

### 6.3 Enteral Nutrition (Other): Continuous vs. Other methods of administration

January 31<sup>st</sup>, 2009

**Recommendation:**

*There are insufficient data to make a recommendation on enteral feeds given continuously vs. other methods of administration in critically ill patients.*

**Discussion:** The committee noted the lack of treatment effect in 3 studies. Concern was also expressed about the safety of bolus feeds given the probability of harm associated with aggressive, early enteral nutrition via bolus feeds as illustrated in a earlier pseudorandomized study (1).

(1) Ibrahim EH, Mehringer L, Prentice D, Sherman G, Schaiff R, Fraser V, Kollef M. Early versus late enteral feeding of mechanically ventilated patients: Results of a clinical trial. JPEN 2002;26:174-181.

	Definition	Score 0, 1, 2 or 3
Effect size	Magnitude of the absolute risk reduction attributable to the intervention listed--a higher score indicates a larger effect size	0
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	1
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 or Reproducibility	Similar direction of findings among trials--a higher score indicates greater similarity of direction of findings among trials	1
Adequacy of control group	Extent to which the control group represented standard of care (large dissimilarities = 1, minor dissimilarities=2, usual care=3)	1
Biological plausibility	Consistent with understanding of mechanistic and previous clinical work (large inconsistencies =1, minimal inconsistencies =2, very consistent =3)	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
Low cost	Estimated cost of implementing the intervention listed--a higher score indicates a lower cost to implement the intervention in an average ICU	3
Feasible	Ease of implementing the intervention listed--a higher score indicates greater ease of implementing the intervention in an average ICU	2
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

### 6.3 Enteral Nutrition (Other): Continuous vs. other methods of administration?

January 31<sup>st</sup>, 2009

**Question:** Does continuous administration of enteral nutrition compared to other methods of administration result in better outcomes in critically ill patients?

**Summary of evidence:** There were 3 level 2 studies, 2 that reviewed compared continuous enteral feeding (started at 20 to 25 ml/hr and increased by 20 to 25 ml increments every 8 to 12 hrs) to bolus (started with a bolus of 100 to 125 mls by gravity over 15 minutes every 4 to 8 hrs and increased by 100 to 125 ml increments every 8 to 12 hrs). One level 2 study compared continuous feeds (over 24 hrs) to intermittent feeds (over 18 hrs).

**Mortality:** One study reported on mortality and found no difference between the groups receiving continuous or intermittent feeds (Bonten 1996). In one study, there was a trend towards a reduction in ICU mortality in the group receiving continuous feeds ( $p$  0.18, MacLeod 2007).

**Infections:** Two studies reported on infections and found no difference between the groups receiving continuous vs. intermittent feeds (Bonten 1996, RR 0.67, 95 % confidence intervals 0.27, 1.64) or continuous vs. bolus feeds ( $p$  = 0.45, MacLeod 2007). Incidence of aspirations detected was not significantly different between the groups receiving continuous and intermittent (Steevens 2002, RR 0.33, 95 % confidence intervals 0.02-7.24).

**LOS & Ventilator days:** Not reported. There were no differences between the groups in the one study that reported on ICU length of stay ( $p$  =0.69, MacLeod 2007)

**Other complications:** There were no significant differences in the frequency of interrupted feeds (RR 0.60, 95 % confidence intervals 0.20-1.8), the % goal feeds achieved, the number of patients with diarrhea (RR 0.40, CI 0.10-1.55) or the onset of diarrhea between the groups receiving continuous feeds and bolus feeds. Patients receiving continuous feeds received larger amounts of feeds than those receiving intermittent feeds and tolerated the feeds better in one study (Bonten 1996).

#### **Conclusion:**

There are no differences in mortality, frequency of interrupted feeds, % goal feeds achieved or diarrhea between patients receiving enteral feeds via continuous vs. other methods of administration.

*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 continuous enteral nutrition vs. other methods of administration in critically ill patients

Study	Population	Methods (score)	Intervention	Mortality # (%)		RR (CI)**	Infections # (%)		RR (CI)**
				Continuous	Intermittent		Continuous	Intermittent	
1) Bonten 1996	Mixed ICU's Mechanically ventilated N=60	C.Random: not sure ITT: yes Blinding: no (8)	Continuous feeds (24hrs) vs. intermittent feeds (18 hrs)	6/30 (20)	9/30 (30)	0.67 (0.27-1.64)	5/30 (17)	5/30 (17)	1.00 (0.32-3.10)
2) Steevens 2002	Multiple trauma patients, surgical, medical ICU's N = 18	C.Random: not sure ITT: yes Blinding: no (8)	Continuous enteral nutrition (started @ 25 ml/hr and ↑ by 25 mls q 12 hrs) vs bolus (125 mls by gravity over 15 minutes q 4 hrs and ↑ by 125 mls q 12 hrs.	Continuous NA	bolus NA	NA	Continuous 0/9 (0)	bolus Aspiration 1/9 (11)	0.33 (0.02-7.24)
3) MacLeod 2007	Trauma patients N = 164	C.Random: not sure ITT: no Blinding: no (5)	Continuous enteral nutrition (started @ 20 ml/hr for 8 hrs and ↑ by 20 mls q 8 hrs) vs. bolus (100 mls q 4 hrs and ↑ by 100 mls q 8 hrs.	Continuous ICU 6/81 (7)	bolus ICU 11/79 (14)	p 0.18	Continuous 33/81 (41)	bolus Pneumonia 38/79 (48)	p 0.45

Study	LOS days		Ventilator days		Cost		Other	RR (CI)**	
	Continuous	Intermittent	Continuous	Intermittent	Continuous	Intermittent			
1) Bonten 1996	Continuous NA	Intermittent NA	Continuous NA	Intermittent NA	Continuous NA	Intermittent NA	Continuous # patients with decreased feeds 2/30 (7)	Intermittent 5/30 (17)	0.40 (0.08-1.90)
2) Steevens 2002	Continuous NA	bolus NA	Continuous NA	bolus NA	Continuous NA	bolus NA	Continuous # patients with diarrhea 2/9 (22)	bolus 5/9 (56)	0.40 (0.10-1.55)
							# patients with interrupted feeds 3/9 (33)	5/9 (56)	0.60 (0.20-1.8)
							% goal feeds achieved 87 %	86.8 %	
3) MacLeod 2007	Continuous ICU 20.1 ± 1.7* (81)	bolus ICU 21.2 ± 2 *(79)	Continuous NA	bolus NA	Continuous NA	bolus NA	Continuous Onset of diarrhea 3/81 (4)	bolus 5/79 (79)	p 0.45
							% total calories for 1 <sup>st</sup> 7 days 58.3 ± 4*	60.2 ± 4.2*	p > 0.05
							Patients extubated prior to day 7 7/81 (9)	5/79 (6)	p 0.58

C.Random: concealed randomization    NA: not available    \* RR = relative risk    CI= confidence intervals    ITT: intent to treat    \* SEM (Standard error mean)

**TOPIC: 6.3 Continuous vs. other methods of administration**

**Article inclusion log**

**Criteria for study selection**

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

	Author	Journal	I	E	Why rejected
1	Hiebert	JPEN 1981		√	No clinical outcomes
2	Kocan	J Neuros Nurs 1986		√	No clinical outcomes
3	Ciocon	JPEN 1992		√	Not ICU patients
4	Bonten	Am J Resp Crit Care Med 1996	√		
5	Skiest	Clin Int Care 1996		√	No clinical outcomes
6	Steevens	Nutr Clin Pract 2002	√		
7	MacLeod	J Trauma 2007	√		

I = included, E = excluded

## Reference List

1. Hiebert JM, Brown A, Anderson RG, Halfacre S, Rodeheaver GT, Edlich RF. Comparison of continuous vs intermittent tube feedings in adult burn patients. *JPEN J Parenter Enteral Nutr* 1981;5(1):73-5.
2. Kocan MJ, Hichisch SM. A Comparison of continuous and intermittent enteral nutrition in NICU patients. *J Neurosci Nurs* 1986;18(6):333-7.
3. Ciocon JO, Galindo-Ciocon DJ, Tiessen C, Galindo D. Continuous compared with intermittent tube feeding in the elderly. *JPEN J Parenter Enteral Nutr* 1992;16(6):525-8.
4. Bonten MJ, Gaillard CA, van der Hulst R, de Leeuw PW, van der Geest S, Stobberingh EE, Soeters PB. Intermittent enteral feeding: the influence on respiratory and digestive tract colonization in mechanically ventilated intensive-care-unit patients. *Am J Respir Crit Care Med*. 1996 Aug;154(2 Pt 1):394-9.
5. Skiest DJ, Khan N, Feld R, Metersky ML. The role of enteral feeding in gastric colonization: a randomized controlled trial comparing continuous to intermittent enteral feeding in mechanically ventilated patients. *Clinical Intensive Care* 1996;7:138-143
6. Steevens EC, Lipscomb AF, Poole GV, Sacks GS. Comparison of continuous vs intermittent nasogastric enteral feeding in trauma patients: perceptions and practice. *Nutr Clin Pract*. 2002 Apr;17(2):118-22.
7. MacLeod JB, Lefton J, Houghton D, Roland C, Doherty J, Cohn SM, Barquist ES. Prospective randomized control trial of intermittent versus continuous gastric feeds for critically ill trauma patients. *J Trauma* 2007;63(1):57-61.