

## Teaching Low Na

GLOBAL MARK			
CLEAR PASS	BORDERLINE PASS	BORDERLINE FAIL	FAIL

### Criteria

Introduces Self, Confirms patient identify, Washes hands	2, 1
Checks comfort level of patient and gains consent for teaching	2, 1
Identifies current level of knowledge of learner	
Sets objectives for the session Structure for Ix low Na Structure for Mx low Na	
Explains control of Na homeostasis Vasopressin (makes serum Na go up by effecting absorption) Aldosterone (makes serum Na go up) ANP (makes Na go down)	
Explains link of Na to H <sub>2</sub> O	
Outlines structure for dealing with low Na What is the osmolality? $2[Na+K]+Gluc+Urea$ Watery (hypotonic), Normal, or Concentrated (Hypertonic)	
Outlines the different types of hypotonic hyponatraemia based on volume status Hypovolaemia (kidney or other) – renal causes (RTA, adrenacorticoid deficiency, ketones), Non renal (vomit, 3 <sup>rd</sup> space, diarrhea, bowel prep Euvolemic – psychogenic, hypotonic IVF, adrenal failure, hypothyroid Hypervolemic – failures kidney, liver, heart	
Explains normal ranges for serum and urine osmolality If urine osmolality >100 too much water intake If urine Na >30 low effective arterial volume (and kidney not scavenging back Na),	
Explains how to use urinary values to help find a cause	
Explains SIADH, and that low Na can cause SIADH as a maladaptive response	
Explains also needs to classify based on severity of symptoms and time of onset, as short term treatment is based on this rather than the cause.	
If Severe symptoms Vomit, CV instability, Seizure, Low GCS Rx with 150ml 3% in 20 mins Repeat twice, until Na up by 5mmol, Then start 0.9% aiming to increase by 10mmol in first 24 hours	
If Mild symptoms (nausea, confusion, headache, falls) AND chronic – fluid restrict	

AND acute 150mls 3% and re-check	
Checks for questions	
Summarises	
Points out extra learning	
Thanks student	