K = 5.1 - 5.5
1. Address underlying cause
2. PCP or ED f/u in 2-3 days

K = 5.6 - 6.4
EKG + Labs
(Mg, Phos, Urine K, Urine Cr)
No EKG changes
EKG Changes
1. Address underlying cause
2. Treat and monitor - Cardiac stabilization + shift + elimination + q2h labs
(See below)

K > 6.5 or EKG changes
EKG + Labs
(Mg, Phos, Urine K, Urine Cr)

Discharge if:
- Underlying cause addressed
- K normal or mildly elevated

Observation or admission:
- Underlying cause addressed
- K 5 but still moderately elevated
- Continue kaliuresis

Admit if:
- Underlying cause cannot be reasonably addressed
- Repeat K is unchanged or increasing

Kaliuresis

Hypovolemic
Assess volume status
Euvolemic or hypervolemic

No
Metabolic acidosis?

Yes
Lactated ringers
Isotonic Bicarbonate 150 meq in 550W 170-250cc/hr (over 4-6 hours)

Diuresis?

Yes

- Furosemide 40-100 mg IV
- * Chlorthalidone 50-1000 mg IV

No

* Caveat: Very expensive
If considering to avoid dialysis, discuss with pharmacist or renal

Dialysis

Cardiac stabilization
3g calcium gluconate IV or 1g calcium chloride IV
- Can repeat q3-10 min x 3 total doses
- Obtain repeat Ca levels

Elimination
Kaliuresis - see algorithm above
Consider: sodium zirconium cyclosilicate 10 g PO
or Kayexylate 15 g PO
Dialysis - consult renal fellow

Intracellular shift
10 units insulin regular IV and 20mg albuterol neb
* if glucose < 250, give 2 amps of D50
(May prefer this choice if rapid effect is desired)

20 units insulin regular IV infusion + D10 infusion and
20mg albuterol neb
(May prefer this option if more gradual effect is desired)
POC glucose q30-60 min