Ambulatory electrocardiographic ST segment changes in healthy volunteers

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SUMMARY Twenty four hour ambulatory monitoring was performed on 120 healthy volunteers using a frequency modulated recorder: 50 men and 50 women below 40 years and 20 men between 40 and 60 years were studied. Twenty eight subjects had episodes of ST segment elevation (range 1–3 mm), which occurred almost invariably at night with a slow heart rate (62.4±10.4 beats/min). ST segment elevation occurred most often in men, and was not found in subjects over the age of 37. Also in 10 subjects horizontal or downsloping ST segment depression (range 1–2 mm) was recorded, usually in association with tachycardia (135±10.5 beats/min). Nine of these exercised on a bicycle ergometer, and widespread ST segment depression was observed in eight. Thus ST segment changes, which are often interpreted as myocardial ischaemia in patients with ischaemic heart disease, are commonly seen in 24 hour electrocardiographic monitoring of healthy volunteers.

Both ST segment elevation\(^1\,\!^2\) and depression\(^3\,\!^4\,\!^5\) recorded during ambulatory electrocardiographic monitoring have been accepted as indicators of cardiac ischaemia in patients with suspected or diagnosed coronary artery disease. Occasionally ST segment displacement has been noted in individuals who were investigated for chest pain and found to have normal coronary arteries.\(^1\,\!^6\,\!^7\) The frequency, magnitude, and morphology of such changes recorded during 24 hour ambulatory monitoring in normal individuals, however, have not been fully evaluated. Such an assessment is clearly important if ambulatory monitoring is to be used in the diagnosis and evaluation of patients with chest pain. We have determined the types of ST segment changes occurring during 24 hour ambulatory electrocardiographic monitoring during normal daily activity in a group of healthy normal volunteers.

Patients and methods

Twenty four hour ambulatory monitoring was performed, on 120 volunteers, most of whom were hospital staff or medical students and who were all free from any past or present cardiovascular symptoms. One hundred subjects, 50 men and 50 women, were aged between 20 and 40 years (mean 27.8±4.8) and 20 men were aged between 40 and 60 years (mean 51.3).

AMBULATORY ELECTROCARDIOGRAPHIC MONITORING

Two pairs of bipolar electrodes were applied precordially to obtain a two channel recording. One channel recorded the lead CM5 with the indifferent electrode on the manubrium and the exploring electrode in the precordial V5 position. The other channel recorded lead CM2 with the indifferent electrode on the left sternoclavicular joint and the exploring electrode in the precordial V2 position. A ground electrode was placed over the lower right ribs. The skin was initially abraded with electrode jelly (Camjel) and gauze until a sufficiently low skin impedance reading was obtained with an Oxford X1-1 electrode impedance tester. Electrodes (Red-Dot 3M) were applied to the above positions, and monitor leads were secured to the electrodes with adhesive tape to prevent displacement. A magnetic tape was calibrated with a 1 mV signal. Twenty four hour, two channel ambulatory recording of the electrocardiogram was performed using a frequency modulated recorder (Oxford Medilog 2, frequency response 0.05–40 Hz).\(^9\) The monitor tapes were subsequently analysed visually (Oxford Medilog MA20 scanner), and areas of interest were printed out at 25 mm/s.

Significant ST segment depression was defined as planar or downsloping shift of the ST segment of 1 mm or more occurring 0.08 s after the end of the QRS complex. Significant ST segment elevation was defined as an upward shift of the ST segment of 1 mm.

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or more at the J point compared with the resting electrocardiogram. The duration of these ST segment abnormalities was at least 30 s. Abnormalities in the ST segments were analysed and agreed by two observers.

EFFECTS OF POSTURE AND RESPIRATION
Recordings were obtained for at least 30 s in various positions, including standing, sitting, and lying supine, prone, and on either side, in 15 subjects who developed ST segment changes during ambulatory monitoring. Also these subjects hyperventilated for about 30 s until they felt light headed.

EXERCISE TESTING
Nine subjects who had significant ST segment depression during ambulatory monitoring exercised on a bicycle ergometer with stepwise increases in work load to achieve their age related maximum heart rate response. A 13 lead electrocardiogram was recorded, which included the conventional 12 lead electrocardiogram and a bipolar lead, CM5, with the leads in positions identical to the first channel of the ambulatory recording.

STATISTICAL ANALYSIS
Data for the various subgroups are presented as mean±standard deviation. Discrete data were analysed using the χ² test.

Results

ST SEGMENT DEPRESSION
Ten subjects, six men and four women between the ages of 22 and 47 years (mean 31.7±8.6) had episodes of significant planar or downsloping ST segment depression during the 24 hours (Fig. 1). Five subjects were below 30 years, three were between 30 and 40 years, and two were between 40 and 50 years. In lead CM5 the ST segment depression was 1–2 mm and simultaneously in lead CM2 there was either no change or a smaller magnitude (0.5–1.0 mm) depression of the ST segment.

The mean heart rate at the onset of ST segment depression was 135±19.5 beats/min, ranging from 100 to 180 beats/min. The number of episodes varied from one to five during the 24 hours, and the mean duration of the episodes was 20.4±27.8 min. None of these subjects suffered any symptoms during these periods. No ST segment depression occurred at night.

In eight of these subjects electrocardiograms were recorded in various positions and during hyperventilation. No appreciable ST segment changes were observed. T wave changes alone were often found, which were related to posture and respiration.

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**Table Number of episodes and characteristics of ST segment elevation in normal volunteers**

<table>
<thead>
<tr>
<th>ST segment elevation</th>
<th>1 mm</th>
<th>1.5 mm</th>
<th>2.0 mm</th>
<th>2.5–3.0 mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of episodes</td>
<td>30</td>
<td>19</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Heart rate at onset</td>
<td>65±7</td>
<td>59±7</td>
<td>57±8</td>
<td>61±16</td>
</tr>
<tr>
<td>(beats/min)</td>
<td>12±3</td>
<td>9±9</td>
<td>7±5</td>
<td>16±7</td>
</tr>
<tr>
<td>Mean duration of</td>
<td>194±160</td>
<td>69±70</td>
<td>82±100</td>
<td>53±52</td>
</tr>
<tr>
<td>episodes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(min)</td>
<td></td>
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</table>
CM2 at the same time as ST segment elevation in lead CM5. Six subjects had ST segment elevation of 0.5–1.5 mm, a change always smaller than that in lead CM5, whereas 11 subjects had depression of the ST segment of 0.05–1.0 mm in lead CM2. The other 11 subjects had no ST segment changes in lead CM2 when there was elevation in lead CM5.

In all these subjects the T wave became upright and peaked in lead CM5 during ST segment elevation (Fig. 2), whereas in lead CM2 the T wave amplitude was either the same or reduced.

In 10 of the 28 subjects these ST segment changes could not be reproduced by posture or respiration.

**EXERCISE TESTING**

Nine of the 10 subjects with ST segment depression during ambulatory monitoring were exercised on the bicycle ergometer. During tachycardia, eight subjects developed significant ST segment depression, often in several leads. At no time did any of these subjects complain of symptoms of cardiac ischaemia.

**Discussion**

Several studies of patients with chest pain have determined the incidence of ST segment depression and compared it with results of coronary arteriography. A few important findings have emerged. Firstly, a number of patients with angiographically proved coronary artery disease had ST segment depression on ambulatory monitoring; a smaller but substantial group without occlusive coro-
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Of ST segment depression were all asymptomatic, normotensive, whites who were not having any treatment. Physical examination and resting electrocardiograms were normal. Furthermore, these changes on the ST segment could not be induced by posture or respiration.

ST segment monitoring has been widely used for evaluating patients with chest pain, and several workers have also used this technique to evaluate drug treatments in ischaemic heart disease. Although ambulatory monitoring may be extremely useful in both circumstances, it is important to be aware of the normal response if meaningful data are to be obtained.

One of the essential prerequisites of using ambulatory electrocardiographic systems for diagnosing myocardial ischaemia is to ensure that the composite system can accurately reproduce ST segment changes. The frequency response of the ST segment during electrocardiographic recording is at the lower frequency range of 0.05–0.5 Hz. Several of the older ambulatory monitoring studies were hampered by the use of direct recording systems which did not have an adequate response at these low frequencies and consequently produced severe distortions in the ST segments. The magnetic tape, frequency modulated recorder, scanner, and print out systems used in this study have an adequate low frequency response, down to 0.05 Hz (3 dB down), and this was tested regularly. We took precautions to minimise baseline drift of the electrocardiogram by adequate skin preparation and electrode adherence.

In conclusion, this study in healthy volunteers shows the frequent occurrence of ST segment changes during ambulatory monitoring. ST segment depression occurred with a tachycardia and could usually be reproduced during conventional exercise testing. ST segment elevation, with peaked T waves, occurred significantly more often in young men and occurred almost invariably at night. T wave changes were commonly observed and were often due to orthostatic changes.

References

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