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Zdravstvena informatika - Standardni komunikacijski protokol - Računalniško podprta elektrokardiografija

Health informatics - Standard communication protocol - Computer-assisted electrocardiography

Medizinische Informatik - Standardkommunikationsprotokoll - Computergestützte Elektrokardiographie; Englische Fassung EN 1064:2005+A1:2007

Informatique de Santé - Protocole de Communication Standard pour L'Electrocardiographie Assistée par Ordinateur

Ta slovenski standard je istoveten z: prEN 1064

ICS:

35.240.80	Uporabniške rešitve IT v zdravstveni tehniki	IT applications in health care technology
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Health informatics - Standard communication protocol - Computer-assisted electrocardiography

Informatique de Santé - Protocole de Communication
Standard pour L'Electrocardiographie Assistée par
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Medizinische Informatik -
Standardkommunikationsprotokoll -
Computergestützte Elektrokardiographie; Englische
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Contents	Page
Introduction	3
1 Scope	5
2 Normative references	6
3 Terms and definitions	6
4 Symbols and abbreviated terms	8
5 Definition of the data contents and format	9
5.1 General considerations	9
5.2 Specifications for the data structure	10
5.3 Pointer section – Section 0	15
5.4 Header information - Patient data / ECG metadata – Section 1	16
5.5 Huffman tables – Section 2	33
5.6 ECG leads definition – Section 3	35
5.7 Reserved for legacy SCP-ECG versions – Section 4	44
5.8 Encoded type 0 reference beat data – Section 5	46
5.9 Short-term ECG Rhythm data – Section 6	49
5.10 Global ECG measurements – Section 7	51
5.11 Storage of full text interpretive statements – Section 8	64
5.12 Storage of manufacturer specific interpretive statements and data related to the overreading trail – Section 9	66
5.13 Per-lead ECG measurements – Section 10	66
5.14 Storage of the universal ECG interpretive statement codes – Section 11	75
5.15 Long-term ECG rhythm data – Section 12	79
5.16 Stress tests, Drug trials and Protocol based ECG recordings Metadata – Section 13	84
5.17 Selected ECG Sequences Repository – Section 14	95
5.18 Beat-by-Beat ECG measurements and annotations – Section 15	99
5.19 Selected ECG beats measurements and annotations – Section 16	114
5.20 Pacemaker Spikes measurements and annotations – Section 17	123
5.21 Additional ECG annotations – Section 18	137
Annex A (normative) Supplementary information and additional encoding specifications	144
Annex B (informative) Universal ECG interpretation statements codes	152
Annex C (informative) Definition of compliance with the SCP ECG standard	178
Annex D (Informative) Methodology of the recommended ECG signal compression technique ..	187
Annex E (informative) Cross-references to other ECG standards	223
Annex F (informative) Implementation Recommendations	226
Annex G (informative) Glossary	228
Bibliography	230

Introduction

The electrocardiogram (ECG) is a recording of voltage changes transmitted to the body surface by electrical events in the heart muscle, providing direct evidence of cardiac rhythm and conduction, and indirect evidence of certain aspects of myocardial anatomy, blood supply and function. During its propagation to the surface, extracardiac tissues may intervene and influence the ECG morphology.

Electrocardiography has been used for many years, and is increasingly used as a key, non-invasive and low cost method in the diagnosis and early detection of coronary heart disease, which is the leading cause of mortality worldwide [56]¹. Of the 57 million global deaths in 2008, 36 million (63 %) were due to non-communicable diseases (NCDs) and 17.3 million (30 %) were due to cardiovascular diseases (CVDs). Out of these 17.3 million cardiovascular deaths, heart attacks were responsible for 7.3 million and strokes were responsible for 6.2 million deaths. More than 3 million of these 17.3 million CVD deaths occurred before the age of 60. The percentage of premature deaths from CVDs ranges from 4 % in high-income countries to 42 % in low-income countries [56].

In 2008, it was estimated that more than 300 million standard 12 lead ECGs are recorded yearly in the US for routine diagnostic and screening purposes [37]. The Mayo Clinic, for example, nowadays performs about 240,000 standard ECG recordings per year [58].

According to Transparency Market Research, the overall shipment of ECG monitoring systems including resting ECG recorders, ECG stress testing systems, Event recorders and Holter monitors, will rise from 262.1 thousand units in 2011 to 374.8 thousand units in 2016, with a 2016 market size estimation of US\$822.1 million [59]. Marketsandmarkets.com on its side estimates that the global Diagnostic ECG Market will reach \$5,435 million by 2020 [57]. The factors driving this market include the increasing geriatric population, rising incidences of lifestyle diseases, technological advancements in diagnostic ECG devices, and high growth rate in developing countries.

Almost all newer electrocardiographs nowadays use digital recording, interpretation and communication techniques, and there is an increasing number of portable and even wearable (mobile) ECG devices that are now used instead of the traditional ECG cart. These stand-alone, microprocessor based machines and devices can be connected to each other, to a host computer, to the internet or to a hospital information system for reporting, long-term storage in the Medical Electronic Record and serial comparison. To this end, various manufacturers have used different techniques.

It is in the general public interest for users not to be restricted in their options by incompatible technical features and services of different systems and devices. ECG processing is increasingly being integrated with various other types of data processing in health care. This evolution will have considerable impact on the storage and communication of ECG data. There are many different end-users who for different purposes (support of patient care, management, drug trials and/or drug management, research and education) want to obtain a copy of the signal data, of the interpretive report and/or measurement results. Being one of the very first ever developed systems for medical decision support, computerized ECG interpretation stretches from departments of cardiology in hospitals, to general practitioners in primary care and health care centres and to home care. In life-threatening acute myocardial infarction, ECGs are now used in ambulances by paramedical personnel to assess the necessity for administering thrombolytic agents or to alert cathlabs to prepare for a coronary intervention, with long-distance monitoring whenever possible, and in self-care situations to detect ischemia or life threatening arrhythmias as early as possible [31].

To facilitate the exchange of information between various systems, it was of utmost importance that a standard communications protocol for computer-aided electrocardiography (SCP-ECG) was established, as defined in this document. Its aim is to specify a data format for transferring ECG signals, metadata and

¹ Figures in square brackets refer to the Bibliography.

prEN 1064:2018 (E)

reports from any vendor's computerized ECG device to any other's vendor central ECG management system. The same standard should also allow standardized transfer of digitised ECG data and results between various computer and information systems, Electronic Medical Records, and ECG data repositories.

Under this standard communications protocol (SCP-ECG), the contents and format of the ECG waveform data, metadata and the measurements from ECG devices of different manufacturers are not expected to be identical. As a result, the determination of the suitability of a device and/or system for any particular application remains with the user/purchaser. The following possible uses of ECG records require special attention:

- serial comparison of ECGs and interpretations;
- printout formats of ECGs;
- maintaining an audit trail of edits and annotations;
- integration into an electronic medical record;
- integration into clinical information systems and data repositories.

The users are cautioned to make sure that the data contents and format of the waveform data, metadata, measurements, and the interpretive statements meet their specific needs. If more than one type of ECG device and/or ECG management system is interconnected, the user is also advised to verify with the manufacturers that the data from different systems and devices are compatible with each other and with the user's needs.

In order to understand this document, the reader needs some basic knowledge of electrocardiology, electrocardiography and signal processing.

This document not only relates to the conventional recording of the electrocardiogram, i.e. the so-called standard 12-lead electrocardiogram and the vectorcardiogram (VCG), but also to other types of ECG such as Holter ECG, physiologic monitoring ECG, stress ECG, intracardiac ECG, home care ECG monitoring and wearable self-care ECG devices. Initially, the electric connections used for recording the ECG were made to the limbs only. These connections to the right arm (RA), left arm (LA) and left leg (LL) were introduced by Einthoven. The electrical variations detected by these electrode connections are algebraically combined to form the bipolar leads I, II, and III. Lead I, for example records the difference between the voltages of the electrodes placed on the left arm and the right arm. The unipolar electrocardiographic leads (VR, VL, VF and the precordial leads V1 to V6) were introduced much later, starting in 1933. In these leads, potentials are recorded at one location with respect to a level which does not vary significantly in electrical activity during cardiac contraction. The "augmented" limb lead potentials (aVR, aVL, aVF) are recorded with reference to the average potential of (L+F), (R+F) and (L+R) respectively, where R, L and F refer to the RA, LA and LL electrodes. The unipolar chest leads are recorded with reference to the average potential of $(RA+RL+LL)/3$ which is called the Wilson "central terminal" (CT). In vectorcardiography recordings are made from three mutually orthogonal leads, running parallel to one of the rectilinear coordinate axes of the body. The axes are the X-axis going right to left, the Y-axis with a top to bottom orientation, and the Z or front to back axis. In 12-Lead stress ECG recordings, the limb electrodes are placed on the torso to reduce limb movement artefacts. The same electrode positions apply to some Holter, emergency and home care recordings, both to limit movement artefacts and undressing.

In some research centres, so-called body surface maps are obtained by placing many (from 24 to 124 or even more) closely spaced electrodes around the torso. This document has not been designed to handle exchange of such recordings, although future extensions could be made to this end. The standard has also not been designed to exchange specialized recordings of intracardiac potentials (electrograms) recorded in the EP (Electrophysiology) laboratories or by cardiac implantable electronic devices (CIED), viz

pacemakers, implantable cardioverter-defibrillators (ICDs) and cardiac resynchronization therapy (CRT) devices, although it could also be used to this intent.

ECG computer processing can be reduced to 3 principal stages:

- 1) data acquisition, encoding, transmission and storage;
- 2) pattern recognition and feature extraction, i.e. ECG measurement;
- 3) diagnostic classification.

In each of these stages there are important needs for standardization and quality assurance testing. The scope of this document is confined to the first of these three stages. Quality assurance of ECG measurement and diagnostic classification have been addressed by the CSE Working Party and to some extent by IEC 60601-2-25:2011 [4]. The latter also addresses the issue of quality assurance testing of the signal acquisition hardware and filtering.

The various data sections that shall be transmitted by means of the standard ECG communications protocol are defined in Clause 5 of this document.

The selection and definition of ECG specific high-level syntaxes and query languages for transfer of messages and data between devices or between devices and hosts or host-to-hosts, using for example Bluetooth, TCP/IP, FTP, USB, Filesystem, HL7, etc., are beyond the scope of this document.

The main goal of the SCP-ECG standard is to address ECG data and related metadata structuring, semantics and syntax, with the objective of facilitating interoperability and thus to support and promote the exchange of the relevant information for ECG diagnosis. Indeed, as recommended by the ACC/AHA/ACP-ASIM task force: “Electrocardiogram readers should understand the importance of comparing a current tracing to previous tracings in order to make correct diagnoses. All abnormal tracings should be compared with available previous tracings. The accuracy of some diagnoses may be considerably enhanced by reviewing previous tracings.” [33]. It is thus of utmost importance to provide a storage format enabling any device or computer program performing the analysis and interpretation of a current ECG to perform a reliable re-analysis of the previous ECGs. For assessing serial changes between ECG measurements it is necessary that the measurements are computed in the same way on each recording in order to avoid any bias.

The binary encoding of ECG data within SCP-ECG and the included content self-control capabilities allow for an efficient encoding, an encapsulation of all ECG-related parameters, and a small memory footprint compliant with mHealth scenarios for an early detection of cardiac diseases, anywhere and anytime [31], [40]. These features not only provide an advantage in data transmission and archiving, but also when the data need to be encrypted (for protecting the data and the confidentiality), or signed (protection against changes).

1 Scope

This document specifies the common conventions required for the interchange of specific patient data (demographic, recording conditions ...), ECG signal data and metadata, ECG measurements and ECG annotations, and ECG interpretation results.

This document specifies the content and structure of the information which is to be interchanged between digital ECG electrocardiographs/devices and computer ECG management systems, as well as other computer or information systems (cloud, etc.) where ECG data can be stored.

This document defines the way to describe and encode standard and medium to long-term electrocardiogram waveforms measured in physiological laboratories, hospital wards, clinics and primary care medical check-ups, ambulatory and home care. It covers electrocardiograms such as 12-lead, 15-lead, 18-lead, Cabrera lead, Nehb lead, Frank lead, XYZ lead, Holter ECGs and exercise ECGs that

prEN 1064:2018 (E)

are recorded, measured and analysed by equipment such as electrocardiographs, patient monitors, wearable devices. It also covers intracardiac electrograms recorded by implantable devices as well as the analysis results of ECG analysis and interpretation systems and software that are compatible with SCP-ECG.

ECG waveforms and data that are not in the scope of this technical specification include real-time ECG waveform encoding and analysis used for physiological monitors, and intra-cardiac or extra cardiac ECG mapping.

2 Normative references

The following documents are referred to in the text in such a way that some or all of their content constitutes requirements of this document. For dated references, only the edition cited applies. For undated references, the latest edition of the referenced document (including any amendments) applies.

ISO/IEC 10646, *Information technology — Universal Coded Character Set (UCS)*

ISO/IEEE 11073-10101:2004,² *Health informatics — Point-of-care medical device communication — Part 10101: Nomenclature*

ISO/IEEE 11073-10102:2014, *Health informatics — Point-of-care medical device communication — Part 10102: Nomenclature — Annotated ECG*[9]

3 Terms and definitions

For the purposes of this document, the following terms and definitions apply.

ISO and IEC maintain terminological databases for use in standardization at the following addresses:

- IEC Electropedia: available at <http://www.electropedia.org/>
- ISO Online browsing platform: available at <http://www.iso.org/obp>

3.1**acquiring cardiograph / acquiring device**

cardiograph/device recording the original ECG signal

3.2**analysis Time Window**

defines the time interval (starting date and time and duration) that will be used to select an ECG excerpt that will be analysed by a computer program and/or by a health professional viz a cardiologist

3.3**confirming**

process whereby a trained and experienced cardiologist reviews the computer-generated (or already overread) interpretation of an ECG in order to confirm the computer-generated (or already overread) interpretation or to make the final changes to the interpretation text. The confirmed ECG is the final clinically acceptable version for diagnosis and treatment

² Impacted by ISO/IEEE 11073-10101:2004/Amd.1:2017

3.4

CSE Project

project supported by DG XII of the European Commission aiming at the development of Common Standards for (Quantitative) Electrocardiography (see references [32] and [44] to [50])

3.5

ECG excerpt

portion of a continuous ECG recording that has been either visually selected by a health professional or by a computer based algorithm or according to a predefined protocol (viz a 10 s excerpt every hour)

3.6

interpretive device

device (cardiograph, wearable equipment, smartphone, computer, cloud, etc.) analysing and interpreting the ECG signal

3.7

message

textual body of information

3.8

overreading

process whereby a cardiologist or a cardiology fellow reviews the computer-generated interpretation of an ECG in order to verify the accuracy or to make changes to the interpretation text

NOTE 1 to entry: An overread ECG is generally not the final clinically acceptable version for diagnosis and treatment. Usually, the overreading process precedes the confirming process.

3.9

record

entire data file which is transmitted, including the ECG data and associated information, such as patient identification, demographic and other clinical data, measurements, annotations, interpretation results, etc.

3.10

reference beat

reference/representative ECG cycle computed through any (but not specified) algorithm comprising the P, QRS and the ST-T waves

3.11

rhythm data

full original ECG data, or the decompressed and reconstructed ECG data if lossless compression is used

NOTE 1 to entry: Rhythm data are typically 10 s in length for a standard 12-Lead ECG (stored in sections 6 and/or 14), but may last several minutes for stress tests, a few hours for drug trials and up to 7 days for Holter recordings (stored in section 12).

3.12

section

aggregate of data elements related to one aspect of the electrocardiographic recording, measurement, annotation or interpretation

prEN 1064:2018 (E)**3.13****universal statement codes**

ECG interpretation codes described in Annex B of this document

NOTE 1 to entry: See glossary in Annex G for other technical terms related to this part of EN 1064.

4 Symbols and abbreviated terms

AAMI	American Association for the Advancement of Medical Instrumentation
AC	Alternating Current
AHA	American Heart Association
AIM	Advanced Informatics for Medicine Programs of the European Commission Directorate General XIII
ANSI	American National Standards Institute
ASCII	American Standard Code for Information Interchange
AVM	Amplitude Value Multiplier (see 5.8.3)
CEN	Comité Européen de Normalisation - European Committee for Standardization
CIED	Cardiac Implantable Electronic Device
CRC	Cyclic Redundancy Check
CRT	Implanted Cardiac Resynchronization Therapy device
CSE	Common Standards for quantitative Electrocardiography
DG	Directorate General (of the European Commission)
EU	European Union
ECG	Electrocardiogram
EN	Europäische Norm (European Standard)
ENV	Europäische Norm Vorausgabe (European Pre-standard)
ICD	Implanted Cardioverter Defibrillator
ID	Identification
IEC	International Electrotechnical Commission
IEEE	Institute of Electrical and Electronic Engineers
ISO	International Organization for Standardization
LSB	Least significant bit
MSB	Most significant bit
RMS	Root Mean Square
SCP	Standard Communications Protocol
SCP-ECG	Standard Communications Protocol for computerized Electrocardiography
TC	Technical Committee
UTF-8	Universal Coded Character Set + Transformation Format - 8-bit (specified in ISO/IEC 10646)
VCG	Vectorcardiogram

5 Definition of the data contents and format

5.1 General considerations

5.1.1 The data record which is to be interchanged shall be divided into different sections. The contents and format of each of these sections are defined in this document.

5.1.2 All text data (character strings) shall be stored in the 8-bit Universal Character Set Transformation Format of ISO/IEC 10646 (also known as UTF-8)

5.1.3 All character strings shall be encoded in UTF-8 and NULL terminated

5.1.4 For all signed binary values 2's-complement coding shall be applied

5.1.5 All single and multiple byte binary values are regarded as unsigned integers, if not otherwise specified

5.1.6 Endianness: binary values spanning more than 1 byte shall be transmitted and/or stored according to the little endian mode, i.e. in ascending order of significance (the least significant byte is transmitted and/or stored first, the most significant byte last)

5.1.7 Consecutive bytes are numbered from left to right (starting with 1). Bits of a byte are numbered from right to left (0 = LSB, 7 = MSB)

5.1.8 The first byte in the record (i.e. the first byte of the Checksum) is defined as Byte 1

5.1.9 ECG samples are indexed and numbered starting with sample number 1. Sample index 0 is not used in the present document. Sample indexes are stored as ones-based 16-bit or 32-bit unsigned integers. The first sample starts at time 0. The second sample is at time $(0 + 2)$ ms in case of 500 samples/s sampling rate

5.1.10 Sections are numbered starting from 0 (the Pointer Section) to 32 767

5.1.11 The term "Reference Beat" used in this document refers to an ECG complex which is chosen as representative of a class of such complexes. No specific statistical meaning is implied by this term; for example, it may be an averaged beat (obtained by averaging the waveforms of a set of beats of the same type), a "Median Beat" (obtained by computing the median of the waveforms of a set of beats of the same type), a selected or any other representative single cycle taken from the total ECG recording. This "Reference Beat" does include the P-wave if present (not in case of atrial fibrillation), the ST-T segment and the T wave of this beat

An ECG may have multiple reference beats. The term "reference Beat type" used in this document refers to any one of an ordered list of reference beats, starting with reference beat type 0 (zero). Reference beat type 0 (sometimes also called "dominant beat") is, in general, the primary heart beat excepting extrasystole or artefact. It is used for the calculation of the full set of global measurements and the per-lead measurements stored in sections 7 (Clause 5.10) and 10 (Clause 5.13) and is, by definition, the reference beat used for the so-called contour interpretation of the ECG. The ordering of the list of reference beats does not imply a temporal sequence within the rhythm data.

The term "Rhythm Data" is used to indicate the ECG recording over the entire recording time, usually 10 s in most standard electrocardiographs, but it may take several minutes for stress tests and up to several days for Holter recordings. Reference Beat type 0 data in 5.8 and the reference beats defined in 5.16 are intended to be used for (re)analysis and for display.

prEN 1064:2018 (E)

A description of these terms and of the recommended lossless data compression methodology, including numerical examples and the methods for conformance testing are given in Annex C and Annex D.

5.1.12 All indexes or pointers to a field are defined in bytes and are ones-based (start at 1) if not otherwise specified.

5.1.13 1 KByte = 1 024 bytes

5.2 Specifications for the data structure

5.2.1 All sections shall start on an odd index (even offset) boundary. This implies that all sections shall contain an even number of bytes. A padding byte has to be added to the end of any section otherwise containing an odd number of bytes. Padding bytes shall always be set to NULL (0x00). Blocks of data within a section may contain either odd or even numbers of bytes. Padding occurs only at the end of a section if needed.

5.2.2 All sections are given Identification numbers. Starting with version V3.0, section ID numbers 0 through 18 are currently defined in the SCP-ECG protocol, numbers 19 through 127 as well as numbers above 1 024 are reserved for future use. Numbers 128 to 1 023 are for manufacturer specific sections. The combination of the manufacturer code (see 5.4.5, tag 14) and section numbers 128 to 1 023 uniquely defines the content of the manufacturer-specific sections. There are no specific rules for the layout and format of these sections. However, use of the structure defined in 5.2.7 is recommended

5.2.3 Inclusion of Sections 2, 5, 7 to 11, 15 to 18 (see section format in 5.2.7 and 5.2.8) is optional. Any SCP-ECG data record shall contain Section 0 (Pointers), Section 1 (Header), Section 3 (ECG Lead Definition) and Section 6 (Short-term ECG Rhythm Data) or Section 12 (Long-term ECG Rhythm Data) or Section 14 (Selected ECG sequences repository). Section 13 (Stress tests, Drug trials and Protocol based ECG recordings Metadata) is compulsory when Section 14 (Selected ECG Sequences Repository) is present. No other consistency checking among the presence of different sections is assumed. Specifically, if any of Sections 8, 9, or 11 is present, it is not assumed that all three shall be present

5.2.4 The ECG record starts with a 6-byte record header, consisting of a 2-byte CRC followed by a 4-byte record length. These are defined as follows

- 1) The 2-byte cyclic redundancy check (CRC) is calculated as a CRC-CCITT, the algorithm of which is described in C.6, and is calculated over the entire range starting with the first byte following the CRC and ending with the last byte in the record.
- 2) The 4-byte record length denotes the number of bytes in the total record, including the 6 bytes of this record header.

5.2.5 SCP-ECG record overview:

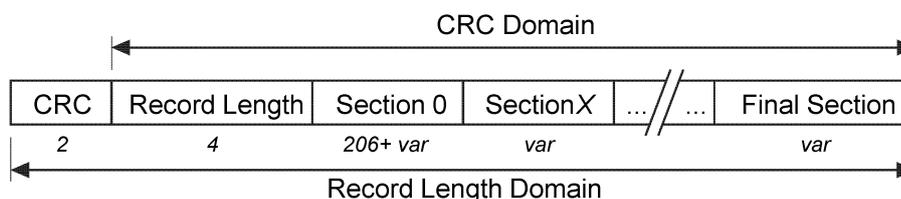


Figure 1 — SCP-ECG record overview

NOTE The length of Section 0 is equal to $(16 + 10(n + 1)) + 10 + mx10$, where $n = 18$ is the number of sections currently described in this version of the protocol and m is the number of additional, manufacturer specific sections (if any) contained in the SCP-ECG record.

5.2.6 The sequence order of the sections of a record is free, with the exception of Section 0 (zero) which shall immediately follow the record header. However, a maximum of one instance of any section is allowed in a SCP-ECG data record.

5.2.7 Each section consists of

- 1) a Section Identification Header (Section ID Header)
- 2) a Section Data Part.

Any section shall start with a “Section ID Header” (16 bytes) defined below:

Bytes	Contents
1 to 2	16 bit CRC-CCITT over the entire section except these 2 bytes.
3 to 4	Section ID number as defined in 5.2.2 (see also 5.3.3.1).
5 to 8	Section length in bytes <u>including</u> the “Section ID Header” (5.3.3.2).
9	Version Number of the Section.
10	Version Number of the Protocol (see 5.4.5, tag 14, byte 15).
11 to 16	Reserved (shall be set to Null (0), except for section 0, see 5.3.2).

Each section shall have a Section Version Number and a Protocol Version Number (see bytes 9 and 10) which may be used to specify different levels of compatibility with the standard when this is updated in the future (see Annex C). For data sections 1 to 18, Section Version Numbers (byte 9) shall be the Protocol Version under which the section was approved. For data sections 128 to 1 023, Section Version shall refer to the manufacturer’s version for that section, independent of the Protocol version.

Version number 3.0 shall be stored as decimal value of 30. For implementation details, see 5.4. 5, Tag 14, byte 15.

The version number of the protocol must match for all sections containing strings (i.e. sections 1, 8, and 10 to 18). Specifically, mixing old and new version sections could corrupt the interpretation of strings (see also section 1, Clause 5.4.5, Tags 14 and 15, byte 15).

5.2.8 Reserved fields shall always be set to NULL (zero).

5.2.9 A global overview of the layout of an SCP-ECG section is presented in Figure 2

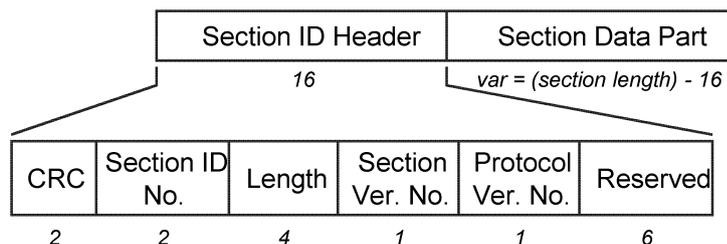


Figure 2 — Section layout overview

5.2.10 The numbers in *italic* in the layout overviews in 5.2.5 and 5.2.9 as well as in all other layout overviews of Clause 5 indicate the length in bytes of the corresponding field or indicated block (*var* = variable length).

5.2.11 A global overview of the SCP-ECG data structure is presented in Table 1

Table 1 — SCP-ECG data structure

Requirement Status	Content
Required	2 BYTES - CHECKSUM - CRC - CCITT OVER THE ENTIRE RECORD (EXCLUDING THIS WORD)
Required	4 BYTES - (UNSIGNED) SIZE OF THE ENTIRE ECG RECORD (IN BYTES)
Required	(Section 0) POINTERS TO DATA AREAS IN THE RECORD
Required	(Section 1) HEADER INFORMATION - PATIENT DATA/ECG METADATA
Optional	(Section 2) HUFFMAN TABLES USED IN ENCODING OF ECG DATA (IF USED)
Required	(Section 3) ECG LEADS DEFINITION
Reserved	(Section 4) RESERVED FOR LEGACY SCP-ECG VERSIONS
Optional	(Section 5) ENCODED TYPE 0 REFERENCE BEAT DATA (IF REFERENCE BEAT IS STORED)
Optional *	(Section 6) SHORT-TERM ECG RHYTHM DATA
* see 5.2.12	
Optional	(Section 7) GLOBAL ECG MEASUREMENTS
Optional	(Section 8) TEXTUAL DIAGNOSIS FROM THE "INTERPRETIVE" DEVICE
Optional	(Section 9) MANUFACTURER SPECIFIC DIAGNOSTIC AND OVERREADING DATA FROM THE "INTERPRETIVE" DEVICE

Requirement Status	Content
Optional	(Section 10) PER LEAD ECG MEASUREMENTS
Optional	(Section 11) UNIVERSAL STATEMENT CODES RESULTING FROM THE INTERPRETATION
Optional * * see 5.2.12	(Section 12) LONG-TERM ECG RHYTHM DATA
Optional * * see 5.2.12	(Section 13) STRESS TESTS, DRUG TRIALS AND PROTOCOL-BASED ECG RECORDINGS METADATA
Dependent on Section 13	(Section 14) SELECTED ECG SEQUENCES REPOSITORY
Optional	(Section 15) BEAT-BY-BEAT ECG MEASUREMENTS AND ANNOTATIONS
Optional	(Section 16) SELECTED ECG BEATS MEASUREMENTS AND ANNOTATIONS
Optional	(Section 17) PACEMAKER SPIKES MEASUREMENTS AND ANNOTATIONS
Optional	(Section 18) ADDITIONAL ECG ANNOTATIONS

5.2.12 The following remarks apply to the data sections identified above:

- <https://standards.iteh.ai/catalog/standards/sist/accf356c-53b1-48c0-bac6-59d62fe71efe/sist-1064-2018>
- 0 This section contains pointers to the start to itself and to the start of each of the following sections. This section is required.
 - 1 This section contains information of general interest concerning the patient (e.g. patient name, patient ID, age, etc.) and the ECG (acquisition date, time, etc.). This section is required.
 - 2 This section contains all of the other than default SCP-ECG Huffman tables used in the encoding of Section 6 short-term ECG rhythm (or “residual signal” in SCP-ECG versions prior to 3.0) and type 0 reference beat data (Section 5). The tables shall be referenced by Sections 5 and 6 by their numerical order in this section. Thus, when reference is made in the type 0 reference beat encoding section to Table 2, this shall refer to the second table defined in Section 2. This section is required, dependent upon Huffman encoding being used in the encoding of ECG signals of Section 6 (short-term ECG rhythm) and of Section 5 (type 0 reference beat, if stored). Starting with SCP-ECG V3.0, this section is no longer mandatory if only the default Huffman table defined in D.4.7.6 is used.
 - 3 This section specifies which ECG leads are contained within section 5 (type 0 reference beat) and section 6 (short-term ECG rhythm) ECG records. This section is required.
 - 4 This section was formerly used to store QRS locations to allow beat subtraction for computing a “residual signal”. This section has been deprecated and is now reserved. It shall no longer be used.
 - 5 This section is used to store lead by lead the type 0 reference beat if the originating device or the (re)analysing device has identified or computed a dominant reference beat. This section is optional.