patients with confirmed pulmonary embolism. *Circulation* 2000; 102: 211–217.

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From the authors:

As D. Jimenez correctly pointed out, our study [1] was based on a large registry, which focused on patients with major, *i.e.* massive or submassive, pulmonary embolism (PE). This is the critical patient population in which not only confirmation of PE itself, but also, particularly a high level of suspicion and the prompt diagnosis (or exclusion) of right ventricular dysfunction may have enormous prognostic and therapeutic implications. We could show that the presence of at least one of pre-specified ECG abnormalities on admission was, apart from the clinical findings at presentation, a predictor of outcome in the acute phase. The message of our study is, therefore, that the ECG may be useful as a simple, noncostly initial (baseline) tool for assessing the patients' prognosis and for guiding further diagnostic work-up. We did not claim that the ECG should, or could, be used as an alternative to imaging studies, such as echocardiography or helical computed tomography, to diagnose RV dysfunction, or that ECG changes, such as the ones we examined could, by themselves, suffice to set the indication for thrombolytic treatment in PE.

Rather, the value of a pathological ECG lies in the fact that it may help a large number of clinicians, regardless of their specialty, suspect and seek to confirm right ventricular dysfunction more frequently than is presently the case.

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