

MANAGEMENT OF HYPERKALAEMIA ($K^+ \geq 6.5\text{mmol/L}$)

CRRT troubleshooting guide, FHFT, CRRT Guideline Version 5.0

Before commencement of CRRT

- Conservative management (*calcium gluconate, salbutamol nebs, glucose-insulin, sodium bicarbonate* etc. see Trust guideline on management of hyperkalaemia)
- In a severe life-threatening case set up CRRT filter early simultaneously with dialysis catheter insertion. Renal replacement can be started once line is secured and blood gas taken from line is deemed to be venous.

At start of CRRT

- Dialysate fluid: CiCa K2 (with citrate anticoagulation) or Multibic K2 (conventional)
- Prescribe higher dialysis rate (35mL/kg/hr)
- Check serum potassium level 1-2 hourly

During CRRT

- Use K2 fluid until $K^+ < 6\text{mmol/L}$
- Once K^+ level is within normal range change to normal dialysis rate (25mL/kg/hr)

If serum potassium level remains high or hyperkalaemia develops during CRRT

Continue with K2 dialysate fluid
Increase dialysis rate to maximum
(Refer to Clearance guideline)
Commence additional medical treatment

Always look for and treat underlying cause (necrotising infection, limb ischaemia, rhabdomyolysis etc.) of hyperkalaemia