) beginning in isometric diastole is opposite in direction on the posterior side to that on the anterior side, suggesting that at this time the entire heart is moving anteriorly, pulling the posterior aspect of the chest inward.

**Discussion**

The distribution of the various movements studied gives some evidence of the underlying
mechanisms involved. Thus a movement localized over the heart suggests that the impact of the heart on the chest wall is responsible. A bilateral distribution of a movement suggests other factors are involved, rather than the local action of the heart. Therefore, the movements can be divided into several categories.

Produced by the impact of the apex against the chest wall. Evidence will be presented later that this is probably the result of the heart rotating to the right, thrusting the apex outward and producing the apex beat. Clinically,

\[
\text{FIG. 7. Diagram of the distribution of the magnitude of the force } I_3-I_4 \text{ (the apical thrust) over the anterior chest. Note that the outward movement is greatest in amplitude over the apical region of the heart, diminishing circumferentially in all directions and being almost absent over the right anterior chest. The localization of this movement to the region of the apex offers evidence that the outward movement } (I_3-I_4) \text{ is produced by the thrusting or the impact of the apex against the anterior chest wall.}
\]

The amplitude of some of the smaller movements, especially those occurring during protosystolic and early isometric contraction \((I_1-I_2)/(I_2-I_3)\), were not measured and, therefore, the distribution of magnitude will not be discussed.

**Movements as the Result of the Impact of the Heart on the Chest Wall.** The marked localization of the outward movement just preceding ejection \((I_3-I_4)\) (fig. 7) suggests that this is produced by the impact of the apex against the chest wall. Evidence will be presented later that this is probably the result of the heart rotating to the right, thrusting the apex outward and producing the apex beat. Clinically,

\[
\text{FIG. 8. Magnitude of the inward motion during rapid ejection } (I_4-E_t \text{ on the left chest and } I_3-E_t \text{ on the right chest) is represented. Note that the area of maximal inward motion occurs in the lower parasternal regions, diminishing on both sides and in the upper anterior chest. There is a small inward motion occurring elsewhere over the chest below 30 microns in magnitude. It is important to point out that this motion is bilaterally symmetric in magnitude, although the inward motion begins slightly earlier on the right side of the chest than that on the left chest. The symmetric aspects of this motion suggest that this is possibly the result of: (1) change in intrathoracic pressure as a result of a shift of blood with ejection; (2) a shift of blood from the lower to the upper aspects of the chest; (3) the movement of the entire heart, posteriorly, pulling inward the anterior surface of the chest.}
\]

this is the movement correlated with the apical thrust, and is larger in magnitude in those subjects with an easily palpable apex beat.

Similarly, the localization of the outward movement beginning during isometric relaxation \((D_1-D_2)\) (fig. 11) suggests that this is the result of an impact. However, the wider distribution over the main cardiac mass, suggests
the entire heart is striking the anterior chest wall. The occurrence of the inward movement, as recorded from the posterior chest wall (fig. 6), simultaneous with the D1-D2 outward movement from anterior chest wall, also adds

![Diagram](https://example.com/diagram.png)

**Fig. 9.** Diagram of the distribution of the magnitudes of the outward movement E1-E2, which parallels the IJ upstroke of the ballistocardiogram. Note that the greatest magnitude is located in the upper right chest, or in the anatomic direction of the ascending aorta. The localization of the greatest magnitude of this movement to the upper right chest suggests that it is the result of the impact of blood in the aorta. The movement does occur over the left anterior chest but is of small magnitude, being most pronounced in the upper left chest. However, in most individuals this movement usually is absent in the left anterior chest. The distribution of the force to the right lower aspect of the chest is possibly the result of a transmission of the outward movement to the more movable portions of the chest wall or to impacts of blood in the pulmonary artery, while it is modified by the presence of the heart on the left side of the chest.

![Diagram](https://example.com/diagram.png)

**Fig. 10.** The inward motion E4-D1 is of small magnitude on all portions of the anterior chest; however, the general distribution is somewhat symmetric in character. This suggests that the heart at this time is moving posteriorly in the chest cavity, pulling the anterior chest wall inward.

more fixed portions of the chest wall (the spine and the clavicular area). It appears that the inward movement (fig. 8) is maximal in the areas of the chest which are more movable. This generalized type of motion is possibly produced by a decrease in pressure in the thoracic cavity as the result of a decrease in the intrathoracic blood volume associated with the ejection process, or a local shift of blood from the lower aspect of the chest to the superior part. An additional possibility is simply that the entire heart is moving posteriorly.

The fact that the right chest begins moving...
inward before the left chest, or about the time of the outward movement (I₄-I₅) of the apical thrust, suggests additional factors initiating the inward movement.

**Movements Due to Impact of Blood on the Great Vessels.** The outward movement (E₁-E₂) which parallels the IJ upstroke of the ballistocardiogram was distributed largely to the right

![Diagram of the distribution of the amplitude of the outward movement D₁-D₂.](image)

**Fig. 11.** Diagram of the distribution of the amplitude of the outward movement D₁-D₂. The greatest amplitude is located just to the left of the sternum over the main myocardial mass. The motion also occurs elsewhere over the anterior chest. However, it is of small magnitude (below 24 microns). The localization of the greatest magnitude of this force to the left parasternal region suggests that this movement is the result of an impact of the heart against the anterior chest wall.

anterior chest (fig. 9). The fact that this motion is synchronous with or may precede the J peak by 0.01 to 0.02 second, is evidence that the two movements are related. If impacts of the blood in the aorta produce the IJ upstroke, as has been demonstrated by Starr and co-workers, then the E₁-E₂ should be directed upward anteriorly and to the right in line with the anatomic path of the great vessels. From figure 9 the force is maximal in the upper right chest, which is consistent with this hypothesis. The force is also distributed to the right lower lateral aspect of the chest and probably represents the impacts on the pulmonary arteries or merely a transmitted movement. The chest, as has been pointed out, is more movable in the lower aspect and, therefore, E₁-E₂ in KV₃R and KV₄R in the fourth and fifth intercostal spaces would be expected to be of fair magnitude.

The almost complete absence of the movement (E₁-E₂) in the left chest is probably the result of local cardiac forces nullifying the impact phenomena. The distribution of forces upward and slightly to the right is, however, somewhat at variance with the spacial vector of the IJK wave, as determined by a rotating ballistocardiograph table. Scarborough and co-workers found the vector of the IJK wave to point to the left and slightly posteriorly. It is possible that as the force actually begins, it points anteriorly and to the right, then rotates to the left and posteriorly. This would be additional evidence of why there is an apparent absence of this movement over the left anterior chest, and why the movement is more pronounced over the posterior aspect of the chest.

**Conclusions**

1. A study of the distribution of forces over the chest wall has been made in normal healthy young adults.
2. The motion associated with the apical thrust (I₄-I₅) has a localized distribution of magnitude.
3. The inward motion (I₄-E₁) associated with ejection is maximal in the lower parasternal region, diminishing peripherally, and is symmetric on both right and left sides of the chest.
4. The outward movement (E₁-E₂) that parallels the IJ upstroke in the ballistocardiogram is maximal in the right upper chest, being almost absent over the left anterior chest.
5. The outward movement (D₁-D₂) that parallels the MN upstroke on the ballistocardiogram is directed anteriorly and slightly to the left, and is centered over the cardiac area.
Sumario Español

Se ha estudiado los varios movimientos de la pared torácica anterior durante el ciclo cardíaco, con particular interés en su magnitud en sujetos normales. Algunos trazados de los movimientos de la pared posterior se incluyen. Análisis del tipo de distribución y localización de ciertos movimientos sugiere su origen en términos de respuesta de la pared torácica a las fuerzas cardíacas.

REFERENCES


The Kinetocardiogram: III. The Distribution of Forces Over the Anterior Chest
E. E. EDDLEMAN, JR. and KATHRYN WILLIS

Circulation. 1953;8:569-577
doi: 10.1161/01.CIR.8.4.569

Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 1953 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/8/4/569

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/