

World Journal of *Cardiology*

World J Cardiol 2019 March 26; 11(3): 94-125



ORIGINAL ARTICLE**Retrospective Cohort Study**

- 94 Improved scoring system for the electrocardiographic diagnosis of left ventricular hypertrophy
Braunstein ED, Croft LB, Halperin JL, Liao SL

SYSTEMATIC REVIEWS

- 103 Risk factors for sudden cardiac death to determine high risk patients in specific patient populations that may benefit from a wearable defibrillator
Khan HM, Leslie SJ

CASE REPORT

- 120 Utility of recognizing early electrocardiogram changes in bronchogenic Takotsubo cardiomyopathy: A case report
Khan M, Watt H, Dahal K, Dominic P

ABOUT COVER

Editorial Board of *World Journal of Cardiology*, Ibrahim Akin, FACC, MD, Professor, First Department of Medicine, University Medical Center Mannheim, University of Heidelberg, Heidelberg, Germany

AIMS AND SCOPE

World Journal of Cardiology (World J Cardiol, WJC, online ISSN 1949-8462, DOI: 10.4330) is a peer-reviewed open access journal that aims to guide clinical practice and improve diagnostic and therapeutic skills of clinicians.

The *WJC* covers topics concerning arrhythmia, heart failure, vascular disease, stroke, hypertension, prevention and epidemiology, dyslipidemia and metabolic disorders, cardiac imaging, pediatrics, *etc.* Priority publication will be given to articles concerning diagnosis and treatment of cardiology diseases. The following aspects are covered: Clinical diagnosis, laboratory diagnosis, differential diagnosis, imaging tests, pathological diagnosis, molecular biological diagnosis, immunological diagnosis, genetic diagnosis, *etc.* We encourage authors to submit their manuscripts to *WJC*.

We will give priority to manuscripts that are supported by major national and international foundations and those that are of great basic and clinical significance.

INDEXING/ABSTRACTING

The *WJC* is now abstracted and indexed in Emerging Sources Citation Index (Web of Science), PubMed, PubMed Central, Scopus, China National Knowledge Infrastructure (CNKI), China Science and Technology Journal Database (CSTJ), and Superstar Journals Database.

RESPONSIBLE EDITORS FOR THIS ISSUE

Responsible Electronic Editor: *Yan-Liang Zhang* Proofing Editorial Office Director: *Jin-Lei Wang*

NAME OF JOURNAL

World Journal of Cardiology

ISSN

ISSN 1949-8462 (online)

LAUNCH DATE

December 31, 2009

FREQUENCY

Monthly

EDITORS-IN-CHIEF

Marco Matteo Ciccone, Ramdas G Pai, Dimitrios Tousoulis

EDITORIAL BOARD MEMBERS

<https://www.wjnet.com/1949-8462/editorialboard.htm>

EDITORIAL OFFICE

Jin-Lei Wang, Director

PUBLICATION DATE

March 26, 2019

COPYRIGHT

© 2019 Baishideng Publishing Group Inc

INSTRUCTIONS TO AUTHORS

<https://www.wjnet.com/bpg/gerinfo/204>

GUIDELINES FOR ETHICS DOCUMENTS

<https://www.wjnet.com/bpg/GerInfo/287>

GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH

<https://www.wjnet.com/bpg/gerinfo/240>

PUBLICATION MISCONDUCT

<https://www.wjnet.com/bpg/gerinfo/208>

ARTICLE PROCESSING CHARGE

<https://www.wjnet.com/bpg/gerinfo/242>

STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

<https://www.f6publishing.com>

Retrospective Cohort Study

Improved scoring system for the electrocardiographic diagnosis of left ventricular hypertrophy

Eric D Braunstein, Lori B Croft, Jonathan L Halperin, Steve L Liao

ORCID number: Eric D Braunstein (0000-0001-5290-9089); Lori B Croft (0000-0003-3962-8922); Jonathan L Halperin (0000-0002-8318-5471); Steve L Liao (0000-0002-8161-0294).

Author contributions: Braunstein ED designed the project, performed data collection and statistical analysis, and drafted the manuscript; Croft LB assisted with data collection and provided critical review of the manuscript; Halperin JL provided critical review of the manuscript; Liao SL designed the project, provided study oversight, and provided critical review of the manuscript.

Institutional review board

statement: The study was reviewed and approved by the Human Research Protection Program at the Icahn School of Medicine at Mount Sinai in October 2015.

Informed consent statement: A waiver of informed consent was granted by the institutional review board due to the retrospective nature of the study, minimal risk to study subjects, and impracticality of obtaining consent from all subjects.

Conflict-of-interest statement: The authors have no relevant sources of funding or conflicts of interest to disclose.

STROBE statement: The guidelines of the STROBE Statement have been adopted for this manuscript.

Open-Access: This article is an open-access article which was selected by an in-house editor and

Eric D Braunstein, Division of Cardiology, Department of Medicine, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, New York, NY 10467, United States

Lori B Croft, Jonathan L Halperin, Steve L Liao, Division of Cardiology, Icahn School of Medicine at Mount Sinai, Mount Sinai Medical Center, New York, NY 10029, United States

Corresponding author: Steve L. Liao, MD, Assistant Professor, Division of Cardiology, Mount Sinai Medical Center, 1176 5th Avenue, New York, NY 10029, United States.

steve.liao@mountsinai.org

Telephone: +1-212-4271540

Fax: +1-212-4107196

Abstract**BACKGROUND**

Left ventricular hypertrophy (LVH) is a common manifestation of cardiovascular disease and a risk factor for cardiovascular morbidity and mortality, but available methods for its electrocardiographic (ECG) diagnosis have limited accuracy.

AIM

To investigate findings associated with LVH on ECG and developed an improved system for the diagnosis of LVH.

METHODS

A cohort study comparing ECG data acquired within 30 days of transthoracic echocardiography (TTE) was performed. Multivariate regression analysis identified ECG findings associated with increased LV mass and mass index. A scoring system was derived and performance compared to established criteria for LVH.

RESULTS

Data from 5486 outpatients with TTEs and corresponding ECGs were included in the derivation cohort, 333 (6.1%) of whom had LVH by TTE. In the primary regression analysis, findings associated with LVH were amplitudes of Q in V3, R in V6, S in V3, T in V6, P' in V1, P in V6, as well as R and T-axis discordance, R peak time in V6, QRS duration, weight, height, sex, and age. From this we derived a score consisting of 5 criteria, and validated it in an independent cohort of 910 patients. With a threshold of 1.5 points, sensitivity and specificity were 67.9% and 81.4%, and 62.5% and 83.2% in the derivation and validation cohorts, respectively. With a threshold of 2 points, sensitivity and specificity were 42.3% and 93.0%, and 37.5% and 93.4% in these cohorts.

fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

Manuscript source: Unsolicited manuscript

Received: November 19, 2018

Peer-review started: November 19, 2018

First decision: December 10, 2018

Revised: December 12, 2018

Accepted: December 24, 2018

Article in press: December 24, 2018

Published online: March 26, 2019

P-Reviewer: Gulel O, Hatipoglu S

S-Editor: Yan JP

L-Editor: A

E-Editor: Zhang YL



CONCLUSIONS

This score had superior sensitivity for detection of LVH by ECG while making a modest sacrifice in specificity compared to conventional criteria.

Key words: Left ventricular hypertrophy; Electrocardiogram; Echocardiogram; Diagnostic criteria; Scoring system

©The Author(s) 2019. Published by Baishideng Publishing Group Inc. All rights reserved.

Core tip: In this study we performed analysis of a large number of echocardiograms with corresponding electrocardiographic (ECG), and though multivariate regression analysis identified ECG findings associated with left ventricular hypertrophy (LVH). Using these findings, a five-item scoring system was developed to diagnose LVH on ECG. The performance characteristics of the system were compared to several conventional criteria, and it was seen to have superior sensitivity, including in an independent validation cohort. Using this scoring system, we believe that the diagnosis of LVH on ECG will be more clinically applicable in certain patient populations given the enhanced sensitivity of this test.

Citation: Braunstein ED, Croft LB, Halperin JL, Liao SL. Improved scoring system for the electrocardiographic diagnosis of left ventricular hypertrophy. *World J Cardiol* 2019; 11(3): 94-102

URL: <https://www.wjgnet.com/1949-8462/full/v11/i3/94.htm>

DOI: <https://dx.doi.org/10.4330/wjc.v11.i3.94>

INTRODUCTION

Left ventricular hypertrophy (LVH) is a common consequence of various cardiovascular diseases, and has been associated with increased risks of morbidity and mortality. Specifically, LVH has been associated with several adverse cardiac outcomes including heart failure, angina pectoris, myocardial infarction, and sudden cardiac death^[1-5]. Upwards of 30 electrocardiographic (ECG) criteria have been proposed for diagnosis of LVH^[6], but most have low sensitivity in the general population. Transthoracic echocardiography (TTE) is often required to confirm the diagnosis^[7,8]. Antihypertensive treatment can promote regression of LVH and prevent adverse cardiovascular events in patients with hypertension^[9,10], and TTE is preferred over ECG to assess myocardial mass in this setting^[8,11], although detection of left ventricular electrical remodeling may have prognostic implications independent of mass^[12-16]. Despite the availability of multiple criteria for ECG diagnosis of LVH, relatively few are widely implemented in clinical practice. Several models have been correlated with echocardiographic, cardiac magnetic resonance imaging, and autopsy measurements of LV mass, but these have not been integrated into commonly used ECG analysis software, while others are too complex for practical use. The aim of this study was to identify ECG findings associated with increased LV mass and develop an improved and easy to use scoring system to facilitate the diagnosis of and screening for LVH.

MATERIALS AND METHODS

Data collection and processing

The Institutional Review Board approved the protocol in October 2015. Clinical data available in the information systems of the Mount Sinai Medical Center, a large urban academic medical center, were derived from two sources, one for ECGs, and another for echocardiographic data. Data from all standard 12-lead ECGs recorded between December 1, 2013 and January 31, 2015 was exported from the MUSE v8.0 SP2 system (GE Healthcare, Chicago, IL, United States). Computer performed measurements including ventricular rate, PR interval, QRS duration, R-axis, T-axis, P-, P'- (second phase of P-wave), Q-, R-, S-, R'- and T-wave maximum amplitude, duration, area and peak time, maximum and minimum ST-segment level, and ST-segment deviation at J-point, mid-ST-segment and end-ST-segment. Measurements in each standard lead

were averaged across the ECG by the MUSE software. ECGs were not manually verified or measured and all ECGs except for those noted below were included in analyses.

Data from all outpatient TTEs acquired from patients ≥ 18 yr of age between January 1, 2014 and December 31, 2014 were exported from a proprietary echocardiography reporting system. Two-dimensional echocardiograms were performed using Siemens SC-2000, Siemens Acuson Sequoia, Phillips IE-33 or GE Vivid 7 cardiac ultrasound equipment. Measurements of the left ventricle were made in the parasternal long-axis view perpendicular to the axis at or immediately below the level of the mitral valve leaflet tips. Internal ventricular dimensions were measured linearly from two dimensional (2D) echocardiographic images to avoid oblique sections, or from 2D-guided M-mode echocardiography. Posterior and septal wall thickness and left ventricular end-diastolic and end-systolic diameters were measured according to the recommendations of the American Society of Echocardiography^[17]. Measurements were made during routine clinical interpretation of the echocardiogram and were not repeated or verified for the purposes of this study. Demographic data including age, sex, height, and weight (patient reported at the time of the study) were also collected.

Left ventricular mass was calculated using the method of Devereux *et al*^[18]. Body mass index, body surface area, and LV mass index were calculated using the standard methods. LVH was defined by LV mass index one standard deviation above the mean, stratified by sex (145 g/m² for males, 125 g/m² for females). Data from the first 10 mo of the study period comprised the derivation set, while those from the final 2 mo were used to validate the derived model.

TTEs and ECGs were matched by selecting the ECG obtained most proximate to each TTE. When patients had more than one TTE during the study period, only the first was included for analyses. Echocardiograms with incomplete demographic or measurement data and those without a corresponding ECG within 30 d were excluded. Also excluded were ECGs showing complete (but not incomplete) left bundle branch block or a paced rhythm, as identified by the MUSE software and confirmed by a board-certified cardiologist.

Statistical analysis

A multivariate linear regression model was constructed using LV mass as the endpoint and covariates including P-, P'- (second phase of P-wave), Q-, R-, S-, R'- and T-wave amplitudes in each lead, R-wave peak time in each lead (intrinsicoid deflection), maximum and minimum ST levels in each lead, ST-segment deviation at the J-point and mid-ST-segment in each lead, QRS duration, PR interval, difference between R-axis and T-axis, and patient weight, height, sex and age (152 degrees of freedom). A similar model using LV mass index as the endpoint yielded similar output with reduced fit parameters. Another model constructed using wave-complex areas (as opposed to maximum amplitudes) was less strongly associated with the endpoint. Covariates most strongly correlated with LV mass (based on regression *P*- and *t*-values, and a *P*-value threshold set at $P \leq 0.005$ in the linear regression model) were retained for multivariate logistic regression analysis. Additional logistic regression models were constructed stratifying the data set by sex in order to assess differences in ECG findings between sexes.

As several of the amplitudes and durations included in the model are correlated, we minimized effects of multicollinearity by calculating variance inflation factors (VIF) for covariates likely to be correlated and manually removing colinear covariates (VIF > 5) in a stepwise fashion while maximizing fit parameters of the overall model. Statistical analyses were performed using SAS version 9.4 (SAS Institute Inc., Cary, NC, United States).

Scoring system development

A scoring system was derived using scaled and rounded regression Wald chi-square and beta-coefficients similar to the method of Sullivan *et al*^[19]. Thresholds for the prediction model were developed based on standard deviations of the covariates, established LVH criteria, and iteration. The derived diagnostic criteria as well as several accepted criteria for LVH (Cornell^[20], Sokolow-Lyon^[21], Cornell product^[22], Sokolow-Lyon product^[23], Gubner-Ungerleider^[24], Sum-of-12-lead^[25], Romhilt-Estes^[26], Framingham-adjusted Cornell^[27], R-wave amplitude in aVL, Peguero-Lo Presti^[28]) were evaluated. Sensitivity and specificity were calculated for each criterion in both cohorts, along with 95% confidence intervals using binomial proportions in the derivation cohort. Positive and negative predictive values were also calculated.

RESULTS

Patient characteristics

During the 1-yr inclusion period, 11087 outpatient TTEs were obtained, while 202706 ECGs were recorded during the bracketed 14-mo period for the study. After matching each TTE with available ECGs and excluding those with incomplete data ($n = 570$), subsequent TTE examinations in the same patients (695), those with left bundle-branch block (128) or paced rhythm (235), and those without corresponding ECGs within 30 days (1396), a total of 5486 cases were entered into the derivation cohort. Applying the same criteria, 910 cases comprised the validation cohort. Patients characteristics were similar between both cohorts, and patients included in analyses in the cohorts had mean age around 60, were on average overweight but not obese, and were about half male (Table 1).

Regression results

In the derivation cohort, 333 patients (6.1%) had LVH as defined by the foregoing TTE criteria. Utilizing the full set of 152 covariates available, multivariate logistic analysis for the endpoint of LV mass yielded a regression coefficient of 0.502. The most highly associated variables ($P \leq 0.005$) included Q-wave amplitude in V3, R-wave amplitude in V6, S-wave amplitude in V3, QRS duration, difference between R and T-wave axis, R-wave peak time in V6, T-wave peak amplitude in V6 (inversely associated with the outcome), P'-wave amplitude in V1 (inversely associated), P-wave amplitude in V6, weight, height, sex, and age. Using these covariates, a logistic regression model was constructed for LVH (Table 2) with area under the ROC curve estimated by the c-statistic at 0.867.

Scoring system development and evaluation

To derive a scoring system (Table 3), we summed the amplitude predictors and set a threshold of two standard deviations above the mean in the derivation cohort data, distinguished by sex. The QRS duration threshold was set arbitrarily at 100 ms, the upper limit of normal. The absence of a positive T-wave component in V6 was set based on the negative association of maximum T-wave amplitude in the regression model. Definition of R- and T-wave precordial axis discordance was set at $\pm 75^\circ$, although similar results were seen at $\pm 45^\circ$ and $\pm 90^\circ$. P-wave negative deflection greater than positive deflection in V1 was used due to the negative association of P'-wave amplitude in V1 in the model. Despite its association with LVH in the regression model, patient height was omitted from the scoring system to enhance clinical convenience.

Additional logistic regression models were constructed stratifying the data set by sex in order to assess differences in ECG findings between sexes (Table 4). Findings in these cohorts were similar to those in the overall analysis; however, notably discordance between R and T-wave axis was only found to be associated with LVH in men but not in women.

The derived prediction model and other criteria for ECG diagnosis of LVH were evaluated in the derivation and validation cohorts, calculating sensitivity and specificity as well as positive and negative predictive values (Table 5). Using a threshold of 2 points, the score exhibited sensitivity superior to previous methods while sacrificing little to no specificity; using a cutoff of 1.5 points, the score improved sensitivity while maintaining specificity $> 80\%$. Looked at another way, the score was also seen to have superior positive predictive values utilizing a cutoff of 2 points than established criteria while maintaining a high negative predictive value; all positive predictive values in this study for the derived and established criteria were relatively low because of the low overall prevalence of LVH in the studied population.

DISCUSSION

In this study of 5486 patients undergoing TTE within 30 d of a 12-lead ECG, several ECG findings were associated with increased LV mass from a set of 147 ECG variables, many of which are included in established criteria for LVH, along with several others heretofore unrecognized. In our model, QRS duration was independently associated with LVH, even when the voltage QRS duration products were tested as the other covariates. For this reason, we included QRS duration rather than a voltage duration product as an independent predictor. This independent association suggests that voltage duration products may not be optimal for identification of LVH. In contrast to established schema, R-wave amplitude in lead aVL was not independently associated with echocardiographic LVH in this analysis,

Table 1 Patient characteristics

Characteristic - no. (%) unless noted	Derivation cohort (n = 5486)	Validation cohort (n = 910)
Age (mean ± SD)	59.1 ± 15.8	58.6 ± 15.2
18-29	265 (4.8)	30 (3.3)
30-39	408 (7.4)	91 (10.0)
40-49	708 (12.9)	105 (11.5)
50-59	1295 (23.6)	224 (24.6)
60-69	1358 (24.8)	242 (26.6)
70 +	1452 (26.5)	218 (24.0)
Male sex	2869 (52.3)	448 (49.2)
Body mass index		
Mean ± SD	28.0 ± 6.6	28.5 ± 6.5
Median (range)	26.9 (12.9-75.2)	27.5 (15.8-66.1)
Left ventricular mass by echocardiogram		
Mean ± SD	167.2 ± 62.1	173.3 ± 64.8
Median (intraquartile range)	155.4 (123.3-200.4)	163.0 (124.1-205.0)
Left ventricular hypertrophy present by echocardiogram	333 (6.1)	80 (8.6)
Time between echocardiogram and electrocardiogram in days (mean, intraquartile range)	6.7 (0-13)	5.9 (0-11)

possibly due to interactions with precordial lead amplitude.

P-wave amplitude in V6 and negative P-terminal force in V1 were associated with LVH, likely reflecting left atrial pathology. P-wave duration (encompassing both positive and negative components), however, was not associated with LVH. These variations suggest the need for further study of the ECG manifestations of left atrial conduction delay. Unlike previous systems for identification of LVH, which typically include only R and S-wave amplitudes, we found an association of Q-wave in addition to S-wave amplitude in V3 with LVH. This could indicate an association of the total negative QRS vector in this lead, rather than the S-wave alone, with LVH. Lead V3 was found to be more highly associated with LVH than lead V1 or V2 as is seen in many other LVH criteria; this may be due to the location of lead V3 being more in line with the LV septum and therefore a better representation of its thickness.

An additional analysis looking at differences in ECG findings associated with LVH between sexes found that although most factors remained similar, R- and T-axis discordance was found to be associated with LVH in men but not in women. This may highlight differences in electrical remodeling as it relates to repolarization between sexes, and could be the subject of further study.

Conventional ECG criteria have low sensitivity for diagnosis of LVH. Several regression equations have been developed to estimate LV mass directly, but are impractical except for implementation in computerized ECG software, and correlate poorly with measurements of LV mass made by echocardiography, cardiac magnetic resonance imaging (MRI), or autopsy. The scheme we derived was evaluated using two thresholds based on distinct objectives. A threshold of 2 points yielded high specificity (approximately 93%) with improved sensitivity (approximately 40%), while a cutoff of 1.5 points markedly improved sensitivity (approximately 65%) while maintaining sensitivity at > 80%. The higher limit may be preferred for general use, while the lower value may be more applicable to patients with hypertension or clinical conditions associated with LVH. Further studies are needed to assess the utility of either cut-point for serial assessments in the same individual, or to identify those who may benefit from echocardiography or other imaging studies to assess LV mass or its response to therapeutic interventions.

The derived scoring system was compared to conventional criteria for the ECG diagnosis of LVH and our system was found to have increased sensitivity with a modest sacrifice in specificity. Most conventional LVH criteria have high specificity but low sensitivity which limits use as a screening test in a general population. The enhanced sensitivity of the presented scoring system may introduce improvement to clinical practice by aiding with patient risk stratification and preventing unnecessary additional testing.

An important limitation of this study was inclusion of only ambulatory outpatients. This was because fluctuating clinical circumstances in acute ill hospital inpatient could influence echocardiographic measurements of wall thickness or produce

Table 2 Multivariate logistic regression analysis for left ventricular hypertrophy

Characteristic	Wald Chi-Square	P value
Q-wave amplitude in V3	19.3	<i>P</i> < 0.0001
R-wave amplitude in V6	39.7	<i>P</i> < 0.0001
S-wave amplitude in V3	135	<i>P</i> < 0.0001
QRS Duration	115.4	<i>P</i> < 0.0001
Discordant R-axis and T-axis (difference ≤ 75 or > 75)	14.6	<i>P</i> = 0.0001
Maximum (positive deflection) T-wave amplitude in V6	38.5	<i>P</i> < 0.0001
Maximum P'-wave amplitude in V1	18.5	<i>P</i> < 0.0001
P-wave peak amplitude in V6	0.19	<i>P</i> = 0.659
Weight	0.008	<i>P</i> = 0.927
Height	25.2	<i>P</i> < 0.0001
Sex	6.3	<i>P</i> = 0.012
Age	0.03	<i>P</i> = 0.864

discordance with ECG's recorded within the requisite 30-d window. It is also worth noting that the ECG data we used was measured automatically, while the echocardiographic measurements were obtained manually. Echocardiographic measurement, while regarding as being relatively accurate, are not the gold standard for LV mass measurement; more accurate measurements of LV mass such as cardiac MRI were not able to be used in this study. We also were not able to collect data on patient race, cardiovascular risk factors, or comorbidities (*e.g.*, hypertension, diabetes), all of which are factors that may influence ECG estimations of LVH. Finally, while the Working Group on ECG diagnosis of LVH suggested that research on LVH focus on the potential relationship of electrical remodeling to clinical outcomes^[13], we lack long-term clinical follow-up of patients to correlate the LVH score with such outcomes.

In conclusion, we identified several ECG findings that are associated with LVH and incorporated them into a score to improve the ECG diagnosis of this common condition. The scoring system may help improve clinical utility by enhancing sensitivity whilst displaying a modest sacrifice in specificity compared to conventional criteria. Further studies are needed to determine whether this scheme optimally reflects changes in the electrical characteristics of the myocardium over time, and whether it may have value for predicting cardiovascular events that are not exposed by measurement of ventricular mass alone.

ACKNOWLEDGMENTS

The authors thank Ejaz Siddiqui for assistance with obtaining ECG data.

Table 3 Components of the electrocardiographic diagnostic score for left ventricular hypertrophy

Criteria	Number of points
Sum of R-wave amplitude in V6 + S-wave amplitude in V3 + Q-wave amplitude in V3 > 4.0 mV in males and 3.2 mV in females	1
QRS duration > 100 ms	1
Absence of positive component of T-wave in V6 (maximum T-wave amplitude < 0) when overall QRS vector in V6 positive (i.e., R-wave larger than S-wave)	1
Discordant limb lead R- and T-wave axis (R- minus T-wave axis ≤ 75 or > 75 degrees)	0.5
Amplitude of negative terminal p-wave deflection in V1 greater than amplitude of positive deflection	0.5

Table 4 Multivariate logistic regression analysis for left ventricular hypertrophy stratified by sex

Characteristic	Male (n = 2869)		Female (n = 2617)	
	Wald Chi-Square	P value	Wald Chi-Square	P value
Q-wave amplitude in V3	14.7	P = 0.0001	5.0	P = 0.025
R-wave amplitude in V6	25.5	P < 0.0001	10.0	P = 0.001
S-wave amplitude in V3	77.0	p < 0.0001	53.6	P < 0.0001
QRS Duration	62.2	P < 0.0001	51.2	P < 0.0001
Discordant R-axis and T-axis (difference ≤ 75 or > 75)	17.8	p < 0.0001	0.63	P = 0.426
Maximum (positive deflection) T-wave amplitude in V6	16.0	P < 0.0001	26.1	P < 0.0001
Maximum P'-wave amplitude in V1	9.4	P = 0.002	4.6	P = 0.031
P-wave peak amplitude in V6	1.0	P = 0.314	3.5	P = 0.061
Weight	0.50	P = 0.477	0.9	P = 0.340
Height	6.8	P = 0.009	21.8	P < 0.0001
Age	1.4	P = 0.245	1.06	P = 0.303

Table 5 Sensitivity, specificity, and positive and negative predictive values of selected electrocardiographic criteria for left ventricular hypertrophy

Criteria	Cutoff	Derivation cohort				Validation cohort	
		Sensitivity (95% CI)	Specificity (95% CI)	PPV	NPV	Sensitivity	Specificity
Derived Criteria	1.5 points	67.9 (62.6-72.9)	81.4 (80.3-82.4)	19.0	97.5	62.5	83.2
""	2 points	42.3 (37.0-47.7)	93.0 (92.3-93.7)	28.2	96.2	37.5	93.4
""	2.5 points	30.0 (25.2-35.3)	96.6 (96.1-97.1)	37.6	95.6	30.0	96.8
Cornell	-	37.8 (32.6-43.1)	92.3 (91.6-93.0)	24.1	95.8	36.2	90.3
Sokolow-Lyon	-	16.5 (12.5-20.5)	95.9 (95.4-96.5)	20.7	94.7	20.0	96.3
Cornell Product		55.0 (49.6-60.3)	88.3 (87.5-89.2)	23.3	96.8	53.8	88.1
Sokolow-Lyon Product		22.5 (18.0-27.0)	95.9 (95.3-96.4)	26.0	95.0	23.8	95.6
Gubner-Ungerleider		27.0 (22.3-31.8)	88.9 (88.0-89.8)	13.6	95.0	27.5	87.7
Sum-of-12-Lead		57.4 (51.9-62.7)	76.1 (74.9-77.3)	13.4	96.5	57.5	77.1
Romhilt-Estes	5 points	35.4 (30.3-40.8)	94.4 (93.7-95.0)	26.2	95.8	35.0	95.0
""	4 points	51.1 (45.5-56.5)	88.2 (87.3-89.0)	21.8	96.5	57.5	90.0
Framingham-adjusted Cornell		42.3 (37.0-47.7)	90.1 (89.3-90.9)	21.7	96.0	51.3	87.6
R-wave amplitude in aVL	1.1 mV	20.1 (16.0-24.8)	92.6 (91.8-93.3)	14.9	94.7	21.3	92.1
Peguero-Lo Presti		24.9 (20.3-29.6)	94.7 (94.1-95.3)	23.3	95.1	26.3	93.5

CI: Confidence interval; PPV: Positive predictive values; NPV: Negative predictive values.

ARTICLE HIGHLIGHTS

Research background

Left ventricular hypertrophy (LVH) is a common manifestation of cardiovascular disease and a risk factor for cardiovascular morbidity and mortality, but available methods for its electrocardiographic (ECG) diagnosis have limited accuracy.

Research motivation

Improvement in the ability of clinicians to diagnose LVH on ECG could aid with patient risk stratification and prevent unnecessary additional testing.

Research objectives

The aim of this study was to investigate findings associated with LVH on ECG and develop an improved system for the diagnosis of LVH.

Research methods

A cohort study comparing ECG data acquired within 30 days of transthoracic echocardiography was performed. Multivariate regression analysis identified ECG findings associated with increased LV mass and mass index. A scoring system was derived and performance compared to established criteria for LVH.

Research results

In regression analysis, findings associated with LVH were amplitudes of Q in V3, R in V6, S in V3, T in V6, P' in V1, P in V6, as well as R and T-axis discordance, R peak time in V6, QRS duration, weight, height, sex, and age. A score consisting of 5 criteria was derived and validated it in an independent cohort. This score had superior sensitivity for detection of LVH by ECG compared to conventional criteria whilst making a modest sacrifice in specificity compared to conventional criteria.

Research conclusions

We identified several ECG findings that are associated with LVH and incorporated them into a score to improve the ECG diagnosis of this common condition. The scoring system may help improve clinical utility by enhancing sensitivity whilst displaying a modest sacrifice in specificity compared to conventional criteria.

Research perspectives

Further studies are needed to determine whether this scheme optimally reflects changes in the electrical characteristics of the myocardium over time, and whether it may have value for predicting cardiovascular events that are not exposed by measurement of ventricular mass alone.

REFERENCES

- 1 Casale PN, Devereux RB, Milner M, Zullo G, Harshfield GA, Pickering TG, Laragh JH. Value of echocardiographic measurement of left ventricular mass in predicting cardiovascular morbid events in hypertensive men. *Ann Intern Med* 1986; **105**: 173-178 [PMID: 2942070 DOI: [10.7326/0003-4819-105-2-173](https://doi.org/10.7326/0003-4819-105-2-173)]
- 2 Levy D, Garrison RJ, Savage DD, Kannel WB, Castelli WP. Left ventricular mass and incidence of coronary heart disease in an elderly cohort. The Framingham Heart Study. *Ann Intern Med* 1989; **110**: 101-107 [PMID: 2521199 DOI: [10.7326/0003-4819-110-2-101](https://doi.org/10.7326/0003-4819-110-2-101)]
- 3 Levy D, Garrison RJ, Savage DD, Kannel WB, Castelli WP. Prognostic implications of echocardiographically determined left ventricular mass in the Framingham Heart Study. *N Engl J Med* 1990; **322**: 1561-1566 [PMID: 2139921 DOI: [10.1056/NEJM199005313222203](https://doi.org/10.1056/NEJM199005313222203)]
- 4 Koren MJ, Devereux RB, Casale PN, Savage DD, Laragh JH. Relation of left ventricular mass and geometry to morbidity and mortality in uncomplicated essential hypertension. *Ann Intern Med* 1991; **114**: 345-352 [PMID: 1825164 DOI: [10.7326/0003-4819-114-5-345](https://doi.org/10.7326/0003-4819-114-5-345)]
- 5 Kannel WB, Cobb J. Left ventricular hypertrophy and mortality--results from the Framingham Study. *Cardiology* 1992; **81**: 291-298 [PMID: 1301257 DOI: [10.1159/000175819](https://doi.org/10.1159/000175819)]
- 6 Hancock EW, Deal BJ, Mirvis DM, Okin P, Kligfield P, Gettes LS, Bailey JJ, Childers R, Gorgels A, Josephson M, Kors JA, Macfarlane P, Mason JW, Pahlm O, Rautaharju PM, Surawicz B, van Herpen G, Wagner GS, Wellens H; American Heart Association Electrocardiography and Arrhythmias Committee, Council on Clinical Cardiology; American College of Cardiology Foundation; Heart Rhythm Society. AHA/ACCF/HRS recommendations for the standardization and interpretation of the electrocardiogram: Part V: electrocardiogram changes associated with cardiac chamber hypertrophy: a scientific statement from the American Heart Association Electrocardiography and Arrhythmias Committee, Council on Clinical Cardiology; the American College of Cardiology Foundation; and the Heart Rhythm Society. Endorsed by the International Society for Computerized Electrocardiology. *J Am Coll Cardiol* 2009; **53**: 992-1002 [PMID: 19281932 DOI: [10.1016/j.jacc.2008.12.015](https://doi.org/10.1016/j.jacc.2008.12.015)]
- 7 Ang D, Lang C. The prognostic value of the ECG in hypertension: Where are we now? *J Hum Hypertens* 2008; **22**: 460-467 [PMID: 18432258 DOI: [10.1038/jhh.2008.24](https://doi.org/10.1038/jhh.2008.24)]
- 8 Bauml MA, Underwood DA. Left ventricular hypertrophy: An overlooked cardiovascular risk factor. *Cleve Clin J Med* 2010; **77**: 381-387 [PMID: 20516249 DOI: [10.3949/ccjm.77a.09158](https://doi.org/10.3949/ccjm.77a.09158)]
- 9 Schiattarella GG, Hill JA. Inhibition of hypertrophy is a good therapeutic strategy in ventricular pressure overload. *Circulation* 2015; **131**: 1435-1447 [PMID: 25901069 DOI: [10.1161/CIRCULATIONAHA.115.013894](https://doi.org/10.1161/CIRCULATIONAHA.115.013894)]
- 10 Okin PM, Devereux RB, Jern S, Kjeldsen SE, Julius S, Nieminen MS, Snapinn S, Harris KE, Aurup P,

- Edelman JM, Wedel H, Lindholm LH, Dahlöf B; LIFE Study Investigators. Regression of electrocardiographic left ventricular hypertrophy during antihypertensive treatment and the prediction of major cardiovascular events. *JAMA* 2004; **292**: 2343-2349 [PMID: 15547161 DOI: 10.1001/jama.292.19.2343]
- 11 **Pewsnr D**, Jüni P, Egger M, Battaglia M, Sundström J, Bachmann LM. Accuracy of electrocardiography in diagnosis of left ventricular hypertrophy in arterial hypertension: systematic review. *BMJ* 2007; **335**: 711 [PMID: 17726091 DOI: 10.1136/bmj.39276.636354.AE]
 - 12 **Bacharova L**, Schocken D, Estes EH, Strauss D. The role of ECG in the diagnosis of left ventricular hypertrophy. *Curr Cardiol Rev* 2014; **10**: 257-261 [PMID: 24827796 DOI: 10.2174/1573403X10666140514103220]
 - 13 **Bacharova L**, Estes HE, Schocken DD, Ugander M, Soliman EZ, Hill JA, Bang LE, Schlegel TT. The 4th Report of the Working Group on ECG diagnosis of Left Ventricular Hypertrophy. *J Electrocardiol* 2017; **50**: 11-15 [PMID: 27890283 DOI: 10.1016/j.jelectrocard.2016.11.003]
 - 14 **Rautaharju PM**, Soliman EZ. Electrocardiographic left ventricular hypertrophy and the risk of adverse cardiovascular events: a critical appraisal. *J Electrocardiol* 2014; **47**: 649-654 [PMID: 25012077 DOI: 10.1016/j.jelectrocard.2014.06.002]
 - 15 **Estes EH**, Zhang ZM, Li Y, Tereschenko LG, Soliman EZ. The Romhilt-Estes left ventricular hypertrophy score and its components predict all-cause mortality in the general population. *Am Heart J* 2015; **170**: 104-109 [PMID: 26093870 DOI: 10.1016/j.ahj.2015.04.004]
 - 16 **Leigh JA**, O'Neal WT, Soliman EZ. Electrocardiographic Left Ventricular Hypertrophy as a Predictor of Cardiovascular Disease Independent of Left Ventricular Anatomy in Subjects Aged \geq 65 Years. *Am J Cardiol* 2016; **117**: 1831-1835 [PMID: 27067620 DOI: 10.1016/j.amjcard.2016.03.020]
 - 17 **Lang RM**, Bierig M, Devereux RB, Flachskampf FA, Foster E, Pellikka PA, Picard MH, Roman MJ, Seward J, Shanewise JS, Solomon SD, Spencer KT, Sutton MS, Stewart WJ; Chamber Quantification Writing Group; American Society of Echocardiography's Guidelines and Standards Committee; European Association of Echocardiography. Recommendations for chamber quantification: a report from the American Society of Echocardiography's Guidelines and Standards Committee and the Chamber Quantification Writing Group, developed in conjunction with the European Association of Echocardiography, a branch of the European Society of Cardiology. *J Am Soc Echocardiogr* 2005; **18**: 1440-1463 [PMID: 16376782 DOI: 10.1016/j.echo.2005.10.005]
 - 18 **Devereux RB**, Alonso DR, Lutas EM, Gottlieb GJ, Campo E, Sachs I, Reichek N. Echocardiographic assessment of left ventricular hypertrophy: comparison to necropsy findings. *Am J Cardiol* 1986; **57**: 450-458 [PMID: 2936235 DOI: 10.1016/0002-9149(86)90771-X]
 - 19 **Sullivan LM**, Massaro JM, D'Agostino RB Sr. Presentation of multivariate data for clinical use: The Framingham Study risk score functions. *Stat Med* 2004; **23**: 1631-1660 [PMID: 15122742 DOI: 10.1002/sim.1742]
 - 20 **Casale PN**, Devereux RB, Alonso DR, Campo E, Kligfield P. Improved sex-specific criteria of left ventricular hypertrophy for clinical and computer interpretation of electrocardiograms: Validation with autopsy findings. *Circulation* 1987; **75**: 565-572 [PMID: 2949887 DOI: 10.1161/01.cir.75.3.565]
 - 21 **SOKOLOW M**, LYON TP. The ventricular complex in left ventricular hypertrophy as obtained by unipolar precordial and limb leads. *Am Heart J* 1949; **37**: 161-186 [PMID: 18107386 DOI: 10.1016/0002-8703(49)90562-1]
 - 22 **Molloy TJ**, Okin PM, Devereux RB, Kligfield P. Electrocardiographic detection of left ventricular hypertrophy by the simple QRS voltage-duration product. *J Am Coll Cardiol* 1992; **20**: 1180-1186 [PMID: 1401620 DOI: 10.1016/0735-1097(92)90376-X]
 - 23 **Okin PM**, Roman MJ, Devereux RB, Kligfield P. Electrocardiographic identification of increased left ventricular mass by simple voltage-duration products. *J Am Coll Cardiol* 1995; **25**: 417-423 [PMID: 7829796 DOI: 10.1016/0735-1097(94)00371-V]
 - 24 **Ungerleider HE**, Gubner R. The Q3 and QS3 deflections in the electrocardiogram; criteria and significance. *Am Heart J* 1947; **33**: 807-818 [PMID: 20242367 DOI: 10.1016/0002-8703(47)90026-4]
 - 25 **Dollar AL**, Roberts WC. Usefulness of total 12-lead QRS voltage compared with other criteria for determining left ventricular hypertrophy in hypertrophic cardiomyopathy: analysis of 57 patients studied at necropsy. *Am J Med* 1989; **87**: 377-381 [PMID: 2529761 DOI: 10.1016/S0002-9343(89)80817-4]
 - 26 **Romhilt DW**, Estes EH. A point-score system for the ECG diagnosis of left ventricular hypertrophy. *Am Heart J* 1968; **75**: 752-758 [PMID: 4231231 DOI: 10.1016/0002-8703(68)90035-5]
 - 27 **Norman JE**, Levy D, Campbell G, Bailey JJ. Improved detection of echocardiographic left ventricular hypertrophy using a new electrocardiographic algorithm. *J Am Coll Cardiol* 1993; **21**: 1680-1686 [PMID: 8496537 DOI: 10.1016/0735-1097(93)90387-G]
 - 28 **Peguero JG**, Lo Presti S, Perez J, Issa O, Brenes JC, Tolentino A. Electrocardiographic Criteria for the Diagnosis of Left Ventricular Hypertrophy. *J Am Coll Cardiol* 2017; **69**: 1694-1703 [PMID: 28359515 DOI: 10.1016/j.jacc.2017.01.037]



Published By Baishideng Publishing Group Inc
7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA
Telephone: +1-925-2238242
Fax: +1-925-2238243
E-mail: bpgoffice@wjgnet.com
Help Desk: <https://www.f6publishing.com/helpdesk>
<https://www.wjgnet.com>

