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Data on association between QRS duration on prehospital ECG and mortality in patients with confirmed STEMI

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A B S T R A C T
Data presented in this article relates to the research article entitled “Association between QRS duration on prehospital ECG and mortality in patients with suspected STEMI” (Hansen et al., in press) [1].

Data on the prognostic effect of automatically recoded QRS duration on prehospital ECG and presence of classic left and right bundle branch block in 1777 consecutive patients with confirmed ST segment elevation AMI is presented. Multivariable analysis, suggested that QRS duration > 111 ms, left bundle branch block and right bundle branch block were independent predictors of 30 days all-cause mortality. For interpretation and discussion of these data, refer to the research article referenced above.

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**Value of the data**

- Data show that short term mortality is significantly higher in patients with suspected STEMI compared to those with confirmed STEMI
- QRS duration is an independent predictor of short term mortality in patients with confirmed STEMI

1. Data

QRS duration has previously shown association with mortality in patients with acute myocardial infarction treated with thrombolysis. Less is known of the prognostic value of QRS duration on prehospital ECG in patients with STEMI in a contemporary population. These data are based on prospective assessment of all patients with confirmed STEMI where an prehospital ECG was available that were referred to two high volume primary PCI centers in Denmark [1].

2. Experimental design, materials and methods

2.1. Study population

Patients admitted with suspected STEMI were consecutively enrolled at the Heart Center, Rigs hospitalet, Copenhagen from March 2015 to March 2016 and at the Department of Cardiology at Odense University Hospital Denmark from October 2015 to August 2016. Patients were excluded, if prehospital ECG was determined without significant ST segment elevation. Further, self-presenters and patients without prehospital ECG were excluded (Fig. 1).

2.2. Pre-hospital ECG

Standard 12 lead ECG was recorded by EMS using a LIFEPAK® 15 monitor/defibrillator (Physio-Control, Inc. Redmond, WA, USA) at a paper speed of 25 mm/s. All prehospital ECGs were later accessed by the medical record system and the automatically measured QRS duration was registered for this study together with presence of RBBB or LBBB. STEMI was identified on ECG as ST-segment elevation at the J-point $\geq 0.1 \text{ mV (mV)}$ in two contiguous leads, other than in leads V2–V3 where following cut-points applied: $\geq 0.2 \text{ mV in men } \geq 40 \text{ years}$, $\geq 0.25 \text{ mV in men } < 40 \text{ years and}$
Z0.15 mV in women. Final diagnosis was based on admission coronary angiography and evaluation of biomarkers of myocardial damage (high sensitive troponins) [2].

2.3. All-cause mortality

All-cause mortality was assessed using the Danish Civil Registration System, where all Danish citizens are recorded with a unique 10-digit personal number and where all deaths in Denmark are registered within 2 weeks. Initial follow up began on the date of admission. Follow-up of patients continued until date of death, or October 30th, 2016. Primary endpoint was all cause 30-day mortality.
Data was analyzed using SPSS (IBM Statistics, Version 21.0). QRS duration was not Gaussian distributed thus the cohort was divided into quartiles of QRS duration ($< 89$ ms, $89–98$ ms, $99–111$ ms and $> 111$ ms).

All-cause mortality was assessed using Cox proportional hazard model to determine the association of QRS duration with mortality. The Kaplan Meier estimate of all-cause mortality was then calculated and plotted according to quartiles of QRS duration. For Cox proportional hazards analyses QRS duration was analysed as a categorical variable with the first quartile ($< 89$ ms) serving as reference. In the Cox analysis patients with LBBB and RBBB were analysed separately, accordingly the group designated QRS duration $> 111$ ms constituted patients with QRS duration $112–120$ ms and those with unspecified conduction delay. In order to assess the value of QRS duration in prehospital triage, a Cox model based on prehospital variables (age, gender, systolic blood pressure, history of DM, diabetes mellitus. LBBB, left bundle branch block. RBBB, right bundle branch block.

<table>
<thead>
<tr>
<th>QRS</th>
<th>Model 1 HR</th>
<th>95% CI</th>
<th>P</th>
<th>Model 2 HR</th>
<th>95% CI</th>
<th>P</th>
<th>Model 3 HR</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>$&lt; 89$</td>
<td>1.0</td>
<td>–</td>
<td>–</td>
<td>1.0</td>
<td>–</td>
<td>–</td>
<td>1.0</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>$89–98$</td>
<td>1.52</td>
<td>(0.75–3.05)</td>
<td>0.24</td>
<td>1.65</td>
<td>(0.82–3.32)</td>
<td>0.16</td>
<td>1.74</td>
<td>(0.82–3.70)</td>
<td>0.15</td>
</tr>
<tr>
<td>$99–111$</td>
<td>1.45</td>
<td>(0.71–2.99)</td>
<td>0.31</td>
<td>1.63</td>
<td>(0.78–3.38)</td>
<td>0.19</td>
<td>1.48</td>
<td>(0.66–3.31)</td>
<td>0.34</td>
</tr>
<tr>
<td>$&gt; 111^a$</td>
<td>4.20</td>
<td>(2.22–7.97)</td>
<td>&lt; 0.0001</td>
<td>4.60</td>
<td>(2.39–8.86)</td>
<td>&lt; 0.0001</td>
<td>3.42</td>
<td>(1.70–6.87)</td>
<td>0.0006</td>
</tr>
<tr>
<td>LBBB</td>
<td>4.80</td>
<td>(1.82–12.63)</td>
<td>0.002</td>
<td>4.37</td>
<td>(1.65–11.56)</td>
<td>0.003</td>
<td>3.46</td>
<td>(1.27–9.41)</td>
<td>0.02</td>
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<tr>
<td>RBBB</td>
<td>9.62</td>
<td>(4.96–18.64)</td>
<td>&lt; 0.0001</td>
<td>8.37</td>
<td>(4.24–16.55)</td>
<td>&lt; 0.0001</td>
<td>3.84</td>
<td>(2.30–10.16)</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Age</td>
<td>1.03</td>
<td>(1.02–1.05)</td>
<td>&lt; 0.0001</td>
<td>1.06</td>
<td>(1.04–1.07)</td>
<td>&lt; 0.0001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (male)</td>
<td>0.58</td>
<td>(0.39–0.86)</td>
<td>0.007</td>
<td>0.65</td>
<td>(0.43–0.98)</td>
<td>0.04</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>History of DM</td>
<td></td>
<td></td>
<td></td>
<td>0.99</td>
<td>(0.59–1.66)</td>
<td>0.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prehospital cardiac arrest</td>
<td></td>
<td></td>
<td></td>
<td>3.75</td>
<td>(2.42–5.82)</td>
<td>&lt; 0.0001</td>
<td></td>
<td></td>
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<tr>
<td>Systolic blood pressure</td>
<td></td>
<td></td>
<td></td>
<td>0.98</td>
<td>(0.97–0.98)</td>
<td>&lt; 0.0001</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Fig. 2. Survival in patients with suspected STEMI where the diagnosis was confirmed (blue) and where STEMI diagnosis was rejected.

### 2.4. Statistics

Data was analyzed using SPSS (IBM Statistics, Version 21.0). QRS duration was not Gaussian distributed thus the cohort was divided into quartiles of QRS duration ($< 89$ ms, $89–98$ ms, $99–111$ ms and $> 111$ ms).

All-cause mortality was assessed using Cox proportional hazard model to determine the association of QRS duration with mortality. The Kaplan Meier estimate of all-cause mortality was then calculated and plotted according to quartiles of QRS duration. For Cox proportional hazards analyses QRS duration was analysed as a categorical variable with the first quartile ($< 89$ ms) serving as reference. In the Cox analysis patients with LBBB and RBBB were analysed separately, accordingly the group designated QRS duration $> 111$ ms constituted patients with QRS duration $112–120$ ms and those with unspecified conduction delay. In order to assess the value of QRS duration in prehospital triage, a Cox model based on prehospital variables (age, gender, systolic blood pressure, history of
diabetes mellitus, previous myocardial infarction and whether the patient had suffered OHCA) was made. A two sided $p$-value $< 0.05$ was considered statistically significant (Table 1 and Figs. 2–4).

Transparency document. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.dib.2017.08.051.
References
