ABSTRACT
Coronary artery disease usually involves the left ventricle and acute myocardial infarction is almost always associated with hemodynamic evidence of predominant left ventricular dysfunction although the right ventricle may be involved in a reasonable proportion of patients dying with myocardial infarction. The lesion is usually accompanied by left ventricular infarction. Involvement of the right ventricle is a common sequel of acute inferior myocardial infarction, especially after proximal right coronary artery occlusion. Patients clinically presenting with hypotension, elevated jugular venous pulse (JVP), and occasionally shock, all in the presence of clear lung fields should raise the suspicion of RVI. The ST-segment elevation of ≥0.1mV in the right precordial leads V4R is a readily available electrocardiographic sign used for diagnosis of (RVI) Right Ventricular Infarction. Electrocardiography is recognized as the most simple and readily available diagnostic tool for identification of RVLECG with the right precordial leads (V3R to V4R) should be a routine part of the initial evaluation of patients with clinical suspicion of acute inferior myocardial infarction for early recognition and treatment of right ventricular infarction.

KEYWORDS: Right Ventricular Infarction, Kussmals Sign, ST Elevation Myocardial Infarction, Right Pre Cardial Leads.

INTRODUCTION
Cardiovascular diseases (CVD) comprise of diseases of heart and vascular system. Worldwide CVD is the most common cause of death due to Non-communicable disease, which is about 17 million. More than one third of these deaths occur in middle aged adults. In developing countries, it is responsible for about one third of such deaths.[1] CAD is a spectrum of diseases consisting of stable angina pectoris and acute coronary syndrome, which includes Unstable angina, non ST elevation MI (NSTEMI) and ST elevation MI (STEMI). Data showed that 25-28% of patients who had acute myocardial infarction die suddenly. Of about 55% of all cardiac deaths occur within the first hour. Of STEMI, the incidence of isolated right ventricular myocardial infarction is very rare which is found to be < 3%. It is usually associated with IWMI. Inferior wall myocardial infarction has high mortality when it is associated with RVMI while comparing to the mortality of isolated inferior wall myocardial infarction (25-30% vs. 6%). So, early recognition of right ventricular myocardial infarction is important to reduce the increased complications and death in IWMI, when it is seen with RVMI. RVMI has high mortality in elderly individual[2]. Moreover, the management of RVMI is also entirely different from other types of myocardial infarction. In RVMI, the treatment consists of achieving adequate preload by intravenous infusion of normal saline, maintaining normal haemodynamic parameters by intravenous infusion of inotropic agents and maintaining of normal rhythm by drugs or cardiac pacemakers. All these measures should be undertaken in addition to the emergency life saving measures and reperfusion therapy, whenever indicated. In contrast to RVMI, reperfusion therapy is the main treatment in other types of myocardial infarction, in which volume loading may lead onto worsening of the cardiac status.

Also, the acute outcome and the long term prognosis in right ventricular myocardial infarction are higher than the other types of myocardial infarction. In right ventricular myocardial infarction, complete recovery of the cardiac status to normal or near normal level results within weeks to months following timely institution of adequate and appropriate measures. Knowing the clinical profile will be helpful for early recognition and treatment of right ventricular infarction. Based on this aim of our study is to study the incidence of isolated right ventricular myocardial infarction and also to study the typical and atypical symptoms various clinical features, risk factors, electrocardiographic and echocardiography features of right ventricular myocardial infarction. Also
to analyze various complications & correlation with clinical features. We also analyzed the occupational and socio economic status of patients presenting with right ventricular myocardial infarction.

**MATERIALS AND METHODOLOGY**

This study was done in Intensive Coronary Care Unit of Tirunelveli government medical college hospital, Tirunelveli between October 2011 to November 2012. This study was done as prospective study after obtaining ethical clearance from institutional ethics committee. This study was done as a prospective study. Patients who were aged above 20 years, both sex and patients’ with ST Segment elevation in V4R in ECG were included in the study. Whereas patients with congenital and other acquired heart diseases, previous history of myocardial infarction and patients with other serious co morbid illness like renal deliver. Failure cases were excluded from study. Complete clinical examination and history taking were done for all patients.

Patient were simultaneously treated with bed rest, nasal oxygen, Intravenous fluids, Narcotics for the control of chest pain. Also started with T. Aspirin 325mg stat, T. Clopidogrel 300mg stat (Beta blockers, Nitrates, Diuretics, Morphine, and Enalapril- avoided if patient is in hypotension, T. Alprazolam, T. Bisacodyl based on symptoms). Intra venous fluids – NS 100 ml/hr was administered if patient is having hypotension. If there is no response, then inotropic agents like dopamine and/or dobutamine is added. Reperfusion therapy was done with Inj. Streptokinase 1.5 million units in 100 ml of NS given over one hour with continuous cardiac monitoring to all patients with AMI, who met the criteria for pharmacologic reperfusion therapy after ruling out the contraindications. Then patients were reassessed after 90 minutes of reperfusion therapy, for successful reperfusion therapy. Most importantly all the patients were obtained proper informed consent for the study.

**RESULTS**

Among 60 patients studied, 37 were male, 23 were female. Lowest age found in this study was 28 years. Highest age found in this study was 70 years. Highest numbers of patients were found to be within the age group of 41- 50 years in male and 51- 60 years in Female. Among the manual workers, patients included were farmers, porters, rickshaw pullers, etc. Skilled laborers included were carpenters, masons, etc., Professionals included were doctors, software engineers, teachers, auditors, etc., Patients having sedentary life included were office clerks, shop owners, etc., Of the patients, manual workers were the highest in number and professionals were the least in number. Most of the patients studied here were from rural areas. They constituted by about 75 %. The patients from urban area constituted by about only 25%. In this study, significant number of non-diabetic patients had onset of symptoms in the period between 12.01 a.m. - to 12.00 p.m., when compared to diabetic patients. The association between diabetic status and time of onset of symptom was significant (p value<0.006). Most of male patients presented within 12 hours. Of these, highest number of patients presented within 8 hours. Most of female patients presented at about 12 hours of onset of symptoms. Highest numbers of female patients were within the period of 12-16 hours.

Among 60 patients, studied 33 patients had typical symptoms of acute myocardial infarction. Remaining 27 patients had atypical symptoms. Among patients who had atypical symptoms, most of the patients (33.33%) were female. Whereas, in male patients 50 % had typical symptoms and 11.6% of patients had atypical symptoms. Most of the patients who had atypical symptoms were elderly and diabetics. Atypical symptoms studied were giddiness, G.I.T. symptoms, syncope & dyspnoea. So, in this study significant number of female patients had atypical symptoms when compared to male patients. (p value <0.001). In this study, most common risk factor in male was smoking. In female, most common risk factor was DM. As a whole, DM was the leading risk factor. Among these risk factors, family history of coronary artery disease was the least common.

**Table 1**

<table>
<thead>
<tr>
<th>Sl. no</th>
<th>Risk factors</th>
<th>Male %</th>
<th>Female %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Smoking</td>
<td>30</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>2</td>
<td>Obesity</td>
<td>8</td>
<td>13.33</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes</td>
<td>16</td>
<td>26.66</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>Hypertension</td>
<td>11</td>
<td>18.33</td>
<td>28.33</td>
</tr>
<tr>
<td>5</td>
<td>Family h/o CAD</td>
<td>3</td>
<td>5</td>
<td>8.33</td>
</tr>
</tbody>
</table>

Although hypotension, clear lung field and elevated jugular venous pulse make the cardinal clinical signs of RVMI, not all the patients in this study had all of these three clinical signs. The most common clinical sign among the patients in this study was bradycardia. It was about 73%. The next most common sign was hypotension, which was about 68%. The elevation of JVP was noted in 77 % of these patients. Only 20 patients of this study were without pulmonary crepitations. In this study, none of the patients were admitted with isolated right ventricular myocardial infarction. Most of the RVMI patients had IWMI or PWMI. Patients with RVMI and IWMI constituted 46.66%. Patients with RVMI, IWMI and PWMI constituted 48.33%. Only 5% of patients had AWMI along with IWMI.
ST elevation in right sided chest leads (V4R) was analyzed. All the patients had ST elevation in right sided chest leads. Of these, 22 patients had ST elevation >2mm and 38 patients had ST elevation < 2mm. All those patients who had ST elevation in V4R >2mm were significantly associated with complications, like cardiogenic shock, complete heart block and ventricular tachycardia/ventricular fibrillation. These complications were less evident in those patients who had ST segment elevation (V4R) by <2mm.

All of the studied patients were underwent echocardiography after emergency treatment and haemodynamic stabilization. The echocardiography was analyzed in terms of right ventricular dyskinesia, right ventricular dilatation, paradoxical interventricular septal movement and other previously mentioned abnormalities. Right ventricular dyskinesia was present in 36.66% of patients of right ventricular myocardial infarction. Right ventricular dilatation was observed in about 20% of patients. Paradoxical septal movement towards left ventricular cavity was seen in 13.33% of patients with right ventricular myocardial infarction. Atrial dilatation was the least commonly seen feature among all patients of right ventricular myocardial infarction, which was about 10%. Of the echocardiographic features observed, right ventricular dyskinesia, right ventricular dilatation, paradoxical septal movement towards left ventricle and right atrial dilatation was consistently associated with complications like cardiogenic shock, complete heart block, ventricular fibrillation/ventricular tachycardia and atrial fibrillation.

### Table 2.

<table>
<thead>
<tr>
<th>Sl. no.</th>
<th>Pattern of MI</th>
<th>No. of patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Isolated RVMI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>RVMI + LVMI</td>
<td>28</td>
<td>46.66</td>
</tr>
<tr>
<td>3.</td>
<td>RVMI+LVMI+PWMI</td>
<td>29</td>
<td>48.33</td>
</tr>
<tr>
<td>4.</td>
<td>RVMI+LVMI+wAMI</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Right ventricular dyskinesia was present in 22 out of 60 patients with right ventricular myocardial infarction. All the patients with right ventricular diskinesia were associated with complications like cardiogenic shock, complete heart block, ventricular tachycardia/ventricular fibrillation. Right ventricular dilatation was present in 12 patients of right ventricular myocardial infarction. The occurrence of right ventricular dilatation was less, when compared to that of right ventricular dyskinesia (36.66% of RV dyskinesia vs. 20% of RV dilatation). All the patients with right ventricular dilatation had fatal complications like cardiogenic shock, complete heart block, ventricular tachycardia/ventricular fibrillation.

Paradoxical septal movement of interventricular septum towards left ventricular cavity was seen in 33.33% of patients with right ventricular myocardial infarction. Among the patients with paradoxical septal movement, most of the patients had features of cardiogenic shock, ventricular tachycardia/ventricular fibrillation and complete heart block.

Right atrial dilatation was seen in 6 patients of right ventricular myocardial infarction. All these patients who had right atrial dilatation also had right ventricular dilatation, right ventricular dyskinesia and paradoxical septal movement towards left ventricular cavity. Only two of the patients with right atrial dilatation had associated transient atrial fibrillation lasting for about 6 hours. Similarly significant tricuspid regurgitation was seen in seven out of the 60 right ventricular infarction patients. All the patients with significant tricuspid regurgitation, also had right ventricular dyskinesia, right ventricular dilatation, and paradoxical septal movement towards left ventricular cavity, and right atrial dilatation.

All the patients with right ventricular infarction had inferior wall infarction. 29 out of 60 patients who had posterior wall infarction also had right ventricular MI and inferior wall infarction. Three of the patients who had anterior wall infarction also had right ventricle and infero-posterior wall infarction. None of the patients in this study had ventricular septal or free wall rupture, papillary muscle rupture and patent foramen of ovale.

The complications observed in this study include cardiogenic shock, electrical complications like sinus bradycardia, all degree of atrioventricular block, intra ventricular conduction defects, atrial fibrillation ventricular tachycardia, ventricular fibrillation and death. Among these complications the most frequently observed one was sinus bradycardia. The least common of these complications seen in the patients with right ventricular myocardial infarction was atrial fibrillation. The electrical complications were seen in 80% of the patients of RVMI. Sinus bradycardia was seen in 44 patients of right ventricular myocardial infarction. The RBBB was present in 20 patients of total 60 right ventricular myocardial infarction. The intra ventricular conduction defect, left anterior hemi block was seen in 6 patients. The patients who had first degree atrioventricular block accounted to be 24 out of 60 right ventricular myocardial infarction patients. Second degree
atrioventricular block was present in seven patients. The most severe one, complete heart block was present in only four patients. The fatal ventricular tachycardia/ventricular fibrillation were present in four out 60 patients with RVMI. The least common arrhythmia seen in this study was atrial fibrillation, which was seen in two patients. Atrial fibrillation here was transient in nature, last for around six hours.

Management
Of the 60 study patients, one patient died within 5 minutes of receiving time, immediately after taking electrocardiogram and checking of vital parameters. That patient presented with features of severe cardiogenic shock with impalpable pulse, immesurable blood pressure; ST segment elevation in inferior wall leads, posterior wall leads, anterior wall leads in addition to ST segment elevation in right sided chest leads (ST elevation in V4R <2mm). All the other patients received emergency measures for the stabilization while simultaneously taking baseline electrocardiography.

Among these 59 patients, 36 patients were thrombolysed with Inj. Streptokinase 1.5 million units in 100 ml of normal saline through intravenous infusion over the period of one hour, after considering the indications and contraindications for thrombolysis. Irrespective of the thrombolysis, all the patients were given Inj. heparin (LMWH) subcutaneously after considering contraindications. All the thrombolysed patients were given Heparin Injection 6 hours after thrombolysis. All the patients were taken electrocardiography 90 minutes after thrombolysis, then three times a day and whenever necessary. All the 59 patients subjected to echocardiography study after haemodynamic stabilization and thrombolysis (in patients who had indications for thrombolysis). Out of 60 study patients five patients were died. One patient died immediately on arrival while the urgent resuscitative measures were taken. The other patients died during the hospital stay period.

DISCUSSION
In our study men were predominantly affected than women. Affected men constituted 61.66%, women constituted 38.33%. This data parallels with data observed in many Studies. Azhar et al[3] found that the incidence of RVMI was about 89% in male and 91% in female[7]. This is mainly because in most of Indian families, male are earners and female are usually housewives. So the male are exposed to accidents, violence and stress at higher level than female. Although psychological stress is commonly present in female, male patients was additionally having the habit of smoking which is the more prevalent and most consistently associated risk factor for AMI in male in India. Similarly in our study the incidence of RVMI in male was higher within 40-50 years of age group than other age groups; Most of female were within 50-60 years of age group. All the female patients with RVMI were more than 40 years of age.Whereas 8 of male patients were under the age of 40 years. In one study Azhar et al and others[4,5] found that the highest number of RVMI occurs within the age group of 37-70 years. This may be due to premature occurrence of CAD in Indian people. This prematurity of CAD in Indian context is due to high risk factor levels at younger age. This is consistent with our study. However in our study women are presented with MI 10 years later than men. This may be due to loss of protective effect of ovarian hormones (such as anti-atherogenic and vasodilatation) in the post menopausal age group, which was the predominant age group of RVMI presentation noted among women in our study.

In our study, most of the patients were manual workers (36.66%) who were actually farmers, porters, rickshaw-pullers, etc. Only three of the female patients were manual workers. Most of the female patients were housewives. Almost all of them came from nearby villages. This inference contrast from many studies conducted across various parts of India. These studies showed that in India the prevalence of CAD increased two-fold in rural areas and nine fold in urban areas increased. The reason for more presentation of rural people in this study may be due to poor educational level, low socio-economic status, poor availability of health facilities and faculties, poor knowledge about CAD preventive measures.

One important observation in this study was the prevalent of beedi smoking among rural peoples. Beedis are prepared from temburi leaf by hand rolling. These are prepared in most of the villages in Tirunelveli district. These are unfiltered and more atherogenic one, available at low cost, when compared to cigarettes. Because of its low cost and easy availability in rural areas, it may be the one of important factors contributing to more prevalence of RVMI among rural people in this study. T Rastogi et al found importance of beedi smoking as a risk factor for the development of CAD in Indian male.[6]

In our study smoking was the most common risk factor for male.Whereas DM was the most common risk factor for female. As a whole, DM was the leading risk factor. This observation was supported by number of studies conducted towards the prevalence of risk factor in Indian people. Interheart Study—South Asia[8] showed that eight risk factors were consistently associated with Indian people with CAD. These are abnormal lipids, smoking, HTN, DM, truncal obesity, psychosocial factors, low fruit and vegetable intake, and lack of physical activity. It also Showed that these are responsible for 89% of the acute coronary syndromes in Indians. Among these risk factors, smoking comes second to abnormal lipids. Abnormal lipids defined in the Interheart-South Asia study was Apo-lipoprotein B-100 and ratio of Apo-lipoprotein B-100 and A-1. Both of these were shown to be elevated in most of Indian peoples with CAD. With
regard to prevalence of risk factors in female with RVMI, DM was the leading risk factor in our study people. This is because most of the women participated in our study were house wives and they were also more number of obese than men in this study. So, the occurrence of DM in our obese female patient as a part of metabolic syndrome (syndrome X), will explain the highest prevalence of DM in female patients in our study. Moreover Sullivan AK et al[10] and Jansen et al[9] concluded in a study that DM has stronger association in female patients with CAD. In our study DM was the leading risk factor for RVMI as a whole. This correlates with the fact that India is known as the diabetes capital of the world; because in India diabetes is 2 to 4 times more common than rest of world. DM was the second common risk factor in our male patients whose are manual workers and mostly thin individuals when compared to female patients. This high incidence of DM in non-obese thin patients is supported by the observations in INTERHEART STUDY SOUTH ASIA. This study showed that diabetes occurs earlier (10 to 15 years) and at a lower body weight (9.1 to 13.6 kg) in Indians than other people. Regarding prevalence of HTN, this comes next to the DM, & smoking in our study. CURES cohort by Mohan et al pointed out that in Chennai every fifth individual is a hypertensive, which equals or even override the DM prevalence.[10,11]

Among our study group most of the patients had time of onset of symptoms between 12.01 A.M. to 08.00 A.M. Among these, most of the patients were non-diabetic. The association between the incidence of diabetes and loss of circadian rhythm seems to be significant in the present study (p value <0.006). Diabetic autonomic neuropathy due to long standing diabetes leads to attenuation of circadian rhythm of ACS. Abnormalities in the circadian rhythm of autonomic tone are the most acceptable explanation for this. This inference is supported by study done by Hjalmarsen et al and many others.[12] Coming to time interval in our study, it varies considerably between male and female. Most of the male presented within 4-8 hours period. But most of female presented within 8-16 hours period. This late presentation in female may be due to higher prevalence of atypical symptoms in female. Atypical symptoms of AMI such as indigestion, giddiness, vomiting, dyspnoea, epigastric pain are more common in women. In this study, most common symptom in female was indigestion. This type of symptom may lead to misinterpretation of RVMI as disease of GIT both by patient themselves and by the attending primary health care physician.

In this study, 55% of the patients (33 patients) had classical chest discomfort and atypical symptom was observed in 45% of patients (27 patients) accounted for atypical symptoms like indigestion, epigastric pain and syncope. In this study, occurrence of atypical symptoms was noted more in the elderly patients than younger patient; diabetics more than non diabetics; female more than male. Here the association of typical and atypical symptoms among male and female patients respectively was significant (p value <0.001). This observations correlates with many studies which showed more prevalence of atypical symptoms among women. Most of RVMI associated with IWMI, which is more frequently associated with GIT symptoms due to increased diaphragmatic and vagal activities (BEZOLD-ZARISH REFLEX).

In this study, around 68.33 % of patients had hypotension, 73.33% of patients had bradycardia, around 76.66% of patients had elevated JVP and 63.33% of patients had basal crepitations. Among 46 patients, who had elevated JVP, and 20 patients showed prominent A wave and X descent in the JVP waveforms. Of these 20 patients with prominent A wave and X descent in JVP wave form, 75 % of patients subsequently had cardiogenic shock. This association of haemodynamically significant RVMI with prominent A wave and X descent in JVP was significant (p value 0.001). This correlates with many studies conducted in the past. In a study conducted by Dell Italia LJ et al[13] it was found that elevated JVP alone has 88 % sensitivity and 69% specificity in diagnosing haemodynamically significant RVMI. In one another study Goldstein et al found that prominent A wave and X descent is most significantly associated with severe right heart failure in RVMI patients who had intact right atrial function. Although hypotension, elevated JVP, clear lung field makes clinical triad of RVMI, it will occur only in haemodynamically significant RV infarct as a features of right heart failure. This observation is similar to observation made in SHOCK trial and Dell Italia LJ et al.[13]

We further analysed the ECG feature and almost all the patients had ST elevation in RV4. Invariably all the patients were associated with IWMI and most of them, were associated with PWMI also. None of the patients had isolated RVMI. The studies conducted in the past showed that isolated RVMI is very rare. The RVMI is usually seen in patients with infero-posterior wall MI. Studies showed that incidence of isolated RVMI is <3%, the incidence of IWMI with RVMI is >30%. In the present study 100 % of RVMI patients also had IWMI and 51.66% of RVMI patients had the involvement of posterior wall. Only 5 % were associated with AWMI.

One of important features of ECG analysis was the degree of ST elevation in RV4. All the patients of RVMI had ST elevation >1mm in V4R. Of these about 36.7% of patients had ST elevation >2mm. Among these patients who had higher degree of ST elevation, most of patients also had clinical features of cardiogenic shock (68.2%). So from this study it is well known that amount of ST elevation in RV4 can be used to asses haemodynamically significant right ventricular myocardial infarction. This observation is similar to conclusion made in a study by Zehender et al.[15] In this...
study about 80% of patients had electrical complications in the form of sinus bradycardia, all degrees of AV block, right bundle branch block, left anterior hemiblock, atrial fibrillation and VT/VF. Right ventricular myocardial infarction increases the risk of arrhythmic complications and death among the patients with inferior wall myocardial infarction. In this study most common arrhythmia encountered was sinus bradycardia (73.33%). This may be due to increased activity in vagal afferent fibers. Vagal nerve fibers more commonly present in the inferior aspect of heart. So, IWMI patients are having more chances to develop bradycardhythms even without the presence of RVMI, due to the presence of Bezold-Jarisch reflex. In the present study, complete heart block was seen in 6.66% of patients. All these four patients were associated with cardiogenic shock, ST segment elevation >2mm in V4R, ECG features of right ventricular dyskinesia, right ventricular dilatation and paradoxical septal movement towards left ventricular cavity. In this study VT/VF occurred in 6.66% of the patients. Among these all the patients were associated with significant haemodynamic disturbances in the form of cardiogenic shock. VT/VF became the most common cause of the death in this study. This observation showed that these arrhythmic complications in RVMI commonly present in severe cases of RVMI and these electrical complications itself worsens the already existing haemodynamic disturbances. This inference correlates with many studies conducted towards complications of right ventricular myocardial infarction.

Coming to Echo findings in the present study, 36.66% of RV diskinesia, 20% of RV dilatation, 13.33% of paradoxical inter ventricular septal movement towards left ventricular cavity, 10% of RA dilatation and bowing of inter atrial septum towards left atrium, 11.66% of significant tricuspid regurgitation and 5% of left ventricular involvement was noted among all RVMI patients. This study showed that RV dyskinesia, RV dilatation and paradoxical movement of interventricular septum towards left ventricle are highly important echocardiographic features in detecting haemodynamically significant RVMI. These observations were similar with study conducted by Dell Italia et al.13

Coming to analysis of treatment and outcome among our patients studied, 8.33% of patients died. In CORE trial it was found that RVMI increases the mortality, cardiogenic shock and arrhythmic complications by three fold in patients of IVMI, when compared to IWMI alone. In the present study, although more death (60%) occurred among non thrombolysed patients, considerable amount of death (40%) also occurred in thrombolysed patients. It indicates that thrombolysis is not well impressive in patients with RVMI, even though it reduces mortality, shock and arrhythmic complications among RVMI patients. This observation correlates with observations made by Bates ER et. Al.16 It also indicates that the preload optimization, inotropic treatment, rhythm optimization are more important in the management of RVMI patients. In a study, Goldstein et al found the importance of preload optimization and rhythm optimization. Dell Italia et al and Brooks et al found that the importance of inotropic support in RVMI patients. Our study correlates with observations made by Dell Italia et al and Brooks et al.13,17

CONCLUSION
The incidence of right ventricular myocardial infarction is increasing. RVMI equally affects lower socio economic people. Smoking now becomes the most common cause of RVMI in male. Diabetes was the leading cause of RVMI in both male and female population in our study. Isolated RVMI is very rarely occurs. RVMI is commonly associated with inferior wall myocardial infarction. So, all patients with IWMI must have right sided chest leads (V4R), which is the most easily available means to diagnose RVMI at earlier period. RVMI if diagnosed earlier has good prognosis. If appropriate preventive measures taken, not only RVMI, the burden of coronary artery disease can be reduced in the community.

REFERENCES