

typically occurs at rest and is caused by intense coronary vasospaby exercise and is most commonly due to coronary atheroabnormalities are found, chest pain may be associated and is ofte comorbidity of psychiatric disorders in patients who present wi therapeutic decision-making. Here we report the case of a patie presented to the emergency room with chest pain.

2. Case Report

This is the case of 61-year-old African-American woman with a h the emergency room in May 2008 with an acute episode of left-sid breath, diaphoresis, and an impending sense of doom lasting 2-2 this event.

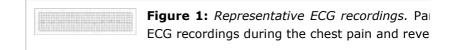
She was admitted and placed on a cardiac telemetry monitoring electrocardiogram, telemetry, and serial cardiac enzymes did not event. There was no family history of coronary artery disease. Me apnea, and a history of smoking (quit 10 years prior) and alcohol the patient voiced concern that her chest pain may have been rela She recalled having similar chest pain 10 years ago. At that time, which was normal, and the pain was diagnosed as panic attacks. A by diazepam and sertraline. As a young adult, the patient descrit other past psychiatric medications included fluoxetine, buspirone, history included a father with depression, a brother with alcohol a and completed suicide (7 years ago). At the time of hospitalizatio discharge, she was scheduled for an outpatient stress test.

Six days after hospitalization, she was seen in the medical clinic. : with decreased energy, lethargy, and decreased interest in activit for 2 weeks, which was titrated up to 50 mg at week 3. A referral

One month after being started on sertraline (early June), she wa tolerating 50 mg of sertraline but without much benefit. She des anxiety than she had previously in psychiatric care years ago. She and sensation of heart racing in the past month. Laboratory analy referral was made to a sleep clinic as she had been diagnosed wit (PSG) test, but failed to follow up. Bupropion (Bupropion SR, 1 depression with anergia, and alprazolam was given for anxiety as on bupropion the patient was still complaining of depression and fa

Three weeks after the bupropion dose change, the PSG results car placed on continuous positive airway pressure (CPAP) therapy. A sleep clinic appointment, the patient experienced substernal chest physician from the sleep clinic made a referral to cardiology, as sł and a stress test. In a psychiatric follow-up (one week after hei better, including improved mood and less fatigue and anxiety.

One week later, the patient was seen in the cardiology outpatient or 15) episodes of severe midsternal chest pain lasting 5 to 10 m The symptoms were neither exercise-induced nor predictable. The she reported no associated diaphoresis or shortness of breath. Th ventricular hypertrophy. The cholesterol panel was unremarkable angiography was performed. The coronary arteries were angic abnormalities, and the ejection fraction was normal. The patient w 5 days the patient experienced two recurrences of her symptoms. associated with anxiety-provoking chest pain (Figure 1). There arrhythmias were recorded. The patient was diagnosed with vastarted on amlodipine (2.5 mg daily) and isosorbide mononitrate



In a subsequent psychiatric follow-up, the patient was free of che off, and sertraline was increased to 75 mg daily because it was f her coronary vasospasm.

3. Discussion

Prinzmetal' s-variant angina is an uncommon cause of precordial negative markers of myocardial necrosis [2, 4]. This type of angi unclear etiology. A definitive diagnosis requires demonstratic hyperventilation, acetylcholine, or ergonovine) ST-segment elevati the reported incidence of variant angina ranges from 4% to 32% elevation associated with the anxiety-provoking chest pain was doc

There are no studies on the incidence of panic disorder in patients third of chest pain patients with angiographically normal coronary worth noting that hyperventilation, a proposed provocative test accompanies panic attacks and hence could trigger coronary systematic research has been conducted on the occurrence of co several cases of coronary vasospasm leading to ischemia were do appear to be less common in patients with panic disorder ai cardiomyopathy, also known as Takotsubo cardiomyopathy or brok

The case we present here is unusual because in addition to docu component of the disorder presented as depression with pa Furthermore, although the patient had been diagnosed with par absent until the episode that led to her most recent hospitaliza increased dramatically (up to 15 episodes in 3 months) during bupropion for treatment of the patient's depression.

It has been suspected that bupropion may be associated with ches young males were diagnosed with ST elevations, normal coronary associated with the use of bupropion [11, 12]. The main mechi inhibition of the central nervous system presynaptic dopamine and it appears that bupropion exerts a direct action on the human my release [13]. Since our patient had a diagnosis of prior angina atta been exacerbated by treatment with bupropion. While majority c improve after the initial 3 – 6 month period of frequent symptoms, the return of symptoms have not been elucidated [14].

4. Conclusion

This patient, who had a prior history of depression and panic atta

chest pain. Using a cardiac event monitor, she was documented associated with anxiety-provoking chest pain. We noted that the during the period that coincided with the introduction of bupr Considering the possibility that bupropion may have a negative in therapy was adjusted to exclude this drug. Although Prinzmetal's needed to assess the routine use of cardiac event monitor in subje good example of how a close collaboration between cardiologists a

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