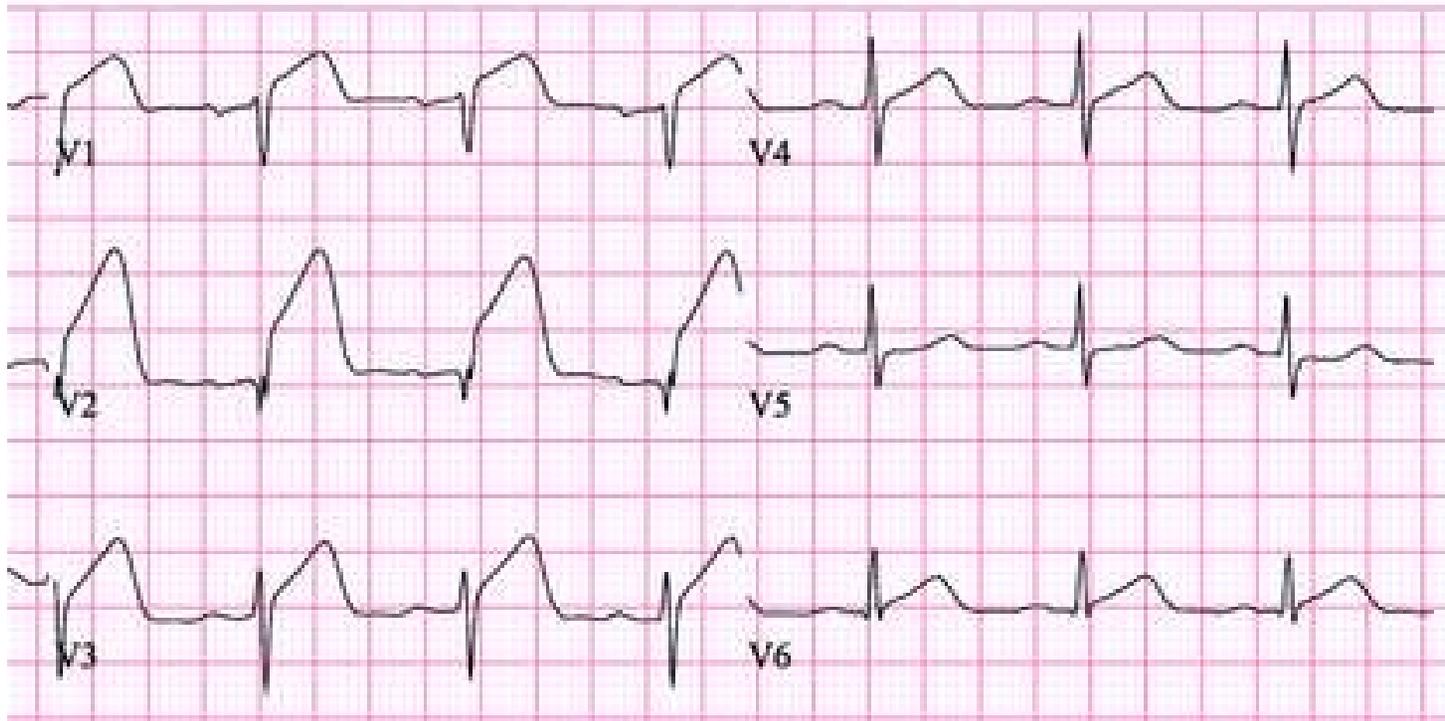


- Anterior or anteroseptal MI (age recent or acute)



*Acute anterior STEMI*

- Significant ST segment elevation in at least 2 contiguous leads between V2 to V4.
- ST elevation  $\geq 2$  mm in leads V2 or V3 in men and  $\geq 1.5$  mm in women
- ST elevation  $\geq 1$  mm in V4

The Boards Score Sheet lists “anteroseptal or anterior MI” as a single code and, for testing purposes, does not distinguish between the two.

In contrast to certifying examinations, in clinical practice, acute anteroseptal MI and acute anterior MI are diagnosed separately:

- Acute anteroseptal MI is diagnosed by significant ST elevation in leads V1 to V3.
- Acute anterior MI is diagnosed by significant ST segment elevation in 2 contiguous leads between V2 to V4.
- Significant ST elevation in lead V1 helps to differentiate anteroseptal from anterior MI.

Many ECG texts consider decreasing R wave voltage from V2 to V5 consistent with old or age indeterminate anterior MI, even in the absence of abnormal Q waves. However, the Board Exams have not considered the loss of R wave voltage across the precordial leads to be consistent with old anterior MI, unless significant Q waves are also present in these leads.

In clinical practice, the diagnosis of acute MI is often made without the presence of abnormal Q waves, as many MIs never develop Q waves or develop them hours-to-days after MI has been diagnosed by serum cardiac biomarkers. Recently, the American Board of Internal Medicine (ABIM) Cardiovascular Disease Board Examination eliminated the need for the presence of abnormal Q waves in 2 or more contiguous leads for the diagnosis of MI. However, the diagnosis of old or age indeterminate MI still requires the presence of abnormal Q waves, or in the case of posterior MI, abnormal R waves in V1 to V3.