

10.2 Strategies to Optimize Parenteral Nutrition and Minimize Risks: Use of lipids

March 2013

There are no new randomized controlled trials since the 2009 update and hence there are no changes to the following summary of evidence.

Recommendation: *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 high in soybean oil should be considered. There are insufficient data to make a recommendation about withholding lipids high in soybean oil 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 high in soybean oil on an individual case-by-case basis in these latter patient populations.*

Discussion: The committee noted a large reduction in infectious complications associated with withholding lipids albeit this effect maybe due to reduced calories or the absence of lipids. The feasibility and cost favoured withholding lipids. One of the studies excluded malnourished patients (McCowen) while the other excluded patients with essential fatty acid deficiency (Batistella). The committee expressed concerns over the effects of long term fat free parenteral nutrition and the paucity of data in malnourished patients. The committee decided that while the concerns regarding withholding lipids (i.e. hypocaloric 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. Given the emerging evidence around the potential benefits of omega 3 fatty acids, it was agreed that this recommendation be made specific to withholding lipid emulsions that were high in soybean oil.

Semi Quantitative Scoring

Values	Definition	2009 Score (0,1,2,3)	2013 Score (0,1,2,3)
Effect size	Magnitude of the absolute risk reduction attributable to the intervention listed--a higher score indicates a larger effect size	3 (infection)	0 (mortality)* 3 (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*	1 (mortality)
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	2
Homogeneity or Reproducibility	Similar direction of findings among trials--a higher score indicates greater similarity of direction of findings among trials	2	2
Adequacy of control group	Extent to which the control group presented standard of care (large dissimilarities=1, minor dissimilarities=2, usual care=3)	3	3
Biological Plausibility	Consistent with understanding of mechanistic and previous clinical work (large inconsistencies=1, minimal consistencies=2, very consistent=3)	2	2
Generalizability	Likelihood of trial findings being replicated in other settings (low likelihood i.e. single centre=1, moderate likelihood i.e. multicentre with limited patient population or practice setting=2, high likelihood i.e. multicentre, heterogenous patients, diverse practice settings=3)	1	1
Low cost	Estimated cost of implementing the intervention listed--a higher score indicates a lower cost to implement the intervention in an average ICU	2	2
Feasible	Ease of implementing the intervention listed--a higher score indicates greater ease of implementing the intervention in an average ICU	3	3
Safety	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*	1*

*The 2009 scoring for effect size, confidence intervals & safety were corrected in December 2012

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Question: Does the presence of lipids in parenteral nutrition affect outcomes in the critically ill adult patient?

Summary of evidence: There were 2 level 2 studies reviewed that compared the use of lipids high in soybean oil to no lipids in parenteral nutrition (Battistella 1997, McCowen 2000).

Mortality: Both studies reported no difference in mortality between the groups and this was confirmed when the data from these 2 studies was aggregated (RR 1.29, CI 0.16-10.7, $p = 0.8$) (figure 1).

Infections: A significant reduction in pneumonia ($p = 0.05$), line sepsis ($p = 0.04$) and total number of infectious complications was seen in trauma patients not receiving lipids compared to those receiving lipids (Battistella 1997). In the McCowen 2000 study, the group that received no lipids (hypocaloric group) showed a trend towards a reduction in infections ($p = 0.2$). Combining these studies, the meta-analysis done showed a significant reduction in infections in the group that received no lipids (RR 0.63, CI 0.42-0.93, $p = 0.02$) (figure 2).

LOS and Ventilator days: A significantly shorter ICU stay ($p = 0.02$), hospital stay ($p = 0.03$) and significantly fewer ventilated days ($p = 0.01$) were observed in trauma patients not receiving lipids compared to those receiving lipids (Battistella 1997). No difference in LOS was seen in the McCowen 2000 study (did not report on ventilator days)

Other complications: Incidence of hyperglycemia was similar in the hypocaloric and standard groups (McCowen 2000).

Conclusions:

- 1) Withholding lipids high in soybean oil does not reduce mortality but is associated with a significant reduction in infections in critically ill patients and may reduce LOS and duration of ventilation in trauma 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 lipids (PN) in critically ill patients

Study	Population	Methods (score)	Intervention	Mortality # (%)†		RR (CI)**	Infections # (%)‡		RR (CI)**
				No lipids	Lipids		No lipids	Lipids	
1) Battistella 1997	Polytrauma patients N=60	C.Random: not sure ITT: no Blinding: no (8)	PN without lipids (1.5 g/kg protein, no lipids) vs. PN with lipids (30 kcal/kg/day + 1.6 gm/kg/d protein, 25 % calories from fat)	2/27 (7)	0/30 (0)	0.18 (0.01-3.60)	No lipids Pneumonia 13/27 (48) line sepsis 5/27 (19) total # infections per group 39/27	Lipids 22/30 (73) 13/30 (43) 72/30	1.52 (0.97-2.38) 2.34 (0.96-5.70) NA
2) McCowen 2000	Probable ICU patients (mostly ventilated) N=48	C.Random: not sure ITT: no Blinding: no (6)	Hypocaloric PN (no lipids), Pro 70g/d CHO 1000kcal/d vs standard PN (with lipids) ,Pro1.5g/kg/d, 25kcal/kg/d + lipids	Hypocaloric PN 2/21 (10)	Standard PN 3/19 (16)	0.60 (0.11-3.23)	Hypocaloric PN 6/21 (29)	Standard PN 10/19 (53)	0.54 (0.24-1.21)

Table 1. Randomized studies evaluating lipids (PN) in critically ill patients (continued)

Study	LOS days		Ventilator days		Cost		Other	
	No Lipids	Lipids	No lipids	Lipids	No lipids	Lipids	No lipids	Lipids
1) 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	No lipids NA Calories received kcal/kg/day 21 ± 2 Protein received gm/kg/day 1.6 ± 0.1	Lipids NA 28 ± 2 1.6 ± 0.2
2) McCowen 2000	Hypocaloric PN 19 ± 14 (21)	Standard PN 17 ± 15 (19)	Hypocaloric PN NA	Standard PN NA	Hypocaloric PN NA	Standard PN NA	Hypocaloric PN Calories received kcal/kg/day 14 ± 3 Protein received gm/kg/day 1.1 ± 0.2 Hyperglycemia 20	Standard PN 18 ± 4 1.3 ± 0.2 26%

Figure 1. Mortality

Comparison: 01 lipids vs no lipids (parenteral)
 Outcome: 01 mortality

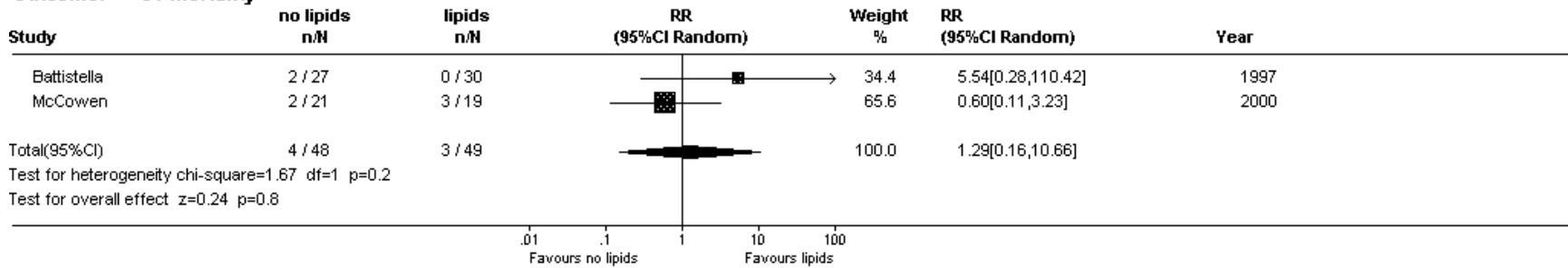


Figure 2. Infections

Comparison: 01 lipids vs no lipids (parenteral)
 Outcome: 02 Infectious complications

