We have read the second opinion of Nguyen et al. [1] related to our work with interest. Our articles address the potential regulatory function of tissue Na⁺ storage in healthy individuals in response to a hypertonic saline infusion and hypotonic fluid load [2, 3]. To estimate the effect of tissue Na⁺ storage on plasma [Na⁺], we used formulas derived from the Edelman equation, based on the 2-compartment model for body fluids and solutes [4]. After both interventions, the observed changes in plasma [Na⁺] were smaller than changes estimated by the Adrogue-Madias, Barsoum-Levine, and Nguyen-Kurtz formulas [5–7]. Consequently, our results suggest that healthy individuals are able to store or release Na⁺ in response to hyper- and hypotonic stimuli. Short after publication of our findings, a lively discussion was provoked [8, 9]. Now Nguyen et al. [10] add to this two additional points of criticism. Their main criticisms relate to the estimation of the total body water (TBW) and the imprecise measurement of plasma [Na⁺]. The authors state that estimation of the TBW leads to inaccurate calculations of the Na⁺ storage pool. In the study by Olde Engberink et al. [2], the Adrogue-Madias and Nguyen-Kurtz formulas were used to estimate change in plasma [Na⁺]. Although we do agree that the use of exact TBW measurements is preferable in an experimental setting, the effect of this inaccuracy on prediction of plasma [Na⁺] is limited as we accurately measured changes in TBW, which were independent of (potentially inaccurate) baseline TBW values. We are therefore confident that measurements of TBW would not have influenced the results [2]. Also, when using the Barsoum-Levine and Nguyen-Kurtz formulas, in which TBW is included in both the numerator and denominator [6, 7], the effect of baseline TBW on plasma [Na⁺] changes is limited. This can be appreciated from the calculations in Table 1 by using the Edelman-based Barsoum-Levine formula with data from Wouda et al. [3]. These calculations reveal after rounding off plasma [Na⁺] values practically no difference.

The second point of criticism relates to the imprecision of the ISE method in measurement of plasma [Na⁺]. The authors refer to a previous study in which they
showed that repeated plasma [Na⁺] measurements on the exact same sample showed differences ranging from 1 to 3 mmol/L [10]. They accordingly suggest that the differences in plasma [Na⁺] found in the study of Olde Engberink et al. [2] and Wouda et al. [3] are within these limits and therefore may not reflect "true differences." Besides the fact that the authors lump together values of both the direct and the indirect ISE methods (where each has its own analytical performance specifications and only those of the indirect ISE method should be applied to the studies of Olde Engberink et al. [2] and Wouda et al. [3]), more importantly, the range encompasses individual differences. As the imprecision is random and deviations are directed toward both directions, when looking at a group mean comprising more individual persons or samples, the difference moves toward zero. This can also be appreciated when looking at the authors' own data (first table of reference [10]): the deviations occur in both directions, and calculating mean group differences between two measurements on the same sample reveals a mean deviation of 0.09 mmol/L for the direct ISE and 0.36 mmol/L for the indirect ISE, being substantially less than the individual differences of 1–3 mmol/L. While in clinical chemistry, increasing efforts are made to reliably assess whether individual differences are "true" or due to analytical or biological variation (together incorporated in the so-called "reference change value" [11]), it is established that in clinical trials (with multiple measurements in multiple people at multiple time points), the effect of analytical and biological variability is significantly attenuated and primarily an issue for measurements in individual patients [12]. Therefore, the observed differences between measured and estimated plasma [Na⁺] are unlikely to be explained by imprecision of the ISE method.

Lastly, the authors suggest that in the study by Olde Engberink et al. [2], oral intake of Na⁺ and K⁺ might have influenced the results. However, after saline infusion, intake of food (and subsequent Na⁺ and K⁺ intake) was not allowed. Moreover, as mentioned in the method section, water intake was standardized to 400 mL and included in the calculation [2].

In the second part of the second opinion, the authors contrast our results to a study by Overgaard-Steensen et al. [13] in which a porcine model of hyponatremia was used. While this model allows precise measurements of the effect of tissue Na⁺ storage on plasma [Na⁺] in acute hyponatremia, it lacks translation to human conditions. Particularly, since the total body content of glycosaminoglycans (GAGs), large carbohydrate molecules that enable transient Na⁺ storage, differs among species [14, 15]. Although studies comparing GAG concentration in tissues between humans and pigs are scarce, one study suggested that the concentration of dermatan sulfate, a sulfated GAG, in the skin is higher in humans than in pigs [16]. In addition, tissue Na⁺ accumulation positively correlates with age and Na⁺ intake [17–19]. Since the pigs were young and fed a supposedly low Na⁺ diet (this was not specified in the publication) [20], the amount of Na⁺ stored may substantially differ from adult males with a habitual high Na⁺ consumption in the study by Wouda et al. [3].

The authors suggest that to answer the question as to whether changes in plasma [Na⁺] can be predicted based on in and output of Na⁺ and K⁺ and TBW in humans, prospective clinical trials are needed in which TBW, Na⁺, and K⁺ are measured by isotope dilution. It is to be noted that this is in conflict with their suggestion to use the Watson formula to estimate TBW. Moreover, in a study comparing the total body content of water, Na⁺, Cl⁻, and K⁺ with values obtained by isotope dilution, it was shown that isotope dilution techniques underestimate total body Na⁺ [21]. This discrepancy can be explained by tissue Na⁺ storage. Yet, whether tissue Na⁺ storage is transient and contributes to modulation of plasma [Na⁺] can only be answered by a dynamic intervention. In line with our observations, we hypothesize that after infusion of radioactive Na⁺, Na⁺ is stored in tissues, and therefore the dilution volume is larger than can be expected based on TBW.

In this commentary, we have demonstrated that our results are valid, implicating that in response to both

### Table 1. Estimated plasma [Na⁺] 120 min after water loading according to the Barsoum-Levine formula assuming different TBW values

<table>
<thead>
<tr>
<th>TBW (L)</th>
<th>Plasma [Na⁺] Estimated 120 min after Water Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>(40 × 140 + 0) / (40 + 0.3) = 138 mmol/L</td>
</tr>
<tr>
<td>47</td>
<td>(47 × 140 + 0) / (47 + 0.3) = 138 mmol/L</td>
</tr>
<tr>
<td>54</td>
<td>(54 × 140 + 0) / (54 + 0.3) = 138 mmol/L</td>
</tr>
</tbody>
</table>

Barsoum-Levine formula

\[
[\text{Na}^+]_{\text{plasma post}} = \frac{([\text{TBW}] \times [\text{Na}^+]_{\text{plasma pre}}) + ([\text{volume input}] \times [\text{Na}^+ + K^+]_{\text{input}}) - ([\text{volume output}] \times [\text{Na}^+ + K^+]_{\text{output}})}{([\text{TBW}] + [\Delta \text{Volume}])}
\]

Plasma [Na⁺] 120 min after water loading assuming a TBW of 47 L (= mean estimated TBW in the study of Wouda et al. [2])

\[
[\text{Na}^+]_{\text{plasma post}} = \frac{((47 \times 140) + (0) - (48))}{(47 + 0.3)} = 138 \text{ mmol/L}
\]

When assuming a TBW of 40 L

\[
[\text{Na}^+]_{\text{plasma post}} = \frac{((40 \times 140) + (0) - (48))}{(40 + 0.3)} = 138 \text{ mmol/L}
\]

When assuming a TBW of 54 L

\[
[\text{Na}^+]_{\text{plasma post}} = \frac{((54 \times 140) + (0) - (48))}{(54 + 0.3)} = 138 \text{ mmol/L}
\]

DOI: 10.1159/000516535

Wouda/Olde Engberink/Wenstedt/ Oppelaar/Vogt
hypo- and hypertonic stimuli, changes in plasma [Na+] cannot be estimated solely based on in and output of Na⁺ and K⁺ and water, but that Na⁺ stored in tissues should be taken into account. Consequently, clinicians should be aware of the effects of tissue Na⁺ storage.

Acknowledgment

The authors gratefully acknowledge the help of Johan Fischer (Amsterdam University Medical Centers, Department of Clinical Chemistry) in providing additional information on the ISE method.

References