



**GE Medical Systems**  
Information Technologies

# MUSE CV<sup>®</sup> Information System Resting ECG Statement Library

(Software Version 005C)

Instructions  
PN 2002783-057

\$SABCOND	Aberrant conduction
\$ACS	** Acute Cardiac Syndrome Criteria **
\$AIS	*** With chest pain presence, consider ACUTE ISCHMIA ***
\$LBBBACS	*** With chest pain presence, consider ACUTE MI if LBBB is new ***
\$LBBBAIS	*** Consider Acute Ischemia due to primary ST-T change ***
\$LBBBAMI	*** Consider Acute MI due to primary ST-T change ***
\$SAND	and
\$SANLERR1	*** Memory allocation failure, no ECG interpretation possible
\$SANLERR2	*** No QRS complexes found, no ECG analysis possible
\$SANLERR3	*** Less than 4 QRS complexes detected, no interpretation possible
\$SCAPTUR	Sinus/atrial capture
\$SFUS	Fusion complexes
\$SIVR	Idioventricular rhythm
\$SOR	or
\$SRETC	with retrograde conduction
\$SVFIB	Ventricular fibrillation
\$SVTACH	Ventricular tachycardia
\$SWITH	with
\$SWQR	Wide QRS rhythm
\$TWLVW	Leads V2, V3, V4 and V6 are interpolated
2ST	with repolarization abnormality
AB	Abnormal ECG
AB-VENT	with intermittent aberrant ventricular conduction
ABER	with premature ventricular or aberrantly conducted complexes
ABER2	with premature ventricular or aberrantly conducted complexes
ABR	Otherwise normal ECG
AC	, possibly acute
ACCEL	Accelerated
ACUMI	*** ** ACUTE MI ** **
ACUT	Acute
AFB	Left anterior fascicular block
AFIB	Atrial fibrillation
AFL	Atrial flutter
AFL-BL	Atrial flutter with 2 to 1 block
AGSPAMI	*** AGE AND GENDER SPECIFIC ECG ANALYSIS ***
AHE	Acquisition hardware fault prevents reliable analysis, carefully check ECG record before interpreting
AINJ	Anterior injury pattern
AIOHAI	ST elevation consider anterior injury or acute infarct
ALAD	Abnormal left axis deviation

ALIHAI	ST elevation consider anterolateral injury or acute infarct
ALINJ	Anterolateral injury pattern
ALMI	Anterolateral infarct
ALT	T wave abnormality, consider anterolateral ischemia
ALTWPW	with fusion or intermittent ventricular pre-excitation (WPW)
AMI	Anterior infarct
ANACP	Manual comparison required for analog tracing
AND	and
ANT	Anterior leads
ANTLAT	Anterolateral leads
ANTSEP	Anteroseptal leads
APCK	Electronic atrial pacemaker
ARAD	Abnormal right axis deviation
ARAT	(atrial rate
ARE-NOL	are no longer
ARE-NOW	are now
ARM	*** Suspect arm lead reversal, interpretation assumes no reversal
ASBINJ	Marked ST abnormality, possible anterior subendocardial injury
ASINJ	Anteroseptal injury pattern
ASMI	Anteroseptal infarct
AT	T wave abnormality, consider anterior ischemia
ATAC	Atrial tachycardia
AU	, age undetermined
AV-COND	Suspect A-V conduction defect
AVDIS	with A-V dissociation
AVPCK	AV sequential or dual chamber electronic pacemaker
AXIS	QRS axis
BAE	Bilateral enlargement
BASIC	Basic rhythm
BIFB	*** Bifascicular block ***
BIFB1	(RBBB and left anterior fascicular block)
BIFB2	(RBBB and left posterior fascicular block)
BIGEM	in a pattern of bigeminy
BIVH	Biventricular hypertrophy
BLKED	Blocked
BO	Borderline
BOQT1	Borderline QT interval
BORD-CRIT	Borderline criteria for
BORDE	Borderline ECG
CCWRT	Counter clockwise rotation of the heart, may invalidate criteria for ventricular hypertrophy
CHB	with complete heart block
CITED	(cited on or before
CJP	with a competing junctional pacemaker
COMP-HB	Complete heart block
COMPAR	When compared with ECG of

CONSEC	Consecutive
CRI-FOR	Criteria for
CRO	Cannot rule out
CRS	Coarse
CSEC	, and consecutive
CUR-UND	Current undetermined rhythm precludes rhythm comparison, needs review
CWRT	Clockwise rotation of the heart, may invalidate criteria for ventricular hypertrophy
DEC-MI	Questionable change in initial forces of
DEMOGR	Warning: demographic data different
DICTATION	Report dictated, transcription pending
DPCK	Demand pacemaker; interpretation is based on intrinsic rhythm
DTOFF	Manual comparison required, data off line and on volume
DXTRO	Dextrocardia
EABRAD	Unusual P axis, possible ectopic atrial bradycardia
EAR	Unusual P axis, possible ectopic atrial rhythm
EARO	Ectopic atrial rhythm
EATACH	Unusual P axis, possible ectopic atrial tachycardia
EDP	Electronic demand pacing
ESCBT	with escape beat
EVO	Serial changes of evolving
FAV	with 1st degree A-V block
FLUT	Atrial flutter
FREQ	with frequent
HAS-CHG	has changed
HAS-DEC	has decreased
HAS-INC	has increased
HAS-NOTCHG	has not changed
HAS-REP	has replaced
HAV-CHG	have changed
HAV-NOTCHG	have not changed
HOWEVER	however
HWV-IT	however it
IDIO-R	Idioventricular rhythm with AV block
IFLAT	Inferolateral leads
IINJ	Inferior injury pattern
IIOHAI	ST elevation consider inferior injury or acute infarct
ILBBB	Incomplete left bundle branch block
ILIHAI	ST elevation consider inferolateral injury or acute infarct
ILINJ	Inferolateral injury pattern
ILT	T wave abnormality, consider inferolateral ischemia
IMI	Inferior infarct
INC-MI	Increased evidence of infarction in
INDAX	Indeterminate axis

INF	Inferior leads
INFPOS	Inferoposterior leads
INJONV	ST elevation, consider injury or variant associated with LVH
INVT-LOWT	Inverted T waves have replaced flat T waves in
IPMI	Inferior-posterior infarct
IRBBB	Incomplete right bundle branch block
IRR	Irregular
IRREG	with undetermined rhythm irregularity
ISBINJ	Marked ST abnormality, possible inferior subendocardial injury
IT	T wave abnormality, consider inferior ischemia
IVCB	Non-specific intra-ventricular conduction block
IVCD	Non-specific intra-ventricular conduction delay
J-ESC	with junctional escape
J-TACH	Junctional tachycardia
JBRAD	Unusual P axis and short PR, probable junctional bradycardia
JESC	with junctional escape complexes
JR	Unusual P axis and short PR, probable junctional rhythm
JST	Junctional ST depression, probably abnormal
JSTN	Junctional ST depression, probably normal
JTACH	Unusual P axis and short PR, probable junctional tachycardia
JUNBRAD	Junctional bradycardia
JUNCT-R	Junctional rhythm
LABRAD	Left atrial bradycardia
LAD	Leftward axis
LAD3	Left axis deviation
LAE	Left atrial enlargement
LAR	Left atrial rhythm
LARG	Large
LAT	Lateral leads
LATACH	Left atrial tachycardia
LBBB	Left bundle branch block
LESS-FLTT	Fewer leads exhibit flat T waves in
LFREQ	Less frequent
LHR	Low heart rate, verify A-V conduction
LINJ	Lateral injury pattern
LIOHAI	ST elevation consider lateral injury or acute infarct
LMI	Lateral infarct
LNGQT	Prolonged QT
LOWT-INTV	Flat T waves have replaced inverted T waves in
LOWT-NOL	Flat T waves no longer evident in
LOWT-NOW	Flat T waves now evident in
LOWV	Low voltage QRS
LSBINJ	Marked ST abnormality, possible lateral subendocardial injury
LT	T wave abnormality, consider lateral ischemia

LVH	Voltage criteria for left ventricular hypertrophy
LVH2	Left ventricular hypertrophy
LVH3	Moderate voltage criteria for LVH, may be normal variant
MAFB	(masked by fascicular block?)
MALT	Marked T wave abnormality, consider anterolateral ischemia
MAT	Marked T wave abnormality, consider anterior ischemia
MBZI	with 2nd degree A-V block (Mobitz I)
MBZII	with 2nd degree A-V block (Mobitz II)
MFREQ	More frequent
MILT	Marked T-wave abnormality, consider inferolateral ischemia
MINI-CRIT	Minimal criteria for
MISIZ	*** QRS contour suggests infarct size is probably
MIT	Marked T wave abnormality, consider inferior ischemia
MLT	Marked T wave abnormality, consider lateral ischemia
MOD	Moderate
MORE-FLTT	More leads exhibit flat T waves in
MRR	Manual reading required due to inconsistent morphologies
MSAR	with marked sinus arrhythmia
MSBRAD	Marked sinus bradycardia
MSTDAL	Marked ST abnormality, possible anterolateral subendocardial injury
MSTDAS	Marked ST abnormality, possible anteroseptal subendocardial injury
MSTDIL	Marked ST abnormality, possible inferolateral subendocardial injury
MULT-AT	Multifocal atrial tachycardia
NEW	, new
NML	Normal ECG
NO-CHG	No significant change was found
NO-SERCOMP	Serial comparison not performed, all previous tracings are of poor data quality
NO-SERIAL	No previous ECGs available
NOLONG	is no longer
NOPF	(no P-waves found)
NOPHONE	Manual comparison required, cannot contact main system
NOW	is now
NQTACH	Narrow QRS tachycardia
NSR	Normal sinus rhythm
NST	Nonspecific ST abnormality
NSTD	Nonspecific ST depression
NSTE	Nonspecific ST elevation
NSTFT	Nonspecific T wave abnormality has replaced inverted T waves in
NSTLS	Nonspecific T wave abnormality, improved in
NSTMW	Nonspecific T wave abnormality, worse in
NSTNF	Inverted T waves have replaced nonspecific T wave abnormality in
NSTNL	Nonspecific T wave abnormality no longer evident in

NSTNW	Nonspecific T wave abnormality now evident in
NSTT	Nonspecific ST and T wave abnormality
NT	Nonspecific T wave abnormality
NWA	Northwest axis
OCC	with occasional
ODIG	or digitalis effect
OLD	, old
PAC	Premature atrial complexes
PAUSE	with sinus pause
PCARD	Acute pericarditis
PCK	Electronic ventricular pacemaker
PDIG	, probably digitalis effect
PEC	Premature ectopic complexes
PEDANL	***** Pediatric ECG Analysis *****
PFB	Left posterior fascicular block
PJC	Premature junctional complexes
PLV	Prominent lateral voltage
PMDPV	Prominent mid-precordial voltage,
PO	Possible
PO-ATP	Possible wandering atrial pacemaker
POOR-DAT	Poor data quality in current ECG precludes serial comparison
POS	Posterior leads
POSTMI	Posterior infarct
PPV	Prominent posterior voltage
PR-SBRAD	Probable sinus bradycardia, verify A-V conduction
PRESENT	Present
PRINT	PR interval
PRM-CON	The premature contractions
PRV-UND	Previous ECG has undetermined rhythm, needs review
PSVC	Premature supraventricular complexes
PULD	Pulmonary disease pattern
PVC	Premature ventricular complexes
PVCF	Premature ventricular and fusion complexes
PXT	, with posterior extension
QCERR	*** Poor data quality, interpretation may be adversely affected
QESPMI	Increased R/S ratio in V1, consider early transition or posterior infarct
QIII	Deep Q in lead III
QRS	QRS
QRS-DUR	QRS duration
QRS-VOL	QRS voltage
QRST	Abnormal QRS-T angle, consider primary T wave abnormality
QRSV	Minimal voltage criteria for LVH, may be normal variant
QRSW	with QRS widening
QRSW-2ST	with QRS widening and repolarization abnormality
QT-LONG	QT has lengthened
QT-SHRT	QT has shortened
QUE-CHG	Questionable change in
QUE-INICHG	Questionable change in initial forces of

QUE-STCHG	Questionable change in ST segment
QUE-TCHG	Questionable change in T waves
QV6	Deep Q-wave in lead V6,
RABRAD	Low right atrial bradycardia
RAD	Rightward axis
RAD4	Right axis deviation
RAD5	Right superior axis deviation
RAE	Right atrial enlargement
RAR	Low right atrial rhythm
RAT-DEC	Although rate has decreased
RAT-INC	Although rate has increased
RATACH	Low right atrial tachycardia
RBBB	Right bundle branch block
RBBRVH	Right bundle branch block -or- right ventricular hypertrophy
RECIP	Reciprocal
REPOL	Early repolarization
RHY	Rhythm
RSAD	Abnormal right superior axis deviation
RSR	RSR' or QR pattern in V1 suggests right ventricular conduction delay
RVE+	, plus right ventricular hypertrophy
RVH	Right ventricular hypertrophy
RVH-2ST	Right ventricular hypertrophy with repolarization abnormality
RVR	with rapid ventricular response
S1S2S3	S1-S2-S3 pattern, consider pulmonary disease, RVH, or normal variant
SA-BLK	with S-A block or transient A-V block
SAB	with sinus arrest or transient A-V block
SABI	with 2nd degree SA block (Mobitz I)
SABII	with 2nd degree SA block (Mobitz II)
SAR	with sinus arrhythmia
SAV	with 2nd degree A-V block
SBRAD	Sinus bradycardia
SEP	Septal leads
SERCHG	Serial changes of
SERYR1	ST elevation, consider early repolarization, pericarditis, or injury
SERYR2	ST elevation, consider early repolarization
SHFT-LFT	Shifted left
SHFT-RGT	Shifted right
SINJ	Septal injury pattern
SMA	Small
SMI	Septal infarct
SNDQA	, may be secondary to QRS abnormality
SNF	Statement not found
SNGCH	Significant changes have occurred
SPR	with short PR
SRSRO	RSR' pattern in V1
SRTH	Sinus rhythm
SSBINJ	Marked ST abnormality, possible septal subendocardial injury
ST&	ST &
ST-(DEC)	Non-specific change in ST segment in
ST-(INC)	Non-specific change in ST segment in

ST-DEPREP	ST depression has replaced ST elevation in
ST-ELVPRS	ST elevation now present in
ST-ELVREP	ST elevation has replaced ST depression in
ST-LESDEP	ST less depressed in
ST-LESELV	ST less elevated in
ST-MORDEP	ST more depressed
ST-MORELV	ST more elevated in
ST-NOLDEP	ST no longer depressed in
ST-NOLELV	ST no longer elevated in
ST-NOWDEP	ST now depressed in
STABAND	ST abnormality and
STACH	Sinus tachycardia
STDEP	ST depression, consider subendocardial injury or digitalis effect
STDIG	ST abnormality, possible digitalis effect
STDPIN	ST depression in
STELIN	ST elevation in
SUNCNF	(Unconfirmed)
SUP-TACH	Supraventricular tachycardia
SVR	with slow ventricular response
SVT	Supraventricular tachycardia
T-DEC	T wave amplitude has decreased in
T-INC	T wave amplitude has increased in
T-INVMOR	T wave inversion more evident in
T-INVNOL	T wave inversion no longer evident in
T-INVNOW	T wave inversion now evident in
T-LESINV	T wave inversion less evident in
T-WAVE	T waves
TINVIN	T-wave inversion in
TRIFB	Trifascicular block
TVT	with transient ventricular tachycardia
UR	Undetermined rhythm
VAVB	with variable A-V block
VENT-FUS	with ventricular fusion
VENT-RAT	Vent. rate
VENT-RTH	Ventricular rhythm
VESC	with ventricular escape complexes
VLAR	Very large
VSMA	Very small
VTACH	Ventricular tachycardia (ventricular or supraventricular with aberration)
W2T1	with 2:1 A-V conduction
W3T1	with 3:1 A-V conduction
W4T1	with 4:1 A-V conduction
W5T1	with 5:1 A-V conduction
WEKH	with Mobitz I (Wenckebach) block
WITH-DEM	with a demand pacemaker
WITH-RATDEC	with rate decrease
WITH-RATINC	with rate increase
WPW	Wolff-Parkinson-White
WPWA	Ventricular pre-excitation, WPW pattern type A
WPWB	Ventricular pre-excitation, WPW pattern type B
WOTACH	Wide QRS tachycardia
WSTR	with strain pattern