Information Needed:

1. History: renal failure, diuretic use especially potassium sparing diuretics like spironolactone, special diets, use of potassium pills or salt substitutes, muscle or other cell breakdown from severe crush injury or chemotherapy.
2. Physical findings: lethargy, weakness, near syncope, irregular pulse, EKG changes of peaked T-waves, blocks, and idioventricular rhythm. Can be the cause of cardiac arrest especially in a renal failure patient.

Treatment:

1. Protect airway and assist ventilation as needed.
2. Administer O_2 moderate to high flow as needed.
3. Determine vital signs (pulse, blood pressure, respirations, SPO2).
4. Perform patient assessment.
5. Cardiac monitor as soon as possible.
6. Begin nebulized albuterol.
7. Obtain IV access.
8. For severe toxicity with toxic EKG changes (idioventricular rhythm) begin with:
    a. Sodium Bicarbonate 50 mEq IV over 2 mins.
    b. Follow with Calcium Chloride 5 – 10 ml IV over 2 – 5 mins.
9. For less severe toxicity (peaked T-waves only):
    a. Sodium Bicarbonate 50 mEq IV over 2 mins.

Notes

1. Albuterol can be started as soon as there is a suspicion of hyperkalemia.
2. Sodium Bicarbonate becomes a first line drug in the renal failure patient in refractory ventricular fibrillation. It may decrease the potassium level and thus make the fibrillating heart more responsive to defibrillation. Bicarb does not appear to make the asystole heart more responsive to epinephrine.