

Treatment

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From Hypernatraemia - Sodium

- Hyponatraemia in hypovolaemic states responds well to saline infusions to correction ECFV depletion.
- Hyponatraemia in oedematous states can be difficult and requires expertise.
- Hyponatraemia in euvolaemic states requires fluid restriction (in SIADH drugs which induce a countering diabetes insipidus state can be used)

Treat underlying cause

The principle of correction is to correct at a rate equivalent to the rate of onset of hyponatraemia; this is because with long standing hyponatraemia rapid corrections can precipitate central pontine myelinolysis (an irreversible neurological disorder). The problem is that in practice often there is uncertainty about this timing. A safe rule is to correct no more rapidly than:

1 to 2 mmol/l/h at any time, and by less than 12 to 20 mmol/l in the first 24 h of treatment - i.e. try to avoid hypertonic sodium infusions or rapid N Saline infusions.

● If sodium 120mmol and patient is severely symptomatic, then an aggressive approach with hypertonic sodium is required (aim simply to get sodium above ~120mmol/l and in control of symptoms (this will require frequent sodium checks) - the rest of the correction can be done slowly.