A 47-year-old woman was transferred to Harper Hospital for recurrent, severe post-AMI angina refractory to maximal medical therapy, 4 days after sustaining a non-Q-wave inferior AMI associated with a diminutive increase in CK to 300 IU. On the day of transfer, she had recurrent rest angina associated with new horizontal ST-segment depression and upright T waves in leads V<sub>4</sub> through V<sub>6</sub>, believed to represent "remote" anterior subendocardial ischemia or recurrent anterior non-Q-wave AMI (Fig. 2, top left). Blood pressure was 110/70 mm Hg, pulse 72 beats/min and lungs were clear. Urgent coronary angiography showed the left coronary system to be normal. Right coronary artery injection disclosed a high-grade stenotic lesion (at least 85% luminal diameter narrowing) involving the midportion of the vessel (Fig. 2, top right). Serial inflations with a 2.0-mm Stimpson Robert balloon catheter dilated the right coronary artery stenosis (Fig. 2, bottom left). Precordial ST-segment depression abated and abnormal tall R waves did not evolve (Fig. 2, bottom right).

Recently, we described the early electrocardiographic findings of posterior AMI in 27 patients randomized to the Diltiazem Reinfarction Study of MB-CK−confirmed non-Q-wave AMI. All patients initially showed a pattern of precordial ST-segment depression with upright T waves, which was believed to represent anterior non-Q-wave AMI; however, before discharge, abnormal right precordial R waves indicative of posterior AMI evolved in all patients. Coronary angiography was not performed on these study patients by trial design.

We have shown 2 contrasting examples of early posterior AMI due to isolated high-grade 1-vessel disease of a circumflex and right coronary artery, respectively. Each case showed significant early precordial ST-segment depression in the absence of left anterior descending coronary artery disease. These findings emphasize that precordial ST-segment depression with upright T waves due to circumflex or right coronary artery obstruction may produce an early electrocardiographic "current of injury," which is projected as reciprocal precordial ST-segment depression (posterior ST-segment elevation). Such patients may have occluded or subtotally occluded infarct-related coronary arteries, and should not be considered ineligible for acute thrombolytic therapy because of the absence of electrocardiographic ST-segment elevation.

on the suddenness, completeness and duration of blood flow deprivation caused by platelet thrombi. Dramatic decreases in mortality and nonfatal AMI have been seen in patients with unstable angina treated with aspirin. An explanation is that coronary artery thrombosis often occurs adjacent to atherosclerotic plaques of less than 60% diameter stenosis. Because the ischemic syndromes in the 2 patients in this report stabilized on aspirin therapy, we avoided the risks of angioplasty in the setting of angiographically detected intracoronary thrombus. Cardiac catheterization performed 1 month later in each patient revealed resolution of the thrombus and a widely patent artery. Thus, neither emergency nor elective angioplasty was performed.