EKG Interpretation Lecture Answers

1. Terminal R noted in AVR consistent with TCA (tricyclic anti-depressant) overdose. Also see widening of the QRS complex. Treat with bicarb, calcium, fluids.

2. RBBB and 1st degree AV block

3. Partial RBBB and some non-specific ST changes

4. Wide complex SVT… possible re-entry rhythm (? Wolff-Parkinson-White syndrome). Treat with fluids. Consider amiodarone, vagal maneuvers, adenosine. Would avoid cardizem given possibility of re-entry tachycardia. No indication for lidocaine as SVT.

5. Inferior wall MI

6. Wide complex QRS, peaked T waves, likely 2:1 Wenckebach (2nd degree type I). Abnormal EKG is secondary to hyperkalemia. Immediate treatment with calcium to stabilize heart muscle, and then bicarb, fluids, albuterol to lower potassium. 2nd EKG shows narrowing of the QRS complex, less peaked T waves, and still a 2nd degree type I block.

7. Re-occlusion of his stent causing acute inferior ischemia and a 3rd degree block

8. Aberrantly conducted SVT versus a limited run of VT

9. 1st EKG shows no acute ischemic changes. There are non-specific inferior changes that may represent chronic or old ischemia. His 2nd EKG confirms his history of a previous inferior wall MI.

10. Rapid atrial fibrillation with PVCs

11. Large amplitude to the QRS complexes and diffuse deep T wave inversions are very suggestion of LVH. He likely has HOCM (hypertrophic obstructive cardiomyopathy).

12. LBBB with Mobitz (2nd degree type II) block

13. 1st degree AV block and non-specific ST changes

14. 1st degree AV block and short QT interval suggestive of hypercalcemia

15. Prolonged QT interval places her at risk for development of Torsades

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16. Narrow complex re-entry SVT. Treated with adenosine. Normal EKG post cardioversion.

17. LBBB makes determining ongoing acute ischemia difficult. However, this does not meet Sgarbossa's criteria.

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