

## 2. Traitement

### 2.1 Objectif du traitement

Le traitement et la vitesse de correction de l'hyponatrémie dépendent de son retentissement clinique et de sa vitesse d'installation :

- Une hyponatrémie chronique dont le retentissement clinique est faible devra être corrigée lentement (+ 8-10 mmol/l par 24 h).
- Une hyponatrémie aiguë mal tolérée neurologiquement devra être corrigée (partiellement) plus rapidement, sous couvert d'une surveillance rapprochée en soins critiques.

Le risque d'une correction trop rapide de la natrémie en cas d'hyponatrémie chronique est la myélinolyse centro-pontine. Les facteurs de risque de myélinolyse centro-pontine sont :

- la chronicité de l'hyponatrémie,
- une natrémie inférieure à 105 mmol/l,
- une hypokaliémie,
- l'alcoolisme,
- la dénutrition,
- une cirrhose,
- le sexe féminin,
- la faible masse musculaire.

### 2.2 Modalités et indications de traitement

- **Mesures générales :**
  - Traitement étiologique, à débiter dès que possible (notamment anticancéreux en cas de SIADH) ;
  - Assurer un apport nutritionnel suffisant ;
  - Éliminer les facteurs (notamment médicamenteux) pouvant aggraver l'hyponatrémie : diurétiques thiazidiques ou situations pourvoyeuses de SIADH ;
  - Rechercher et corriger les facteurs de risque de myélinolyse centro-pontine, notamment hypokaliémie ;
  - Assurer une surveillance clinique et biologique stricte : poids et diurèse quotidiens, biologie urinaire régulière.
- **Restriction hydrique :** la première ligne de traitement est systématiquement la restriction hydrique :
  - L'ensemble des apports liquidiens (café, soupe, « perfusettes ») doit être pris en compte ;
  - Son volume est celui de la diurèse des 24 h moins 500 cc ;
  - Certains éléments sont associés à un échec de la restriction hydrique :
    - osmolalité urinaire > 500 mosm/l,
    - diurèse inférieure à 1500 ml/24h,
    - hausse journalière de la natrémie inférieure à 2 mmol/l dans les 24-48 premières heures.
- **Sérum salé hypertonique à 3% :** 150 ml en 20 minutes, uniquement en cas d'hyponatrémie symptomatique, de préférence en milieu réanimatoire.
- **Tolvaptan (Samsca®) :**
  - Il s'agit d'un antagoniste des récepteurs V2 de l'AVP.
  - L'initiation doit être hospitalière avec une surveillance rapprochée pendant au moins 48 heures avec natrémie de contrôle toutes les 4 à 6 heures. La restriction hydrique doit être levée pendant les 24 à 48 premières heures d'utilisation. Il ne doit pas être utilisé conjointement aux autres traitements.
  - Pas de données dans les hyponatrémies asymptomatiques inférieures à 120 mmol/L.
  - La posologie initiale est de 15 mg/jour jour (il est possible de débiter à 7,5 mg/jour si le patient est à risque de correction trop rapide) avec possibilité d'augmenter progressivement jusqu'à 60 mg.
  - **AMM : traitement des patients adultes présentant une hyponatrémie secondaire à un SIADH chez lesquels une restriction hydrique est inefficace ou impossible.**

- Inconvénients : non recommandé par les experts européens (contrairement aux américains) en raison des risques de correction trop rapides de la natrémie, durée d'utilisation limitée à 4 semaines (recommandation FDA en raison de la survenue d'hépatopathie), molécule onéreuse.

- Une analyse *post-hoc* poolée des deux études de phase 3 comparant l'utilisation de Tolvaptan vs placebo chez des patients présentant un SIADH para-néoplasique a montré une efficacité et un profil de tolérance correct dans cette population (123).

- **Urée :**

- Posologie : de 0,25 à 0,50 g/kg/jour.

- Inconvénients : goût (à boire avec du jus d'orange, préparation pharmaceutique en sachet : urée 10 g + NaHCO<sub>3</sub> 2 g + acide citrique 1,5 g + sucrose 200 mg, à dissoudre dans 100 mL d'eau), préparation pharmaceutique.

- **Furosémide + supplémentation sodée :**

- Posologie : 20-40 mg de furosémide par jour selon volémie et réponse clinique, associé à 2-4 g de sel en plus de l'alimentation (pour un total de 10-12 g).

- Surveillance du ionogramme et de la volémie.

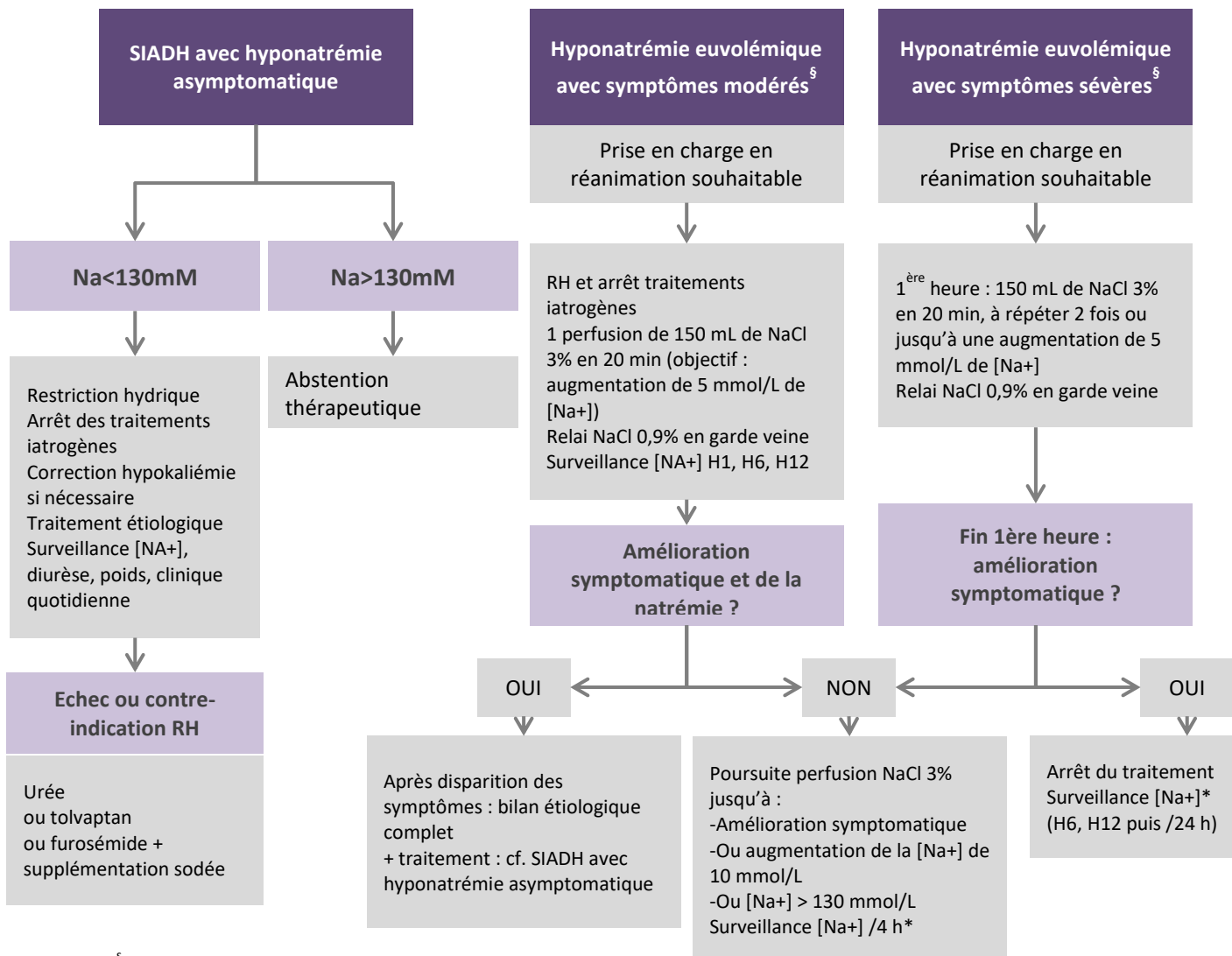
- **Ne sont pas indiqués pour le traitement correctif de l'hyponatrémie :**

- Sérum salé isotonique (NaCl 0,9%).

Plusieurs traitements sont proposés en 2<sup>ème</sup> ligne par les différentes recommandations, après échec ou intolérance de la restriction hydrique. Aucun n'a démontré de supériorité par rapport aux autres, et le praticien devra tenir compte de la tolérance, de la disponibilité des traitements, de ses habitudes et du coût dans le choix d'une thérapeutique.

	Recommandations européennes 2014 (122)	Recommandations américaines 2013 (124)
<b>Urée</b>	Recommandé en 2 <sup>ème</sup> ligne après RH	Recommandé en 2 <sup>ème</sup> ligne après RH
<b>Lasilix + supplémentation sodée</b>	Recommandé en 2 <sup>ème</sup> ligne après RH	Non mentionné
<b>Tolvaptan</b>	Non recommandé	Recommandé en 2 <sup>ème</sup> ligne après RH, avec précautions d'emploi nécessaires

**Tableau 29 – Recommandations européennes et américaines sur l'indication des traitements de 2<sup>ème</sup> ligne du SIADH.**



§ En cas d'hyponatrémie vraie euvolémique, si le patient présente des symptômes, il est recommandé de faire un traitement d'épreuve (perfusion NaCl 3%) avant de réaliser l'ensemble du bilan étiologique

\* Prélèvement sanguin sur le bras opposé à la perfusion

Figure 8 – Prise en charge thérapeutique d'une hyponatrémie

### 2.3 Conduite à tenir en cas de correction trop rapide

En cas d'augmentation de la natrémie supérieure à 10 mmol/L dans les 24 premières heures ou supérieure à 8 mmol/L/jour ensuite :

- Arrêt du traitement correctif en cours.
- Avis néphrologique pour perfusion de glucose (10 ml/kg en 1 heure) et/ou perfusion de desmopressine 4 µg.

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