


## Author Reply

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Dear Editor,

We thank the authors of the submitted Letter to the Editor<sup>1</sup> for their interest in our article<sup>2</sup> and would like to offer a Letter of Reply to their inquiries.

As described in the second paragraph of the Results section,<sup>2</sup> as well as the in the title for Table 1,<sup>2</sup> this table displays the time intervals for calls which had a full set of times available. While advanced statistical analysis would be ideal in describing these times, it was not within the scope or purpose of this retrospective study, and as such, data are presented using the 25<sup>th</sup>, 50<sup>th</sup>, and 75<sup>th</sup> percentiles. Furthermore, while time between first medical contact and time to primary coronary intervention would certainly be interesting to examine, those data were not available for analysis.

It is not particularly clear to us what “average time spent on imaging” is referring to. The number which is cited in the Letter to the Editor is the time that Emergency Medical Service crews spent on scene, and while that does include acquiring and transmitting a 12-lead electrocardiogram, it also encompasses getting to the patient, assessing and treating the patient, packaging the patient for transport, and moving the patient to the ambulance. As such, the authors of the Letter to the Editor seem to suggest an incorrect assumption regarding what they deem to be a “delay seen in the first imaging.”

### References

1. Kuas C, Canakci ME. The effect of prehospital ECGs on patient care in STEMI. *Prehosp Disaster Med.* In Press.
2. Kotelnik V, Pesce K, Masterton WM, et al. 12-lead electrocardiograms acquired and transmitted by emergency medical technicians are of diagnostic quality and positively impact patient care. *Prehosp Disaster Med.* 2021;36(1):47–50.