

10.1 Strategies to Optimize Parenteral Nutrition and Minimize Risks: Dose of PN

June 28th, 2005

Recommendations:

Based on 4 level 2 studies, in critically ill patients who are not malnourished, are tolerating some EN, or when parenteral nutrition is indicated for short term use (< 10 days), low dose parenteral nutrition should be considered. There are insufficient data to make recommendations about the use of low dose parenteral nutrition in the following patients: those requiring PN for long term (> 10 days); obese critically ill patients and malnourished critically ill patients. Practitioners will have to weigh the safety and benefits of low dose PN on an individual case-by-case basis in these latter patient populations.

Discussion: Our recommendation on low dose PN is in the context of our earlier recommendation that EN be used preferentially to PN and that strategies to maximize EN be utilized prior to initiating PN. The issue of low dose PN is only relevant to those patients tolerating some (inadequate) EN where practitioners, on a case-by case basis are deliberating about adding PN (see section 1 and 7 i.e. EN vs PN and combination EN + PN). Given the inconsistencies in the definition of low dose PN amongst the studies included, the committee could not agree upon a specific definition. It was agreed that low dose PN could be achieved by either withholding lipids or reducing carbohydrate load. The committee had concerns about including the trial (Ahrens et al) that compared 27 Kcal/kg/day to 37 kcal/kg/day in the meta-analysis as the lower dose group from this study had substantially greater calories than the lower dose group of the other studies. When a sensitivity analysis was done without this paper, there was a large treatment effect on infectious complications. There was no evidence from the studies that showed low dose PN was harmful. Low dose parenteral nutrition may be equivalent to standard PN with respect to cost and feasibility. Two of the studies excluded malnourished patients (McCowen, Ahrens) and the committee was concerned about the paucity of data in this population and also about the safety and unknown effects of long term Low dose parenteral nutrition. The committee decided that while the concerns regarding low dose parenteral nutrition and essential fatty acid deficiency were probably minimal for those patients tolerating some EN and requiring PN for short term (< 10 days), this cannot be extrapolated to those who have an absolute contraindication to EN and need PN for a longer duration.

Values	definition	Score: 0, +, ++, +++
Effect size	magnitude of the absolute risk reduction attributable to the intervention listed--a higher score indicates a larger effect size	3+ (for infection)
Confidence interval	95% confidence interval around the point estimate of the absolute risk reduction, or the pooled estimate (if more than one trial)--a higher score indicates a smaller confidence interval	2+
Validity	refers to internal validity of the study (or studies) as measured by the presence of concealed randomization, blinded outcome adjudication, an intention to treat analysis, and an explicit definition of outcomes--a higher score indicates presence of more of these features in the trials appraised	2+
Homogeneity	similar direction of findings among trials--a higher score indicates greater similarity of direction of findings among trials	0
Cost	estimated cost of implementing the intervention listed--a higher score indicates a lower cost to implement the intervention in an average ICU	2+
Feasible	ease of implementing the intervention listed--a higher score indicates greater ease of implementing the intervention in an average ICU	3+
Safe	estimated probability of avoiding any significant harm that may be associated with the intervention listed--a higher score indicates a lower probability of harm	2+

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Question: Does the dose of parenteral nutrition affect the outcome of critically ill patients?

Summary of evidence: Four level 2 studies have evaluated this question. Choban et al looked at low dose feeding in obese patients specifically. In the McCowen and Battistella studies, the control group was also given lipids as a source of calories. Ahrens et al studied the effect of a higher lipid, lower CHO parenteral solution (27 Kcal/kg/day) vs. a higher CHO, lower lipid PN solution (37 Kcal/kg/day)

Mortality: A meta-analysis of all 4 studies showed no effect on mortality (RR 0.61, 95 % CI 0.20,1.85, $p = 0.4$). This did not change when a sensitivity analysis was done without Ahrens et al (RR = 0.78, 95%CI 0.17, 3.56, $p = 0.7$) or without McCowen (RR = 0.65, 95% CI 0.10,4.05, $p = 0.6$). See page 10.1- 5

Infections: Three studies reported on the number of patients with infections. Battistella et al found a significant reduction in pneumonia in the low dose PN group ($p < 0.05$) and in the McCowen et al study, low dose PN was associated with a trend towards a reduction in infections ($p = 0.2$) while Ahrens et al found no significant difference in the number of patients with infectious complications ($p = 0.4$). When these 3 studies were aggregated, low dose PN has no effect on infectious complications (RR = 0.73, 95%CI 0.41,1.31, $p = 0.3$). In a sensitivity analysis without the Ahrens, low dose PN was associated with a significant reduction in infectious complications (RR=0.63, 95 % CI-0.42,0.93, $p = 0.02$). See figures, page 10.1-7

LOS: A significantly shorter ICU stay ($p = 0.02$) and hospital stay ($p = 0.03$) was observed in trauma patients receiving low dose PN (Battistella). No differences in LOS were seen in the other three other studies (McCowen, Choban, Ahrens).

Ventilator days: Were reported in 2 studies. Significantly fewer ventilated days ($p = 0.01$) were observed in trauma patients receiving low dose PN (no lipids) compared to those receiving higher dose PN (with lipids) (Battistella). No differences were observed between the groups in surgical critically ill patients (Ahrens).

Other complications: Incidence of hyperglycemia was similar in the low dose and standard groups (McCowen), but significantly lower in the Ahrens et al study.

Conclusions:

- 1) Low dose parenteral nutrition without lipids maybe associated with a reduction in infections in critically ill patients.
- 2) Insufficient data to comment on the effects of low dose parenteral nutrition in obese patients.

Level 1 study: if all of the following are fulfilled: concealed randomization, blinded outcome adjudication and an intention to treat analysis.

Level 2 study: If any one of the above characteristics are unfulfilled

Table 1. Randomized Studies Evaluating Dose Of Parenteral Nutrition In Critically Ill Patients

Study	Population	Methods (score)	Intervention	Mortality # (%)†		Infections # (%)‡		RR (CI)**
				Low dose	High dose	Low dose	High dose	
1) Ahrens 2005	Surgical + ICU patients N = 40	C:Random: not sure ITT: yes Blinding: no (7)	Low dose PN (lipids/CHO) Pro 1.61g/kg/d±0.13, 27 kcal/kg/d vs. Standard PN, (lipids/CHO) Pro 1.53±0.26g/kg/d 37 kcal/kg/d	1/20 (5)	3/20 (15)	5/20 (25)	2/20 (10)	2.50 (0.28-2.52)
2) Battistella 1997	Polytrauma patients N = 60	C:Random: not sure ITT: no Blinding: no (8)	Lipid-free PN, Pro: 1.6g/kg/d 28.5kcal/kg/d vs. Standard PN (lipids/CHO), Pro 1.6g/kg/d 37kcal/kg/d	2/27 (7)	0/30 (0)	Pneumonia 13/27 (48) Line Sepsis 5/27 (19) Total # infections per group 39/27	Pneumonia 22/30 (73) Line Sepsis 13/30 (43) Total # infections per group 72/30	Pneumonia 0.66 (0.42-1.03) Line Sepsis 0.43 (0.18-1.04)
3) Choban 1997	ICU & hospital Obese patients ICU patients N = 13	C: Random: yes ITT: yes Blinding: no (10)	Low dose PN (low lipids/CHO) Pro 2g/kg/d, 22kcal/kg/d vs. Standard PN, (low lipids/CHO) Pro 2 g/kg/d, 36 kcal/kg/d	0/6 (0) hospital	2/7 (29) hospital	NA	NA	NA
4) McCowen 2000	Probable ICU patients (mostly ventilated) N=48	C:Random: not sure ITT: no Blinding: no (6)	Low dose PN (no lipids), Pro 1.5 g/d, 14 kcal/kg/d vs. Standard PN (lipids,CHO), Pro 1.5 g/d, 18 kcal/kg/d	2/21 (10)	3/19 (16)	6/21 (29)	10/19 (53)	0.54 (0.24-1.21)

Table 1 (continued). Randomized Studies Evaluating Dose Of Parenteral Nutrition In Critically Ill Patients

Study	LOS days		Ventilator days		Hyperglycemic Episodes	
	Low dose PN	StandardPN				
1) Ahrens 2005	14 (10-21) ICU 15 (11-26) hospital	24(10-37) ICU 25 (15-39) hospital	10 (4-15)	19 (4-35)	Low dose ≥200 mg/dl: 0 ≥300mg/dl: 0 ≥400mg/dl: 0 # pts with hyperglycemia 5/20 (25 %)	Standard ≥200mg/dl: 33.1%(0-58.4) ≥300mg/dl: 5 % (0-13.8) ≥400 mg/dl: 0% (0-1.5) # pts with hyperglycemia 14/20 (70%)
2) Battistella 1997	18±12 (27) ICU 27 ±16 (27) hospital	29±22 (30) ICU 39±24 (30) hospital	15±12 (27)	27±21 (30)	NA	NA
3) Choban 1997	48±30 (6) hospital	45±38 (7) hospital	NA	NA	NA	NA
4) McCowen 2000	19±14 (21)	17±15 (19)	NA	NA	20%	26%

C. Random: concealed randomization

ITT: intent to treat

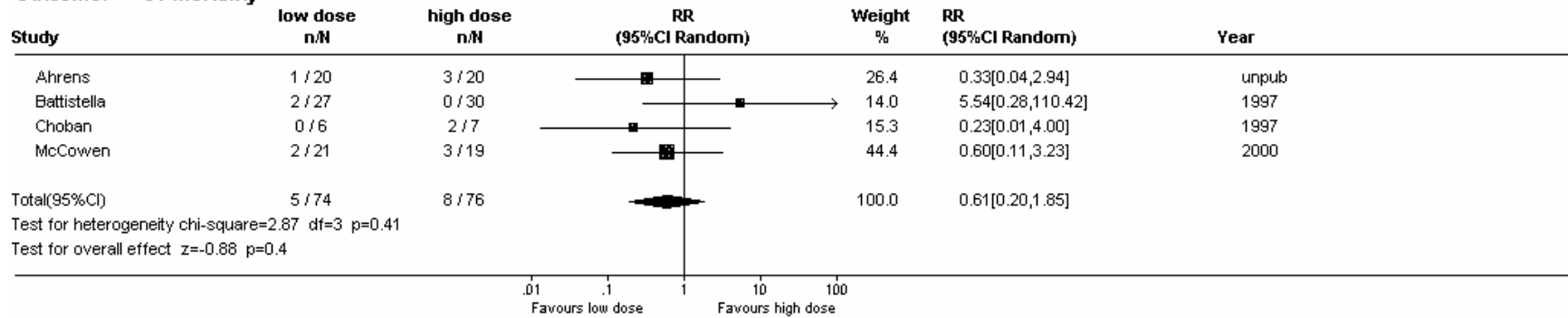
† presumed ICU mortality unless otherwise specified

±():mean±Standard deviation (number)

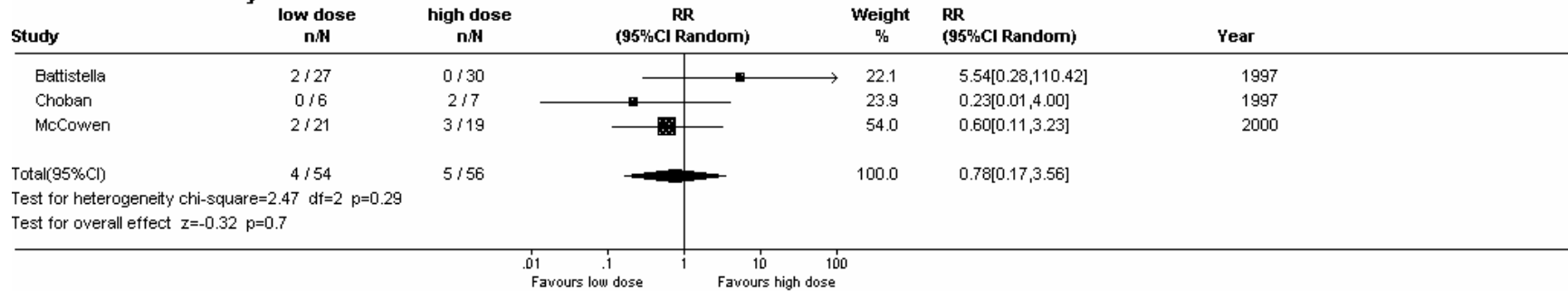
‡ refers to the # of patients with infections

** RR= relative risk, CI=Confidence Intervals

Mortality with Ahrens
Comparison: 01 Dose of PN
Outcome: 01 mortality



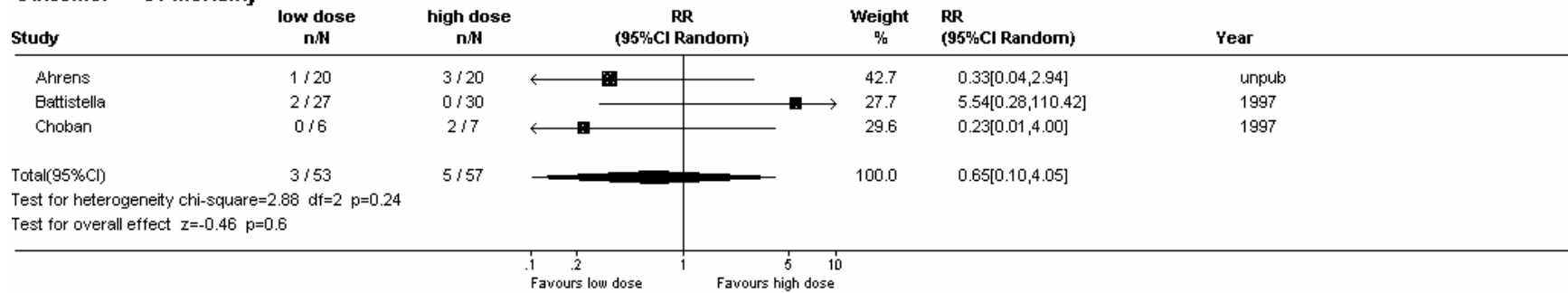
Sensitivity Analysis (Without Ahrens)
Comparison: 01 Dose of PN
Outcome: 01 mortality



Sensitivity Analysis without McCowen

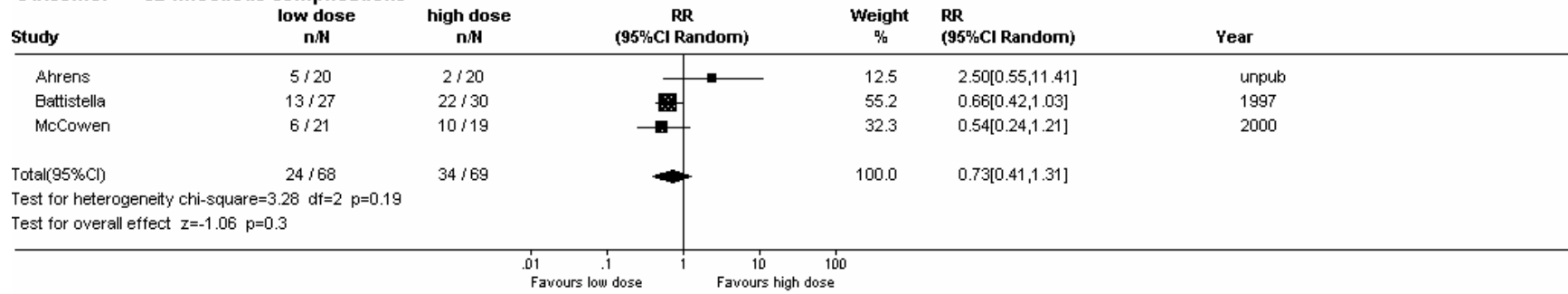
Comparison: 01 Dose of PN

Outcome: 01 mortality



Comparison: 01 Dose of PN

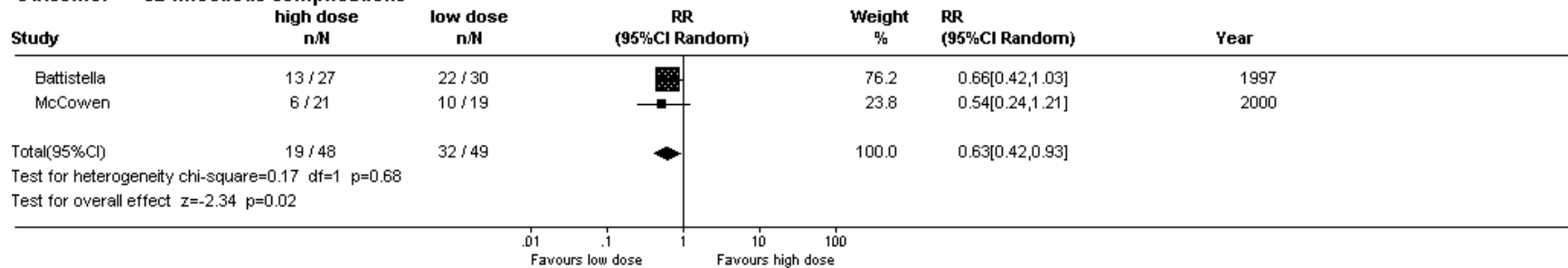
Outcome: 02 Infectious complications



Sensitivity Analysis without Ahrens

Comparison: 01 Dose of PN

Outcome: 02 Infectious complications



TOPIC: 10.1 Strategies to Optimize Parenteral Nutrition: Dose of PN

(Reviewers: Ulrich Suchner, Minto Jain, John Drover and Brian Jurewitsch)

Article inclusion log

Criteria for study selection

Type of study: RCT or Meta-analysis
Population: critically ill human patients (no elective surgical patients)
Intervention :TPN and /or EN
Outcomes: mortality, LOS, QOL, functional recovery, complications, cost. Exclude studies with only biochemical, metabolic or nutritional outcomes.

ID #	Author	Journal	I	E	why rejected
1.	1. Battistella (lipids vs no lipids)	J Trauma 1997		√	
	2. DeChalain (lipids vs no lipids)	J Surgical Research 1992			√ Excluded as crossover trial and no significant outcomes
65.	3. Choban	Am J Clin Nutr 1997		√	
	4. Ahrens	Unpublished		√	
	5. McCowen	CCMedicine 2000		√	
	6. Dickerson	Am J Clin Nutr 1986			√ Not RCT, not ICU pts.
	7. Burge	JPEN 1994			√ Not ICU pts.
	8. Jiminez	Clinical Nutrition 1995			√ Surgical patients

I = included, E = excluded

References

1. Bastistella FD, Widergren JT, Anderson JT, et al. A prospective, randomized trial of intravenous fat emulsion administration in trauma victims requiring total parenteral nutrition. *J Trauma* Jul;43(1):52-8; discussion 58-60, 1997
2. Choban PS, Burge JC, Scales D et al. Hypoenergetic nutrition support in hospitalized obese patients: a simplified method for clinical application. *Am J Clin Nutr.* Sep;66(3):546-50, 1997.
3. McCowen KC, Friel C, Sternberg J, et al. Hypocaloric total parenteral nutrition: Effectiveness in prevention of hyperglycemia and infectious complications. A randomized clinical trial. *Crit Care Med.* Nov;28(11):3606-11, 2000.
4. De Chalain TM, Michell WL, O'Keefe SJ, Ogden JM. The effect of fuel source on amino acid metabolism in critically ill patients. *Surg Res.* 1992 Feb; 52(2): 167-76.
5. Dickerson RN, Rosato EF, Mullen JL. Net protein anabolism with hypocaloric parenteral nutrition in obese stressed patients. *Am J Clin Nutr.* 1986 Dec; 44(6): 747-55.
6. Burge JC, Goon A, Choban PS, Flancbaum L. Efficacy of hypocaloric total parenteral nutrition in hospitalized obese patients: a prospective, double-blind randomized trial. *JPEN J Parenter Enteral Nutr.* 1994 May-Jun; 18(3): 203-7.