LETTER TO THE EDITOR

To Change a Dogma Can Be Very Difficult

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To the Editor:

We have read carefully and with pleasure the editorial written by R. Case and A. Moss¹ recommending the revision of the standard presentation of the FP, including the reversal of Lead aVR to avR. We agree that it is time for this change because it will allow all physicians to better follow the pathway of stimuli in different pathological conditions,

thereby permitting a better perspective for electrocardiography and vectorcardiography (ECG-VCG) correlation and deductive training in electrocardiography.²

As the authors state, several changes have already been proposed since 1958.¹ Later, repeated suggestions were made for the adoption of an overall angular presentation of six leads (VL, I, -VR,

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Figure 1. Two angular views in a normal patient.

STANDARD ECG**RIGHT CONFIGURATION****INVERSE CONFIGURATION**

Figure 2. Two angular views a case of RBBB.

II, VF, and III). In fact, some manufacturers have already been advised to include this alternative presentation in the new devices. However, we prefer for the frontal plane to maintain the same angular perspective, but starting from Lead III to VL (Fig. 1). We believe that this type of presentation may help in understanding ECG patterns.²

It is not surprising to anyone that changing these types of dogmas is difficult. As this often occurs in all aspects of science, so too are we faced with it in the field of electrocardiography. Burch and De Pasquale said in 1958³ that "because of efforts by some to advance their own ideas rather than the science itself, progress in electrocardiography has, at times, been hindered. Even obviously simple prob-

lems, such as nomenclature, were made difficult because of individual prejudices. Fortunately, truth finally prevails and the best ideas supervene. However, much time and effort is required before the truth is recognized, as is well exemplified by the history of the development of the clinical use of the precordial leads".

We have included some examples of how different types of ECG patterns may be seen with this angular view (Figs. 1–3).

It is our hope that physicians using this new global angular approach will be able to better understand the pathway of cardiac stimulus from right to left, not only in the horizontal plane (V_1 to V_6) but also in the frontal plane (from III to VL).

Figure 3. Two angular views in a case of left main trunk subocclusion. Observe how the injury vector points to VR, explaining the ST descent in all 12 leads.

REFERENCES

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