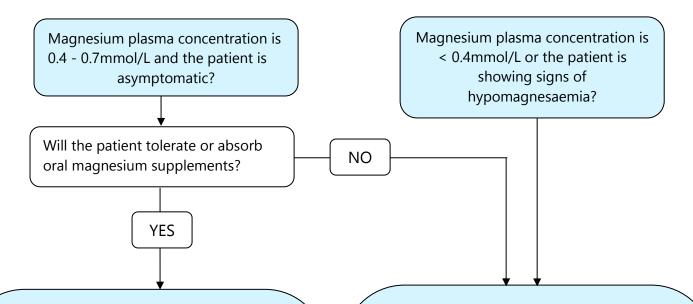
Management of Hypomagnesaemia

N.B. Establish and correct cause of hypomagnesaemia if possible



Oral magnesium supplements

(**N.B.** read notes below before prescribing)

Magnesium aspartate dihydrate 10mmol sachet (Magnaspartate®): 1 - 2 sachets daily in 50 ml - 200 ml water, tea or orange juice.

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Magnesium glycerophosphate 4mmol chewable tablets:

Start at 12-24 mmol/day in three to four divided doses. Titrate up to 36mmol/day depending on patient's requirement and tolerance.

- Renal impairment (eGFR <30ml/min): reduce dose by 50% and use with caution (off-label).
- Monitor plasma magnesium concentrations (daily in renal impairment).
- Monitor for diarrhoea: reduce dose or consider IV replacement.

Intravenous magnesium supplementation as magnesium sulphate 20mmol to 30mmol per day for up to 3 days.

Add 20 or 30 mmol (available as magnesium sulphate 50% 4mmol/2ml injection) to a 500ml or 1000ml infusion bag of either sodium chloride 0.9% or glucose 5% and infuse over 12 - 24 hours.

- Renal impairment (eGFR <30ml/min) reduce dose by 50%
- In renal impairment or risk of fluid overload infusion can be given in a smaller volume or over a shorter duration – seek specialist advice.
- Monitor plasma magnesium concentrations (daily if renal impairment). Blood sample should be taken at least 2 hours after infusion has stopped and from the opposite arm.
- In some patients, e.g. colorectal patients, a 5 day infusion may be required to correct deficit. Discuss with senior if unsure of course duration.
- After the initial IV replacement, ongoing oral supplements may be required if the patient has chronic losses or malabsorption issues.

Doses shown are suggested starting doses. Further advice is available from the Biochemistry Department.