

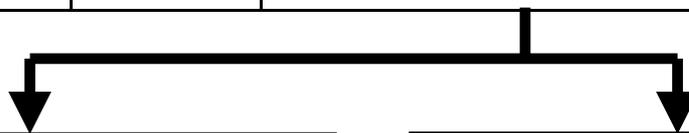


Treatment of hyperkalaemia must be individualised; the risk of complications including arrhythmias is variable and can be difficult to define. Note that the degree of hyperkalaemia does not always correlate with ECG changes. These are guidelines only.

See other side of page for drug dosages and administration information.

ACUTE HYPERKALAEMIA – Approach to Management

STEP 1	STEP 2	STEP 3	STEP 4
<p>Exclude pseudohyperkalaemia (e.g. haemolysed sample, leukocytosis, thrombocytosis)</p>	<p>Urgent ECG +/- cardiac monitoring</p>	<p>Categorise risk and treat Any of the following factors increase risk:</p> <ul style="list-style-type: none"> • ECG changes • Potassium ≥ 6.5 mmol/L, acute increase • Pre-existing cardiac disease • Other electrolyte abnormalities • Oliguria 	<p>Seek and address cause</p>



High Risk Patient

Treat urgently, as asystole may occur without preceding ECG changes.
Contact Renal team for advice.

Block adverse effects of potassium on the myocardium

- Calcium gluconate IV (except if digoxin toxicity suspected, or hypercalcaemia)

Redistribute potassium from outside to inside cells

- Salbutamol (nebulised) *and/or*
- Insulin with glucose (BM stix for up to 12 hrs)
- Correct acidosis if present

Enhance potassium excretion

- Frusemide (if kidneys functioning)
- Rectal Resonium® (*not oral*) + oral sorbitol

If insufficient response, or in severe toxicity or no urine output, consider:

- Laxative (e.g. high dose sorbitol)
- Dialysis

Lower Risk Patient

Enhance potassium excretion

- Rectal Resonium® (*not oral*) + oral sorbitol
- Frusemide

Address cause of hyperkalaemia

These include:

Potassium retention

- Drug-induced – ACEIs, angiotensin II antagonists, spironolactone, amiloride, triamterene, NSAIDs, cyclosporin, heparin, trimethoprim, pentamidine
- Renal failure, other nephropathies, urinary tract obstruction
- Mineralocorticoid deficiency e.g. adrenal insufficiency

Increased Potassium Intake or Transcellular Potassium Shift

- Drug-induced - β -blockers, suxamethonium, digoxin toxicity
- Cell injury e.g. burns, haemolysis, rhabdomyolysis, tumour lysis syndrome
- Diabetes mellitus (insulin deficiency)
- GI bleeding (swallowed blood)
- Acidosis
- Potassium supplements, dietary excess or salt substitutes (in renal failure)

[Note: In chronic hyperkalaemia, consider medication review, dietary modification, diuretic if oedematous, oral bicarbonate if acidotic, fludrocortisone if normotensive, laxative if constipated and/or oral Resonium®.]

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References available on request.

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