SPECIALTY

Nephrology

Arista|MD

CHIEF COMPLAINT

CKD w/ Chronic Hyponatremia

COMMENTS TO SPECIALIST

83F with PMHx HTN, DM2, breast ca, COPD NSTEMI, and acute/chronic diastolic CHF and is a resident. Her Port was infected. She was recently hospitalized for bacteremia. Blood culture with staph. Aureus. She received vancomycin, Ceftarolin, and Ancef. Her Mediport was removed. Upper extremity PICC line inserted for 6 weeks antibiotic. She was discharged on Ancef. She is on Torsemide Oral Tablet 20 MG (Torsemide) 20 mg by mouth one time a day for chronic CHF. She is on sodium chloride 1 gm daily. She has long HX of hyponatremia and chronic CHF: her Lexapro was changed in 2022 for Cymbalta. 12/21/22 - Hgb 8.8, Cr 0.6, Na 130 12/28/22 - Hgb 8.8, Cr 0.7, Na 129 1/6/23 - Hgb 8.6, Cr 0.6, Na 133, albumin 2.5, LFTs otherwise WNL 1/30/23 - Cr 0.6, Na 130, BNP > 2500 3/1 - Na 124, Cr 0.6, Mg 1.2

The plan is to continue Entresto BID, hold torsemide for 3 days for worsening Na, and restart at 10 mg daily. To help with NA, but at the same time, she has chronic CHF. Continue Entresto and metoprolol for HTN stable . Continue metformin 500 mg BID with SSI. Continue Advair, duonebs, singulair for COPD, stable. Continue protonix for GERD, stable. Continue anastrozole, s/p Herceptin therapy for breast cancer Continue cymbalta BID Continue with sodium chloride 1 gm daily.

MAIN QUESTION

What else can we do for her to help with her chronic hyponatremia without affecting her CHF treatment?

Specialist Response

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Thank you for the consultation. Do you know her ejection fraction? What is her volume like currently? Is she hypervolemic, and does she have signs of volume overload currently (edema, orthopnea, etc.)? The cost for her hyponatremia may be multi-factorial, given the fact that she is presently on duloxetine, and there may be a component of SIADH. However, many patients with severe or advanced heart failure can often have hyponatremia, especially when their CHF is not well controlled, and they are volume overloaded. Loop diuretics shouldn't worsen hyponatremia and are more likely to raise the serum sodium than drop it. What have her blood pressures and weight been like? I'm just trying to make sure I'm not missing anything. I certainly don't think salt tabs (NaCl) are useful in this case. They don't seem to be helping so far and can worsen CHF by leading to volume retention and heart failure exacerbation.

My recommendations are

1. Stop sodium chloride tabs.
2. Continue the torsemide.
3. Monitor her BP and weight to make sure it remains stable.
4. A better alternative to sodium chloride tabs is Ure-Na. This is a medical food that can help with chronic hyponatremia and SIADH. It is just urea powder that patients mix with water or juice and take once daily. It is benign and has no adverse effects. It acts as an osmolar agent to help with the excretion of free water without losing important electrolytes. It usually helps get the sodium back to a level of 130 and helps keep it stable going forward to prevent worsening hyponatremia. The dose for Ure-Na is 15 grams daily.
5. Our goal is to maintain a serum sodium of 130. This should prevent any overt symptoms.
6. Please order serum uric acid, urine sodium, urine creatinine, urine osmolality, and urine chloride with the next set of labs.

Please keep me updated with any new findings. If you have any other questions, please feel free to reach out, and I will be happy to clarify them. I will attach a link for Ure-Na. It is considered medical food, and not all insurance covers it. It may not be carried at all pharmacies, so it may need to be pre-ordered. If, for some reason, she cannot obtain this, then let me know, and we may have to consider stopping her duloxetine if this might be the cause of her hyponatremia. Again, I'm curious to know her volume status because if she is hypervolemic, then diuresing her and getting her euvolemic will certainly help normalize her serum sodium.