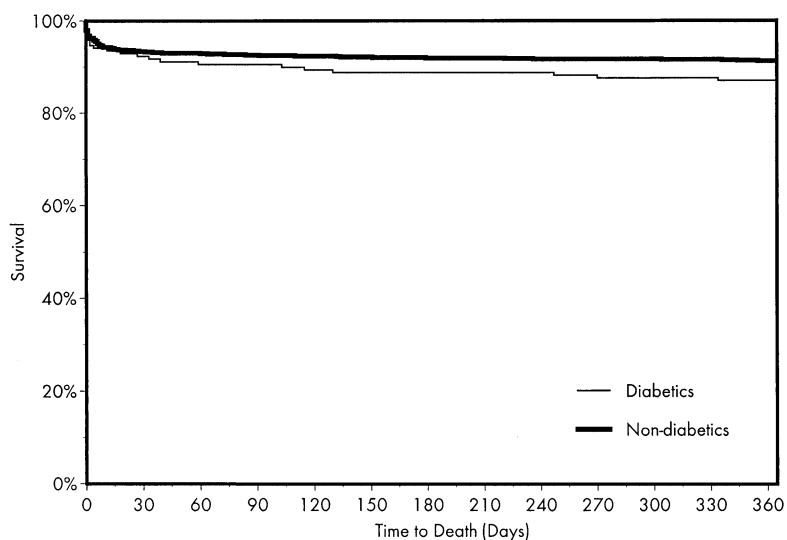


## CORRECTIONS

**Diabetes Mellitus and Outcome After Primary Coronary Angioplasty for Acute Myocardial Infarction: Lessons from the GUSTO-IIb Angioplasty Substudy. J Am Coll Cardiol 2000;35:1502-12. There is an error in Figure 2**

**on page 1510. The horizontal axis should have read as follows: Time to Death (Days). The corrected Figure 2 appears below.**



**Figure 2.** Kaplan-Meier curves depicting the estimated survival for diabetic and nondiabetic patients within 12 months of follow-up after (Re)MI. (Re)MI = reinfarction.

**Detection of Myocardial Ischemia Using Additional Left Posterior and Right Precordial Leads During Exercise Electrocardiography. Abstract—Cardiac Function and Heart Failure, Session 1139-121. J Am Coll Cardiol 2000;35:210A.** This abstract was presented at the 49th Annual Scientific Session of the American College of Cardiology, Anaheim, California. The first author of this abstract was incorrectly listed as “Vijendra Swamp.” The first author’s correct name is “Vijendra Swarup.” In addition, the first sentence in the Conclusions should have read as follows: The addition of right precordial and left posterior leads to the standard 12 lead ECG significantly improves the sensitivity of the exercise ECG for the diagnosis of myocardial ischemia. We regret these printing errors. The corrected abstract appears below:

1139-121

**Detection of Myocardial Ischemia Using Additional Left Posterior and Right Precordial Leads During Exercise Electrocardiography**

Vijendra Swarup, Neal Skop, Joel S. Raichlen, *Thomas Jefferson University, Philadelphia, Pennsylvania, USA*

**Background:** Although stress electrocardiography (ECG) is less expensive than imaging stress studies, it is relatively insensitive for detecting myocardial ischemia. We examined the value of adding two right sided (RV3, RV4) and two left posterior (V8, V9) leads (16 lead ECG) to improve the sensitivity of exercise ECG for detecting myocardial ischemia.

**Methods:** We prospectively studied 229 patients (141 men and 88 women) with a mean age of  $56 \pm 22$  who were undergoing nuclear exercise stress testing. 49% were hypertensive, 18% diabetic, 48% hypercholesterolemic, 20% smoked and 45% had a family history of premature coronary artery disease (CAD); 32% had known CAD (prior infarction or revascularization).

**Results:** Patients exercised  $8.8 \pm 6$  minutes achieving an average heart rate of 151 bpm with 79.5% achieving their target heart rate. Ischemia was present in 38 patients (16.6%) as evidenced by at least one reversible perfusion defect. There was evidence of myocardial ischemia on the standard 12 lead ECG in 34 patients (14.8%). An additional 12 patients met criteria for ischemia on the 16 lead ECG. The 16 lead ECG increased the sensitivity of the 12 lead ECG from 41.9% to 65.1% ( $p < 0.001$ ) with no reduction in specificity (91.4% versus 90.3%). The 16 lead ECG improved the sensitivity for detecting ischemia in women for 42.8% to 71.4%, in patients with known CAD from 32.0% to 57.1% and in patients who did not achieve their target heart from 41.6% to 58.3%.

**Conclusion:** The addition of right precordial and left posterior leads to the standard 12 lead ECG significantly improves the sensitivity of the exercise ECG for the diagnosis of myocardial ischemia.