DOSES BELOW

# Hyponatremia and sodium overcorrection

START HERE · Establish baseline and correction already given
Review timed sodium values, chronicity, symptoms and ODS risk. Count correction before OR and all planned sodium loads.

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## Severe symptoms, planned correction or overcorrection?

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| **Severe symptoms attributable to hyponatremia** → | Activate the monitored hypertonic saline pathway. Recheck sodium after each bolus and stop rapid correction after the initial goal. |
| **Chronic or uncertain duration, no severe symptoms** → | Use the high-risk correction target below when indicated. Plan transfusion, fluids and renal support with the team. |
| **Correction ahead of target or new brisk diuresis** → | Stop active correction where safe, measure sodium and urine output frequently and call for expert-guided relowering. |

## DOSE AND ADMINISTRATION

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| NaCl 3% · severe symptoms<br>Guideline | **European emergency example: sodium chloride 3%, 150 mL IV over 20 min. Reassess symptoms and sodium. Initial rise goal about 5 mmol/L.** [47] [48] |
| High-risk chronic correction limit<br>Guideline | **Chronic or uncertain duration, high risk of osmotic demyelination: aim for 4–6 mmol/L in 24 h and do not exceed 8 mmol/L. Include earlier correction.** [47] [49] [67] |
| Relowering · specialist-directed example<br>Product or evidence specific | **European specialist example: glucose 5%, 10 mL/kg IV over 1 h under strict monitoring. Consider adding desmopressin 2 micrograms IV, at least 8 h apart.** [47] [48] |

Reassess and escalate · Follow the rolling 24-hour change across handover. Document the value, time, target and person checking next.

Clinical scope · Plan a smaller correction target for this high-risk population. The daily ceiling is a safety limit. Relowering requires ICU or nephrology supervision and close sodium and fluid monitoring.

Sources [47] EASL cirrhosis 2018 • [48] European sodium guideline • [49] LT sodium cohort 2021 • [53] Cambridge LT ICU handover • [67] AASLD ascites guidance