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# From Lab Alert to Action Plan: Monitoring Potassium Without Undermining Cardiorenal Protection

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**Dr. Swift:**
This is Continuing Education with the Global Learning Collaborative, and I'm Dr. Pauline Swift, and here with me today is Dr. Jim Burton.

So, Jim, pleasure to be talking with you today. As healthcare professionals, we need to maintain a delicate balance, don't we, when we're applying the relevant guideline recommendations, when we have to monitor the patients' labs, talk to them about their diet, and knowing exactly when we should be adjusting their therapy, ideally to maximally titrate it.

Jim, I would be really grateful if you'd share some of your best practices with our learners.

**Dr. Burton:**
Yeah, absolutely, Pauline. Thank you very much. It's great to be here with you.

And very simply, my practical approach begins with one principle, and that is that we should manage potassium while at the same time preserving disease-modifying therapy. That is absolutely key.

So before starting an ACE inhibitor or an angiotensin receptor blocker, or indeed an MRA like finerenone, I get a current measure of the kidney function, including potassium, and of course, get their blood pressure and their volume status, and that's in line with KDIGO guidance that recommends rechecking blood pressure, kidney function, and potassium 2 to 4 weeks after initiating or increasing the dose of therapies that could change kidney function or potassium. And for someone with more advanced CKD or heart failure or diabetes or previous hyperkalemia, particularly, then I'd certainly check that closer to 2 weeks because we know that they're at an increased risk of developing hyperkalemia.

ESC guidance is a little bit more proactive around potassium management and particularly with MRAs. Check renal function and potassium before treatment and then again a week and 4 weeks later after initiation or a dose escalation, with further checks.

And I guess the bottom line in all of this is that monitoring is individualized. I think that hyperkalemia is predictable, and those who are more at risk of changes in their potassium, we should be checking more often.


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So in those times where the potassium comes back and it's high, then of course if it's severe, perhaps over 6.5, then emergency procedures kick into place, and we follow our local guidance around that. That's very important when things could potentially be life threatening. But in a more chronic environment where the potassium is persistently elevated, perhaps between 5.5 and 6, then KDIGO offer us a useful sequence. We would address correctable factors, for example, stop potassium supplements. Talk about diet, other contributory medications like nonsteroidal anti-inflammatory drugs, for example, treat constipation. That all of those things are very important.

And as well, talking about individualized therapy, diuretics might be appropriate, and of course, sodium bicarbonate might be useful if a patient has metabolic acidosis. And sodium is important, and the risk of fluid retention in people with heart failure. So all of that is coming around to the fact that things should be individualized, but ultimately, a potassium binder is absolutely a recommended strategy when hyperkalemia is persistent, especially if it is preventing the initiation or titration up to maximum tolerated doses of guideline-directed medical therapies. That's really important. And the choice of binder really depends on the individual that is in front of you, and again, we're covering that in another one of these episodes.

**Dr. Swift:**
Jim, it's always a pleasure to listen to you and to your insights. And thank you so much for sharing your perspective. And thanks so too to our audience for tuning in.

**Dr. Burton:**
Thanks, Pauline, good to be here.

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