Morphologies Suggestive of V₁ and V₂ Lead Misplacement

To the Editor:

Many of the electrocardiograms (ECG) that are done every day present artefacts generated by inadequate placement of the electrodes. It is very important for the correct interpretation of the ECG that the leads are situated in their assigned places. Variation in the placement of the precordial electrodes is a common source of error (Figure 1). Wenger et al determined the differences in their placement among 30 experienced technicians as compared with their correct placement, and found that in over 50% of cases the V₁ and V₂ electrodes were placed above the fourth intercostal space. These electrodes are the “guide” electrodes for the other leads in the horizontal plane. From a clinical point of view, relevant changes are produced in more than 50% of the automated interpretations of the ECG due to incorrect placement of the precordial electrodes. Important alterations are found in all the waves and all the segments of the ECG with the high recording of V₁ and V₂, identifying images that might lead to false diagnoses and important changes in the P wave, and an increase in the negative component is frequently recorded in this latter with the upward displacement of the V₁ and V₂ leads (Figure 2A). However, an exclusively or predominantly negative P wave in V₁, and sometimes in V₂, can be recorded with the electrodes correctly situated in persons with certain cardiac disorders that cause left atrial growth. As a result of the high placement of V₁, Bayés de Luna described the recording of the rSr’ morphology accompanied by an exclusively negative P wave as a sign of incorrect placement (Figure 2B). The appearance of an rSr’ electrocardiographic pattern in V₁ can be predicted if an r’ of a certain magnitude is recorded in aVR or a notch in the ascending branch.
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of the S wave in V1 with the electrode correctly placed. Here it is important to stress the importance of the correct placement of the V1 and V2 electrodes, especially in order not to diagnose that a patient has right bundle branch block when rSr' is recorded in V1. The presence of a negative P wave in the same lead, the duration of the QRS ≤0.1 s and the disappearance of the rSr' morphology after placing electrodes in the fourth intercostal space ensure that it is due to incorrect placement of the leads and not to disease. Additionally, in this case the rSr' morphology presents a narrow r', and although the T wave may be negative, there is no rise in the ST, which distinguishes it from the morphology seen in the Brugada syndrome.5

We must therefore suspect inadequate placement of the electrodes in a patient with no cardiac disorder who has an exclusively negative P wave in V1, especially if this is accompanied by a rSr' morphology. Additionally, the V2 recording of the negative component of the P wave, on many occasions accompanied by a diphasic P wave in V1 with a usual predominance of the negative component, is also a firm indication of the high placement of these electrodes.

REFERENCES


Javier García-Niebla
Centro de Salud Valle del Golfo, El Hierro, Santa Cruz de Tenerife, Spain