



SODIUM/NA

Sodium is measured by ion-selective electrode potentiometry. In the calculation of results for sodium, concentration is related to potential through the Nernst equation.

The i-STAT System uses direct (undiluted) electrochemical methods. Values obtained by direct methods may differ from those obtained by indirect (diluted) methods.¹

See below for information on factors affecting results. Certain substances, such as drugs, may affect analyte levels *in vivo*.²

If results appear inconsistent with the clinical assessment, the patient sample should be retested using another cartridge.

Intended Use

The test for sodium, as part of the i-STAT System, is intended for use in the *in vitro* quantification of sodium in arterial, venous, or capillary whole blood.

Contents

Each i-STAT cartridge contains one reference electrode (when potentiometric sensors are included in the cartridge configuration), sensors for the measurement of specific analytes and a buffered aqueous calibrant solution that contains known concentrations of analytes and preservatives. For cartridges that contain a sensor for the measurement of sodium, a list of reactive ingredients is indicated below:

Reactive Ingredient
Sodium (Na ⁺)

Metrological Traceability

The i-STAT System test for sodium measures sodium amount-of-substance concentration in the plasma fraction of arterial, venous, or capillary whole blood (dimension mmol L⁻¹) for *in vitro* diagnostic use. Sodium values assigned to i-STAT's controls and calibration verification materials are traceable to the U.S. National Institute of Standards and Technology (NIST) standard reference material SRM956. i-STAT System controls and calibration verification materials are validated for use only with the i-STAT System and assigned values may not be commutable with other methods. Further information regarding metrological traceability is available from Abbott Point of Care Inc..

Expected Values

Test/Abbreviation	Units*	Reportable Range	Reference Range ³
Sodium/Na	mmol/L (mEq/L)	100–180	138 – 146

*The i-STAT System can be configured with the preferred units.

The i-STAT reference range for whole blood listed above is similar to reference ranges derived from serum or plasma measurements with standard laboratory methods.

The reference range programmed into the analyzer and shown above is intended to be used as a guide for the interpretation of results. Since reference ranges may vary with demographic factors such as age, gender and heritage, it is recommended that reference ranges be determined for the population being tested.

Clinical Significance

Tests for sodium in the blood are important in the diagnosis and treatment of patients suffering from hypertension, renal failure or impairment, cardiac distress, disorientation, dehydration, nausea and diarrhea. Some causes of increased values for sodium include dehydration, diabetes insipidus, salt poisoning, skin losses, hyperaldosteronism and CNS disorders. Some causes for decreased values for sodium include dilutional hyponatremia (cirrhosis), depletional hyponatremia and syndrome of inappropriate ADH.

Performance Characteristics

The typical performance data summarized below was collected in health care facilities by health care professionals trained in the use of the i-STAT System and comparative methods.

Precision data were collected in multiple sites as follows: Duplicates of each control fluid were tested in the morning and in the afternoon on five days for a total of 20 replicates. The averaged statistics are presented below.

Method comparison data were collected using NCCLS guideline EP9-A⁴. Venous blood samples were collected in lithium heparin Vacutainer® tubes and analyzed in duplicate on the i-STAT System. A portion of the specimen was centrifuged and the separated plasma was analyzed in duplicate on comparative methods within 20 minutes of collection.

Deming regression analysis⁵ was performed on the first replicate of each sample. In the method comparison table, n is the number of specimens in the data set, Sxx and Syy refer to estimates of imprecision based on the duplicates of the comparative and the i-STAT methods respectively, Sy.x is the standard error of the estimate, and r is the correlation coefficient.*

Method comparisons will vary from site to site due to differences in sample handling, comparative method calibration and other site specific variables.

Interference studies were based on NCCLS guideline EP7.⁶

*The usual warning relating to the use of regression analysis is summarized here as a reminder: For any analyte, "if the data is collected over a narrow range, the estimate of the regression parameters are relatively imprecise and may be biased. Therefore, predictions made from these estimates may be invalid".⁴ The correlation coefficient, r, can be used as a guide to assess the adequacy of the comparative method range in overcoming this problem. As a guide, the range of data can be considered adequate if $r > 0.975$.

Precision Data (mmol/L or mEq/L)

Aqueous Control	Mean	SD	%CV
Level 1	120.0	0.46	0.4
Level 3	160.0	0.53	0.3

Method Comparison (mmol/L or mEq/L)

	Beckman Synchron CX®3	Kodak Ektachem™ 700	Nova STAT Profile® 5
n	189	142	192
Sxx	0.74	0.52	0.54
Syy	0.53	0.58	0.53
Slope	1.00	0.98	0.95
Int't	-0.11	3.57	5.26
Sy.x	1.17	1.04	1.53
Xmin	126	120	124
Xmax	148	148	148
r	0.865	0.937	0.838

Cartridge Comparison

The performance characteristics of the sensors are equivalent in all cartridge configurations. System difference analysis was performed on 40 patient samples using the i-STAT 6+ and i-STAT EC4+ cartridges. In the 130–150 mmol/L range the average difference was 0.750.

Factors Affecting Results*

Sodium heparin may increase sodium results up to 1mmol/L⁷.

Hemodilution of the plasma by more than 20% associated with priming cardiopulmonary bypass pumps, plasma volume expansion or other fluid administration therapies using certain solutions may cause clinically significant error on sodium, chloride, ionized calcium and pH results. These errors are associated with solutions that do not match the ionic characteristics of plasma. To avoid these errors when hemodiluting by more than 20%, use physiologically balanced multi-electrolyte solutions containing low-mobility anions (e.g. gluconate) such as Normosol®-R (Abbott Laboratories), Plasma-Lyte®-A (Baxter Healthcare Corporation), and Isolyte®-S (B Braun Medical) rather than solutions such as normal saline or Ringer's Lactate.

Interferent	Effect
β-hydroxybutyrate	16 mmol/L (166 mg/dL) β-hydroxybutyrate will decrease sodium results by 5 mmol/L.
Bromide	37.5 mmol/L bromide will increase sodium results by 5 mmol/L.
Lactate	20 mmol/L lactate will decrease sodium results by 5 mmol/L.

*It is possible that other interfering substances may be encountered. These results are representative and your results may differ somewhat due to test-to-test variation. In some instances, results may be suppressed ("star out"). The degree of interference at concentrations other than those listed might not be predictable.

References

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2. D.S. Young, Effects of Drugs on Clinical Laboratory Tests, 3rd ed. (Washington, DC: American Association of Clinical Chemistry, 1990).
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4. NCCLS. *Method Comparison and Bias Estimation Using Patient Samples; Approved Guideline*. NCCLS document EP9-A [ISBN 1-56238-283-7]. NCCLS, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania 19087-1898, USA 1995.
5. P.J. Cornbleet and N. Gochman, "Incorrect Least-Squares Regression Coefficients in Method-Comparison Analysis," *Clinical Chemistry* 25:3, 432 (1979).
6. NCCLS. *Interference Testing in Clinical Chemistry; Proposed Guideline*. NCCLS document EP7-P [ISBN 1-56238-020-6]. NCCLS, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania 19087-1898, USA 1986.
7. *Tips on Specimen Collection*. Vol 1. Monograph of Medical Laboratory Observer's "Tips from the Clinical Experts", published by Medical Economics in collaboration with Becton, Dickinson and Company. Mark Zacharia, ed. Montvale NJ; 1997:26.

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