Introduction

Myocardial infarction is still the most common life threatening disease and the first cause of death in the world; especially in the first hours. So, early diagnosis is important to admit the patient to coronary care unit (CCU). The prognosis of acute myocardial infarction is greatly improved with early management ***(Hamm, 1994).***

Acute myocardial infarction of inferior wall is due to occlusion of right coronary artery (RCA) or the left circumflex (LCx) coronary artery. The outcome of patients depends mainly on the culprit artery. Therefore, the presumptive prediction of the culprit artery based on the electrodiagram recorded at admission is of clinical importance ***(Foil et al., 2004).***

ST segment elevation in inferior leads indicates an evolving myocardial infarction (MI) of the inferior wall. This infarction in nearly 80% of cases is due to RCA and the rest by LCx coronary artery occlusion ***(Scalrowsky et al , 1999).***

The outcome of patients with RCA as a culprit artery is determined mainly by the location of occlusion ***(Berger et at., 1990)***. Proximal RCA occlusion usually leads to right ventricular (RV) involvement and this determines worse prognosis and higher mortality ***(Zehender et al., 1993).***

Additionally, proximal RCA occlusion is more often accompanied by conduction atrioventricular (AV) disturbances ***(Braat et al., 1984).***

Therefore, it is extremely important form the clinical point of view to recognize where the location of occlusion to determine the optimal treatment and management of evaluated patient is ***(Carillo et al., 2004)***.

The criteria previously described to determine the location of RCA occlusion based on ST changes in aVL allow us to predict the location of occlusion in clinical practice ***(Turhan et al., 2003).***