Hyponatraemia

- Hyponatraemia (serum sodium level lower than 135 mmol/L) is generally asymptomatic when mild
- Chronic hyponatraemia is generally better tolerated than acute hyponatraemia
- Therapeutic approach to hyponatraemia depends on the severity of clinical features, particularly:
  - Any alteration of the conscious state
  - The likely cause
  - Rate of development

Information Required

- Presence of Red Flags
- Duration of symptoms
- History – heart failure, liver cirrhosis, renal failure, malignancy, psychiatric condition
- Drugs that commonly cause hyponatraemia are:
  - Diuretics (especially indapamide and hydrochlorothiazide)
  - SSRIs and SNRIs
  - Carbamazepine

Investigations Required

- EUC Creatinine
- TFTs – Free T4, TSH
- Cortisol (0900h)
- Serum, urine osmolality and Na
- Marked hyperglycaemia and hypertriglyceridaemia can cause pseudohyponatraemia

Fax Referrals to

GP Plus Marion	7425 8687	GP Plus Noarlunga	8164 9199

Red Flags

- Direct to Emergency Department if serum sodium <120 mmol/L, mental confusion, gait disturbance, impaired consciousness and seizures
- Features of adrenal insufficiency, hypopituitarism

Suggested GP Management

- The diagnosis can generally be established from clinical context and the relationship between urine and serum osmolality, which should be assessed in concurrent samples
- Discontinue the offending drug may be all that is needed to correct the abnormality

Clinical Resources

- Therapeutic Guidelines

General Information to assist with referrals and the and Referral templates for FMC and RGH are available to download from the SALHN Outpatient Services website www.sahealth.sa.gov.au/SALHNoutpatients and SAFKI Medicare Local website www.safkiml.com.au

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