Optimal Management of Hospitalized Patients with Hyponatremia: Case Scenarios

Presented as a Live Webinar

Wednesday, May 21, 2014
12:00 p.m. – 1:00 p.m. ET

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2. Telephone to dial the toll-free number and listen to the presentation (if you choose not to use Voice Over IP [VoIP] via your computer).

Webinar System Requirements
Be sure to view the webinar system requirements for Windows, Mac, iOS, and Android prior to the activity.
Activity Faculty

Joseph F. Dasta, M.S., FCCM, FCCP, Activity Chair
Professor Emeritus
The Ohio State University College of Pharmacy
Adjunct Professor
The University of Texas College of Pharmacy
Austin, Texas

Joseph F. Dasta, M.S., FCCM, FCCP, is Professor Emeritus at The Ohio State University College of Pharmacy in Columbus and Adjunct Professor at The University of Texas College of Pharmacy in Austin. He retired from The Ohio State University (OSU) in 2007 after 31 years, and he currently lives in Austin. He serves as a health care consultant to pharmaceutical and device companies, and he provides pharmacy consulting services for the intensive care unit (ICU) at a local hospital.

Mr. Dasta earned his Bachelor of Science degree in pharmacy from West Virginia University School of Pharmacy. He began his academic career at OSU following completion of his Master of Science degree and residency in hospital pharmacy there in 1976. He developed one of the first practice sites and post-doctoral training programs in critical care pharmacy at OSU, through which he trained 11 residents and 9 fellows who are prominent practitioners, researchers, and leaders in the profession and pharmaceutical industry. He received OSU’s Jack L. Beal Post-baccalaureate Alumni Award in 2008.

Mr. Dasta was one of the first pharmacist members of the Society of Critical Care Medicine (SCCM), and he helped establish the role of pharmacists in this multidisciplinary society. He was a member of SCCM Council, the governing body of SCCM, from 2007-2010. SCCM honored him by creating the Joseph F. Dasta Critical Care Pharmacy Outcomes Research Grant in 2000. Ten years later, he was the first pharmacist to receive the SCCM Distinguished Investigator Award. Mr. Dasta’s contributions have also been recognized by other organizations. He received the Education Award from the American College of Clinical Pharmacy (ACCP) in 2002 and the Russel Miller award in 2013. Professor Dasta received the Sustained Contributions to the Literature Award from the American Society of Health-System Pharmacists in 2010. He serves on the editorial board of Critical Care Medicine and Annals of Pharmacotherapy.

Mr. Dasta is a fellow of ACCP and the American College of Critical Care Medicine. He has authored more than 200 peer-reviewed publications, abstracts, brief communications, and book chapters, and he has given over 250 lectures on topics related to critical care and health outcomes. Mr. Dasta’s research has focused on health economics and patient safety of acute care pharmaceuticals. Specific areas of interest include hyponatremia, acute pain, sedation, sepsis, acute kidney injury, acute heart failure, and hypertensive emergencies.
Disclosure Statement

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- Amy L. Dzierba, Pharm.D., BCPS, FCCM
- Jodie L. Pepin, Pharm.D.
- Carla J. Brink, M.S., B.S.Pharm.
- Susan R. Dombrowski, M.S., B.S.Pharm.

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Activity Overview

Hyponatremia remains a frequently overlooked and undertreated electrolyte disorder in hospitalized patients, often with serious clinical and economic outcomes. In this activity, the faculty will use patient case scenarios to illustrate important concepts for managing hyponatremia safely and effectively in different types of hospitalized patients. To set the stage for the patient scenarios, the clinical and economic burden of hyponatremia in hospitalized patients will be presented.

Time for questions and answers from the webinar audience will be provided at the end of the presentation.

Learning Objectives

At the conclusion of this application-based educational activity, participants should be able to

- Describe the impact of hyponatremia on morbidity, mortality, and use of health care resources in hospitalized patients.
- Recommend a strategy for monitoring and managing a patient's hyponatremia based on volume status, clinical presentation, and co-morbidities.

List of Abbreviations

For a list of abbreviations used in this activity, please see page 19.

Continuing Education Accreditation

The American Society of Health-System Pharmacists is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This activity provides 1.0 hour (0.1 CEU) of continuing pharmacy education credit (ACPE activity #0204-0000-14-468-L01-P).

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Optimal Management of Hospitalized Patients with Hyponatremia: Case Scenarios

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Professor Emeritus
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Learning Objectives

After attending this activity, you should be able to
• Describe the impact of hyponatremia on morbidity, mortality, and use of health care resources in hospitalized patients.
• Recommend a strategy for monitoring and managing a patient’s hyponatremia based on volume status, clinical presentation, and co-morbidities.

Hyponatremia Definition

• Commonly defined as serum sodium concentration <136 mEq/L, but cut-off values often vary by laboratory
• Degree of severity is associated with serum sodium concentration

<table>
<thead>
<tr>
<th>Serum Sodium Concentration (mEq/L)</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>131-135</td>
<td>120-130</td>
<td>&lt;120</td>
<td></td>
</tr>
</tbody>
</table>


Incidence of Hyponatremia

• Most common electrolyte disorder
  – 6-15% of hospitalized patients at admission and an additional 5% during the hospital stay
• 25% of patients in ICU are hyponatremic
• If not treated appropriately, can lead to significant morbidity, mortality, and costs
• Insufficient data to determine if hyponatremia is a “marker” or “mediator” of adverse outcomes

Common Symptoms Associated with Severity of Hyponatremia

<table>
<thead>
<tr>
<th>Serum [Na+] 130-135 mEq/L</th>
<th>Serum [Na+] 120-130 mEq/L</th>
<th>Serum [Na+] &lt;120 mEq/L</th>
</tr>
</thead>
</table>
| • Asymptomatic
  • Headache
  • Nausea
  • Vomiting
  • Fatigue
  • Confusion
  • Anorexia
  • Muscle cramps
  • Depressed reflexes
| • Malaise
  • Unsteadiness
  • Headache
  • Nausea
  • Vomiting
  • Fatigue
  • Confusion
  • Anorexia
  • Muscle cramps
| • Headache
  • Restlessness
  • Lethargy
  • Seizures
  • Brainstem herniation
  • Respiratory arrest
  • Death

### How is Hyponatremia Classified?

<table>
<thead>
<tr>
<th>Classification</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilutional Hyponatremia</td>
<td>Total body water increased</td>
</tr>
<tr>
<td>Depletion Hyponatremia</td>
<td>Total body sodium reduced</td>
</tr>
<tr>
<td>Hypervolemic Sodium loss</td>
<td>Total body sodium increased</td>
</tr>
<tr>
<td>Euvolemic (no edema)</td>
<td>Total body sodium unchanged</td>
</tr>
</tbody>
</table>

- Heart failure
- Cirrhosis
- Nephrotic syndrome

SIADH = syndrome of inappropriate antidiuretic hormone


### Various Causes of SIADH

- **CNS Disorders**
  - Acute psychosis
  - Stroke
  - Hemorrhage
  - Trauma
  - Inflammatory and demyelinating diseases
  - Mass lesions

- **Medications**
  - HIV infection
  - Saline
  - Vasopressin
  - Prolonged exercise
  - Severe nausea

- **Tumors**
  - Extra-adrenal
  - Medullary
  - Pulmonary

- **Miscellaneous**
  - Pain
  - Postoperative state
  - Prolonged exercise
  - Severe nausea


### Vasopressin Concentrations Inappropriately Elevated in Patients with SIADH

- Caused by excessive levels of vasopressin as a result of disease, drug-induced pituitary release of arginine vasopressin (AVP)
- AVP secretion not suppressed appropriately when plasma osmolality falls below the osmotic threshold
- Inability to suppress AVP secretion results in
  - Impaired renal water excretion
  - Increased total body water
  - Hyponatremia


### Outcomes Associated with Declining Sodium Concentrations

- Defined – serum sodium concentration <138 mEq/L on admission and further decline of at least 2 mEq/L over first 48 hours
- This level of decline occurs in 8% of community-acquired hyponatremia patients
- OR for inpatient mortality
  - 2.30 (1.75-3.02) with decline
  - 1.46 (1.31-1.64) with no decline
- OR 1.40 (1.32-1.49) for prolonged length of stay (LOS)
- Sets stage for impact of therapies

OR = odds ratio

### Preoperative Hyponatremia in CABG Patients and Outcomes

- Of 4370 patients, 21% had hyponatremia
- Were sicker and had more co-morbid conditions and organ dysfunction
- Adjusted outcomes for patients with hyponatremia
  - 31% higher overall mortality (early and late)
  - 26% increase in length of stay
  - 64% increase in postoperative complications
- Suggests need for optimal preoperative correction of hyponatremia in CABG patients

CABG = coronary artery bypass graft

### Sodium Fluctuations and Outcomes in ICU Patients

- Evaluation of dysnatremia in 11,000 ICU patients from 2004 to 2009 in one ICU
- Dysnatremia either at admission or during ICU stay is associated with higher mortality
- Median fluctuation of sodium in ICU 4 mEq/L (IQR 2-7)
- Sodium fluctuation > 6 mEq/L in normonatremia
  - Higher risk of hospital death (OR 1.5)
  - Possible changes in osmolality in serum and brain
  - First study to implicate serum sodium fluctuations

IQR = interquartile range
Outcomes of Patients with Hyponatremia*

<table>
<thead>
<tr>
<th>Variable**</th>
<th>Hyponatremia (n = 10,900)</th>
<th>No Hyponatremia (n = 187,400)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital mortality (%)</td>
<td>5.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Ventilated (%)</td>
<td>5.0</td>
<td>2.8</td>
</tr>
<tr>
<td>ICU (%)</td>
<td>17.3</td>
<td>10.9</td>
</tr>
<tr>
<td>Median LOS (days)</td>
<td>8.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Hospital costs ($)</td>
<td>16,500</td>
<td>13,560</td>
</tr>
</tbody>
</table>

*From a database of 200,000 patients.
**All variables significantly different between groups at p < 0.001.

Adjusted incremental hospital cost = $2289


Cost of Hyponatremia in Patients with Heart Failure

- Association of hyponatremia and adverse outcomes in heart failure well known
- Study of 51,000 patients with heart failure with and without hyponatremia to assess costs
- After adjusting, hyponatremic patients had
  - 21.5% higher hospital LOS
  - 25.6% higher hospital costs
  - 24.6% higher ICU costs
  - Higher all-cause 30-day readmission (OR 5.1)


Key Points

- Hyponatremia is common in hospitalized patients
  - Has complex pathophysiology
  - Associated with poor clinical outcomes
  - Have consistent documentation of high economic burden
- Sets stage for appropriate identification and treatment

Patient Case: CD

CD is a 76-year-old woman presenting to ED after hitting her head as a result of a fall. She complains of hip pain, nausea, and dizziness and relates that she has been "unsteady on her feet" over the past few days.

PMH: HTN, hyperlipidemia, DJD (hip and knees), depression

Physical exam: Laceration to right brow, right hip pain, normal skin turgor, and slightly dry oral mucosa

Vitals: temp 98.2°F, BP 150/80 mm Hg, HR 88 bpm

Neuro: Slightly confused; no focal deficits

Head CT: negative

X-ray hip: Evidence of hip fracture

Laboratory data: Sodium 117 mEq/L, potassium 3.9 mEq/L, creatinine 0.9 mg/dL, BUN 10 mg/dL, glucose 102 mg/dL

Additional Laboratory Results for CD

- Serum osmolality = 240 mOsm/kg
- Urine osmolality = 211 mOsm/kg
- Urine sodium = 45 mmol/L
- TSH = within normal limits
- Cortisol = within normal limits

Question:
  - What category of hyponatremia is CD exhibiting?

CD’s Home Medications

- Lisinopril 40 mg orally daily
- Metoprolol 25 mg orally twice daily
- Aspirin 81 mg orally daily
- Simvastatin 20 mg orally daily
- Citalopram 40 mg orally daily
- Acetaminophen 325 mg orally every 4 hours as needed for pain
Hyponatremia: Classification

- **Dilutional Hyponatremia**
  - Total body water INCREASED
  - Hypovolemic (edema)
    - Heart failure
    - Cirrhosis
    - Nephrotic syndrome
  - Euvolemic (no edema)
    - SIADH
    - Hypothyroidism
    - Secondary adrenal insufficiency
- **Depletional Hyponatremia**
  - Total body sodium DECREASED
  - Hypovolemic
    - Sodium lost
  - Euvolemic (no edema)
    - Total body sodium UNCHANGED

**SIADH** = syndrome of inappropriate antidiuretic hormone

Features of SIADH

- **Hyponatremia**
- **Urinary osmolality > 100 mOsm/kg**
- **Exclusion of hypovolemia**
  - Urine sodium > 20-30 mmol/L
  - No hypotension
  - No edema
- **Absence of**
  - Adrenal insufficiency
  - Hypothyroidism

Mechanisms of Drug-induced Hyponatremia

- **Hypothalamic production of vasopressin**
- **Vasopressin effect at renal tubule level**
  - Antidiuretic drugs (chlorpropamide, metolazone)
  - Anti-epileptics (carbamazepine, valproic acid)
  - Antineoplastic agents
  - Opiates

- **Alter sodium and water homeostasis**
  - Thiazide diuretics and indapamide
  - Amiloride
  - Loop diuretics

- **SSRI-induced Hyponatremia**
  - Incidence 0.5%-32%
  - Occurs most often during 1st few weeks
    - Normal serum sodium usually achieved within 2 weeks of discontinuing drug
  - Risk factors
    - Older age
    - Concomitant diuretic therapy
    - Low body weight
    - Baseline serum sodium concentration <133 mEq/L

SSRI-induced Hyponatremia

- Incidence 0.5%-32%
- Occurs most often during 1st few weeks
  - Normal serum sodium usually achieved within 2 weeks of discontinuing drug
- Risk factors
  - Older age
  - Concomitant diuretic therapy
  - Low body weight
  - Baseline serum sodium concentration <133 mEq/L

**Falls: Common Symptom of Chronic “Asymptomatic” Hyponatremia**

- **Adj OR 67.4, 95% CI 7.5-607.4, p < 0.001**

Acute versus Chronic Hyponatremia

<table>
<thead>
<tr>
<th>Acute (≤ 48 hr)</th>
<th>Chronic (&gt; 48 hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td><strong>Symptoms</strong></td>
</tr>
<tr>
<td>Cerebral edema</td>
<td>Nausea and vomiting</td>
</tr>
<tr>
<td>Seizures</td>
<td>Confusion or personality changes</td>
</tr>
<tr>
<td>Increased mortality risk</td>
<td>Neurologic dysfunction</td>
</tr>
<tr>
<td></td>
<td>Gait disturbances</td>
</tr>
<tr>
<td>Rapid correction reverses cerebral edema without sequelae</td>
<td>Rapid correction may cause brain dehydration and osmotic demyelination syndrome (ODS)</td>
</tr>
</tbody>
</table>

Patient CD: Outcomes

- Pharmacist in ED recommended discontinuation of citalopram.
- Pharmacist reminded physician that it may take up to two weeks to completely clear the citalopram and alternate approach would need to be instituted in the mean time.
- Fluid restriction order was written for 1500 mL/day.
  - Day 1: Citalopram discontinued and NPO for hip surgery. Post-op fluid restriction order – Na+ = 119 mEq/L
  - Day 2: Continued fluid restriction – Na+ = 121 mEq/L
  - Day 3: Patient mental status improving – Na+ = 123 mEq/L
  - Day 4: Discharge to rehab facility with recommendation to continue monitoring sodium – Na+ on discharge = 125 mEq/L

Key Points

- When treating hyponatremia consider chronicity and severity of neurological symptoms
- Consider contribution of home medications to hyponatremia and fall
- Take into account the elimination half-life of the offending drug
  - Many have long half-lives
  - Estimate duration of drug effect on changes in sodium
  - Recommend other interventions during time of drug elimination
- Consider placing pharmacist on falls awareness team

Patient Case: BB

BB is a 66-year-old, 70-kg man presenting to the ED with increasing shortness of breath, fatigue, and marked edema

PMH: DM, CKD (stage II), and CHF (EF 30%)

Physical exam: jugular venous distension and rales

Neuro: alert, following commands

CXR: bilateral pleural effusions, retrocardiac opacity

Vitals: temp 100.4°F, BP 100/60 mm Hg, HR 95 bpm

Laboratory data: sodium 124 mEq/L, creatinine 1.5 mg/dL, urine sodium 7 mEq/L, and plasma osmolality 265 mOsm/kg

What type of hyponatremia does BB exhibit?
Hyponatremia: Classification

Dilutional Hyponatremia
Total body water INCREASED

Depletional Hyponatremia
Total body water DECREASED

Hypervolemic
(+) edema
Total body sodium INCREASED

Hypovolemic
(-) edema
Total body sodium DECREASED

SIADH = syndrome of inappropriate antidiuretic hormone

SIADH
Hypothyroidism
Secondary adrenal insufficiency

Heart failure
Cirrhosis
Nephrotic syndrome

Diathea
Pancreateatitis
Diuretic excess
Bums
Renal salt wasting
Trauma
Primary adrenal insufficiency

Euvolemic
(no edema)
Total body sodium UNCHANGED

SIADH
Hypothyroidism
Secondary adrenal insufficiency

Heart failure
Cirrhosis
Nephrotic syndrome

Diathea
Pancreateatitis
Diuretic excess
Bums
Renal salt wasting
Trauma
Primary adrenal insufficiency

Patient Case: BB

ED course:
✓ Oxygen saturations began to drop ➔ intubated

BB is transferred to the MICU for further care

Repeat laboratory data: sodium 122 mEq/L

Considerations for Treating BB’s Hyponatremia

• Chronicity of hyponatremia
• Presence of significant neurologic signs
• Appropriate rate of correction
• Optimal method of raising the plasma sodium concentration

What is the best option for correcting BB’s hyponatremia?

a. 0.9% sodium chloride infusion
b. Fluid restriction + furosemide
c. Hypertonic saline infusion + furosemide
d. Conivaptan
e. Tolvaptan

Hyponatremia: Strategies for Correction

\[
\text{Serum sodium concentration} \sim \frac{\text{Na}^+ + \text{K}^+}{\text{Body water}}
\]

NOT Ideal Therapies for BB

• 0.9% sodium chloride infusion
  – BB is already volume overloaded with symptoms
• Hypertonic saline infusion + furosemide
  – Option if BB was severely symptomatic with rapidly falling serum sodium\(^1\)
• Tolvaptan
  – Decreased bioavailability via NGT administration\(^2\)

Fluid Restriction

• 500-900 mL/day
• Can be used in asymptomatic hyponatremic patients or patients with less serious hyponatremia
• Raises serum sodium approximately 1 to 2 mEq/L/day

Goldsmith SR. Am J Cardiol. 2005; 95(Suppl):14B-23B.

Implementation of Fluid Restriction

BB’s medication list
Dobutamine 250 mg/250 mL D5W at 10 mcg/kg/min (1000 mL/day)
Furosemide 100 mg/100 mL D5W at 25 mg/hr (600 mL/day)
Chlorothiazide (250 mL D5W / day)
Azithromycin (250 mL D5W / day)
Ceftriaxone (50 mL D5W / day)
Vancomycin (1500 mL D5W / day)
Famotidine (100 mL D5W / day)
Fentanyl IVP pm for pain
Heparin SQ ~4000 mL per day of free water from medications

Implementation of Fluid Restriction

Alterations to BB’s medication list
Dobutamine 250 mg/250 mL D5W at 10 mcg/kg/min (1000 mL/day)
Dobutamine 1000 mg/250 mL D5W at 10 mcg/kg/min (250 mL/day)
Furosemide 100 mg/100 mL D5W at 25 mg/hr (600 mL/day)
Furosemide 500 mg/100 mL D5W at 25 mg/hr (120 mL/day)

~2000 mL per day of free water from medications

Patient Case: BB

Within 15 minutes after the change in medication concentrations, BB’s condition changes
BP: 40/25 mm Hg (MAP= 30 mm Hg)
HR: 180 beats per minute
EKG: PVCs

Problem: infusion pump was not changed to reflect the 4-fold increase in concentration of dobutamine and therefore delivered 40 mcg/kg/min when the same dose was intended

Pitfalls of Fluid Restriction

• Fluid restriction
  • Pharmacist unaware of a fluid restriction order
  • Often 8-12 IV drugs providing daily volume of 4-8 L
  • Cost implications
    • Time to change drug concentration
    • Increase pharmacy workload and drug waste
    • Potential for errors if pump not re-programmed correctly
  • Diuretic therapy
    – Electrolyte and acid-base disturbances

Patient Case: BB

Three days after initiating fluid restriction and diuretics, BB is extubated; however, only minimal reduction in total body volume and frequent PVCs are noted on EKG.
Laboratory data: sodium 127 mEq/L, potassium 2.0 mEq/L, creatinine 2.0 mg/dL, urine sodium 9 mEq/L, and plasma osmolality 270 mOsm/kg

Is there a role for conivaptan or tolvaptan?
Vasopressin Receptor Antagonists

<table>
<thead>
<tr>
<th>Agent</th>
<th>Receptor Selectivity</th>
<th>Formulation</th>
<th>Half-life, hr</th>
<th>Urine Volume</th>
<th>Urine Osmolality</th>
<th>FDA Approval Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conivaptan</td>
<td>Mixed (V_{1a}+V_{2})</td>
<td>IV</td>
<td>5</td>
<td>↑</td>
<td>↓</td>
<td>Approved 2004</td>
</tr>
<tr>
<td>Tolvaptan</td>
<td>V_{2}</td>
<td>Oral</td>
<td>12</td>
<td>↑</td>
<td>↓</td>
<td>Approved 2009</td>
</tr>
</tbody>
</table>

- Induce highly hypotonic urine and aquarexis without substantially affecting electrolyte excretion
- Can lift fluid restriction

Conivaptan (IV)
- Administer IV via large veins
  - Infusion-site reactions (63–73%), change infusion site every 24 hr
- Available as 20 mg/100 mL premixed in 5% dextrose
- Dosing: 20 mg IV loading dose over 30 min, then 20 mg as continuous infusion over 24 hr
  - Moderate liver impairment: initiate half of normal dose
- Duration of infusion limited to 4 days
- Limited data on IV drug–drug compatibility
- Contraindicated with potent CYP3A4 enzyme inhibitors
  - Examples: ketoconazole, itraconazole, indinavir

Tolvaptan (Oral)
- Indicated for clinically significant hypervolemic and euvolemic hyponatremia (serum sodium < 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure, cirrhosis, and SIADH
- Available in 15-mg and 30-mg tablets
- Dosing: 15 mg orally once daily
  - May increase at intervals >24 hr to maximum 60 mg once daily
- Limit therapy to 30 days
- Should only be initiated and re-initiated in hospital setting
  - Must review FDA-approved medication guide with every patient
- Contraindicated with potent CYP3A4 enzyme inhibitors
  - Examples: ketoconazole, itraconazole, indinavir

Safety Warning for Tolvaptan: Prescribing Information Revised
- Serious and potentially fatal liver injury
- Clinical trial, polycystic kidney disease (n = 1400)
  - Significant elevations in liver function tests
  - Reversible following tolvaptan discontinuation
  - Doses of 120 mg/day (higher than in hyponatremia)
- Liver damage not reported in hyponatremia trials
- Precautions
  - Limit use to 30 days
  - Avoid use in patients with underlying liver disease
  - Discontinue if symptoms of liver injury

Patient Case: BB
- Tolvaptan initiated at 15 mg orally daily for 4 days
- Over that time there was a decrease in total body water and increase in serum sodium
- Tolvaptan discontinued and discharged home

<table>
<thead>
<tr>
<th>Serum Sodium (mEq/L)</th>
<th>△ Serum Sodium from Baseline</th>
<th>SCr (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>127</td>
<td>0</td>
</tr>
<tr>
<td>Day 2</td>
<td>130</td>
<td>3</td>
</tr>
<tr>
<td>Day 3</td>
<td>131</td>
<td>4</td>
</tr>
<tr>
<td>Day 4</td>
<td>132</td>
<td>4</td>
</tr>
</tbody>
</table>
Key Points

- Hypervolemic hyponatremia is commonly chronic in nature
- Chronic hyponatremia must be corrected slowly
- Consider volume status of patient in hypervolemia and apply treatments that do not exacerbate condition
- Fluid restriction with diuretics may provide modest improvement in hyponatremia
- Vasopressin receptor antagonists are an attractive alternative in patients with heart failure promoting aquarexis
- Consider safety, need, and resources for outpatient continuation of oral vasopressin antagonist therapy

Patient Case: GH

GH is a 34-year-old, 70-kg woman brought to the ED by EMS with new-onset seizures after being found unresponsive on the ground outside a club

PMH: none
Physical exam: no evidence of fluid overload
Neuro: obtunded
Head CT: negative
Vitals: temp 98.2°F, BP 110/70 mm Hg, HR 80 bpm
Laboratory data: sodium 116 mEq/L, urine sodium 8 mEq/L, and plasma osmolality 266 mOsm/kg

Considerations for Treating GH’s Hyponatremia

- Chronicity of hyponatremia
- Presence of significant neurologic signs
- Appropriate rate of correction
- Optimal method of raising the plasma sodium concentration

What is the best option for correcting GH’s hyponatremia?

a. 0.9% sodium chloride infusion
b. Fluid restriction + furosemide
c. Hypertonic saline infusion
d. Conivaptan

NOT Ideal Therapies for GH

- 0.9% sodium chloride infusion
- Fluid restriction + furosemide
- Conivaptan

GH is experiencing severe symptoms with a rapidly falling serum sodium

Increase Serum Sodium to More Normal Level at Appropriate Rate

Patients with severe malnutrition, alcoholism, or advanced liver disease may be especially susceptible, and slower rates of correction may be advisable

Use of 3% Sodium Chloride in GH

- **Equation**
  \[ \Delta sNa = (\overline{\text{iNa}} - sNa) \div (\text{TBW} + 1) \]
  
  - TBW for GH: 0.5 L/kg x 70 kg = 35 L
  - \( \Delta sNa = (\overline{513} - 116) \div (35 + 1) = 11 \text{ mEq/L} \)

- 1 liter of 3% sodium chloride will correct GH’s serum sodium by 11 mEq/L
- Administer 3% sodium chloride @ 90 mL/hr for 5 hours

\( \text{Na} = \text{infusate sodium}; \ sNa = \text{serum sodium} \)

---

Patient Case: GH

GH is transferred to the Neuro ICU where she is placed on cEEG monitoring and 3% saline is initiated.

<table>
<thead>
<tr>
<th>Time into Infusion</th>
<th>Serum Sodium (mEq/L)</th>
<th>Serum Sodium from Baseline</th>
<th>Neurological Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 hour into infusion</td>
<td>119</td>
<td>3</td>
<td>Obtunded</td>
</tr>
<tr>
<td>2 hours into infusion</td>
<td>122</td>
<td>6</td>
<td>Obtunded</td>
</tr>
<tr>
<td>3 hours into infusion</td>
<td>122</td>
<td>6</td>
<td>Arouses to painful stimuli</td>
</tr>
<tr>
<td>4 hours into infusion</td>
<td>123</td>
<td>7</td>
<td>Opens eyes on command</td>
</tr>
<tr>
<td>1 hour after infusion discontinued</td>
<td>124</td>
<td>8</td>
<td>Follows commands</td>
</tr>
<tr>
<td>2 hours after infusion discontinued</td>
<td>124</td>
<td>8</td>
<td>Follows commands</td>
</tr>
</tbody>
</table>

Monitoring of 3% Sodium Chloride

- **Overall goal:** Avoid overcorrection
- **Monitor**
  - Basic metabolic panel
  - Frequent serum sodium levels
  - Neurologic function
  - Serum osmolality
  - Urine osmolality and sodium concentration
  - Fluid intake and output

---

Managing Overcorrection

- Rapid increase in serum sodium (>12 mEq/L/24 hr) may result in serious neurologic sequelae
  - Withhold current therapies known to increase serum sodium
  - Administer 5% dextrose in water or oral water
  - Consider desmopressin

---

Patient Case: GH’s Outcome

- No additional hypertonic saline administered
- Awake and alert on day 4 with no additional seizures
- Serum sodium at discharge: 135 mEq/L

---

Key Points

- Acute severe hyponatremia can lead to severe symptoms
- Cautious correction of sodium is important to prevent demyelination as fluid leaves the brain
- Hypertonic saline infusion requires vigilant monitoring to avoid overcorrection
Selected References

Optimal Management of Hospitalized Patients with Hyponatremia: Case Scenarios


Self-assessment Questions

1. As demonstrated by Zilberberg et al. (2008) in an evaluation of a large database, hospitalized patients with hyponatremia had all of the following outcomes compared with patients without hyponatremia EXCEPT
   a. Increased hospital costs.
   b. Increased mortality.
   c. Higher percentage of patients requiring intensive care.
   d. Smaller percentage of patients requiring mechanical ventilation.

2. BB is a 66-year-old, 70-kg man transported to the ED by ambulance with increasing shortness of breath, fatigue, and marked edema. Past medical history includes diabetes mellitus, stage II chronic kidney disease, and congestive heart failure (ejection fraction 30%). Physical exam shows jugular venous distension and rales. He is alert and following commands, and his vital signs are normal. Laboratory data include serum sodium 124 mEq/L, serum creatinine 1.5 mg/dL, urine sodium 7 mEq/L, and plasma osmolality 265 mOsm/kg. What type of hyponatremia does BB exhibit?
   a. Hypervolemic hyponatremia.
   b. Euvolemic hyponatremia.
   c. Hypovolemic hyponatremia.

3. Which of the following is the best initial option for correcting BB’s hyponatremia?
   a. 0.9% sodium chloride infusion.
   b. Fluid restriction and furosemide.
   c. Hypertonic saline infusion and furosemide.
   d. Conivaptan.

4. BB is intubated in the ED as his oxygen saturation began to drop. After being sedated, his blood pressure dropped and he is transported to the medical intensive care unit for further care. Repeat laboratory tests indicate that serum sodium is now 122 mEq/L. Why is tolvaptan not a good option for treating his hyponatremia?
   a. Warning in diabetes mellitus.
   b. Warning in kidney disease.
   c. Decreased bioavailability via nasogastric tube administration.
   d. Increased bioavailability via nasogastric tube administration.

5. If a patient admitted to the intensive care unit has no evidence of fluid overload, is experiencing rapidly falling serum sodium, and has severe neurological symptoms, which of the following would be the best option for correcting the patient’s hyponatremia?
   a. 0.9% sodium chloride infusion.
   b. Fluid restriction plus furosemide.
   c. Hypertonic saline infusion.
   d. Conivaptan.
   e. Tolvaptan.

Answers
1. d  2. a  3. b  4. c  5. c
## List of Abbreviations Used in Presentation

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVP</td>
<td>arginine vasopressin</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>bpm</td>
<td>beats per minute</td>
</tr>
<tr>
<td>BUN</td>
<td>blood urea nitrogen</td>
</tr>
<tr>
<td>CABG</td>
<td>coronary artery bypass graft</td>
</tr>
<tr>
<td>cEEG</td>
<td>continuous electroencephalography</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>CI</td>
<td>confidence interval</td>
</tr>
<tr>
<td>CKD</td>
<td>chronic kidney disease</td>
</tr>
<tr>
<td>CNS</td>
<td>central nervous system</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>D5W</td>
<td>dextrose 5% in water</td>
</tr>
<tr>
<td>DJD</td>
<td>degenerative joint disease</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes mellitus</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>EF</td>
<td>ejection fraction</td>
</tr>
<tr>
<td>EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>EMS</td>
<td>emergency medical services</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HR</td>
<td>heart rate</td>
</tr>
<tr>
<td>HTN</td>
<td>hypertension</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
</tr>
<tr>
<td>iNa</td>
<td>infusate sodium</td>
</tr>
<tr>
<td>IQR</td>
<td>interquartile range</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>IVP</td>
<td>intravenous push</td>
</tr>
<tr>
<td>K+</td>
<td>potassium</td>
</tr>
<tr>
<td>LOS</td>
<td>length of stay</td>
</tr>
<tr>
<td>MAOI</td>
<td>monoamine oxidase inhibitor</td>
</tr>
<tr>
<td>MAP</td>
<td>mean arterial pressure</td>
</tr>
<tr>
<td>MICU</td>
<td>medical intensive care unit</td>
</tr>
<tr>
<td>Na+</td>
<td>sodium</td>
</tr>
<tr>
<td>NGT</td>
<td>nasogastric tube</td>
</tr>
<tr>
<td>NPO</td>
<td>nothing by mouth</td>
</tr>
<tr>
<td>ODS</td>
<td>osmotic demyelination syndrome</td>
</tr>
<tr>
<td>OR</td>
<td>odds ratio</td>
</tr>
<tr>
<td>PMH</td>
<td>past medical history</td>
</tr>
<tr>
<td>pm</td>
<td>as needed</td>
</tr>
<tr>
<td>PVC</td>
<td>premature ventricular contraction</td>
</tr>
<tr>
<td>SCr</td>
<td>serum creatinine</td>
</tr>
<tr>
<td>SIADH</td>
<td>syndrome of inappropriate antidiuretic hormone</td>
</tr>
<tr>
<td>sNa</td>
<td>serum sodium</td>
</tr>
<tr>
<td>SQ</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitor</td>
</tr>
<tr>
<td>TBW</td>
<td>total body water</td>
</tr>
<tr>
<td>TCA</td>
<td>tricyclic antidepressant</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid stimulating hormone</td>
</tr>
</tbody>
</table>
Optimal Management of Hospitalized Patients with Hyponatremia: Case Scenarios

Instructions for Processing CE Credit with Enrollment Code

Pharmacists and Technicians:
Per ACPE, CPE credit must be claimed no later than 60 days from the date of the live activity or completion of a home study activity. All ACPE accredited activities which are processed on the eLearning site will be reported directly to CPE Monitor. To claim pharmacy credit, you must have your NABP e-profile ID, birth month, and birth day. If you do not have an NABP e-Profile ID, go to www.MyCPEMonitor.net for information and application. Please follow the instructions below to process your CPE credit for this activity.

1. The ASHP eLearning site allows participants to obtain statements of continuing education conveniently and immediately using any computer with an internet connection. Type the following link into your web browser to access the e-Learning site: http://elearning.ashp.org/my-activities

2. If you already have an account registered with ASHP, log in using your username and password. If you have not logged in to any of the ASHP sites before and/or are not a member of ASHP, you will need to set up an account. Click on the Register link and follow the registration instructions.

3. Once logged in to the site, enter the enrollment code for this activity in the field provided and click Redeem.
   Note: The Enrollment Code was announced at the end of the live activity. Please record the Enrollment Code in the grid below for your records.

4. The title of this activity should now appear in a pop-up box on your screen. Click on the Go button or the activity title.

5. Complete all required elements. A green ✔ should appear as each required element is completed. You can now claim your credit.

6. Available credit(s) will appear beneath the completed required activities. Look for your profession in the list of available credits and click the appropriate Claim button. You might have to click to see more credit options if you don’t see your profession listed.
   CPE Credit for Pharmacists and Technicians: To claim continuing pharmacy education (CPE) credit, you will need to enter your NABP e-Profile ID, birth month, and birth day. Once you have entered this information the first time, it will auto fill in the future. Please note: All CPE credit processed on the eLearning site will be reported directly to CPE Monitor.

7. Review the information for the credit you are claiming. If all information appears to be correct, check the box at the bottom and click Claim. You will see a message if there are any problems claiming your credit.

8. After successfully claiming credit, you may print your statement of credit by clicking on Print. If you require a reprint of a statement of credit, you can return here at any time to print a duplicate. Please note that for CPE credit, printed statements may not be necessary because your credit will be reported directly to CPE Monitor.

Date of Activity | Activity Title | Enrollment Code | Credit Hours
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Wednesday, May 21, 2014 | Optimal Management of Hospitalized Patients with Hyponatremia: Case Scenarios | - | 1.0

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