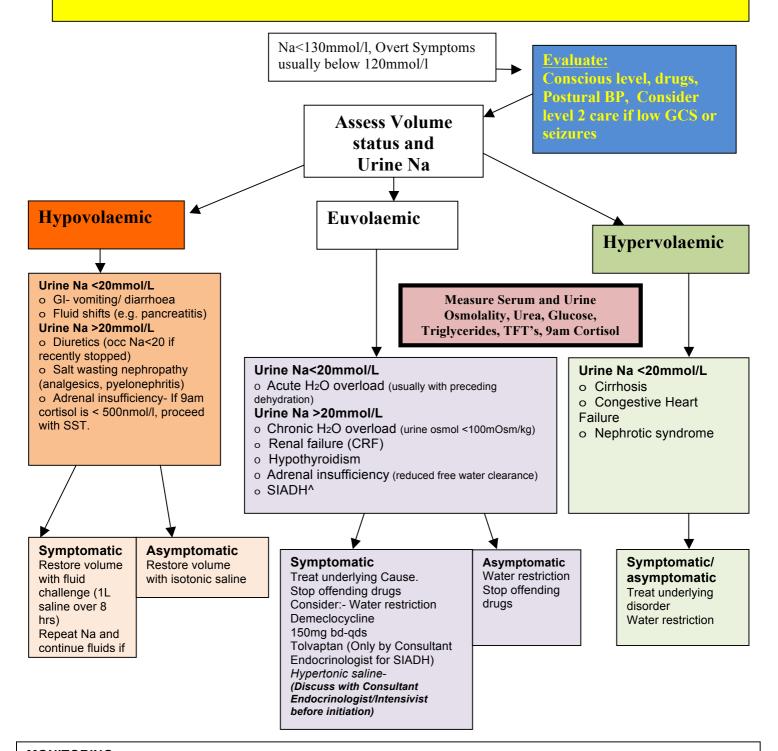
HYPONATRAEMIA ASSESSMENT AND TREATMENT ALGORITHM



MONITORING

Fluid balance, Strict Input and Output chart. Na should not increase by Greater than 10-12mmol in 24 hours. Urgent Serum U+E/Sodium should be checked every 12 hours.

In marked 'non-acute' hyponatraemia, aim for cautious Na replacement due to risk of demyelination.

During active treatment of severe hyponatraemia serum Na should be reassessed hourly. (HDU environment if possible) Refer to ICCU/ITU URGENTLY If Na<115 mmol/l or evidence of neurological insult e.g Seizures, declining GCS.

Think of Pseudohyponatraemia- e.g. lipaemic, paraprotein OR Intracellular shift (hyperglycaemia) osmolar gap~

*Drugs such as diuretics (thiazides, amiloride/ Frumil, spironolactone), carbamazepine, ACE inhibitors and antidepressant SSRIs are notable causes. PPI's have also been implicated.

Symptoms depend critically on rapidity of onset and severity of hyponatraemia **Acute hyponatraemia** can cause cerebral oedema and requires urgent treatment. **Chronic hyponatraemia** if corrected **too rapidly** can cause osmotic demyelination

^SIADH is a diagnosis of exclusion in euvolaemic hyponatraemia with Urine Na>20 and Ur Osm>200. If no response to fluid restriction, consult an Endocrinologist for exploring role of Vasopressin receptor antagonist such as Tolvaptan^^ (^^ Urine Na should be more than 40 mmol/L, Urine Osm >200 and Urine/plasma electrolyte ratio =/>1**)

[** U/P electrolyte ratio= Urine Na + Urine K / Plasma Na]

Calculated Osmolality = [2x (Na + K)] + Urea + Glu