

Home Page
Project Book
Search Site
Admission Page
Index
Referring Visitor
Referral Notes
Admission Notes
Discharge Notes
Unstable Patients
Hyponatraemia
Hypernatraemia
Hyponatraemia
Hypernatraemia
Puberty
Adolescent Health
Pain Management
Exacerbation of COPD
Acute Asthma
Chronic Asthma
Disorders of the
Hypertension
Tachycardia
Tachycardia Treatment
Shock
Saturation Falling
Tachypnoea
Urine Output Falling
Pericarditis
Bradycardia
Atrial Fibrillation
Acidosis
Hypercalcaemia
Hyperkalaemia
Hypokalaemia
Hypoxia
Hyponatraemia

Diagnostic features

- Mild hyponatraemia is common if taking a diuretic
- Confusion and irritability occur with serum levels $\sim 120\text{mmol/L}$
- Coma, fits and death occur with serum levels $\sim 110\text{mmol/L}$
- Assessment of volume status helps diagnosis and management

Management

- **Exclude pseudohyponatraemia.** Lipaemic serum, hyperglyc and mannitol (et al) give a falsely low reading. Calculate the o $[2 \times (\text{Na}^+ + \text{K}^+) + \text{urea} + \text{glucose}]$ and compare with the measured osmolarity. Is there an \uparrow osmolar gap?
- **If coma or fits.** Start infusion of 0.9% sodium chloride $\sim 500\text{ml}$ hypertonic saline available. Give 1.8% sodium chloride at $70\text{ml Na}^+/\text{hr}$ until serum sodium $> 120\text{mmol/L}$
- **If volume depleted (dehydrated).** Start 0.9% sodium chloride. Add colloid if hypotensive. Monitor urine output and CVP. Bew cardiac failure.
- **If not dehydrated.** For patients with SIADH restrict input to $800\text{ml}/24\text{hr}$. If $\text{Na}^+ < 125\text{mmol/L}$ and unresponsive to fluid restriction consider demeclocycline 300mg tds po . Seek expert help early

The diagnosis of the cause of hyponatraemia and its management is a complex issue, requiring the early involvement of the appropriate consultants.

Adapted from Frimley Park Hospital guidelines

(C) 2004 Crown. All rights reserved