To define whether patient is in:

- Acute hyperkalemia^ 
- Chronic hyperkalemia*
- Pseudo-hyperkalemia+

**eGFR and bicarbonate should also be closely monitored in all hyperkalemia situations**

### Management

#### Acute hyperkalemia
- Refer to the KDIGO acute K+ management algorithm recommendations

#### Chronic hyperkalemia

- Mild (5.0-5.5)
- Moderate (>5.5-6.0)
- Severe (>6.0)

  (See page 2 for more details on chronic hyperkalemia)

### Pseudo-hyperkalemia

- Pseudo-hyperkalemia is typically defined as a difference of >0.3-0.4 mmol/L between serum and plasma K+
- Serum K+ measurement should be immediately repeated.
- Ensure blood is sampled appropriately/or eventually taken as arterial sample.
- In case of hemolysis, to consider whether this occurred in the sample or in the body

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^**Acute hyperkalemia** is defined where a potassium concentration above the upper limit of normal, is not known to be explained by a chronic cause.

*Chronic hyperkalemia* is defined where a potassium concentration above the upper limit of normal, is likely to be explained by a chronic cause (e.g. chronic kidney disease, heart failure, induced by regular medication/supplements), and K+ > 5.0mmol/L from repetitive measurements over a 3 month period.

+**Pseudo-hyperkalemia** is defined where there is a falsely elevated serum potassium concentration, which can occur due to mechanical trauma, prolonged tourniquet use (>1 minute) or fist clenching during the process of blood drawing, and through blood clotting, centrifugation, elevated white blood cell count, or thrombocytosis.
Chronic hyperkalemia Management

Mild (5.0-5.5)
- Review K⁺ inducing medications and eliminate K⁺ supplements
- See information on dietary approaches to hyperkalemia in this tool

Moderate (>5.5-6.0)
- Review K⁺ inducing medications and eliminate K⁺ supplements
- See more information on dietary approaches to hyperkalemia in this tool
- Consider loop diuretics if not prescribed for patients with volume overload, increase loop diuretic dose if already previously prescribed
- Correct acidosis if present

Severe (>6.0)
- Need to reduce K⁺ to <5.0.
- Withhold RAASi and evaluate eGFR, bicarbonate and K⁺ to determine whether RAASi could be restarted
- Consider K⁺ binder initiation if available to facilitate RAASi reinitiation

RAASi-specific management
- If on RAASi, aim to maintain RAASi dose and monitor K⁺ levels
- Do not start RAASi if not already prescribed when serum K⁺ >5.0mmol/L
- If indication is for heart failure, consider switch to ARNI from RAASi if available

- Consider K⁺ binder initiation if available to avoid dose reduction
- If on RAASi, and K⁺ binder not available, reduce RAASi dose and monitor K⁺ levels

Important measures to manage hyperkalemia
- Review K⁺ inducing medications and eliminate K⁺ supplements
- See more information on dietary approaches to hyperkalemia in this tool

Additional management in a specific case-to-case basis
- To consider the prescription of SGLT2 inhibitors for patients with eGFR > 25 mL/min/1.73m²

ARNI: Angiotensin receptor II blocker-neprilysin inhibitor, ECG: Electrocardiogram, eGFR: Estimated Glomerular Filtration Rate; K⁺: Potassium, KDIGO: Kidney Disease Improving Global Outcomes; MRA: Mineralocorticoid Receptor Antagonists, RAASi: Renin-angiotensin-aldosterone system inhibitors, SGLT2: Sodium-glucose Cotransporter-2,