POTASIUM LOWERING TREATMENTS IN DIALYSIS PATIENTS – GUIDANCE NOTES

TARGET AUDIENCE	Secondary Care
PATIENT GROUP	End stage kidney disease on regular dialysis (haemodialysis and peritoneal dialysis)

Clinical Guidelines Summary

- Novel potassium lowering drug treatments (Patiromer (Veltassa) and Sodium Zirconium Cyclosilicate (Lokelma)) are now available and have been used in regular dialysis patients
- Their use is recommended only in secondary care under the supervision of renal specialists

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Lokelma and Patiromer are licensed for use in dialysis patients as follows:

Lokelma

For patients on dialysis Lokelma should only be dosed on non-dialysis days. The recommended starting dose is 5 g once daily. To establish normokalaemia (4.0 5.0 mmol/L), the dose may be titrated up or down weekly based on the pre-dialysis serum potassium value after the long inter dialytic interval (LIDI). The dose could be adjusted at intervals of one week in increments of 5 g up to 15 g once daily on non-dialysis days. It is recommended to monitor serum potassium weekly while the dose is adjusted; once normokalaemia is established, potassium should be monitored regularly (e.g. monthly, or more frequently based on clinical judgement including changes in dietary potassium or medication affecting serum potassium).

Patiromer

There is limited data on the use of Veltassa in patients on dialysis. No special dose and administration guidelines were applied to these patients in clinical studies.

Use in dialysis patients falls outwith the current SMC restriction and Renal Association guidance, but is widely recognised and practised in the UK.

Authorisation for use in dialysis patients should be sought via the PACS2 peer review process. In practice, emergency use of these medicines may be necessary prior to authorisation being granted.

Examples of use:

- Regular dialysis patients with recurrent or serious hyperkalaemia despite optimisation of diet / dialysis access / dialysis parameters
- Regular dialysis patients with temporary failure of dialysis access where controlling or preventing hyperkalaemia may reduce the risk of temporary dialysis access procedures
- Regular dialysis patients with heart failure who may benefit from RAASi

Timing and frequency of monitoring patients on these medicines should be clearly considered and planned in secondary care, with the responsibility to ensure safe monitoring (and dose titration) resting with the initiating clinician in secondary care. Monitoring should be determined on a case by case basis.

References/Evidence

https://www.medicines.org.uk/emc

Appendices

1. **Governance information for Guidance document**

Lead Author(s):	Jack Fairweather
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Contributing Author / Authors	Jack Fairweather Alison Yule
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Distribution	

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
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