

Flowchart for low sodium

(GP)

Admit if acute fall in sodium, symptomatic (neurological) or cause is unclear

'Odd' result – check with lab if possibility of sample interference and consider repeating

Check

Urine sodium and osmolality
(random, off any drugs causing hyponatraemia if possible)

Check endocrine causes

TSH /fT4 - hypothyroidism
9am cortisol - adrenal insufficiency

Check drugs (common cause)

Diuretics - esp thiazide
SSRIs - fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram
TCAs - amitriptyline, imipramine, chlomipramine, lofepramine, trimipramine, nortriptyline, dothiapin, doxepin
MAOIs - phenelzine, tranylcypromine
Antipsychotics - phenothiazines, trifluoperazine, thioridazine, haloperidol, risperidone, olanzapine
Anticonvulsants - carbamazepine
ACEI - captopril, enalapril, lisinopril
Sulphonylureas - chlorpropamide, tolbutamide
NSAID - naproxen, ibuprofen, indomethacin, diclofenac, piroxicam
Antifungal - ketoconazole
Anti cancer - Cyclophosphamide, cisplatin, carboplatin, vincristine, Vinblastine, melphalan

(There are others, so check with Medicines Information in Pharmacy)

Check fluid status

Hypovolaemic

Plasma urea tends to be high
Extrarenal loss - urine sodium < 30 mmol/l
Renal loss - urine sodium > 30 mmol/l

Admit patient to correct the volume depletion

Euvolaemic

Plasma urea tends to be low
Urine sodium usually > 30 mmol/l
Consider **SIADH** if inappropriately elevated urine osmolality

*Admit for fluid restriction (<1l/day)
Demeclocycline
(Hypertonic saline)*

Hypervolaemic

Usually easy to diagnose clinically

Admit for treatment of underlying condition.

Fluid deprivation, demeclocycline or both may help