tion laboratory and did not convert to overt ST-segment elevation. Furthermore, the majority of our patients showed a total occlusion of the proximal LAD artery and, despite successful primary percutaneous coronary intervention in all cases, had a considerable loss of myocardium (median myocardial type creatine kinase 290 µg/l). This seems in contradiction to previous suggestions that ST-segment depression and tall positive T waves in the precordial leads are associated with regional subendocardial ischaemia⁵ and a favourable outcome.⁴ Therefore, we think it is important to emphasise that in some patients, this novel ECG pattern may be associated with persistent proximal LAD artery occlusion and transmural ischaemia of the anterior myocardium. These patients must be distinguished from patients with regional subendocardial ischaemia and be referred for immediate reperfusion therapy.

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CORRECTION

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Wackers J. Chest pain in the emergency department: role of cardiac imaging. The author's reply. *Heart* 2009;**95**:1802. In the third paragraph, the first sentence should read “I believe though that there is a place for exercise ECG in the evaluation of patients in an ED chest pain centre (CPC).” The journal apologises for the error which has been corrected online.