Correspondence-middle-aged man with acute onset quadriplegia

Sir,

With reference to your letter, we wish to make the following clarifications to the response by Iyer et al.1

1. Rare causes like renal tubular acidosis (Type 1 and 2), metabolic acidosis, Liddle’s syndrome and Bartter’s syndrome were mentioned with an aim to highlight some causes of persistent hypokalemia in general that a physician should consider. While discussing the causes pertinent to our patient only Cushing’s syndrome and Secondary hyperaldosteronism from a high renin state have been mentioned.

2. As pointed out urinary chloride estimation is indeed of great value in unraveling the cause of hypokalemia and finds its application specifically in conditions like hypokalemia due to remote vomiting or remote diuretic use. We did not go ahead with these urine tests since we had a couple of other clinical clues to bank on, namely peripheral edema, diabetes, hypertension, metabolic acidosis and skin pigmentation. We completely agree with the assertion that hypomagnesemia is a cause for low serum K+ levels. Thyroid disorders and liquorice intake (usually as a food additive) are other causes that merit mention as rare causes of hypokalemia. Again we would like to state that these conditions were essentially less relevant to our case and hence omitted from the discussion to keep the article concise and interesting.
3. We regret the typographical error in the manuscript,[1] it should have read alkalosis and not acidosis.

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Reference