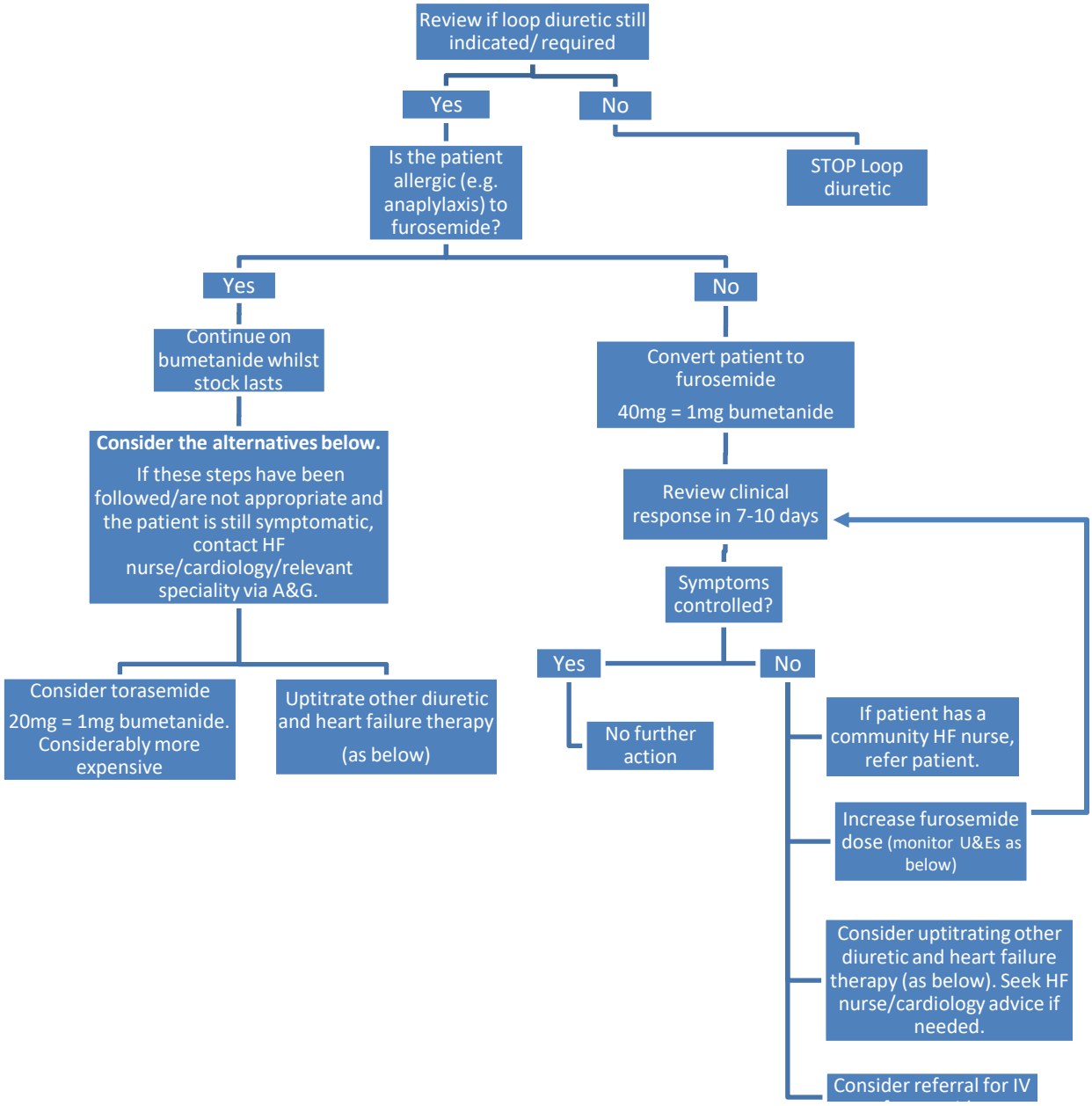
Flowchart for diuretic management of patients in primary care during bumetanide shortage



Further information:

- There is **NO** need to recheck U&Es after a direct switch (i.e., 1mg bumetanide to 40mg furosemide).
- After switching, patients should be advised to weigh themselves daily (at the same time each day) plus monitor fluid levels (oedema) and report any increase in either.
- Possible large variations in oral furosemide bioavailability between individuals may mean higher 'equivalent' doses are required. The dose should be up titrated according to response.
- Ensure appropriate monitoring of U&Es 1-2 weeks after each dose titration/ treatment escalation.
- Patients who have previously taken furosemide with no allergy, can be switched, but may need higher doses.
- If above steps have been exhausted and the patient is still symptomatic, contact cardiology/ relevant specialty via advice and guidance.

Alternative diuretic and heart failure therapies.

1. If heart failure, add SGLT2 inhibitor unless contraindicated.
2. Increase Mineralocorticoid Receptor Antagonist, MRA, (spironolactone or eplerenone) up to 50mg OD in the presence of other Renin-angiotensin-aldosterone system inhibitors (ACE inhibitor, ARB, or Sacubitril / Valsartan).
3. Increase spironolactone up to 200mg daily without other RAASi. Potassium monitoring required.
4. Consider Bendroflumethiazide, titrate from 5mg once weekly to 5mg daily.
5. Consider Amiloride 5-10mg twice a day if eGFR prohibits MRAs. Potassium monitoring required.

Nottinghamshire Area Prescribing Committee, October 2023. Review September 2025
Developed in collaboration with NUH and SFHT cardiology teams.
Flowchart reviewed by NUH Cardiology Team in view of NatPSA/2025/003/DHSC no changes to flowchart (10/07/2025)