Management of Acute Hyperkalemia

Note: This guideline is not encompassing of all patients who present with hyperkalemia, but is merely a guide in effort to improve patient care. Changes to disposition should involve fellow/attending to fellow/attending discussion among consulted services.

**High clinical suspicion of hyperkalemia (i.e. missed hemodialysis, ECG changes)**

**OR**

**Confirmed hyperkalemia >6 (via blood gas or non hemolyzed BMP)***

- Start IV fluid bolus
  - 2 g calcium gluconate IV over 5-10 minutes
  - 10 units regular Insulin and 1 amp (25g) of D50W IV if blood glucose < 250 mg/dL (consider 2 amps [50g] if ESRD)
  - 20 mg albuterol via nebulizer
  - Loop diuretics if patient makes urine

Pt unstable? (i.e. respiratory distress, severe acidosis, arrhythmias, shock)

- Contact Nephrology Fellow for emergent HD
- Give additional dose of calcium gluconate 2g IV over 5-10 minutes or consider CaCl 1g via central line

Chronic kidney disease AND asymptomatic

- Contact MRICU for admission
- If bed available in MRICU patient to be transported to MRICU for dialysis if safe. If not, HD to be started in ED, patient transported to MRICU when possible or complete.

---

*** If the patient has a metabolic (i.e.DKA) or toxic (i.e.digoxin) cause for hyperkalemia WITHOUT ECG CHANGES treat underlying cause first.

1) Known cause of hyperkalemia AND
2) Expected to resolve in 24 hours AND
3) No ECG changes

MAA admit with telemetry. Renal consult on floor if desired.