

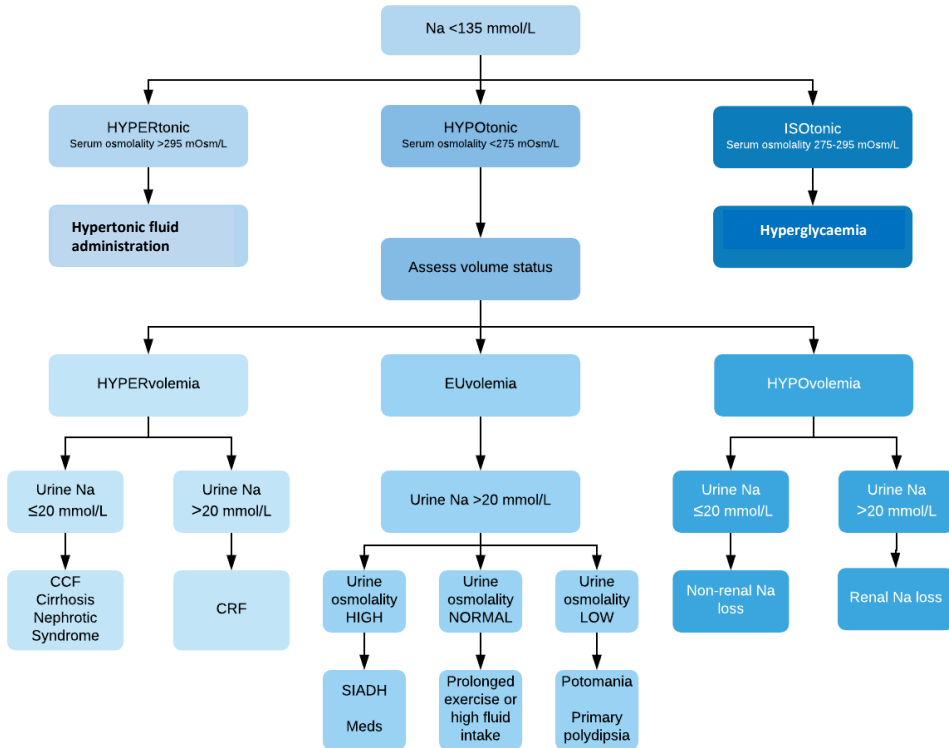


# SCGH ED Adult Hyponatraemia Management Guidelines

## Hyponatraemia Causes

Be aware of spurious causes of hyponatraemia: hyperproteinaemia, hypercholesterolemia, lab error, collection error (IV fluid administration).

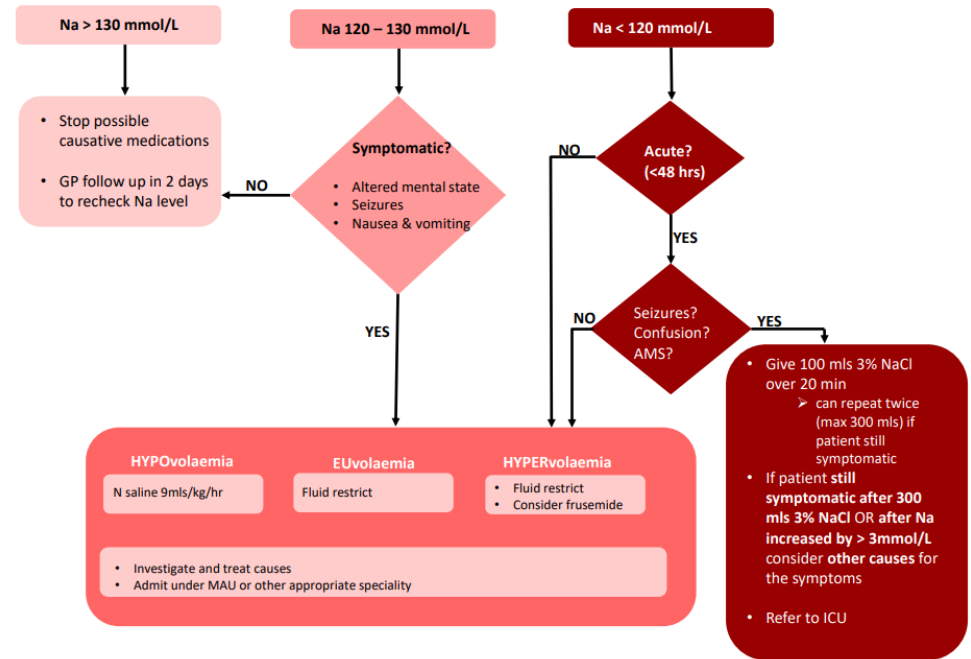
Investigations should be tailored, but ALL patients require a plasma osmolality, urine Na and urine osmolality.



## Hyponatraemia Management

Avoid overcorrection. Aim to increase by 2-3 mmol/L in the 1<sup>st</sup> hour, 6-8 mmol/L in 24 hours.

Correct coexistent hypokalaemia.



Na content in IV fluids	
0.045% NaCl	77 mmol Na/L
0.9% NaCl	154 mmol Na/L
CSL	131 mmol Na/L
1.8% NaCl	308 mmol Na/L
3% NaCl	513 mmol Na/L
8.4% NaHCO <sub>3</sub>	1000 mmol Na/L
20% NaCl	3400 mmol Na/L
23.4% NaCl	4000 mmol Na/L

Making 3% saline (if ready-made bags not available): add 26mL of 23.4% NaCl to 250mL normal saline (total volume 276mL, total Na is 142.5 mmol).

Dextrose solutions *DO NOT* contain Na and should be avoided in patients with hyponatraemia.

Regardless of cause, Na replacement should target 6 - 8 mmol/L /24 hrs and should not exceed 10 mmol/L/24 hrs until Na level is ≥130 mmol/L.

\* if overcorrection occurs, seek advice from Endocrinology and/or ICU about reversal.