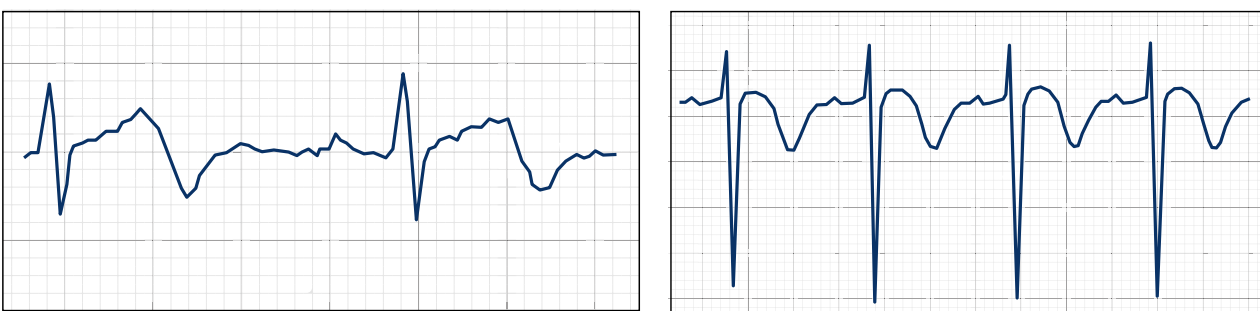
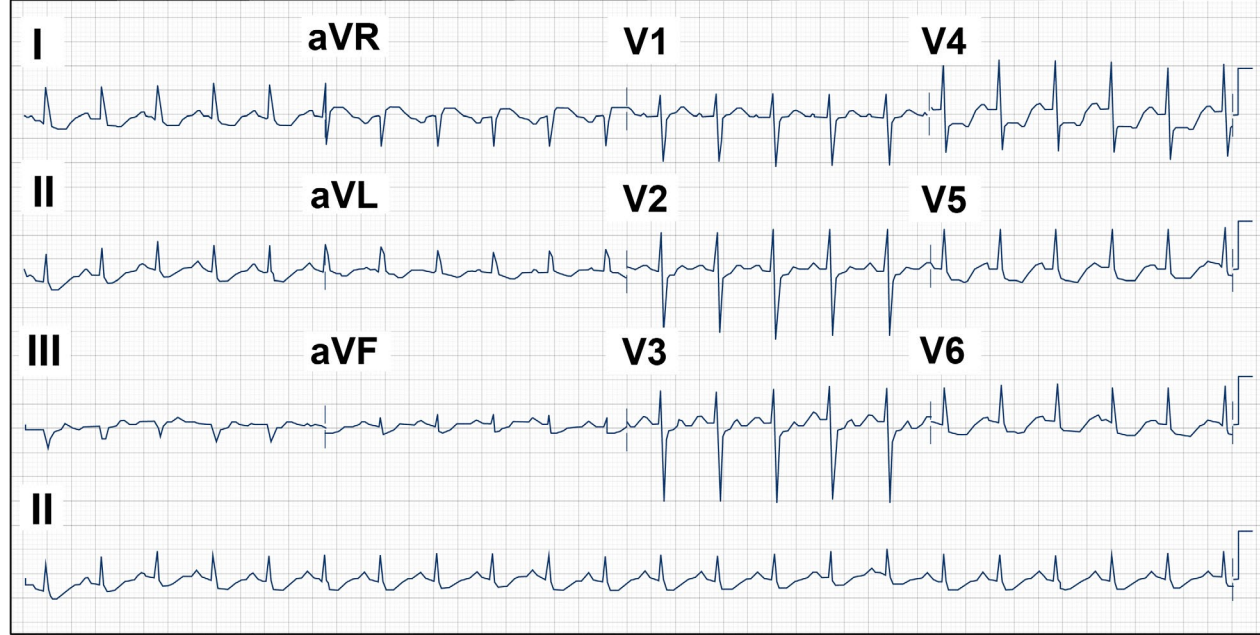
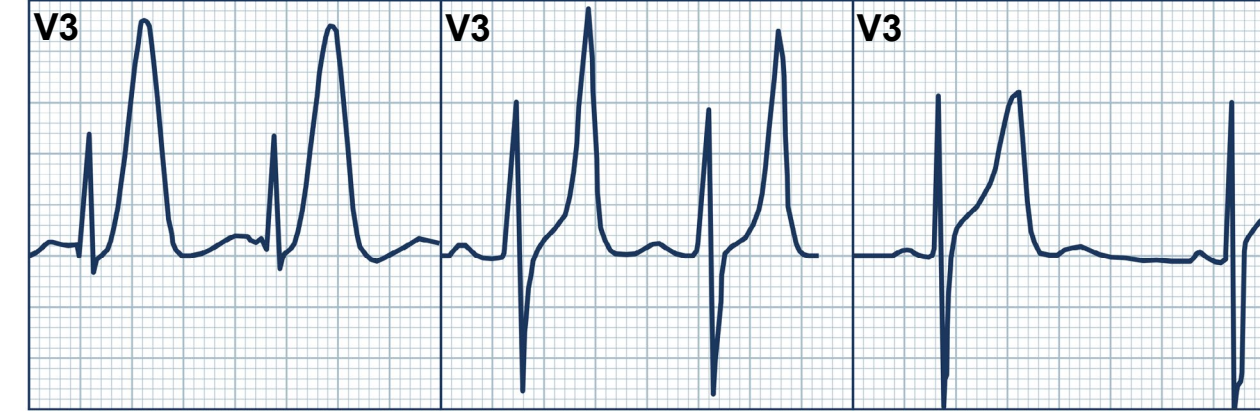
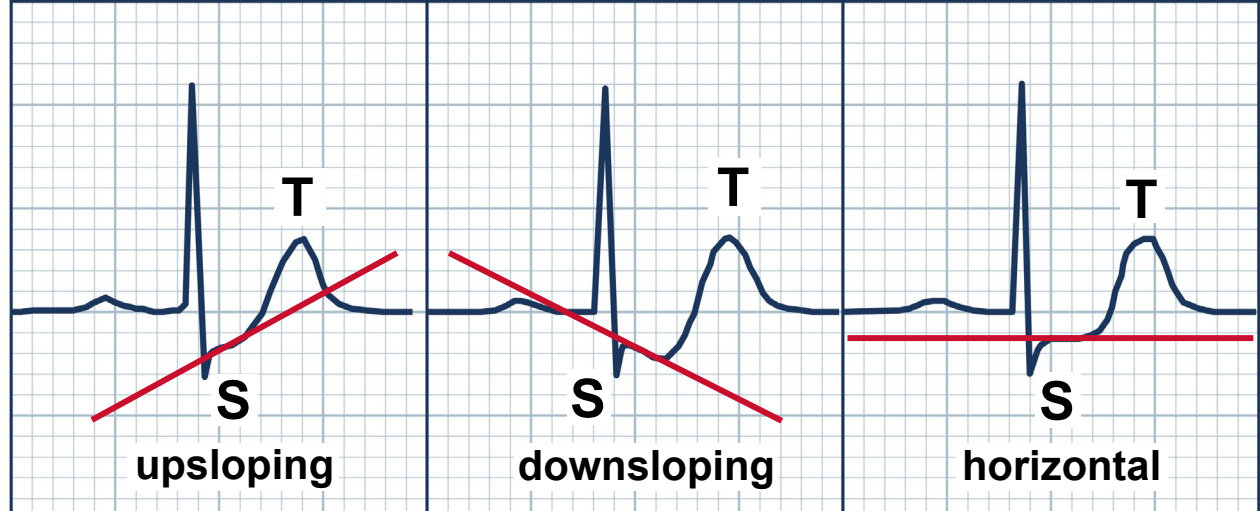
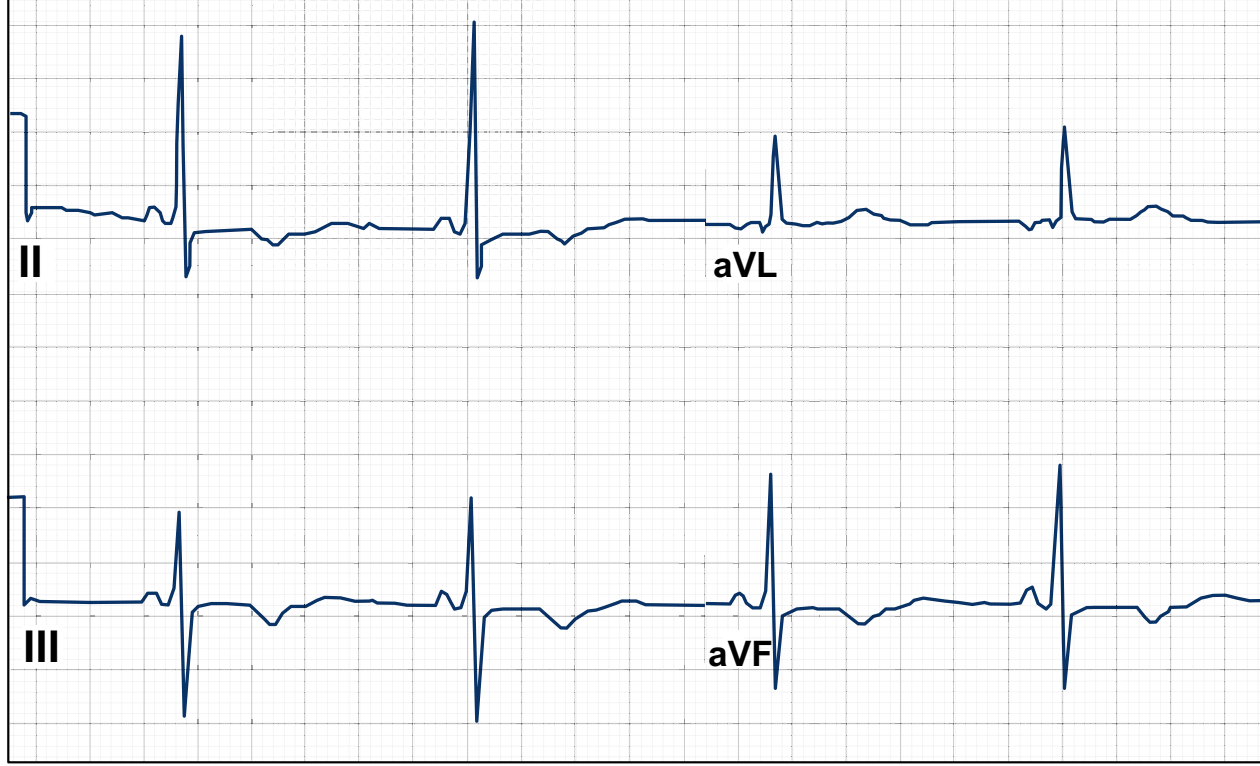


	Criteria	Supporting information and illustration	Recommendation for clinical action
<b>A. Wellens criteria</b>	Isoelectric or minimally elevated J-point <1 mm AND either biphasic T waves V2, V3 (Type A) or symmetric TWI V2, V3 (sometimes V1, V4, V5, V6) (Type B).	<p>Type A                      Type B</p>  <p>Biphasic T wave                      Deeply inverted T wave</p> <p>Pattern appears when pain free. "Pseudonormalisation" of ECG changes with symptoms of ischaemia (e.g. chest pain).</p>	Urgent consultation with cardiology. Continuous cardiac monitoring and serial ECGs. No functional testing. Low threshold for invasive angiography.
<b>B. Diffuse STD in multiple leads and STE in aVR</b>	STE aVR >1 mm Multi-lead STD I, II, aVL and V1-6 Absence of STE in other leads.		Consider early reperfusion if ECG findings persist despite management of symptoms or seek alternative cause. Correct hypotension, hypoxia, anaemia.
<b>C. Hyperacute T waves</b>	Large, symmetrical, broad-based T waves. Regional distribution.	<p>Conditions associated with tall T waves</p> <p>Hyperacute ischaemia    Hyperkalaemia    Normal variant</p>  <p>Symmetric, narrow-based, pointed                      Asymmetric, not narrow</p>	Continuous cardiac monitoring and serial ECGs.
<b>D. STD</b>	Horizontal or down-sloping STD ≥0.5 mm at the J-point in ≥2 leads is suggestive of subendocardial ischaemia. STD which is sustained for ≥0.08 s in ≥1 lead (except aVR) is most significant.	<p>ST segment depression</p> 	Continuous cardiac monitoring and serial ECGs. If persists or worsens treat as per NSTEMI recommendations.
<b>E. TWI</b>	Significant for ischaemia if ≥1 mm deep; present in ≥2 contiguous leads or changing acutely in leads with a normally upright T wave (all except lead III, aVR and V1). Wide differential. If new or dynamic, consistent with ischaemia.		Continuous cardiac monitoring and serial ECGs.