

Summary of Topics and Recommendations

June 28th, 2005

1.	Enteral Nutrition vs.. Parenteral Nutrition	Does enteral nutrition compared to parenteral nutrition result in better outcomes in the critically ill adult patient?	Based on 1 level 1 study and 12 level 2 studies, when considering nutrition support for critically ill patients, we strongly recommend the use of enteral nutrition over parenteral nutrition.
2.	Early vs. delayed nutrient intake	Does early enteral nutrition compared to late enteral nutrition result in better outcomes in the critically ill adult patient?	Based on 10 level 2 studies, we recommend early enteral nutrition (within 24-48 hours following admission to ICU) in critically ill patients.
3.1	Dose of EN: Use of indirect calorimetry vs. predictive equation for EN	Does the use of indirect calorimetry vs.. a predictive equation for determining energy needs result in better outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation on the use of indirect calorimetry vs.. predictive equations for determining energy needs for enteral nutrition in critically ill patients.
3.2	Dose of EN: Achieving target dose of EN	Does achieving target dose of enteral nutrition result in better outcomes in the critically ill adult patient?	Based on 1 level 2 study, when initiating enteral nutrition in head injured patients, strategies to optimize delivery of nutrients (starting at target rate, higher threshold of gastric residual volumes and use of small bowel feedings) should be considered . In other critically ill patients, there are insufficient data to make a recommendation.
4.1 (a)	Composition of EN: Immune Enhancing Diets: Diets supplemented with arginine and other select nutrients	Compared to standard enteral feeds, do diets supplemented with arginine and other select nutrients result in improved clinical outcomes in the critically ill adult patient?	Based on 4 level 1 studies and 16 level 2 studies, we recommend that diets supplemented with arginine and other selected nutrients not be used for critically ill patients.
4.1 (b)	Composition of EN: Immune Enhancing Diets: Fish oils	Does the use of an enteral formula with fish oils, borage oils, and antioxidants result in improved clinical outcomes in the critically	Based on one level 1 study, the use of an enteral formula with fish oils, borage oils, and antioxidants should be considered in patients with acute respiratory distress

		ill adult patient?	syndrome (ARDS).
4.1 (c)	Composition of EN: Immune Enhancing Diets: Glutamine	Compared to standard care, does glutamine-supplemented EN result in improved clinical outcomes in the critically ill adult patient?	Based on 2 level 1 and 5 level 2 studies, enteral glutamine should be considered in burn and trauma patients. There are insufficient data to support the routine use of enteral glutamine in other critically ill patients.
4.1 (d)	Composition of EN: Ornithine Ketoglutarate (OKG)	Does supplementation of enteral nutrition with ornithine ketoglutarate (OKG) influence outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation regarding the use of ornithine ketoglutarate in burn patients and other critically ill patients.
4.2 (a)	Composition of EN: CHO/FAT: High fat, low CHO	Does a high fat/low carbohydrate enteral formula influence outcomes in the critically ill adult patient?	There are insufficient data to recommend high fat/low CHO diets for critically ill patients.
4.2 (b)	Composition of EN: CHO/FAT: Low fat, high CHO	Does a low fat/high carbohydrate enteral formula influence outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation regarding the use of a low fat formula in critically ill patients.
4.2 (c)	Composition of EN: High Protein vs.. Low Protein	Does the use of a higher protein enteral formula, compared to a lower protein enteral formula, result in better outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation regarding the use of high protein diets for head injured and other critically ill patients.
4.3	Composition of EN: Protein/peptides	Does the use of peptide based enteral formula, compared to a whole protein formula, result in better outcomes in the critically ill adult patient?	Based on 4 level 2 studies, when initiating enteral feeds, we recommend the use of whole protein formulas (polymeric) in critically ill patients.
4.4	Composition of EN: pH	Do acidified feeds (low pH) compared to standard feeds result in better outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation regarding the use of low pH feeds in critically ill patients.

4.5	Composition of EN: Fibre	Do enteral feeds with fibre, compared to standard feeds result in better outcomes in the critically ill adult patient?	There are insufficient data to support the routine use of fibre (pectin or soy polysaccharides) in enteral feeding formulas in critically ill patients.
5.1	Strategies to optimize delivery and minimize risks of EN: Feeding Protocols	Does the use of a feeding protocol result in better outcomes in the critically ill adult patient?	There are insufficient data from randomized trials to recommend the use of a feeding protocol in critically ill patients. If a feeding protocol is to be used, based on 1 level 2 study, a protocol that incorporates prokinetics (metaclopramide) at initiation and tolerates a higher gastric residual volume (250 mls) should be considered as a strategy to optimize delivery of enteral nutrition in critically ill adult patients.
5.2	Strategies to optimize delivery and minimize risks of EN: Motility agents	Compared to standard practice (placebo), does the routine use of motility agents result in better clinical outcomes in the critically ill adult patient?	Based on a systematic review and 1 level 2 study, in critically ill patients who experience feed intolerance (high gastric residuals, emesis), the use of metaclopramide as a motility agent should be considered .
5.3	Strategies to optimize delivery and minimize risks of EN: Small Bowel feeding	Does enteral feeding via the small bowel compared to gastric feeding result in better outcomes in the critically ill adult patient?	Based on 11 level 2 studies, small bowel feeding compared to gastric feeding maybe associated with a reduction in pneumonia in critically ill patients. In units where obtaining small bowel access is feasible, we recommend the routine use of small bowel feedings. In units where obtaining access involves more logistical difficulties, small bowel feedings should be considered for patients at high risk for intolerance to EN (on inotropes, continuous infusion of sedatives, or paralytic agents, or patients with high nasogastric drainage) or at high risk for regurgitation and aspiration (nursed in supine position). Finally, in units where obtaining small bowel access is not feasible (no access to fluoroscopy or endoscopy and blind techniques not reliable), small bowel feedings should be considered for those select

			patients who repeatedly demonstrate high gastric residual volumes and are not tolerating adequate amounts of EN delivered into the stomach.
--	--	--	---

5.4	Strategies to optimize delivery and minimize risks of EN: Body position	Do alterations in body position result in better outcomes in the critically ill adult patient?	Based on 1 level 2 study, we recommend that critically ill patients receiving enteral nutrition have the head of the bed elevated to 45 degrees. Where this is not possible, attempts to raise the head of the bed as much as possible should be considered .
6.1	EN Other: Closed vs. open system	Does the use of a closed system for enteral feeding result in better outcomes when compared to an open system in the critically ill adult patient?	There are insufficient data to make a recommendation on the administration of EN via a closed vs.. open system in critically ill patients.
6.2	EN Other: Probiotics	Does the addition of probiotics to enteral nutrition result in better outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation on the use of probiotics in critically ill patients.
6.3	EN Other: Continuous vs. other methods of administration	Does continuous administration of enteral nutrition compared to other methods of administration result in better outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation on enteral feeds given continuously vs.. other methods of administration in critically ill patients.
7.	EN in combination with PN	Does the use of parenteral nutrition in combination with enteral nutrition result in better outcomes in the critically ill adult patient?	Based on 5 level 2 studies, for critically ill patients starting on enteral nutrition, we recommend that parenteral nutrition not be started at the same time as enteral nutrition. In the patient who is not tolerating adequate enteral nutrition, there are insufficient data to put forward a recommendation about when parenteral nutrition should be initiated. Practitioners will have to weigh the safety and benefits of initiating PN in patients not tolerating EN on an individual case-by-case basis. We recommend that PN not be started in critically ill patients until all strategies to maximize EN delivery (such as small bowel feeding tubes, motility agents) have been attempted.

8.	PN: PN vs. standard care	Compared to standard care (IV fluids, oral diet, etc.), does parenteral nutrition result in better outcomes in critically ill patients who have an intact GI tract?	Based on 5 level 2 studies, in critically ill patients with an intact gastrointestinal tract, we recommend that parenteral nutrition not be used routinely.
9.1	Composition of PN: Branched Chain Amino acids (BCAA)	Does the addition of BCAA to parenteral nutrition influence outcomes in the critically ill adult patient?	In critically ill patients who are receiving parenteral nutrition, there are insufficient data to make a recommendation regarding the use of branched chain amino acids.
9.2	Composition of PN: Type of lipids	Does the type of lipids in parenteral nutrition influence outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation on the type of lipids to be used in critically ill patients who are receiving parenteral nutrition.
9.3	Composition of PN: Zinc	Does zinc supplementation (via IV/PN) given either alone or in combination with other nutrients result in better outcomes in the critically ill patient?	There are insufficient data to make a recommendation regarding IV/PN zinc supplementation in critically ill patients
9.4	Composition of PN: Glutamine	Does glutamine supplementation of parenteral nutrition influence outcomes in the critically ill adult patient?	Based on 3 level 1 studies and 5 level 2 studies, when parenteral nutrition is prescribed to critically ill patients, parenteral supplementation with glutamine, where available, is recommended . There are insufficient data to generate recommendations for intravenous glutamine in critically ill patients who are receiving enteral nutrition.
10.1	Strategies to optimize benefits and minimize risks of PN: Dose of PN	Does the dose parenteral nutrition influence outcomes in the critically ill adult patient?	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.
--	--	--	--

10.2	Strategies to optimize benefits and minimize risks of PN: Use of lipids	Does the presence of lipids in parenteral nutrition influence outcomes in the critically ill adult patient?	Based on 2 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), withholding lipids should be considered . There are insufficient data to make a recommendation about withholding lipids in critically ill patients who are malnourished or those requiring PN for long term (> 10 days). Practitioners will have to weigh the safety and benefits of withholding lipids on an individual case-by-case basis in these latter patient populations.
10.3	Strategies to optimize benefits and minimize risks of PN: Mode of lipid delivery	Does the mode of delivery of lipids influence outcomes in the critically ill adult patient?	There are insufficient data to make a recommendation on mode of lipid delivery in critically ill patients who are receiving parenteral nutrition.
10.4	Strategies to optimize benefits and minimize risks of PN: intensive insulin therapy	Does tight blood sugar control result in better outcomes in the critically ill adult patient?	Based on 2 level 2 studies, in surgical critically ill patients receiving nutrition support, intensive insulin therapy to tightly control blood sugars between 4.4-6.6 should be considered . There are insufficient data to make a recommendation regarding intensive insulin therapy in other critically ill patients.
11.1	Supplemental antioxidant nutrients: combined vitamins and trace elements	Does the addition of supplemental antioxidant combined vitamins and trace elements result in better outcomes in the critically ill patient?	Based on 4 level 1 and 7 level 2 studies, the use of supplemental combined vitamins and trace elements and should be considered in critically ill patients.
11.2	Supplemental antioxidant nutrients: parenteral selenium	Does parenteral selenium supplementation (alone or in combination with other antioxidants) result in better outcomes in the critically ill patient?	There are insufficient data to make a recommendation regarding IV/PN selenium supplementation alone or in combination with other antioxidants in critically ill patients.