Computer aided exercise electrocardiographic testing and coronary arteriography in patients with angina pectoris and with myocardial infarction

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SUMMARY A set of electrocardiographic criteria for the diagnosis of coronary artery disease was evaluated in two different groups of patients examined by computer aided 12 lead exercise electrocardiographic stress testing and coronary arteriography. One group consisted of patients with severe angina pectoris and the other of patients who had suffered a myocardial infarction three years before the study. Angiographically determined categories of patients could be identified with satisfactory precision by the electrocardiographic criteria under test in the patients with angina pectoris but not in those with infarction. A new method of classifying patients on the basis of data from coronary arteriography improved the correlation with ST segment analysis compared with conventional classification.

Exercise electrocardiographic testing is commonly used to detect coronary artery disease and also to evaluate the severity of disease and to observe the effect of treatment. Several reports suggest that the electrocardiographic response during exercise may correlate with the findings of coronary arteriography. Results have, however, also shown that exercise electrocardiographic testing poorly identifies patients with coronary artery disease.

Several factors influence the results of such investigations: (a) patient selection; (b) the reference method; (c) the definition of disease by the reference method; and (d) the procedures used in applying a method.

The aim of this investigation was to determine whether a set of ST segment amplitude criteria could identify critical coronary lesions in two differently selected groups of patients, one group consisting of patients with severe angina pectoris, who were to undergo coronary bypass surgery, and the other of patients who had had a myocardial infarction. A further aim was to determine whether the correlation between the results of exercise testing and coronary arteriography was improved by applying a new method of classifying patients angiographically.

Patients and methods

Two groups of patients with documented coronary artery disease were studied. The method of selection for the two groups was quite different.

PATIENT SELECTION

Angina group—This consisted of 63 men and four women (age range 34–63 (mean 55) years) with severe angina pectoris (NYHA functional classes III and IV) being assessed for possible coronary bypass surgery. Beta blocking agents were given to 87% of the patients, and the dose was not reduced before the exercise test.

Infarction group—This consisted of 42 men (age range 31–59 (mean 50) years) who had survived a clinically documented myocardial infarction three years earlier. Coronary arteriography had been per-

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Accepted for publication 6 March 1984
formed three months after the infarction. As part of a
follow up study these patients were re-examined
regardless of the presence of symptoms. Beta blocking
agents were given to all of these patients. The night
before exercise testing, however, only half the dose
was taken, and no beta blocker was taken on the
morning of the test.

Twelve patients (18%) from the angina group were
excluded from the ST segment analysis because they
showed abnormal Q waves (Minnesota Codes 1.1 and
1.2) in the chest to head lead CH2, and 11 patients
(26%) were excluded from the infarction group for the
same reason.

Angina subgroup—Sixty per cent of the patients
with angina had had a myocardial infarction between
20 years and three months before examination. To
assess the influence of an infarction in these patients
the group was subdivided into those with (a) a definite
infarction (n=29), (b) an uncertain infarction (n=11),
and (c) absence of infarction (n=27). A patient was
classified as having a definite infarction or an uncer-
tain infarction according to the diagnosis at the time
of the infarction.

EXERCISE TESTING
The patients were examined by exercise testing on the
day before coronary arteriography. The work was per-
formed on a bicycle ergometer. A minicomputer was
used to process and store the electrocardiographic
signals recorded by an electrocardiograph. The lead
system consisted of six chest to head leads (CH1–
CH6) and a modification of the standard six limb
leads.8 It was possible to obtain all the information
from the six limb leads by recording only two signals.
The six chest to head leads and limb leads I and II
were digitised at a rate of 500 Hz continuously
throughout the test, and an eight channel average
complex was calculated and stored on disk every 10
seconds.9

The starting workload was 30 W and was increased
by 10 W per minute until intolerable chest pain,
intense fatigue, a decrease in blood pressure, or
significant arrhythmia occurred. The electrocardio-
gram was then recorded during a 10 minute period of
rest after exercise.

ECG measurements
The ST segment displacement amplitudes were
measured 60 ms after the end of QRS complex with
the PQ level as a reference level. The ST60 depression
was calculated as the change in ST amplitude from a
value recorded while the patient was resting on the
bicycle before exercise to that recorded at maximal
workload.

ST segment displacement was also determined in
relation to heart rate. To make the measurement of

ST segment displacement less sensitive to the
influence of the T wave at high heart rates, the time
offset from the end of QRS complex to the point of
amplitude measurement was decreased. At heart rates
above 120 beats/min a factor of the square of (120/
heart rate) was used to adjust the offset. This correc-
tion factor reflects the change of position of the T
wave with varying heart rate.10

The criteria for ST segment displacement were: (a)
ST60 depression >0.033 mV in lead I, (b) ST60
depression >0.2 mV in any chest lead, and (c) either
of the two above or both.11

CORONARY ARTERIOGRAPHIC CLASSIFICATION
Coronary arteriography was performed using Jud-
kins’s technique.12 The findings for the angina group
were coded according to the American Heart Associa-
tion grading system.13 In the infarction group the
findings were coded according to Friesinger et al.14
The data for these two groups were collected as part of
a separate study by experienced examiners. In addi-
tion, the clinical report of the arteriographic results
was available.

Vessel disease
In the present study the term “significant narrowing”
denoted a diameter reduction of >50%. “Critical
coronary disease” denoted the presence of significant
narrowing at one or more sites in the main left coro-
nary artery (MLCA) or in the left anterior descending
artery proximal to the first septal branch or in all three
major branches simultaneously.11

Global flow index
An index was designed to estimate the effect of nar-
rrowing on the ratio of actual to normal blood flow at
high workloads. At each site the value of the index is
determined by the proximal narrowing and colla-
lars. As detailed data are missing on how these and
other factors affect the arterial flow, simple relations
were used to calculate the index. A narrowing was
represented by the diameter rather than by the area,
mainly for the sake of simplicity. In the aortic root,
where the coronary arteries originate, the flow index
is set equal to 1. The effect of a diameter narrowing of x
per cent is given by: index (distal)=index (proximal)
(100-x)/100. The index is constant between adjacent
narrowings. A vessel segment supported by collaterals
can have a higher index value distal to a narrowing
than proximal to it. A collateral described as having a
good flow is set to contribute to the index at the collat-
eral destination by: (index (collateral source)−index
(collateral destination))/3. A collateral with a reduced
flow will give rise to a proportionally reduced con-
tribution to the index. Blood flow indices calculated at
16 sites in the arterial tree are multiplied by the esti-
Angiogenic findings in patients with angina and with myocardial infarction

<table>
<thead>
<tr>
<th>Angina group</th>
<th>Infarction group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No of patients</td>
<td>67</td>
</tr>
<tr>
<td>No studied*</td>
<td>55</td>
</tr>
</tbody>
</table>

No with:
- Significant narrowing in MLCA or proximal LAD
- Significant 3 vessel disease
- Critical coronary disease
- No significant narrowing

*After exclusion of patients with abnormal Q waves. MLCA, main left coronary artery; LAD, left anterior descending (artery).

Table 1. Most patients in the angina group had significant narrowing, and more patients had critical coronary disease than in the infarction group.

Table 2 shows the distribution of patients according to angiographic classification for the two groups. In the angina group 35 of the 36 patients with critical coronary disease also had a global flow index <0.4. The corresponding numbers in the infarction group were nine of 14. Although the number of patients in the infarction group, classified as having severe disease by each of the two methods, was similar, in only 60% did the classifications overlap.

In the infarction group, 12 patients experienced anginal pain during exercise. Six of these interrupted the exercise test because of chest pain. No correlation was found between the development of angina during exercise and the degree of angiographically determined coronary artery disease (Table 3).

Table 4 shows the mean values for maximal workload and heart rate at maximal workload as well as the global flow index. The angina group had values for these indices well below the corresponding values in the infarction group. The differences in mean values for heart rate at maximal load and maximal load between the angina group as a whole and the infarction group as a whole were significant at the 0.1% level, and for the global flow index the difference was significant at the 2% level. Within the angina group no significant differences existed in heart rate at maximal workload or in maximal workload between the two angiographic categories.

Table 3. Number of patients in the infarction group presenting with angina pectoris in relation to the angiographic classification

<table>
<thead>
<tr>
<th>Angiographic category</th>
<th>Angina intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>No critical coronary disease</td>
<td>10</td>
</tr>
<tr>
<td>Critical coronary disease</td>
<td>9</td>
</tr>
<tr>
<td>Global flow index &gt;0.4</td>
<td>10</td>
</tr>
<tr>
<td>Global flow index &lt;0.4</td>
<td>9</td>
</tr>
</tbody>
</table>

Angina intensity: 0, no angina; 1, angina present but not limiting; 2, angina pectoris was the determining factor for discontinuing the exercise test.
In the infarction group patients with critical coronary disease had the same mean heart rate at maximal workload as those without. The mean maximal load was not significantly higher for patients with critical coronary disease than for those without. When the angiographic classification was based on the global flow index, however, significant differences were noted. Patients with a global flow index of >0.4 reached higher heart rates at maximal workload (p<0.01) and higher values for the maximal load (p<0.002) than patients with a value below this limit.

ELECTROCARDIOGRAPHIC CRITERIA

The evaluation of ST segment changes in terms of sensitivity, specificity, and predictive value for detecting critical coronary disease is shown in Table 5. For all three combinations of leads the sensitivity was significantly lower and the specificity higher in the infarction group than in the angina group.

The use of ST measurements dependent on heart rate resulted in marginal changes for the angina group; this was to be expected since most of these patients had a low maximum heart rate. No increase in the sensitivity for the infarction group was found, although these patients had a mean maximum heart rate of 141 beats/min.

Table 6 shows the relation between electrocardiographic results and the global flow index. As in Table 5 the sensitivity was significantly lower and the specificity higher in the infarction group than in the angina group. When Table 5 and Table 6 are compared the predictive value is higher for all lead combinations in both patient groups. In the angina group there is a consistent lowering of the sensitivity (maximum 5%) and an increase in the specificity (maximum 11%) in all lead combinations when the angiographic classification is based on the global flow index. The corresponding change in the infarction group is an increase in both sensitivity (maximum 18%) and specificity (maximum 18%).

The effect of a previous infarction on the electrocardiographic criteria in the angina group is shown in Table 7 (patients with a Q wave in CH2 are included). The tendency for an infarction to increase specificity and decrease sensitivity is shown for all three criteria, although the differences are small within the angina group.

Table 5 Sensitivity, specificity, and predictive value (%) of electrocardiographic ST segment changes for detecting patients with angiographically determined critical coronary disease

<table>
<thead>
<tr>
<th>ST segment response</th>
<th>Angina group</th>
<th>Infarction group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensitivity</td>
<td>Specificity</td>
</tr>
<tr>
<td>ST segment depression:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥0.033 mV (lead I)</td>
<td>92</td>
<td>68</td>
</tr>
<tr>
<td>≥0.2 mV (any CH lead)</td>
<td>81</td>
<td>68</td>
</tr>
<tr>
<td>≥0.033 mV (lead I) or ≥0.2 mV (any CH lead)</td>
<td>94</td>
<td>58</td>
</tr>
</tbody>
</table>
Table 6  Sensitivity, specificity, and predictive value (%) of ST segment changes for detecting patients with a global flow index ≤0.4

<table>
<thead>
<tr>
<th>ST segment response</th>
<th>Angina group</th>
<th>Infarction group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensitivity</td>
<td>Specificity</td>
</tr>
<tr>
<td>ST segment depression:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥0.033 mV (lead I)</td>
<td>88</td>
<td>79</td>
</tr>
<tr>
<td>≥0.02 mV (any CH lead)</td>
<td>76</td>
<td>71</td>
</tr>
<tr>
<td>≥0.033 mV (lead I) or ≥0.2 mV (any CH lead)</td>
<td>90</td>
<td>64</td>
</tr>
</tbody>
</table>

Discussion

Patients with a Q wave in lead CH2 of the resting electrocardiogram were excluded because those with this sign of transmural anterior myocardial infarction show mainly ST segment elevation during exercise.16 17

One group consisted solely of men and the other contained 6% of women. Analysis of the ST segment response in women during stress testing is reported to be difficult, but this cannot explain the present result since the women were in the group in which the ST segment criteria correlated well with the angiographic findings. Another difference between the groups is the mean age. It is unlikely, however, that the same degree of ischaemia would produce a different ST segment response in relation to age.

The difference between the two groups in the degree of beta bloqueade at the time of the exercise test should be small, although the infarction group were given a reduced dose 18 hours before the examination.18

The formulas for calculating the flow index were chosen because of their simplicity and need modification to reflect the arterial flow more accurately. The length and structure of the narrowing probably also influence the effect of a stenosis on the peak flow. Another important determinant of flow is the myocardial peripheral resistance, which is not easily assessed by coronary arteriography. Vasospasm is a possible obstacle to flow, which may develop during exercise and not at rest during coronary arteriography. Normalisation of the flow index taking into account the presence of infarcted muscle and the accompanying lesser demand for blood supply is suggested as a step towards formulating an index that correlates with ischaemia. A fundamental characteristic of the indices used is that they allow continuous grading of the measurements as opposed to the usual division into groups—for example, critical and non-critical coronary disease. Thus an individual with a 40% stenosis in the main left coronary artery would be classified as having non-critical disease, whereas with the flow index the stenosis would be graded according to its severity.

It should be noted that differences in the methods of exercise testing and coronary arteriography were negligible between the groups, and the divergence of results was thus due to patient selection.

Our results imply that some patients with non-critical coronary disease may have a lower total supply of blood to the myocardium than some patients with critical coronary disease. Thus an electrocardiographic criterion that correlates with ischaemia should not be expected to correlate exactly with the existence of critical coronary disease.

Myocardial ischaemia is associated with ST segment changes.19 20 In the absence of an adequate supply of blood by collaterals a coronary artery narrowing will result in a reduction of the maximal blood flow. At rest the supply of blood can still be sufficient to prevent ischaemia. At some levels of exercise, however, the demand will exceed the capacity for supplying blood, and ischaemic ST segment changes will occur. This approach explains the results in the angina group but not those in the infarction group.

Table 7  Sensitivity, specificity, and predictive value PV(+) (%) of three ST criteria based on ST segment amplitude change for three subgroups of patients in the angina group including those patients with an abnormal Q wave in CH2 for detecting patients with a global flow index ≤0.4

<table>
<thead>
<tr>
<th>ST segment depression:</th>
<th>Definite infarction</th>
<th>Uncertain infarction</th>
<th>Absence of infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensitivity</td>
<td>Specificity</td>
<td>PV(+)</td>
</tr>
<tr>
<td>≥0.033 mV (lead I)</td>
<td>76</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>≥0.02 mV (any CH lead)</td>
<td>60</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>≥0.033 mV (lead I) or ≥0.2 mV (any CH lead)</td>
<td>80</td>
<td>80</td>
<td>95</td>
</tr>
</tbody>
</table>
There are factors indicating that the degree of ischaemia developed by the infarction patients classified as having critical coronary disease was less than would be expected from the angiographic findings. The difference in mean maximal workload between the infarction group and the angina group was larger than would be expected from the difference in age. Few of the patients in the infarction group had severe angina pectoris. In the infarction group neither the existence of critical coronary disease nor the value of the global flow index showed the same degree of correlation with ST segment changes as was found in the angina group. An old infarction indicates that part of the myocardium has changed to scar tissue, for which the demand of blood is negligible. A healed completely infarcted area is electrically inactive, and no ischaemic ST segment changes will originate from such an area. The development of collaterals, supporting the surviving tissue, can to some extent prevent ischaemia even during exercise despite significant narrowing. Consequently, less chest pain and ST segment depression should be expected in these cases. Thus in the infarction group there was no correlation between angina during exercise and the severity of the coronary artery narrowing.

The angina group, however, consisted of 60% of patients with a myocardial infarction, and yet this group showed a correlation between the ST segment measurements and angiographic classification. This may be explained by a difference between the two patient groups. The patients in the angina group had a progression of their angina and probably also of their ischaemia and coronary disease, but most of the infarction patients had not experienced increasing symptoms since their infarction three years earlier. Thus the heart appears to be able to adapt to a certain degree of coronary artery disease—for example, by developing collaterals—and can function reasonably well.

These findings show that information on coronary artery narrowing alone is not sufficient when findings from coronary arteriography are correlated with the results of exercise electrocardiographic testing. The functional capacity of collaterals and the amount of infarcted ventricular muscle are important factors which must be taken into consideration. The rate of the progression of the coronary artery disease may be a considerable degree determine the ischaemic effect of the narrowing. Furthermore, coronary arteriography is performed with the patient at rest, and data should not be expected to agree exactly with results obtained during stress testing.

The promising results obtained in the angina group agree well with the results from a previous study by Ejdeback et al in a similarly selected group. This is encouraging since patients with critical coronary dis-

CONCLUSION

In limb lead I the sensitivity for detecting patients with severe coronary artery disease in the angina and infarction groups was 92% and 29% respectively, when the patients were classified by a conventional angiographic method. The corresponding values were 88% and 47% when a new method for angiographic classification was used. The specificity increased in both patient groups. The difference in results obtained with the two methods for angiographic classification suggests that a more detailed analysis of the size and extent of coronary artery narrowing is valuable, and that the presence of collaterals should be included in the classification.

The divergence of the results between the two groups of patients in their ability to distinguish between severe and less severe coronary artery disease by means of ST segment analysis is evident. The rate of progression of the coronary disease, which was different in the two groups, is proposed as the main reason for this. Thus in the evaluation as to what extent a coronary artery narrowing gives rise to ischaemia the rate of progression is an important factor as it affects the degree of adaptation to the narrowing—for example, by developing collaterals.

References


