Minutes of the meeting of the CREST Sub-Group on the Management of Hyponatraemia in the Adult Patient, held on Wednesday 27 February 2002, at 2.00pm in Conference Room 414, Dundonald House.

Present: Dr C Russell (Chair)
Dr E Bergin
Ms R Devlin
Dr P Flanagan
Dr G McVeigh
Dr A Montgomery
Dr T Trinick
Mr G Hannan } Secretariat
Miss A Lowry }

Apology: Dr K Fitzpatrick

In attendance: Dr M McCarthy

1. Introduction and apologies

[redacted]

2. Setting the Scene

Dr Russell explained that the Department had approached CREST regarding the dissemination and 'kite-marking' of guidelines on the Prevention of Hyponatraemia in Children Receiving Intravenous Fluids. After debate on the guidelines at the CREST meeting on 8 November 2001, it had been agreed that a small working group, to include the relevant Consultant and Nursing specialties, should be convened to look at Hyponotraemia in Adult Patients.

Dr Russell felt that, after the presentation by Dr McCarthy, the group should consider if it was sufficient to bring the problem of Hyponatraemia to the attention of those specialists who were likely to encounter it or to produce management guidance.

3. Prevention of Hyponatraemia in Children Receiving Intravenous Fluids

Dr McCarthy, Senior Medical Officer, DHSSPS, reported that some months ago, the Department had been approached by Paediatricians, expressing concerns over an increase in the condition of Hyponatraemia and had felt in need of urgent guidance. Consequently a small multi-professional group comprising Paediatric Anaesthetists and Surgeons, Public Health Medicine, Nursing and Chemical Pathology specialties had been convened.

The outcome was the production of an A2 sized laminated wall chart, targeted at junior staff and non-specialists. This chart was intended to raise awareness of the problem with the recommendation that each Unit should draw up its own protocol, using the guidelines as advice. Dr McCarthy said that the wall chart would be published shortly and would be distributed to all units treating children as in-patients.

4. Open Forum

Dr Russell thanked Dr McCarthy and asked members for suggestions on a suitable approach the group could take; do we need to produce Management guidelines or would it suffice to bring the prevalence of Hyponotraemia to the attention of staff?

Issues raised included:

Dr Bergin felt that the risk of Hyponatraemia in adults was higher in certain populations and that it was not as big a prevention risk in adults as in children.

Dr Flanagan suggested that post-operative prevention measures, eg in elderly fracture patients, could be put in place.

Dr Trinick felt that there were differences in GP and hospital and indeed, inter-hospital practice and these issues should be addressed. He said that in his Trust, all patients undergo a U&E analysis every other day and as such, the condition would be hard to miss.

Dr McVeigh expressed concerns over the management of acute and chronic cases, especially elderly people presented from nursing homes. Here, there was no readily available case history and clinicians were unsure of how rapidly to raise the sodium levels of patients.

Ms Devlin felt that from a junior doctor's point of view, they would not have the time to look up blood and U&Es. She said nursing staff would also recognise potassium levels quicker than sodium levels.

Dr Montgomery reported that most problems in her specialty arose from the use of anti-depressants and SSRI's.

Dr McCarthy indicated that the Departmental Working Group had stressed that prescribing and monitoring of fluid balance was often delegated to the most junior member of staff.

5. Plan of Action and Work Schedule

After deliberation, the following plan of action was agreed.

Dr Trinick undertook to verify the number of cases of Hyponatraemia at the Ulster and to ask colleagues in other hospitals to do the same.

All members agreed to research the literature base and forward papers to the Secretariat.

Dr McVeigh undertook to provide a list of drugs which could cause Hyponatraemia.

Each member to highlight, where they see Hyponotraemia as being a problem in their specialty, for discussion at the next meeting.

This should include investigations which may be required:

A physical examination (vomiting, diarrhoea and diabetes).
Fluid Balance – from a junior doctor and nursing viewpoint.

Types of fluid to be prescribed.

Urinosmolarity and urinary sodium levels to be analysed.

A work-up of the 'well' patient to include: Thyroid function tests (glucose, lipids and protein).

High-risk patients to be highlighted to include diabetics on anti-diuretics and pneumonia in the elderly.

Drs McVeigh and Russell to forward flow charts to the Secretariat.

It was also agreed to consider the guidelines from a GP and nursing 'out-of-hours' viewpoint to include 'causes' and 'who to contact'. Dr McVeigh also said it was essential to stress that it was water balance and not salt balance that was the cause of the condition.

Dr Russell also agreed to approach the Eastern Board to ask if the finalised guidance could be published in one of their future issues of the GP Formulary. He also emphasised that it was essential and indeed was standard practice in all recent CREST guidelines, that the guidance should include an audit tool.

Members envisaged that the group should only need to further meet on 2 or 3 occasions and most communication would be by e-mail. It was agreed that a draft outline document would be circulated to members, who should then complete their relevant sections within the next 6 weeks.

6. Date of the next meeting

The next meeting of the group was arranged for Wednesday 24 April 2002, at 2.30pm in Conference Room 414, Dundonald House.