**SEVERE CHEST PAIN MIMICKING ACUTE CORONARY SYNDROME IN A DIABETIC PATIENT WITH MYASTHENIA GRAVIS**

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*Objectives*: To describe a case of typical angina in a patient with uncontrolled hyperglycemia, diabetes, myasthenia gravis, and normal epicardial coronary arteries on angiogram

*Background*: Pyridostigmine remains the cornerstone of symptomatic treatment for myasthenia gravis (MG), however, its anticholinergic side effects include abdominal muscle spasms which may be difficult to differentiate from angina in a patient with multiple coronary artery disease (CAD) risk factors.

*Methods*: A 75 year old man with type-1 diabetes, hypertension, dyslipidemia, CAD status post right coronary artery stenting and recently diagnosed, refractory MG was admitted for further myasthenia workup. He was started on high dose prednisone, in addition to frequent use of pyridostigmine. Several hours after the first dose of prednisone he developed hyperglycemia and severe chest pressure, associated with shortness of breath, diaphoresis and sensation of impending doom. EKG showed new ST segment elevation in aVR and ST depressions in anteroseptal and lateral leads. The pain lasted more than 30 min and did not respond to sublingual nitroglycerin. A recent evaluation at an outside institution revealed a normal EKG and negative adenosine nuclear perfusion study (MIBI). With concerns for left main disease (ST elevation in aVR) and balanced coronary ischemia (normal MIBI) the patient was sent emergently to the cardiac catheterization laboratory.

*Results*: Coronary angiogram revealed clear epicardial coronary arteries and myocardial bridging of the mid-distal left anterior descending artery. Microvascular disease, endothelial dysfunction and hyperglycemia-induced vasospasm were hypothesized. Serial troponins remained negative. Optimal medical management and aggressive CAD risk factor modification were emphasized. Neurology discontinued the pyridostigmine. *Conclusions*: This vignette illustrates a clinical scenario with typical angina and dynamic EKG changes without obstructive epicardial coronary leasions. Endothelial dysfunction, microvascular disease, hyperglycemia-induced vasospasm and myocardial bridging may all have contributed. Pyridostigmine should be avoided in patients with chest pain and concern for anticholinergic side effects.