**SUPPLEMENT MATERIAL**

**Online supplement 1.** Full Embase electronic search strategy.

**Online supplement 2.** Full Cochrane Library electronic search strategy.

**Online supplement 3.** Questions evaluated for each domain of AGREE II and AGREE-REX

**Online supplement 4.** Calculation Domain Scores for AGREE II and AGREE-REX

**Online supplement 5.** Individual scoring of AGREE II for each CPG.

**Online supplement 6.** Individual scoring of AGREE-REX for each CPG.

**Online supplement 7**. Recommendations of CPGs evaluated with AGREE-REX regarding the nutrition care process of critically ill patients.

**Online supplement 8**. Recommendations of CPGs evaluated with AGREE-REX regarding specific conditions in critically ill patients.

**Online supplement 1.** Full Embase electronic search strategy.

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| ('critical care' OR 'intensive care' OR 'surgical intensive care' OR 'intensive care unit' OR 'critical illness' OR 'critical illnesses' OR 'critically ill' OR 'critically ill patients') AND ('nutrition therapy' OR 'diet' OR 'nutrition' OR 'medical nutrition therapy' OR 'medical nutrition' OR 'nutritional support' OR 'nutrition support' OR 'artificial feeding' OR 'artificial nutrition' OR 'enteral nutrition' OR 'enteral feeding' OR 'force feeding' OR 'tube feeding' OR 'gastric tube feeding' OR 'gastric feeding tube' OR 'gastric feeding tubes' OR 'gastric feeding' OR 'intestinal feeding' OR 'parenteral nutrition' OR 'parenteral feeding' OR 'parenteral feedings' OR 'intravenous feeding' OR 'nutrition assessment' OR 'nutritional assessment' OR 'nutritional assessments' OR 'nutritional evaluation' OR 'nutrition evaluation' OR 'nutrition screening' OR 'nutrition diagnosis' OR 'nutritional screening' OR 'nutritional diagnosis' OR 'nutrition care procedures' OR 'nutrition care process') AND ('clinical pathway' OR 'clinical protocol' OR 'consensus' OR 'consensus development confereces as topic' OR 'critical pathways' OR 'guideline' OR 'guidelines as topic' OR 'practice guidelines as topic' OR 'health planning guidelines' OR 'treatment guidelines' OR guideline OR 'practice guideline' OR 'consensus development conference') AND .pt. OR 'position statement' OR 'practice parameter' OR 'best practice' OR standards OR guideline OR guidelines OR '((practice or treatment\* or clinical) adj guideline\*).ab.' OR '(cpg or cpgs).ti.' OR 'consensus' OR '((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol))' OR 'recommendat\*.ti.kf.kw' OR '(care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab,kf,kw.' OR '(algorithm\* adj2 (screening or examination or test or tested or testing or assessment\* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab,kf,kw.' |

**Online supplement 2.** Full Cochrane Library electronic search strategy.

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| ("Critical Care" OR "Intensive Care" OR "Surgical Intensive Care" OR "Intensive Care Units" OR "Intensive Care Unit" OR "Critical Illness" OR "Critical Illnesses" OR "Critically Ill" OR "Critically Ill Patients"):ti,ab,kw AND ("Nutrition Therapy" OR "Medical Nutrition Therapy" OR "Nutritional Support" OR "Artificial Feeding" OR "Enteral Nutrition" OR "Enteral Feeding" OR "Force Feeding" OR "Tube Feeding" OR "Gastric Feeding Tubes" OR "Parenteral Nutrition" OR "Parenteral Feeding" OR "Intravenous Feeding" OR "Nutrition Assessment" OR "Nutritional Assessment" OR "Nutrition care procedures" OR Nutrition OR Diet):ti,ab,kw AND ("Clinical pathway" OR "Clinical protocol" OR Consensus OR "Consensus development" OR "Critical pathways" OR Guideline OR Guidelines OR Guide-line OR "Practice guidelines" OR "Clinical Practice Guidelines" OR "Health planning guidelines" OR "position statement" OR "policy statement" OR "practice parameter" OR "best practice" OR standards OR CPG OR CPGs):ti,ab,kw |

**Online supplement 3.** Questions evaluated for each domain of AGREE II and AGREE-REX

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| **AGREE-II** |
| **Domains** | **Items** |
| **1. Scope and Purpose** | 1. The overall objective(s) of the guideline is (are) specifically described.2. The health question(s) covered by the guideline is (are) specifically described.3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described. |
| **2. Stakeholder Involvement** | 4. The guideline development group includes individuals from all the relevant professional groups.5. The views and preferences of the target population (patients, public, etc.) have been sought.6. The target users of the guideline are clearly defined. |
| **3. Rigour of Development** | 7. Systematic methods were used to search for evidence.8. The criteria for selecting the evidence are clearly described.9. The strengths and limitations of the body of evidence are clearly described.10. The methods for formulating the recommendations are clearly described.11. The health benefits, side effects, and risks have been considered in formulating the recommendations.12. There is an explicit link between the recommendations and the supporting evidence.13. The guideline has been externally reviewed by experts prior to its publication.14. A procedure for updating the guideline is provided. |
| **4. Clarity of Presentation** | 15. The recommendations are specific and unambiguous.16. The different options for management of the condition or health issue are clearly presented.17. Key recommendations are easily identifiable. |
| **5. Applicability** | 18. The guideline describes facilitators and barriers to its application.19. The guideline provides advice and/or tools on how the recommendations can be put into practice.20. The potential resource implications of applying the recommendations have been considered.21. The guideline presents monitoring and/ or auditing criteria. |
| **Domain 6. Editorial Independence** | 22. The views of the funding body have not influenced the content of the guideline.23. Competing interests of guideline development group members have been recorded and addressed. |
| **AGREE-REX** |
| **1. Clinical Applicability** | 1. Evidence2. Applicability to Target Users3. Applicability to Patients/Populations |
| **2. Values and Preferences** | 4. Values and Preferences of Target Users5. Values and Preferences of Patients/Populations6. Values and Preferences of Policy/Decision-Makers7. Values and Preferences of Guideline Developers |
| **3. Implementability** | 8. Purpose9. Local Application and Adoption |

Adapted from: AGREE Next Steps Consortium (2017) and AGREE-REX Research Team (2019)

**Online supplement 4.** Calculation Domain Scores for AGREE II and AGREE-REX

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| If 4 reviewer give the following scores for Domain 1 (Scope and purpose):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Item 1 | Item 2 | Item 3 | **Total** |
| Reviewer 1 | 5 | 6 | 6 | **17** |
| Reviewer 2 | 6 | 6 | 7 | **19** |
| Reviewer 3 | 2 | 4 | 3 | **9** |
| Reviewer 4 | 3 | 3 | 2 | **8** |
| **Total** | **16** | **19** | **18** | **53** |

Maximum possible score = 7 (strongly agree) x 3 (items) x 4 (reviewers) = 84Minimum possible score = 1 (strongly disagree) x 3 (items) x 4 (reviewers) = 12The scaled domain score will be:

|  |
| --- |
| Obtained score – Minimum possible score |
| Maximum possible score – Minimum possible score |

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| --- | --- | --- | --- |
| 53 – 12 | x 100 = | 41 | x 100 = 0.5694 x 100 = 57% |
| 84 – 12 | 72 |

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Adapted from: AGREE Next Steps Consortium (2017)

**Online supplement 5.** Individual scoring of AGREE II for each CPG.

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Domain 1: Scope and Purpose** | **Domain 2: Stakeholder involvement** | **Domain 3: Rigour of development** | **Domain 4: Clarity of Presentation** | **Domain 5: Applicability** | **Domain 6: Editorial Independence** |
|  | **1** | **2** | **3** | **Total** | **4** | **5** | **6** | **Total** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **Total** | **15** | **16** | **17** | **Total** | **18** | **19** | **20** | **21** | **Total** | **22** | **23** | **Total** |
| **SEMICYUC-SENPE, 20111-10** | 6 | 4 | 5 | 15 | 3 | 1 | 3 | 7 | 3 | 2 | 3 | 4 | 2 | 4 | 2 | 1 | 21 | 6 | 3 | 5 | 14 | 1 | 1 | 1 | 1 | 4 | 6 | 4 | 10 |
| **AND, 201218** | 6 | 5 | 7 | 18 | 4 | 6 | 7 | 17 | 6 | 7 | 6 | 6 | 6 | 6 | 6 | 6 | 49 | 6 | 6 | 6 | 18 | 4 | 5 | 6 | 1 | 16 | 7 | 4 | 11 |
| **SFAR, 201413** | 2 | 3 | 2 | 7 | 4 | 3 | 2 | 9 | 1 | 1 | 5 | 5 | 4 | 5 | 1 | 2 | 24 | 5 | 4 | 6 | 15 | 1 | 1 | 1 | 1 | 4 | 1 | 1 | 2 |
| **Canadian, 201511** | 5 | 5 | 7 | 17 | 4 | 1 | 2 | 7 | 5 | 5 | 6 | 4 | 4 | 6 | 5 | 2 | 37 | 5 | 6 | 6 | 17 | 2 | 2 | 1 | 1 | 6 | 4 | 1 | 5 |
| **SCCM/ASPEN, 201614** | 3 | 4 | 7 | 14 | 5 | 1 | 7 | 13 | 3 | 3 | 6 | 4 | 5 | 7 | 2 | 5 | 35 | 6 | 7 | 7 | 20 | 1 | 2 | 1 | 1 | 5 | 7 | 4 | 11 |
| **ESICM, 201715** | 6 | 6 | 6 | 18 | 5 | 5 | 2 | 12 | 7 | 6 | 7 | 6 | 6 | 7 | 1 | 1 | 41 | 7 | 7 | 7 | 21 | 1 | 1 | 2 | 1 | 5 | 7 | 6 | 13 |
| **BRASPEN, 201817** | 1 | 2 | 3 | 6 | 2 | 1 | 2 | 5 | 1 | 1 | 4 | 2 | 2 | 5 | 1 | 1 | 17 | 6 | 5 | 6 | 17 | 1 | 1 | 1 | 1 | 4 | 1 | 1 | 2 |
| **DGEM, 201912** | 5 | 4 | 5 | 14 | 5 | 1 | 5 | 15 | 1 | 2 | 3 | 6 | 5 | 4 | 1 | 2 | 24 | 5 | 6 | 6 | 17 | 2 | 1 | 2 | 1 | 6 | 4 | 7 | 11 |
| **ESPEN, 201916** | 5 | 6 | 5 | 16 | 5 | 1 | 1 | 7 | 5 | 5 | 6 | 4 | 5 | 7 | 2 | 4 | 38 | 6 | 7 | 6 | 19 | 1 | 1 | 2 | 1 | 5 | 7 | 5 | 12 |
| **ASPEN, 2021** | 5 | 7 | 7 | 19 | 5 | 1 | 7 | 13 | 6 | 6 | 6 | 2 | 3 | 7 | 1 | 5 | 36 | 6 | 7 | 7 | 20 | 1 | 1 | 1 | 1 | 4 | 7 | 5 | 12 |

**\*Legend:** Academy of Nutrition and Dietetics (AND); American Society for Parenteral and Enteral Nutrition (ASPEN); European Society for Clinical Nutrition and Metabolism (ESPEN); European Society of Intensive Care Medicine (ESICM); German Society for Nutritional Medicine (DGEM); Intraclass correlation coefficient (ICC); Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias **(**SEMICYUC); Sociedad Española de Nut rición Parenteral y Enteral (SENPE); Sociedade Brasileira de Nutrição Parenteral e Enteral (BRASPEN); Société francaise d’anesthésie et de réanimation (SFAR); Society of Critical Care Medicine (SCCM).

**Online supplement 6.** Individual scoring of AGREE-REX for each CPG.

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|  | **Domain 1: Clinical Applicability** | **Domain 2: Values and Preferences** | **Domain 3: Implementability** |
|  | **1** | **2** | **3** | **Total** | **4** | **5** | **6** | **7** | **Total** | **8** | **9** | **Total** |
| **AND, 201218** | 6 | 6 | 6 | 18 | 2 | 6 | 3 | 1 | 12 | 6 | 5 | 11 |
| **SCCM/ASPEN, 201614** | 6 | 6 | 5 | 17 | 1 | 1 | 1 | 1 | 4 | 5 | 2 | 7 |
| **ESICM, 201715** | 7 | 7 | 6 | 20 | 1 | 4 | 1 | 3 | 9 | 6 | 3 | 9 |
| **DGEM, 201912** | 3 | 6 | 5 | 14 | 4 | 1 | 1 | 1 | 7 | 6 | 1 | 7 |
| **ESPEN, 201916** | 6 | 6 | 5 | 17 | 1 | 1 | 1 | 1 | 4 | 5 | 2 | 7 |
| **ASPEN, 2021** | 6 | 7 | 6 | 19 | 2 | 1 | 1 | 1 | 5 | 5 | 1 | 6 |

**\*Legend:** Academy of Nutrition and Dietetics (AND); American Society for Parenteral and Enteral Nutrition (ASPEN); German Society for Nutritional Medicine (DGEM); European Society for Clinical Nutrition and Metabolism (ESPEN); European Society of Intensive Care Medicine (ESICM); Society of Critical Care Medicine (SCCM).

**Online supplement 7**. Recommendations of CPGs and quality of evidence regarding nutrition care process steps in critically ill patients.

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|  | **AND, 201218** | **SCCM/ASPEN, 201614** | **ASPEN, 2021** | **ESICM, 201715** | **DGEM, 201912** | **ESPEN, 201916** |
| **Nutrition screening** | NR | NRS-2002 or NUTRIC score should be performed on all patients admitted to the ICU.QE: Expert consensus | NR | NR | The authors comment that all patients have high nutritional risk | All critically ill patient staying for > 48h in the ICU should be considered at risk for malnutritionQE: Strong consensus |
| **Nutrition Assessment** | Food and Nutrition-Related History, Anthropometric Measurements, Nutrition-Focused Physical Findings, and Client HistoryQE: Consensus, imperative | Evaluation of comorbid conditions, function of the GI tract, and risk of aspiration.QE: Expert consensus | NR | NR | Criteria for disease-specific malnutrition proposed by DGEM, or SGA may be used.QE: Uncertain recommendation, consensus | Anamnesis, report of unintentional weight loss or decrease in physical performance, physical examination, body composition, and muscle mass and strength, if possible.QE: Strong consensus |
| **Nutrition Intervention: Energy Requirement** | 1. If IC is not available - Penn State University equation in non-obese, critically ill mechanically ventilated adults.QE: Fair, conditional | 1. ICQE: Very low2. Predictive equations or 25–30 kcal/kg/day).QE: Expert consensus | 12-25 kcal/kg in the first 7–10 days of ICU stayQE: Moderate, weak | NR | 1. ICQE: Weak2. Carbon dioxide production rate (VCO2 method).QE: Uncertain3. Non-obese critically ill patients 24 kcal/kg ABW/dayQE: Weak | 1. ICQE: B and strong consensus2. VO2 from pulmonary arterial catheter or VCO2 derived from the ventilator will (REE = VCO2 x 8.19).QE: Consensus3. 20-25 kcal/kg/day. QE: Consensus |
| **Nutrition Intervention: Protein Requirement**  | NR | 1.2–2.0 g/kg ABW/dayQE: Very low | 1.2–2.0 g/kg/dayQE: Low, weak | NR | 1.0-1.2 g/kg of ABW/dayQE: Weak, consensus | 1.3 g/kg/day QE: 0, strong consensus |
| **Nutrition Intervention: Start of nutrition therapy** | If EN is not contraindicated, it should be started within 24 to 48 hours following ICU admission QE: Strong, conditional | Early EN within 24–48 hours when patient is unable to maintain volitional intake.QE: Very Low | NR | Early EN (in the first 48h) QE: low (GRADE 2C) | First 24h in those patients who are unable to maintain sufficient volitional intake during the early acute phase of critical illness.QE: Uncertain | If oral intake is not possible, early EN (within 48 h) in critically ill adult patients should be initiated QE: B, strong consensus |
| **Nutrition Intervention: Route of nutrition therapy** | EN over PN QE: Strong, conditional | EN over PNQE: Low to Very Low | Either PN or EN is acceptable.QE: High, strong | EN rather than PNQE: low (GRADE 2C) | EN if patient is unable to maintain sufficient volitional intakeQE: Weak, Strong consensus | - Oral diet shall be preferred over EN or PN patients who are able to eat.QE: GPP, strong consensus- If oral intake is not possible, EN shall be initiated rather than PN.QE: A, strong consensus |
| **Nutrition Intervention: Position of enteral tube** | Small bowel feeding tube placementQE: Fair, conditional | - Acceptable to initiate EN in the stomach.QE: Expert consensus- Post pyloric enteral access in patients deemed to be at high risk for aspiration.QE: Moderate to high | NR | NR | Gastric access route, except when aspiration risk/gastric residual volume is high, and when there is little technical effort to insert a feeding tube.QE: Weak, Strong consensus | - Gastric access should be used as the standard approach.QE: GPP, strong consensus- Post pyloric in patients at high risk for aspiration.QE: GPP, strong consensus- Post pyloric in patients with gastric feeding intolerance not solved with prokinetic agentsQE: B, strong consensus |
| **Nutrition Intervention: Type of enteral formulae** | NR | Standard polymeric formula. Avoid the routine use of all specialty formulas.QE: Expert consensus | NR | NR | Fiber-containing enteral formulas should not be used in the acute phase, when there is a high risk of intestinal ischemia.QE: Weak, strong consensus | NR |
| **Nutrition Intervention: Parenteral nutrition indication** | NR | - When EN is not feasible, exclusive PN should be started as soon as possible in patient with high nutrition risk or severely malnourished.QE: Expert consensus- In low nutrition risk patient, exclusive PN be withheld over the first 7 days following ICU admission if volitional intake can not me maintained and if early EN is not feasible.QE: Very Low | Not initiate supplemental PN prior to day 7 of ICU admission.QE: High, strong | NR | If there are contraindications for an EN supply, PN should be initiated.QE: Weak, strong consensus | - Early and progressive PN can be provided in case of contraindications for EN in severely malnourished patients. QE: 0, strong consensus- In case of contraindications to oral and EN, PN should be implemented within three to seven days QE: B, consensus |
| **Nutrition Monitoring** | - It is recommend against holding EN when GRV <500ml in the absence of signs of intoleranceQE: Fair, conditional- Monitor and evaluate at each visit the nutrient intake QE: Consensus, imperative | - Tolerance of EN should be monitored daily and inappropriate cessation of EN and ordering NPO should be avoided. QE: Expert consensus- GRVs should not be used as part of routine care to monitor ICU patients receiving ENQE: Low | NR | NR | NR | NR |

**\*Legend**: Actual body weight (ABW); Academy of Nutrition and Dietetics (AND); American Society for Parenteral and Enteral Nutrition (ASPEN); Body Mass Index (BMI); German Society for Nutritional Medicine (DGEM); Energy Expenditure (EE); Enteral Nutrition (EN); European Society for Clinical Nutrition and Metabolism (ESPEN); European Society of Intensive Care Medicine (ESICM); Gastric Residual Volume (GRV); Gastrointestinal (GI); Good Practice Points (GPP); Grading of Recommendations Assessment, Development and Evaluation (GRADE); Indirect Calorimetry (IC); Intensive Care Unit (ICU); Nil Per Os (NPO); Not Reported (NR); Nutrition Risk in the Critically ill (NUTRIC); Nutrition Therapy (NT); Nutritional Risk Screening (NRS-2002); Parenteral Nutrition (PN); Quality of evidence (QE); Society of Critical Care Medicine (SCCM); Subjective Global Assessment (SGA).

**Online supplement 8**. Recommendations of CPGs and quality of evidence regarding specific conditions in critically ill patients

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|  | **AND, 201218** | **SCCM/ASPEN, 201614** | **ESICM, 201715** | **DGEM, 201912** | **ESPEN, 201916** |
| **Diarrhea** | NR | - EN should not be automatically interrupted for diarrhea - Small peptide formulations or a commercial mixed fiber-containing formulation should be used if persistent diarrhea.QE: Expert consensus | Use early EN in critically ill adult patients with diarrhea.QE: expert opinion (GRADE 2D) | EN should be discontinued in refractory severe diarrhea.QE: Weak, Consensus | NR |
| **Renal Replacement Therapy** | NR | - Protein should not be restricted as a means to avoid or delay initiating dialysis therapy. - Maximum of 2.5 g/kg/day.QE: Very Low | NR | The same protein offers as in patients not having this treatment.QE: Uncertain, Strong consensus | NR |
| **Severe Acute Pancreatitis** | NR | - EN should be started at a trophic rate early. QE: Very Low- Use of EN over PN is indicated.QE: Low- EN should be provided to patient by either the gastric or jejunal route.QE: Low- PN should be considered after 1 week from the onset of the pancreatitis episode.QE: Expert consensus | Use early EN.QE: Conditional, based on low quality evidence (GRADE 2C) | NR | Early EN should be prescribed.QE: B, strong consensus |
| **Sepsis** | NR | - EN within 24–48 hours, as soon as resuscitation is complete and the patient is stable.QE: Expert consensus- Not using exclusive PN or supplemental PN with EN.QE: Very Low- Trophic feeding (10–20 kcal/h or up to 500 kcal/d) for the initial phase of sepsis, advancing after 24–48 hours to >80% of target energy.QE: Expert consensus | NR | NR | - Early and progressive EN should be used in septic patients after stabilization.If contraindicated, EN should be replaced by progressive PN.QE: GPP, strong consensus |
| **Hepatic Failure** | NR | - Use dry weight or usual weight.QE: Expert consensus- No evidence for BCAA formulations in patients with encephalopathy who is already receiving first-line therapy with luminal-acting antibiotics and lactulose.QE: Expert consensus | Starting low dose of EN in patients with acute liver failureQE: Conditional, based on expert opinion (GRADE 2D) | NR | Low dose EN should be administered in patients with acute liver failure QE: B, strong consensus |
| **Pulmonary Failure** | Should be used immune-modulating enteral formulas with fish oil, borage oil and antioxidants.QE: Strong, conditional | Not use high-fat/low-carbohydrate formulations to manipulate the respiratory quotient and reduce CO2.QE: Very Low | NR | NR | NR |
| **Obesity** | - Use IC for energy requirementQE: GRADE A- For morbid obesity, hypocaloric diet (50-60% of EE, or 18-20 kcal/ kg of IBW/day) QE: GRADE B- For non-morbid obesity, hypocaloric nutrition estimated as 20-25kcal/kg of AdBW/ day.QE: GRADE C- Protein: 1,8-2,5 g/kg of IBW/ day.QE: GRADE B | - High-protein hypocaloric feeding to preserve lean body mass, mobilize adipose stores, and minimize the metabolic complications of overfeeding.QE: Expert consensus- Enteral formula with low caloric density (1kcal/mL) and a reduced NPC:N. should be used. QE: Expert consensus - Not exceed 65%–70% of target energy requirements measured by IC. If IC is unavailable and BMI 30-50: 11–14 kcal/kg of ABW/ day or BMI >50: 22–25 kcal/kg of IBW/ dayQE: Expert consensus- Protein: if BMI 30-40: 2.0 g/kg of IBW/ dayor BMI > 40: 2.5 g/kg of IBW/ dayQE: Expert consensus | NR | - Use IC for energy requirement QE: Weak, Strong consensus- 60% of the measured EE or 11-14 kcal/kg of ABW/day if BMI 30-50 kg/m² or 22-25 kcal/kg of IBW/day if BMI >50 kg/m².QE: Strong consensus-Protein: if BMI >30 kg/m² the target of protein in the acute phase should be 1.5 g protein (or at 1.8 g amino acids)/kg of IBW/day.QE: Strong consensus | - Isocaloric high protein diet, guided by IC measurements and urinary nitrogen losses should be provided.QE: 0, consensus- If IC is not available, energy requirement can be based on AdBW. QE: GPP, consensus- Protein: Guided by urinary nitrogen losses or lean body mass, and if it is not available, protein intake can be 1.3 g/kg of AdBW/day.QE: GPP, consensus |

**\*Legend**: Academy of Nutrition and Dietetics (AND); Adjusted Body Weight (AdBW); American Society for Parenteral and Enteral Nutrition (ASPEN); Body Mass Index (BMI); Branched-Chain Amino Acid (BCAA); Energy Expenditure (EE); Enteral Nutrition (EN); European Society for Clinical Nutrition and Metabolism (ESPEN); European Society of Intensive Care Medicine (ESICM); Gastrointestinal (GI); Good Practice Points (GPP); Grading of Recommendations Assessment, Development and Evaluation (GRADE); Ideal Body Weight (IBW); Indirect Calorimetry (IC); Not Reported (NR); Nutrition Therapy (NT); Parenteral Nutrition (PN); Society of Critical Care Medicine (SCCM); Subjective Global Assessment (SGA).

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