Interview coding matrices (**3.0** Medical conditions)

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|  | **3.0** Medical conditions | | |
| **3.1** Condition seen on ECG | **3.2** General medical condition | **3.3** Patient history |
| P2F |  |  |  |
| P5M |  |  | If I don’t know the patient history it can be problematic, as some patients have other problems that different tests can detect – ECG can give lots of information but they can also mistake stuff. |
| P6F | The simple things, like AF/VT are noticed quite easily. But congenital problems, like long QT, right heart failure etc, require more time and are harder to interpret. |  |  |
| P9M | Normally I categorised into rhythm or ischaemia and then look at the corresponding lead group. |  |  |
| P10F |  |  |  |
| P11F |  |  | Now I find I want to diagnose straight away but these weren’t in the context of everything which was harder, you get very used to having clinical history. |
| P13M | Heart blocks, VT, other tachycardias – quite pathology based. |  |  |
| P16F | people of Afro-Caribbean descent have ECGs that naturally have ST elevation so it looks like they’ve had myocardial infarctions. |  | With the primary PCIs recently introduced we get a lot of ambulance staff diagnosing ECGs en route, and people coming in thinking they’ve had heart attacks and they haven’t. Now we give people a copy of their ECGs so they know it’s their normal ECG – this mistake costs a fortune. |
| P18F | Here VF stands out straight away. |  |  |
| P19F | I’ve been taught to look for the 5 dangerous rhythms – myocardial infarction, SVT, VT, atrial systole and 1 other…I can’t remember. |  |  |
| P20F |  |  |  |
| P21M |  |  |  |
| P23F | Some things you can just pick up, like VT or VF |  |  |
| P24M |  |  |  |
| P25F | The first thing I always go for is - is it dangerous? Do I need to go screaming for a doctor, i.e. is it VF/VT or atrial systole, complete heart block, are they passing out  what’s the rate, is it bradycardic/tachycardic  Some I can just look at and know straight away – like VF.  Brugada syndrome, can be mistaken for an anterior myocardial infarction  Like the SVTs, they’re quite complex – it’s an umbrella term and you just take it to someone more senior. You only start learning what type of SVT it is at a later stage. |  |  |
| P26F | The heart block you like to measure it out to see whether there’s association or dissociation with the QRS complexes.  but when you see AF, because I know there’s no P waves and the pattern, is automatic. The same with atrial flutter.  there’s one that looks like it might be VT but as I do electrophysiology studies I actually think it would be an accessory pathway as I have a lot of patients coming in with ECGs that look like that. |  | Assumption is the biggest. People have a set idea of what they think it is and they may be wrong. A patient history may influence this. Without knowing the patient history you may take more from an ECG. |
| P27F |  |  |  |
| P28F | I’m only interested in the dangerous things, like VF/VT, things that straight away you can tell they’re horrid.  For certain rhythms you know to look at a certain lead or if you see something immediately, like myocardial infarction, your eye gets drawn immediately to that area. |  |  |
| P29F | I tend to always go for V1 first to see if there’s any bundle branch blocks |  |  |
| P30M | if I’m just observing then I can say it’s sinus tachycardia but couldn’t work out the rate from sat here.  I never treat the ECG, sometimes you can lots of movement that replicates other things but if the patient is talking to me I know they’re not in VF – that’s very common sense.  Also things like if one lead shows me a wandering baseline that’s a little bit irregular that looks like AF and the other leads don’t show that then you mustn’t just look at one lead – you need to be able to take the whole picture.  I didn’t think there was anything hidden away there – there was no epsilon waves, no Brugada syndrome, no peculiar little things.  If you’re an electrophysiologist then you focus on the electrical features of the ECG, you focus more on V1 and V6. WPW would stand out very quickly as you’re used to seeing it. |  |  |
| P31F | a lot of people get AF and atrial flutter mixed up, and there’s no need to as flutter is a specific shape but fibrillation can fox you. That’s one major thing. Lack of basis knowledge about morphology shapes as well. |  |  |
| P32M | LBBB jumps off the page at you and you don’t need to say much more than that.  Some of them where I didn’t know what the rhythm was which made it harder. When things look a bit strange, like left ventricular pre-excitation, then you might take a minute to work out what’s going on.  Sinus rhythm jumps off the page at you but other things take a bit longer.  Students sometimes can’t tell the difference between LBBB and right bundle branch block. |  |  |
| P33F | Yes, the common errors are that without a clinical setting you shouldn’t really be making a diagnosis but people commonly get some of the rhythms mixed up. Like the 3 to 1 heart block\complete heart block – it probably was complete but I couldn’t see that.  Fibrillation can be commonly mistaken with ectopic beats, ST changes can be commonly mistaken with hypertrophy. |  |  |
| P34M | All you’re really concerned about is things that are acute and problematic; acute myocardial infarctions, resting ischaemia, abnormal rhythms that you’ve not known about or not treated. |  |  |
| P36F |  |  |  |
| P37F | To make sure it has normal sinus rhythm, and to make sure the heart rate is appropriate and there’s no myocardial infarctions or anything. |  |  |
| P38F | There seemed to be quite a lot of bundle branch block but maybe that was part of the task.  A lot of the time people see artifact as atrial conduction and will say it’s AF when it isn’t, it’s actually sinus rhythm. The first thing you do when you do an ECG is make sure you have really good contact. After that, everything should be fine. |  |  |
| P39F | Any complaint related to cardiology, blackouts etc it might be because of conduction, or pauses, or very slow heart rate or non-cardiological cause. | A patient coming in with chest pain you’d expect ST changes, T wave inversion.  We assess patients starting with ECG and if we don’t find anything (for instance blood pressure related). Every investigation in cardiology begins with the ECG. |  |
| P40F |  |  |  |
| P41F |  |  |  |
| P42F |  |  |  |