A 19-year-old woman with no significant cardiac or pulmonary history presented with exertional dyspnea, which had begun a few months earlier. Auscultation revealed a loud pulmonary component of the second heart sound and a diastolic murmur heard along the upper left sternal border. Her 12-lead electrocardiogram is shown in Figure 1.

Q: Which of the following can cause prominent R waves in lead V1?

- Normal variant in young adults
- Wolff-Parkinson-White syndrome
- Posterior wall myocardial infarction
- Right ventricular hypertrophy
- All of the above

A: The correct answer is all of the above.
The patient's electrocardiogram shows a right atrial abnormality and right ventricular hypertrophy. Right atrial enlargement is evidenced by a prominent initial P wave in V1 with an amplitude of at least 1.5 mm (0.15 mV). A P wave taller than 2.5 mm (0.25 mV) in lead II may also suggest a right atrial abnormality.1

Multiple criteria exist for the diagnosis of right ventricular hypertrophy. Tall R waves in V1 with an R/S ratio greater than 1 (ie, the R wave amplitude is more than the S wave depth) is commonly used.2 Deep S waves with an R/S ratio less than 1 in V6 is another criterion. Tall R waves of amplitude greater than 7 mm in V1 by themselves may represent right ventricular hypertrophy. Most of the electrocardiographic criteria are specific but not sensitive for this diagnosis.3

Other causes of tall R waves in V1 are given in Table 1.

Q: Which of the following diseases can present with an electrocardiographic pattern of right ventricular hypertrophy in young patients?

☐ Pulmonary hypertension
☐ Atrial septal defect
☐ Tetralogy of Fallot
☐ Pulmonary stenosis
☐ All of the above

A: The correct answer is all of the above.4

Our patient underwent multiple investigations. On echocardiography, her estimated right ventricular pressure was 80 mm Hg, and on cardiac catheterization her mean pulmonary arterial pressure was 55 mm Hg and her pulmonary capillary wedge pressure was 6 mm Hg. She was diagnosed with pulmonary arterial hypertension, which was the cause of her right ventricular hypertrophy. She eventually underwent bilateral lung transplantation.

Table 1

<table>
<thead>
<tr>
<th>Differential diagnosis of tall R waves in lead V1</th>
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<tbody>
<tr>
<td>Normal variant in children and young adults</td>
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<tr>
<td>Right bundle branch block</td>
</tr>
<tr>
<td>Posterior myocardial infarction</td>
</tr>
<tr>
<td>Dextrocardia</td>
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<tr>
<td>Type A Wolff-Parkinson-White syndrome</td>
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<tr>
<td>Hypertrophic cardiomyopathy</td>
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<tr>
<td>Duchenne muscular dystrophy</td>
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<tr>
<td>Right ventricular hypertrophy</td>
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</tbody>
</table>

REFERENCES


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