Syndrome of inappropriate antidiuresis

Sir,

In their review article "Syndrome of inappropriate anti diuretic hormone secretion: Revisiting a classical endocrine disorder,"[1] the authors have covered the topic very lucidly. However, we feel that one common and very pertinent cause of SIADH, more so in a Third World country like India, is tuberculosis which can cause SIADH by its pulmonary, central nervous system as well as miliary inflictions.[2] Also, in primary and secondary level hospital settings where serum and urinary osmolality measurement facilities are not available, supplemental criteria may also be used to suggest diagnosis of SIADH, which include the following:

1. Plasma uric acid < 4 mg/dl
2. Blood urea nitrogen < 10 mg/dl
3. Fractional sodium excretion > 1%; fractional urea excretion > 55%
4. Failure to correct hyponatremia after 0.9% saline infusion
5. Correction of hyponatremia through fluid restriction
6. Abnormal result on test of water load (<80% excretion of 20 ml of water per kilogram of body weight over a period of 4 hours), or inadequate urinary dilution (specific gravity < 1.010)
7. Elevated plasma AVP levels, despite the presence of hypotonicity and clinical euvolemia.[3]

Also, regarding management, a simple way of sodium replacement is to start 3% saline infusion at 1–2 ml/kg body weight per hour for acute severe symptomatic hyponatremia and at half the rate for chronic hyponatremia. Measure the serum sodium after 2 hours and adjust the

rate to achieve desired correction of 8–12 mmol/l in 24 hours. We have successfully treated an elderly patient of severe symptomatic hyponatremia with very low serum sodium (98 mmol/l) using the above method, which is least cumbersome, easy to remember and devoid of much calculations.[4]

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