

Reply to comment on: Sailer CO, et al. Primary polydipsia in the medical and psychiatric patient: characteristics, complications and therapy

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We read with great interest the comment pertaining to our review article on primary polydipsia in the medical and psychiatric patient [1, 2].

Dr Branimir Margetić underlines the importance of hyponatraemia induced by primary polydipsia in the psychiatric setting [2]. Indeed, primary polydipsia has mainly been described in the psychiatric setting [3] and is associated with increased morbidity and mortality [4, 5]. Identification of risk factors for hyponatraemia and preventive measures in patients with primary polydipsia should be elaborated. We therefore fully support the recommendation by Dr Margetić to monitor these patients with frequent sodium and weight measurements. Additionally, a drinking protocol is highly recommended for patients and physicians alike in order to raise awareness of the amounts that the patient drinks. However, this is especially challenging in patients with psychiatric disorders as they often not only refuse blood sampling, but also have a low sense of self-perception and thus are often unwilling to change their behaviour.

Dr Margetić points out the interplay of hyponatraemia, hypokalaemia and diet, which is indeed an interesting hypothesis. According to animal and human case studies, a diet rich in potassium might restore normonatraemia by stabilising the intra- and extracellular gradient [6, 7]. The remaining question is whether the potassium is the main factor, or whether a balanced diet in general, including proteins and other important micro- and macronutrients, is the means for restoring normonatraemia. We showed that, in patients with primary polydipsia-induced hyponatraemia, potassium levels were in the normal range but levels were higher in patients with beer potomania who were mainly malnourished [5]. Nevertheless, we agree that potassium

should be measured on a regular base in patients with hyponatraemia; however, prospective studies are required before potassium supplementation can be considered as adjunct therapy for hyponatraemia.

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