

## Introduction

Acute myocardial infarction (AMI) remains a leading cause of morbidity and mortality worldwide. Myocardial infarction occurs when irreversible myocardial cell damage or death occurs (**Bolooki and Askar,2010**).

ST segment elevation myocardial infarction (STEMI) is the most serious presentation of atherosclerotic coronary artery disease (CAD) carrying the most hazardous consequences and it is caused by occlusion of major coronary artery (**Tosteson et al.,1996**).

Primary coronary intervention (PCI) is the preferred reperfusion strategy especially when performed by an experienced team within the shortest possible time from first medical contact (**Van de Werv et al, 2008**).

One of the methods to estimate infarct size is 12 lead ECG by using QRS score system (**Wagner et al,1982**).QRS score has been shown to correlate with pathologic infarct size such that a high QRS score is associated with large myocardial infarction (**Roak et al, 1983**).QRS score has also correlated with left ventricular function after initial myocardial infarction (**Fioretti et al,1985**). Each point of selvester QRS score correspond to 3% of left ventricular mass (**Sevilla et al,1990**).

On the basis of the available scientific evidence, SPECT imaging with Tc-99m sestamibi is the best available measurement tool for infarct size in clinical medicine.Tc-99m sestamibi scintigraphy is considered a reliable method to assess myocardial salvage (difference between the actual and potential infarct size) achieved by reperfusion therapy (**Gibbons et al., 2000**).