

Learning Objectives

- Describe the underlying pathophysiology, risk factors, and risk stratification of hospitalized patients with hyponatremia
- Identify the mechanisms in which hyponatremia complicates the management of chronic medical conditions
- Assess the pharmacists role and current treatment options for hyponatremia in the hospital setting.
- Examine the role of vasopressin receptor antagonists in the management of hyponatremia in the hospitalized patient



**MANAGING
HYPONATREMIA:**
*Challenges & Opportunities
for the Hospital Pharmacist*

Faculty Disclosures

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NO RELATIONSHIPS TO DISCLOSE

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NO RELATIONSHIPS TO DISCLOSE

**PLEASE ANSWER THE
HYPONATREMIA PRE-ACTIVITY
TEST QUESTIONS**



Question 1

**How confident are you in your ability to summarize
the Hyponatremia Treatment Guidelines: 2007 Expert
Panel Recommendations?**

1. Not at all confident
2. Somewhat confident
3. Confident
4. Very Confident
5. Extremely Confident



Question 2

**Compared with standard diuretics, vasopressin
receptor antagonists act at a different site of the
nephron to induce selective water diuresis without
affecting sodium and potassium excretion.**

- A. True
- B. False



Patient Case:
Asymptomatic Hyponatremia

- 75-yr female, stable CHF and type 2 DM
- Fell while coming down the stairs in her house, now severe leg pain, pleuritic chest pain, SOB
- ER: left hip fracture, multiple rib fractures, small pleural effusions bilaterally, no pneumothorax
- Admitted to ICU for monitoring, physical exam: patient is awake and oriented; blood pressure is 130/80; no focal neurological deficits; bibasilar rales; point tenderness over rib cage



Patient Case:
Asymptomatic Hyponatremia

Labs:

Na = 128, K = 3.4, Cl = 104, HCO₃ = 24
 glucose = 185, BUN = 20, Cr = 1.3
 Hct = 36

Posm = 275, Uosm = 350, UNa⁺ = 60

O₂ sat = 90% room air



Question 3

Is this patient a candidate for vasopressin antagonist therapy for hyponatremia?

- A. Yes
 B. No



Question 4

How common is hyponatremia in your institution or practice? You see hyponatremia in:

- A. Less than 5% of patients
- B. 5-10% of patients
- C. 10-15% of patients
- D. More than 10% of patients



Question 5

According to data from the Study of Ascending Levels of Tolvaptan in Hyponatremia 1 and 2 (SALT 1 and 2) serum sodium concentrations _____ in the tolvaptan group when compared to the placebo group during the first 4 days and after the full 30 days of therapy.

- A. Did not change
- B. Increased
- C. Decreased
- D. Were equal



Question 6

Of patients treated for hyponatremia, what percentage are initially treated as inpatients?

- A. 10% - 25%
- B. 26% - 43%
- C. 44% - 54%
- D. 55%-63%



Question 7

Which of the following non-peptide AVP receptor antagonists is available as an intravenous (IV) formulation:

- A. Tolvaptan
- B. Conivaptan
- C. Lixivaptan
- D. Satavaptan



Hyponatremia

- **Most common electrolyte abnormality**
- **Associated with many systemic diseases**
 - Major: dilution of extracellular fluid
 - Minor: total body losses of sodium
- **Acute vs. Chronic**
 - Often duration is difficult to determine



Hyponatremia can be caused by dilution from retained water, or by depletion from electrolyte losses in excess of water

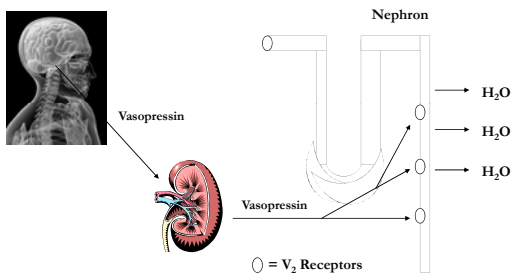


Role of Vasopressin

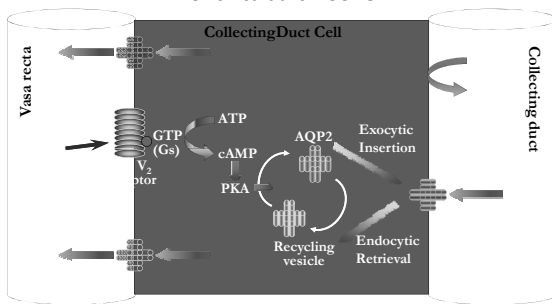
- **Vasopressin = ADH = antidiuretic hormone**
- **Physiologic sodium/water balance**
 - Thirst: stimulated by rise in osmolality
 - Osmoreceptors
 - Water excretion: regulated by vasopressin
 - Osmoreceptors
 - \uparrow Osmolality = \uparrow vasopressin secretion = \uparrow H_2O reabsorption
 - \downarrow Osmolality = \downarrow vasopressin secretion = \downarrow H_2O reabsorption



Role of Vasopressin



AVP regulation of water reabsorption from renal tubular cells

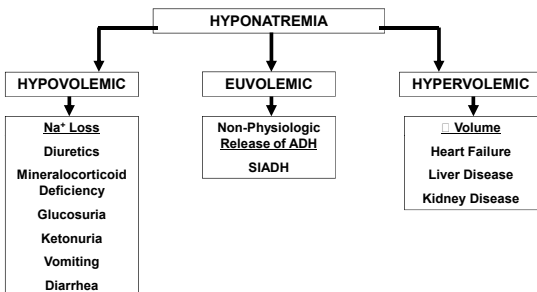


Classification: Osmolality

- **Hypotonic hyponatremia**
 - Sodium directly related to osmolality
 - Most cases
- **Isotonic/Hypertonic hyponatremia**
 - Pseudohyponatremia
 - Non-sodium solutes increase osmolality
 - Glucose
 - \uparrow osmolality \rightarrow fluid shifts \rightarrow dilution of sodium



Classification: Volume Status



Drug-Related Causes

Sodium Loss

- Diuretics

\uparrow Vasopressin/ADH effects

- Antipsychotics
- Antidepressants
- DDAVP
- Oxytocin



Risk Stratification

• Acute vs. Chronic

- Acute = less than 48 hours in duration
 - Concerned about neurologic sequelae
 - Osmotic differential between brain and blood
 - Brain swelling
- Chronic = greater than 48 hours in duration
 - Symptoms may be more modest
 - Brain has time to adapt

• Duration of hyponatremia

- How aggressive?
- How fast?



Symptomatic Hyponatremia: Neurological Manifestations

- Headache
- Irritability
- Nausea/Vomiting
- Mental Slowing
- Confusion/Delirium
- Disorientation

→ Chronic

- Stupor/Coma
- Convulsions
- Respiratory Arrest

→ Acute



Symptoms Associated with Chronic Hyponatremia

- Malaise/Lethargy: 109 (49%)
- Dizzy Spells: 104 (47%)
- Vomiting: 77 (35%)
- Confusion/Obtundation: 39 (17%)
- Falls: 37 (17%)
- Headache: 13 (6%)
- Seizures: 2 (0.9%)

223/223 resolved symptoms with correction of [Na⁺] via cessation of thiazide treatment



Increased Risk of Falls with "Asymptomatic" Hyponatremia

Group	n	Falls	Odds Ratio	Adjusted Odds Ratio*
"Asymptomatic" Chronic Hyponatremia	122	21.3%	9.45 (2.64-34.09) $p < .001$	67.43 (7.48-607.42) $p < .001$
Normonatremic controls	244	5.35%	1.00	1.00

Adapted from: Renneboog B, et al. *Am J Med*. 2006;119(1): 71. e1-8.

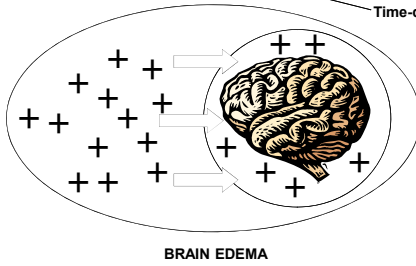


Sodium and the Brain

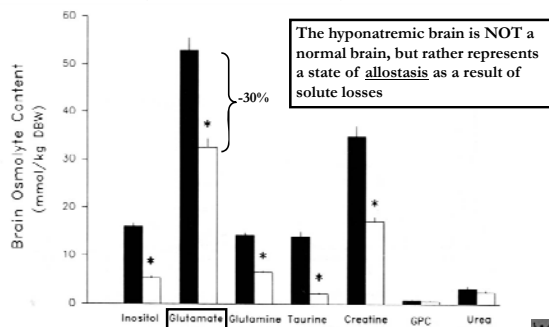
Na⁺ moves from high concentrations to low

Water follows Na⁺

Time-dependent



Reductions of Brain Organic Osmolytes after 14 days of Sustained Hyponatremia



*P < 0.01 compared to normonatremic control rats.

Adapted from: Verbalis JG, et al. *Brain Res*. 1991; 567(2):274-82.

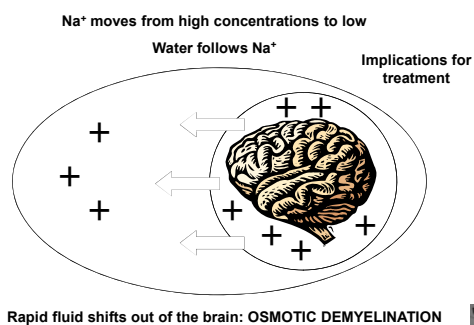


Acute vs. Chronic and the Brain

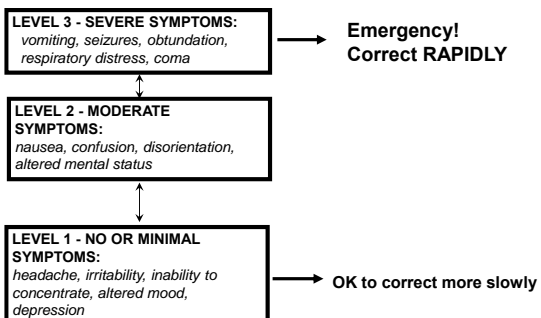
- **Acute hyponatremia**
 - Rapid onset
 - Greater likelihood of rapid fluid shifts and brain edema
- **Chronic hyponatremia**
 - Insidious onset
 - Less likelihood for brain edema
 - Time for compensatory increases in organic osmolytes



Sodium and the Brain



How Aggressive? How Fast?



Hyponatremia and Heart Failure



Implications of Hyponatremia

Heart failure

- There are an estimated 7 million Americans with HF (2% of US population).
- Hyponatremia is one of the newer and emerging risk factors for an adverse prognosis in chronic heart failure
- Inadequate release of vasopressin may result in excess fluid retention and hyponatremia.



In-hospital mortality risk groups according to the ADHERE risk stratification

- Age > 78 years → 1.88 (1.74 – 2.04)
- BUN > 42 → 3.34 (3.08 – 3.62)
- SCr > 3.2 → 1.99 (1.78 – 2.24)
- SBP ≤ 115 → 3.09 (2.85 – 3.35)
- DBP ≤ 55 → 2.87 (2.62 – 3.14)
- Serum Na⁺ < 134 → 2.26 (2.08 – 2.47)
- HR > 84 → 1.20 (1.11 – 1.30)
- Dyspnea at Rest → 1.57 (1.45 – 1.70)

Abraham WT, et al. JACC 2005;46:57-64



Hyponatremia and Liver Disease



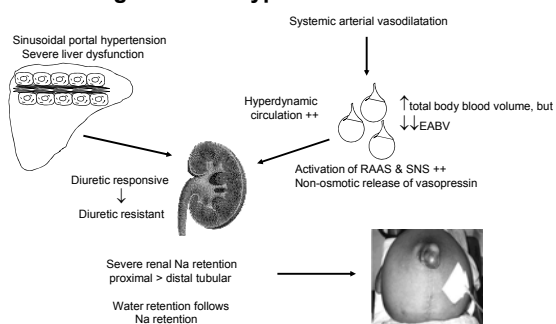
Implications of Hyponatremia

Liver Disease

- Associated with poor prognosis & reduced survival
- Impairs the management of ascites
- Predisposes to hepatic encephalopathy
- Impairs quality of life



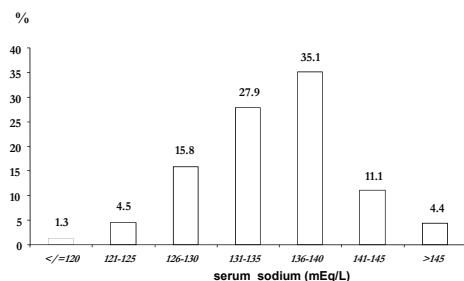
Pathogenesis of Hyponatremia in Cirrhosis



When water retention > Na retention, hyponatremia develops



Distribution of serum sodium in patients with liver cirrhosis & ascites (n=983)



Adapted from P. Angeli et al. *Hepatology* 2006; 44:1535-1542



Serum Sodium and Mortality

Liver Transplant candidates in the VA system, 97-03 (n= 507)

- Hepatitis C (68%), EtOH (67%)
- MELD 16.2 ± 6.7
- Hyponatremia (<130 mEq/L): 31%
- Persistent Ascites/Hydrothorax: 38%

• Predictors of 6-month mortality

	Odds Ratio	p
MELD	1.25 (1.16-1.35)	<0.001
Na < 135 mEq/L	2.76 (1.31-5.81)	0.008
Persistent Ascites	2.72 (1.31-5.71)	0.008

Heuman DM, et al. *Hepatology*, 2004;40(4):802-10.



Syndrome of inappropriate antidiuretic hormone (SIADH) secretion



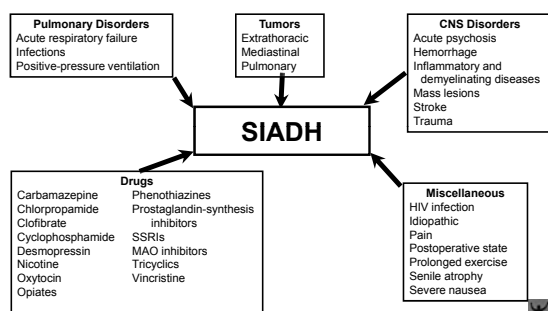
Syndrome of Inappropriate Anti-diuretic Hormone (SIADH): Essential Criteria

- True plasma hypoosmolality
- Urine concentration inappropriate for plasma osmolality ($U_{osm} > 100 \text{ mOsm/kg H}_2\text{O}$)
- Clinical euolemia, no diuretic therapy
- Absent renal sodium conservation ($U_{Na} > 30 \text{ mmol/L}$)
- Normal thyroid, adrenal and renal function

Bartter FC, et al. *Am J Med.* 1967; 42:790-806.



Causes of Syndrome of Inappropriate Anti-diuretic Hormone (SIADH):

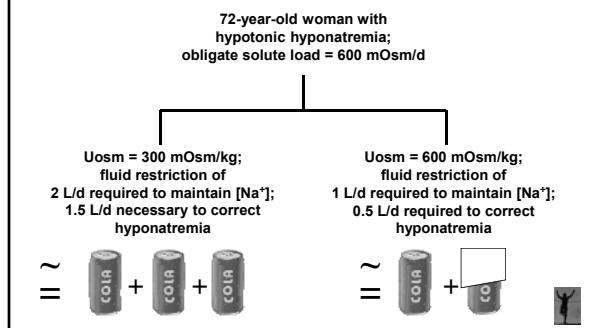


Current Treatment Strategies

AGENT	LIMITATIONS
Fluid restriction	<ul style="list-style-type: none"> • Slow to correct over days (1-2 mEq/L/day) • Poorly tolerated due to thirst • Should not be used with high AVP level and urine osmolality
Diuretics	<ul style="list-style-type: none"> • Allows relaxation of fluid restriction • Potential for ototoxicity, volume depletion, and K⁺ and Mg⁺ depletion
Demeclocycline	<ul style="list-style-type: none"> • Not FDA approved for hyponatremia • Slow to correct over days • Nephrotoxic in cirrhosis and heart failure
Lithium	<ul style="list-style-type: none"> • Slow to correct • Must monitor serum levels • CNS side effects, cardiotoxic, GI disturbances



Urine Concentration Determines the Stringency of Water Restriction



Current Treatment Strategies

AGENT	LIMITATIONS
Isotonic saline	<ul style="list-style-type: none"> • Ineffective in dilutional hyponatremia • Should not be used in setting of edema • No safety data • Complex calculations
Hypertonic saline	<ul style="list-style-type: none"> • No consensus regarding appropriate infusion rates • Overcorrection can cause osmotic demyelination syndrome • Should not be used in setting of edema • No safety data • Complex calculations

Hypertonic Saline Considerations

- **Use equations to calculate rate/duration**
 - Medication safety issues?
- **7.1 mEq/L in 24 hours**
- **10% rate of overcorrection**
 - Higher risk for overcorrection when $\text{Na}^+ < 120 \text{ mEq/L}$

Adrogué, et al. *N Engl J Med* 2000;342:1561-9.
Mohmand, et al. *Clin J Am Soc Neph* 2007;2:1110 - 7.

Overcorrection Defined

- **Increase in Na⁺**

- Within 24 hours
 - >10 – 12 mEq/L
- Within 48 hours
 - >18 mEq/L

Verbalis JG, et al. *Am J Med* 2007; 120:S1-S21
Mohmand, et al. *Clin J Am Soc Neph* 2007;2:1110 - 7



What do they do?

Diuresis:

increased excretion of urine by the kidney;
includes water and typically increased solute
excretion as well

Aquaresis:

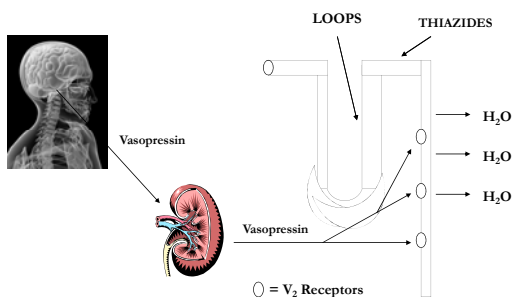
increased excretion of water by the kidney without
increased solute, i.e., electrolyte-sparing excretion
of free water by the kidney



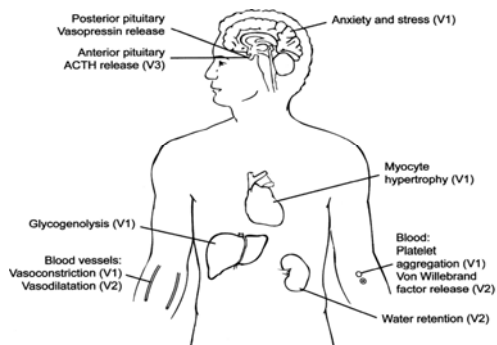
Newest Option for Hyponatremia: Vasopressin Antagonists



Mechanism of Vasopressin Antagonists



Vasopressin Receptors



Non-peptide AVP receptor antagonists

	Conivaptan	Lixivaptan	Satavaptan	Tolvaptan
Receptor	V _{1a} /V ₂	V ₂	V ₂	V ₂
Route of administration	IV	Oral	Oral	Oral
Urine volume	↑	↑	↑	↑
Urine osmolality	↓	↓	↓	↓
Na ⁺ excretion/ 24 hrs	↔	↔ low dose ↑ high dose	↔	↔

FDA Approved

Lee CR, et al. *Am Heart J* 2003;146:9-18.

CONIVAPTAN



Conivaptan: Pivotal Phase III Trial

- **R, MC, DB, PC**
 - n = 84 patients
- **4 day continuous infusion**
 - Placebo
 - Conivaptan 40mg/day
 - Conivaptan 80mg/day
- **Primary endpoint**
 - Δ in serum sodium from baseline (AUC)
- **Secondary endpoints**
 - Time from 1st dose to sodium ≥ 4 mEq/L, time sodium ≥ 4 mEq/L from baseline, # patients with ≥ 6 mEq/L increase in sodium or normal (≥ 135 mEq/L).

Zeltser D, et al. *Am J Nephrol* 2007;27:447-57.



Patient Population

- **Inclusion criteria**
 - Age > 18 years
 - Serum Na⁺ = 115 – 130mEq/L
 - Posm < 290mOsm/kg
 - Fasting BG < 275mg/dl
 - Euvolemic or hypervolemic
- **Exclusion criteria**
 - Hypovolemic hyponatremia
 - Uncontrolled HTN, bradyarrhythmia or tachyarrhythmias
 - Medications interact with CYP3A4
 - Emergent treatment for hyponatremia

Zeltser D, et al. *Am J Nephrol* 2007;27:447-57.



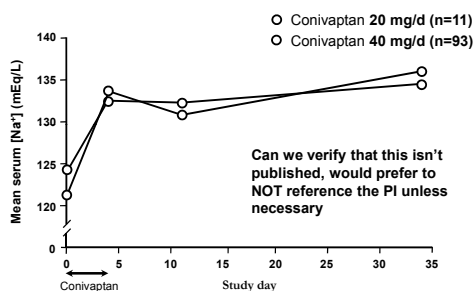
RESULTS

Endpoint	Placebo N = 29	Con 40mg IV N = 29	Con 80mg IV N = 26
Δ in baseline Na AUC, <i>mean (SE), mEq*hr/L</i>	12.9 (61.2)	490.9 (56.8) †	716.6 (60.4) †
Time 1 st dose to Na \geq 4mEq/L from BL, median hrs (95% CI)	NE	23.7 (95%CI 10.0, 24.0) †	23.4 (95%CI 6.0, 24.0) †
Total time serum Na above baseline, <i>mean (SE), h</i>	14.2 (5.25)	53.2 (5.17) †	72.7 (5.43) †
Change in Na from baseline to end of treatment, <i>mean (SE), mEq/L</i>	0.8 (0.80)	6.3 (0.74) †	9.4 (0.79) †
Increase Na \geq 6mEq/L or > 135mEq/L, <i>n (%)</i>	6 (20.7%)	20 (69.0%) †	23 (88.5%) †

† p < 0.001, NE = not estimable

Zeltser D, et al. *Am J Nephrol* 2007;27:447-57.

Conivaptan: open label extension study

Conivaptan hydrochloride injection.
Prescribing information; February 2006.

Conivaptan Adverse Events

	Placebo (n=29)	Con 40 mg (n=29)	Con 80 mg (n=26)
Phlebitis	6.9%	24.1%	30.8%
Hypotension	6.9%	13.8%	19.2%
Postural Hypotension	0%	13.8%	3.8%
Injection Site Inflammation	0%	6.9%	11.5%
Pyrexia	0%	10.3%	7.7%
Hyperkalemia	3.4%	0%	
Injection-site Thrombosis	0%	10.3%	0%
Overcorrection	0%	6.9%	7.7%

Zeltser D, et al. *Am J Nephrol* 2007; 27: 447-457.

Special Populations: Heart Failure

- **Do not use to TREAT heart failure**
 - No benefit
 - No worsening of heart failure
- **Risk of adverse effects must be outweighed by anticipated benefits of increasing sodium**



Special Populations: Neurology

2 retrospective case series, neuro ICU patients

Series	n	Dosing	Timing	6mEq/L Rise	Safety
#1	22	Bolus + Infusion	24 hrs	86% 24h post D/C = 47%	No excessive correction 5 pts with phlebitis
#2	24	Bolus only*	72 hrs	Single Bolus: 56% Double Bolus: 52%	1 pt with excessive correction No phlebitis

*Concomitant 1.25% or 2% saline permitted

Wright, et al. *Neurocritical Care* 2009;11:6-13
Murphy T, et al. *Neurocritical Care* 2009;11:14-19



Conivaptan: Practical Considerations

- **20 mg IV over 30 minutes, then 20 mg continuous IV infusion over 24 hours**
 - May increase to 40 mg daily if inadequate response
 - Administer x 1 to 3 days
 - Only compatible with 5% dextrose.
 - Limited data on IV drug-drug compatibility.
 - To minimize the risk of vascular irritation
 - Administer through large veins
 - Change infusion site every 24 hours
- **Contraindication: Co-administration with potent CYP3A4 enzyme inhibitors**
 - ketoconazole, itraconazole, indinavar

Conivaptan hydrochloride injection. Prescribing information. February 2006.



TOLVAPTAN



SALT – 1 and SALT – 2

Study of Ascending Levels of Tolvaptan in Hyponatremia

- **Two MC, R, DB, PC trials**
 - Tolvaptan 15 mg (increased to 30 – 60 mg)
 - Placebo
- **Primary Endpoints:**
 - Δ in AUC for the serum Na^+ concentration
 - Baseline to day 4
 - Baseline to day 30

Schrier RW, et al. *NEJM*. 2006; 355(20):2099 -2112.



SALT – 1 and 2 Patient Population

- **Inclusion criteria**
 - > 18 years of age
 - Sodium < 135
 - CHF
 - Cirrhosis
 - SIADH
- **Exclusion criteria**
 - Hypovolemic hyponatremia
 - Cardiac surgery, MI, SVT, angina, CVA, Pulmonary HTN
 - Hypotension, Uncontrolled diabetes mellitus
 - $\text{SCr} > 3.5\text{mg/dl}$
 - Child-Pugh > 10

Schrier RW, et al. *NEJM*. 2006; 355(20):2099 -2112.



SALT – 1 RESULTS

AUC for serum Na⁺ (mmol/L)

Endpoint	Placebo n = 103	Tolvaptan n = 103	p-value
All Patients: Day 4	0.25 ± 2.08	3.62 ± 2.68	< 0.001
All Patients: Day 30	1.66 ± 3.59	6.22 ± 4.10	< 0.001
Mild (130 – 135 mmol/L): Day 4	- 0.32 ± 2.27	2.52 ± 1.95	< 0.001
Mild (130 – 135 mmol/L): Day 30	0.68 ± 2.78	3.87 ± 3.01	< 0.001
Marked (< 130 mmol/L): Day 4	0.76 ± 1.77	4.56 ± 2.88	< 0.001
Marked (< 130 mmol/L): Day 30	2.54 ± 4.01	8.24 ± 3.84	< 0.001

SALT – 2 Data not shown but similar

Note: Na⁺ concentration similar to placebo within 5 days of D/C

Schrier RW, et al. *NEJM*. 2006; 355(20):2099–2112.



Special Populations: Heart Failure

EVEREST TRIALS: Short-term

- **2 identical short term trials**
- **R, DB, PC, MC**
- **Patients:**
 - Hospitalized for HF, EF < 40%, HF symptoms
 - Not required to have HYPONATREMIA
- **Treatment**
 - Tolvaptan 30 mg daily
 - Placebo
- **Primary Endpoint**
 - Global clinical status and body weight
 - Discharge or 7 days

Gheorghiade M, et al. *JAMA* 2007;297:1332-43.



Special Populations: Heart Failure

EVEREST TRIALS: Long-term Outcomes

- **Extension of short term trials**
- **Minimum 60 day treatment (median = 9.9 mos)**
 - Tolvaptan/Placebo
 - On top of standard HF therapy
- **Primary Endpoint**
 - All-cause mortality
 - Superiority/Non-inferiority
 - Composite: CV death or hospitalization for HF
 - Superiority
- **Secondary Endpoint**
 - Δ in dyspnea, body weight, edema

Konstantin MA, et al. *JAMA* 2007;297:1319-31.



Special Populations: Heart Failure

EVEREST TRIALS: Results

The Endpoints

Short – term results

- Global clinical status and body weight
 - Improvement with tolvaptan

Long – term results

- All-cause mortality
 - No difference
- Composite: CV death or hospitalization for HF
 - No difference
- Δ in dyspnea, body weight, edema
 - Improvement with tolvaptan

Konstantin MA, et al. JAMA 2007;297:1319-31
Gheorghide M, et al. JAMA 2007;297:1332-43



Tolvaptan: Practical Considerations

- **Indicated for symptomatic hyponatremia**
 - $< 125 \text{ mEq/L}$
 - Unresponsive to correction with fluid restriction
 - In-hospital initiation
- **Administered by oral route once daily**
 - 15 mg/30 mg/60 mg
- **Contraindication: Co-administration with potent CYP3A4 enzyme inhibitors**
 - ketoconazole, itraconazole, indinavir
- **Patients should be encouraged to drink when thirsty**
- **Co-administration with hypertonic saline: NR**

Tolvaptan [package insert]; 2009.



Tolvaptan Adverse Effects

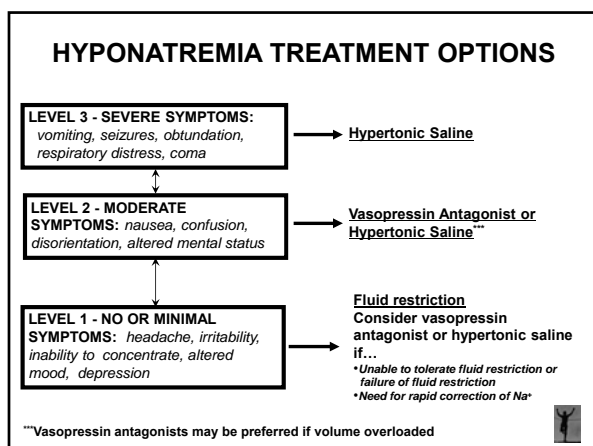
SALT studies

- No osmotic demyelination
- Excessive Na^+ correction = 1.8%

EVEREST

- Thirst
- Polyuria
- Pollakiuria
- Hypernatremia





Vasopressin Antagonist Formulary Considerations

- **Vasopressin antagonist vs. Hypertonic Saline?**
 - Unable to tolerate fluids
 - Degree of hyponatremia
- **Restrict to a specific service?**
 - Endocrine, nephrology, hepatology?
- **Tolvaptan and insurance status**
 - Reversible effect on sodium upon discontinuation

Conclusions

- **Considerations in Management**
 - Pathophysiology/Classification
 - Symptoms (Type, Severity, Duration, Onset)
 - Underlying disease states
- **Primary treatment options**
 - Fluid restriction, Hypertonic saline, Vasopressin receptor antagonists
- **Role of the pharmacist**
 - Global policies related to use
 - Agent selection
 - Monitoring

Questions/Discussion



Question 8

How confident are you in your ability to summarize the Hyponatremia Treatment Guidelines: 2007 Expert Panel Recommendations?

1. Not at all confident
2. Somewhat confident
3. Confident
4. Very Confident
5. Extremely Confident



Question 9

Of patients treated for hyponatremia, what percentage are initially treated as inpatients?

- A. 10% - 25%
- B. 26% - 43%
- C. 44% - 54%
- D. 55%-63%



Question 10

Compared with standard diuretics, vasopressin receptor antagonists act at a different site of the nephron to induce selective water diuresis without affecting sodium and potassium excretion.

- A. True
- B. False



Patient Case:
Asymptomatic Hyponatremia

- 75-yo female, stable CHF and type 2 DM
- Fell while coming down the stairs in her house, now experiencing severe leg pain and pleuritic chest pain
- ER: left hip fracture, multiple rib fractures, small pleural effusions bilaterally, no pneumothorax
- Admitted to ICU for monitoring, physical exam: patient is awake and oriented; blood pressure is 130/80; heart rate is 76 bpm; no focal neurological deficits; bibasilar rales; point tenderness over rib cage



Patient Case:
Asymptomatic Hyponatremia

Labs:

Na = 128, K = 3.4, Cl = 104, HCO₃ = 24
 glucose = 185, BUN = 20, Cr = 1.3
 Hct = 36

Posm = 275, Uosm = 350, UNa⁺ = 60

O₂ sat = 90% room air



Question 11

According to the ADHERE risk stratification which of the following factors places this patient at risk for mortality?

- A. Her age
- B. Her blood urea nitrogen (BUN)
- C. Her Serum Na⁺
- D. Her heart rate



Question 12

The hyponatremic brain is NOT a normal brain, but rather represents a state of _____ as a result of solute losses.

- A. Allostasis
- B. Homeostasis
- C. Static serum osmolality
- D. Normonatremia



Question 13

SIADH is characterized by (1) the presence of hyponatremia, (2) low plasma osmolality without volume depletion or edema, (3) high urine osmolality >100 mOsm/kg, (4) urine [Na⁺] excretion >20 mEq/L, and (5) normal renal, adrenal, thyroid, and cardiac function.

- A. True
- B. False



Question 14

Which of the following is not a neurological manifestations commonly seen in cases of acute symptomatic hyponatremia?

- A. Stupor/Coma
- B. Convulsions
- C. Atopy
- D. Respiratory Arrest



Question 15

According to data from the Study of Ascending Levels of Tolvaptan in Hyponatremia 1 and 2 (SALT 1 and 2) serum sodium concentrations _____ in the tolvaptan group when compared to the placebo group during the first 4 days and after the full 30 days of therapy.

- A. Did not change
- B. Increased
- C. Decreased
- D. Were equal



Question 16

How do you anticipate that your attendance at this educational program will change your clinical practice? (Please select all that apply)

1. Improve my ability to recommend/develop institutional protocols for hyponatremia management
2. Improve my compliance with Hyponatremia Treatment Guidelines: 2007 Expert Panel Recommendations
3. Improve my ability to risk-stratify patients with presumed hyponatremia
4. Improve clinical outcomes in my patients
5. I do not anticipate a change in my practice