

# ENTERAL NUTRITION by Nick Mark MD

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## OBJECTIVES:

- Adequate nutrition is essential to maintain normal physiologic functions
- Enteral feeding also helps maintain an important immunological barrier
- 30-50% of ICU pts are malnourished, malnutrition associated w/ [poor outcomes](#)

## WHEN TO START ENTERAL FEEDS?

- Early enteral nutrition (>48 hrs after onset of critical illness) is associated with **reduced mortality and reduced incidence of infections** (particularly pneumonia).
- Deliberate underfeeding is not associated with improved outcomes ([PERMIT 2019](#))
- No survival advantage with early parenteral nutrition ([EPN 2021](#))
- Enteral nutrition can be safely given while in the [prone position](#) or [receiving ECMO](#).
- EN can also be given [while on neurovascular blockers](#) or [while on ECMO](#).

## WHEN NOT TO START ENTERAL FEEDS?

- Early EN may be poorly tolerated in patients in shock ([OUTRILLA 21](#)); however the only absolute contraindications to initiating enteral nutrition (EN) are bowel obstruction, perforation, mesenteric ischemia, or major GI bleeding.

## ENTERIC FEED FORMULA:

- [Formulas](#) contain a mixture of macronutrients (carbohydrates, lipids, & protein) as well as micronutrients (electrolytes, vitamins, & trace elements). Select based upon clinical context.

- Despite theoretical basis, there is little clinical evidence for many novel disease specific formula (ARDS, COPD, liver).

- There is also limited evidence for additives like glutamine, etc

	Carbohydrate	Lipids	Protein	
	4.0 kcal/g	9 kcal/g	4.0 kcal/g	Energy content
	0.7 U/g	1.4 U/g	0.8 U/g	O <sub>2</sub> produced
	0.9 - 1.0	0.7	0.8	Respiratory quotient

Formula Type	Examples
<b>Standard</b> (1 kcal/ml) - similar to typical US diet in terms of <a href="#">calorie density</a> , used in most ICU patients <div>50-60% 25-40% 10-20%</div>	Ensure, Isosource, Boost, Omnilite
<b>Concentrated</b> (1.5-2.0 kcal/ml) - same contents, less volume, useful in patients on fluid restriction <div>50-60% 25-40% 10-20%</div>	Ensure plus, Impact 1.5, Taseal HN, Nutren, Renal, Nutren 2.0
<b>High protein</b> - useful for patients with high protein needs (>1.5 g/kg/day) <div>45-55% 30-35% 10-20%</div>	Isosource HN, Omnilite HN, Replete, Boost HP, Peptamen VHP, Ensure HP, Promote
<b>Pre-digested</b> (1.5 kcal/ml) - Low <a href="#">lipid</a> content, partially digested/easily absorbed peptides, used in malabsorption <div>&gt;60% &lt;10% 10-20%</div>	Peptamen, Vionate PLOS, Vivonex TEN, Atilaq
<b>High fiber</b> - contains soluble & insoluble fiber, used when there is persistent diarrhea on other feeds <div>50-60% 25-40% 10-20%</div>	Jevity, Ensure with fiber, Promote with fiber, Nutren 1.0 fiber, Compleat, Ultracal
<b>Renal</b> - Concentrated (1.5-2.0 kcal/ml), low K <sup>+</sup> & PO <sub>4</sub> , low protein, used for people with renal failure <div>40-40% 10-40% &lt;10%</div>	Nepro, Magnacal Renal, Suplena, Novasource Renal, Renacal
<b>Diabetic</b> - lower <a href="#">carbohydrate</a> content, used in diabetics <div>20-40% 40% 20%</div>	Choice DM, Glucerna Select, Glytrol, Diabetisource AC

## CALCULATING CALORIC NEEDS:

- Energy expenditure depends on mass, metabolism, & illness.
- It is not necessary to meet full caloric needs; many benefits of early feeding are realized with any EN. Paradoxically, achieving 100% of caloric needs in the 1<sup>st</sup> week [can be harmful](#). Thus, while early feeding is preferable the goal need not be full calories.

- Simple formula to estimate basal energy expenditure (BEE)  
 $BEE \text{ kcal/day} = 25 \times \text{weight (kg)}$

For most people use actual weight. If volume overloaded, use dry weight. If obese (BMI > 30 kg/m<sup>2</sup>) use 110% of BW.

- Disease can modify caloric needs:
  - Fever 10% more calories per degree C
  - Peritonitis 30-50% more, Sepsis 40-80% more
  - Trauma: 20-60% more Burns: >50-100% depends on BSA

- Higher protein may be beneficial in select population ([TARGET 2018](#))

Most critically ill patients require 1.2-1.5 g/kg/day of protein

- Patient with burns may require high protein 2 g/kg/day (add supplements if needed)

- Consider branched chain amino acids (BCAA) in patients with [hepatic encephalopathy](#)

- Indirect calorimetry measures VCO<sub>2</sub> & VO<sub>2</sub> to calculate EE

$$EE \text{ kcal/day} = 1440 \times [(3.94 \times V\dot{O}_2) + (1.11 \times V\dot{CO}_2)]$$

- Only possible to obtain accurate measurements if FIO<sub>2</sub> is < 0.6
- Respiratory quotient [can identify problems](#) or fine-tune feeding:
  - RQ >1 suggests overfeeding → decrease carbs or lipids
  - RQ <0.8 suggest underfeeding → increase calories

Indirect calorimetry results in [more calories & protein administered](#).



Use a [calculator](#) to determine the rates of a particular enteral feed.

## RESIDUALS:

- Residuals** are contents that remain in the stomach, after tube feeding is paused.
- At least 500ml of residuals can be safely tolerated without intervention ([MAGNUS 2019](#))
- If TF are poorly tolerated (residuals >500, vomiting, gastric distension), consider the following:
  - Maintain head up >30 degrees (good practice to prevent VAP)
  - Administer pro-kinetic agents (erythromycin is superior to metoclopramide)
  - Consider advancing FT post-pyloric or into jejunum (especially if vomiting)
- Increasingly, there is evidence for NOT checking residuals at all (less RN work, no improvement in outcomes)

## FEEDING TUBES (FT):

- Nasal can be used in intubated or non-intubated patients but there is a [higher risk of sinusitis](#) among people who are intubated.

- Gastric - used for bolus or continuous feeds

- Post-pyloric & jejunal can be used only for continuous feeds.

- Post-pyloric (duodenal)** - small  
Decrease in pneumonia risk; used in patients w/ gastric outlet obstruction, vomiting.

- Jejunal** - used in specific patients (vomiting, intolerance), O<sub>2</sub>/N<sub>2</sub> not superior O<sub>2</sub>/N<sub>2</sub> ([BENNETT 2014](#))

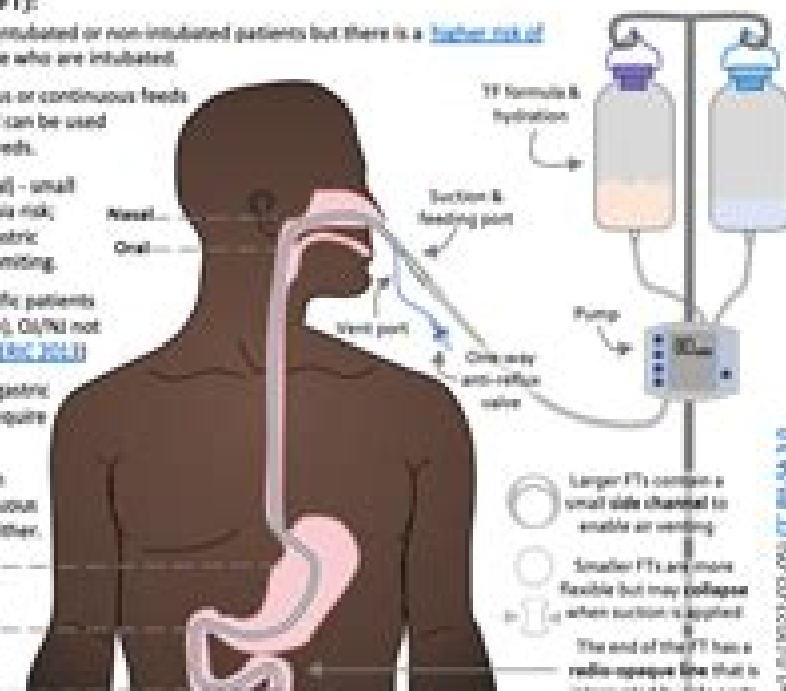
- Consider permanent gastric tube in people who require FT for >4-6 weeks

- [Similar outcomes](#) with intermittent & continuous tube feeds. Can use either.

Gastric 10-15ml

Post-pyloric 10-15ml (via duodenal)

Jejunal 10-15ml



# Pediatric Enteral Nutrition Guidelines

**CO Houle**



## **Pediatric Enteral Nutrition Guidelines:**

## The Enigmatic Realm of **Pediatric Enteral Nutrition Guidelines**: Unleashing the Language is Inner Magic

In a fast-paced digital era where connections and knowledge intertwine, the enigmatic realm of language reveals its inherent magic. Its capacity to stir emotions, ignite contemplation, and catalyze profound transformations is nothing short of extraordinary. Within the captivating pages of **Pediatric Enteral Nutrition Guidelines** a literary masterpiece penned by a renowned author, readers attempt a transformative journey, unlocking the secrets and untapped potential embedded within each word. In this evaluation, we shall explore the book's core themes, assess its distinct writing style, and delve into its lasting impact on the hearts and minds of people who partake in its reading experience.

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