Supplementary Online Content


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This supplementary material has been provided by the authors to give readers additional information about their work.
**eMethods**

- **Inclusion Criteria**

  Patients were eligible for inclusion if they met all of the below criteria. Criteria 1-3 must have been present within a 24-hour time period:

  Acute onset (defined below) of:

  1. $\text{PaO}_2 / \text{FiO}_2 \leq 300$. If altitude > 1000m, then $\text{PaO}_2 / \text{FiO}_2 \leq 300 \times (\text{PB}/760)$

  2. Bilateral infiltrates consistent with pulmonary edema on frontal chest radiograph. The infiltrates could be patchy, diffuse, homogeneous, or asymmetric

  3. Requirement for positive pressure ventilation via endotracheal tube, and

  4. No clinical evidence of left-sided cardiac failure to account for bilateral pulmonary infiltrates.

  5. Intention of primary medical team to provide enteral nutrition to the patient

  The 48-hour enrollment time window began when criteria 1-3 were met. If a patient met the first three inclusion criteria but had a PAOP (Pulmonary Arterial Wedge Pressure) greater than 18 mmHg, then the first four criteria had to persist for more than 12 hours after the PAOP had declined to $\leq 18$ mmHg, and still be within the 48-hour enrollment window.

  “Acute onset” was defined as the duration of the hypoxemia criterion (#1) and the chest radiograph criterion (#2) must have been present for $\leq 28$ days at the time of randomization. Opacities considered “consistent with pulmonary edema” included any opacities not fully explained by mass, atelectasis, or effusion or opacities known to be chronic (greater than 28 days). Vascular redistribution, indistinct vessels, and indistinct
heart borders alone were not considered “consistent with pulmonary edema” and thus
did not count as qualifying opacities for this study.

- **Exclusion Criteria**

1. Age < 13 years
2. Greater than 48 hours since all inclusion criteria met
3. Neuromuscular disease that impairs ability to ventilate without assistance, such as:
   a. cervical spinal cord injury at level C5 or higher
   b. amyotrophic lateral sclerosis
   c. Guillain-Barré Syndrome
   d. myasthenia gravis
   e. Kyphoscoliosis or chest wall deformity resulting in severe exercise restriction, secondary polycythemia, or respirator dependence
4. Pregnant or breast-feeding
5. Severe chronic respiratory disease, demonstrated by any of:
   a. FEV1 < 20 ml/kg PBW
   b. FEV1/VC < 50% predicted
   c. Chronic hypercapnea with PaCO₂ > 45 mm Hg
   d. Chronic hypoxemia with PaO₂ < 55 mm Hg on FiO₂ = 0.21
   e. Radiographic x-ray evidence of any chronic over-inflation or chronic interstitial infiltration
   f. Hospitalization within the past 6 months for respiratory failure
   g. Chronic restrictive, obstructive, neuromuscular, chest wall, or pulmonary vascular disease
      resulting in severe exercise restriction, secondary polycythemia, severe pulmonary hypertension with mean PAP > 40 mm Hg, or respirator dependency
6. Burns greater than 40% total body surface area
7. Malignancy or other irreversible disease or condition for which 6-month mortality is estimated to be greater than 50%:
   a. Poorly controlled neoplasms
   b. Known HIV positive with known end stage process and known CD4 count < 50 / mm$^3$
   c. Prior cardiac arrest requiring cardiopulmonary resuscitation without fully demonstrated neurologic recovery
   d. New York Heart Association Class IV exercise restriction
   e. Chronic condition making patient respirator dependent
8. Allogeneic bone marrow transplant in the last 5 years
9. Patient, surrogate, or physician not committed to full support (Exception: a patient was not excluded if he/she would receive all supportive care except for attempts at resuscitation from cardiac arrest).
10. Severe chronic liver disease (Child-Pugh Score of 11-15) $^{E1}$
11. Diffuse alveolar hemorrhage from vasculitis.
12. Morbid obesity (> 1kg/cm body weight)
13. No consent/inability to obtain consent
14. Unwillingness or inability to utilize the ARDS network 6 ml / kg PBW lung protective ventilation protocol
15. Moribund patient not expected to survive 24 hours
16. No intent to obtain central venous access for monitoring intravascular pressures.
17. Greater than 72 hours since initiation of mechanical ventilation
18. Refractory shock, defined by any of the following:
   a. Dopamine infusion at rate $\geq 15$ mcg / kg / min
   b. Dobutamine infusion at rate $\geq 15$ mcg / kg / min
   c. Epinephrine or Norepinephrine infusion at rate $\geq 30$ mcg / min
   d. Phenylephrine infusion at rate $\geq 50$ mcg / min
   e. Milrinone infusion at rate $\geq 0.5$ mcg / kg / min
f. Vasopressin infusion at rate > 0.04 U / min

g. Intra-aortic Balloon Pump

19. Unable to obtain enteral access

20. Presence of partial or complete mechanical bowel obstruction, or ischemia, or infarction

21. Current TPN use or intent to use TPN within 7 days

22. Severe malnutrition with BMI < 18.5 or loss of > 30% total body weight in the previous 6 months

23. Laparotomy expected within 7 days

24. Unable to raise head of bed 30 degrees

25. Short-bowel syndrome or absence of gastrointestinal tract

26. Presence of high-output (> 500 cc/day) enterocutaneous fistula

27. INR > 5.0 or platelet count < 30,000 / mm³ or history of bleeding disorder

28. Intracranial hemorrhage within the previous month

29. Allergy to enteral formula, n-3 fatty acids, gamma-linolenic acid, vitamin E, vitamin C, beta-carotene, taurine, or L-carnitine

30. Requirement for, or physician insistence on, enteral formula supplemented with n-3 fatty acids (ex: Oxepa®, Impact®) or providing n-3 fatty acid, GLA, or anti-oxidant supplementation

_Conservative Fluid Management Protocol_

This fluid protocol was initiated within four hours of randomization and continued until the earlier of UAB or study day 7.

1. Discontinue maintenance intravenous fluids.

2. Manage electrolytes and blood products per usual practice.

3. For shock, use any combination of fluid boluses† and vasopressor(s) to achieve MAP ≥ 60 mmHg as fast as possible. Wean vasopressors as quickly as tolerated beginning four hours after blood pressure has stabilized.

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4. Withhold diuretic therapy in renal failure § and until 12 hours after last fluid bolus or vasopressor given.

<table>
<thead>
<tr>
<th>CVP (recommended)</th>
<th>PAOP (optional)</th>
<th>MAP ≥ 60 mm Hg AND off vasopressors for ≥ 12 hours</th>
<th>Average urine output &lt; 0.5 ml/kg/hr</th>
<th>Average urine output &gt; 0.5 ml/kg/hr</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;8</td>
<td>&gt; 12</td>
<td>Furosemide*</td>
<td>Reassess in 1 hour</td>
<td>Furosemide*</td>
</tr>
<tr>
<td>4-8</td>
<td>8-12</td>
<td>Give fluid bolus as fast as possible§</td>
<td></td>
<td>Reassess in 4 hours</td>
</tr>
<tr>
<td>&lt; 4</td>
<td>&lt; 8</td>
<td></td>
<td>Reassess in 1 hour</td>
<td>No intervention</td>
</tr>
</tbody>
</table>

§ Renal failure is defined as dialysis dependence, oliguria with serum creatinine > 3.0 mg/dL, or oliguria with serum creatinine 0.1-3.0 mg/dL with urinary indices indicative of acute renal failure.

# Recommended fluid bolus= 15 mL / kg crystalloid (round to nearest 250 mL) or 1 Unit packed red cells or 25 grams albumin

* Recommended Furosemide dosing = begin with 20 mg bolus or 3 mg / hr infusion or last known effective dose. Double each subsequent dose until goal achieved (oliguria reversal or intravascular pressure target) or maximum infusion rate of 24 mg / hr or 160 mg bolus reached. Do not exceed 620 mg / day. Also, if patient has heart failure, consider treatment with dobutamine.
Data Collection

All baseline assessments were obtained after obtaining informed consent from the participant or their legally authorized representative, but prior to initiation of study procedures. Baseline assessments were recorded from the 24 hour interval prior to randomization. If more than one value was available for this period, the value closest to the time of enrollment was utilized. If no values were available from the 12 hours prior to randomization, then values were measured during the 12 hours post randomization but prior to initiation of enteral feeds. Baseline assessments included demographics, co-morbidities, height, measured weight, weight loss in the previous 6 months, vital signs, location of the feeding tube (i.e. gastric vs. post-pyloric), Acute Physiology, and Chronic Health Evaluation (APACHE) III scores, FiO2, Positive End-Expiratory Pressure (PEEP), and ventilator mode. Type of ICU and etiology of ALI was also collected at baseline. Serum electrolytes, blood urea nitrogen, creatinine, glucose, complete blood count, total protein, albumin, total bilirubin and arterial PaO₂, pH, and PaCO₂ were collected at baseline and daily through day 12 when available. Number and type of gastrointestinal intolerances were collected daily on patients mechanically ventilated to the earlier of extubation or day 12. Administration of sedatives, narcotics, vasopressors, pro-kinetic agents, anti-diarrheal agents, laxatives, and anti-emetics were recorded daily until the earlier of study day 12, death, or extubation. Enteral feeding volume and calories, morning blood glucose levels, and 8AM insulin infusion rates were recorded daily for the same time period. Assessments for cardiovascular, pulmonary, coagulation, renal, hepatic, and central nervous system dysfunction, and mortality, ventilator, and ICU requirements were collected daily through Day 28. Number of quadrants with infiltrates was collected from chest X-rays when available until extubation. Development and site of new infections, defined by the primary medical team, including ventilator-associated pneumonia, bacteremia, and Clostridium difficile-associated diarrhea, were collected from days 3 through 28.

Enteral Feeding Procedures
In conjunction with the primary team, dietary specialists completed an evaluation within 24 hours of mechanical ventilation, and selected the enteral formula to be used. Full-feeding rates were determined using 25-30 kcal/kg ideal body weight/day of non-protein energy and 1.2-1.6 g/kg ideal body weight/day of protein as targets. All patients received a commercially available standard formula chosen by the primary team except formulas enriched with omega-3 fatty acids were not allowed. The type of enteral feeding tube (nasogastric, nasoenteric, oro gastric, oroenteric, percutaneous endoscopic gastrostomy tube, etc) was determined by the patient’s primary medical team. The decision to use prokinetic agents and/or change gastric to post-pyloric feeding tubes in patients who experienced elevated gastric residuals, vomiting, aspiration, or regurgitation was left to the discretion of the primary team. Patients randomized to trophic feeding who were extubated and re-intubated prior to 144 hours were restarted on trophic feeds and advanced to full-feeding rates per protocol at 144 hours from study entry.

Gastric Residual Volumes (GRV)

GRV were checked every 6 hours while feeding rates were being increased to full-feeding rates and every 12 hours if the patient was receiving trophic rates or once full-feeding rate was achieved. Elevated gastric residual volumes (GRV) were defined as greater than 400 cc of tube-feed containing gastric contents withdrawn from the gastric tube during any one check. Gastric residuals were only measured in patients with post-pyloric feeding tubes if a separate gastric port on the feeding tube or separate gastric tube was in place. After the first episode of elevated GRV, 400 cc of the residual was returned to the patient via the feeding tube and the feeding rate was maintained for an additional two hours. GRV was then rechecked, and if also above 400 cc, 400 cc were returned to the patient and enteral feeds were held. GRV were checked every 2 hours until levels were below 400 cc. Once GRV levels were below 400 cc, enteral feeding was restarted at a rate 25 cc/hr less than the previous rate in the full-feeding group and at 10cc/hr in the trophic group.
Other Gastrointestinal Intolerances

Patients were evaluated for other GI intolerances, including abdominal distention or cramping, nausea, vomiting, diarrhea, aspiration, and regurgitation, by the bedside nurse or primary team at least every 6 hours as feeding rates were being increased and every 12 hours when rates were stable. Standardized criteria for and actions in response to each gastrointestinal intolerance were defined *a priori*. The bedside nurse or primary team could evaluate patients for feeding complications more frequently if warranted by the clinical condition. Abdominal distention was defined as the presence of a tense or rigid abdomen with guarding or rebound on exam. In cases of abdominal distention, enteral feeding rate was decreased by 25 cc/hr and the patient re-evaluated every 6 hours until distention improved at which time rates were increased to previous rates. Aspiration, defined as the presence of food in the lungs either visually or in material suctioned from the endotracheal tube resulted in holding of enteral feeds for 6 hours. Feeds could be restarted after the later of 6 hours or GRV less than 400 cc. Regurgitation was defined as enteral feeds visualized in the oropharynx or nasopharynx. When regurgitation was discovered, the location of the feeding tube was checked and repositioned if it ended in the esophagus. If it was in the stomach or post-pyloric, feeds were held and restarted at 25 cc/hr below the previous rate as long as the GRV was less than 400cc after 6 hours. Vomiting was defined as expulsion of gastric contents from the oro- or nasopharynx. When vomiting occurred, feeds were held for 6 hours. After 6 hours and confirmation of correct tube position, feeds were restarted at a rate 25 cc/hr slower than previous. Diarrhea was defined as more than 3 liquid bowel movements in 24 hours and constipation was defined as the absence of a bowel movement requiring intervention. For either diarrhea or constipation, the primary team was encouraged to minimize offending medications and initiate pharmacologic treatments. Although discouraged, the primary team could interrupt or halt enteral feeding for diarrhea or constipation if it was thought necessary for the patient’s health.

Endpoints
VFDs were defined as the number of days alive and on unassisted breathing. In patients who required more than one episode of assisted breathing through day 28, only the final period of unassisted breathing was included in VFDs. Any level of Continuous Positive Airway Pressure (CPAP) was considered unassisted breathing, but non-invasive positive pressure ventilation (NIPPV) with separate inspiratory and expiratory pressures was considered assisted breathing, regardless of its indication. Patients receiving assisted breathing on day 28 or who died before day 28 were assigned zero VFDs. Patients discharged home alive prior to day 28 were assumed alive at day 28. ICU-free and all other organ failure-free endpoints were calculated similarly to VFDs. Patients were considered free of cardiovascular failure if blood pressure was maintained without use of vasopressor agents, free of hematologic system failure if platelet counts were greater than 80,000/microliter and free of hepatic or renal failure if the bilirubin or creatinine remained < 2.0 mg/dL, respectively.

The secondary endpoint of GI intolerances was analyzed both daily and overall through day 12. Daily GI intolerances were recorded through day 12 as ever occurring on that day or not occurring on that day, reported as a percentage of patients experiencing the intolerance each day, and compared using chi-square tests. Overall GI intolerance is reported as percent of days fed with intolerance for both all GI intolerances cumulatively and each specific intolerance. For both, number of days with an intolerance was computed and divided by number of days fed through day 12 for each patient. Differences in mean percentages of fed-days with an intolerance were then compared between groups using a t-test.

Statistical Analysis

The two-sided P-value for determining significance of VFD at the final analysis was 0.0429. Alpha and beta spending boundaries were used for interim analyses as described by DeMets and Ware (zl=2.277,delta=1.663,zu=2.025,m=4, mu=3.3837) E2. P-values ≤ 0.05 were considered significant for other analyses. Post-hoc subgroup analyses were undertaken separately for patients with shock, ARDS (i.e. P/F ≤ 200), and BMI <18.5, 18.5-25, 25-30, and ≥ 30.
**Efficacy and Futility Stopping Rules**

The maximum sample size was planned to be 1000 patients. The study was monitored using a flexible group sequential design with stopping rules for both efficacy and futility. The reported confidence intervals on the treatment difference were adjusted for the group sequential design using the method of Jennison & Turnbull.\textsuperscript{e4}

In order to allow flexibility we used alpha and beta spending boundaries as described by DeMets and Ware (z_l=2.277,\delta=1.663,\z_u=2.025,\mu=3.3837).\textsuperscript{e5} Factors were considered as one sided with a separate upper efficacy boundary and lower futility boundary.

In this method of interim monitoring we specified a function $a(t)$ and $b(t)$ called the alpha and beta spending functions. The function $a(t)$ gave the amount of the p-value that was “spent” by a given time “t” in the study, where time runs from 0 at study start to 1 when all patients have been entered. It represented the probability under the null hypothesis that the trial would stop for efficacy at or before time t. The function $b(t)$ was the type II error that was “spent” by the interim monitoring plan to allow futility stopping. It represented the probability under the alternative hypothesis that the study would stop for futility at or before time t or that at the last look, the efficacy boundary would not be exceeded.

The table below shows the alpha-spending boundary $a(t)$ where $t$ is the proportion of patients accrued at that DSMB meeting. In the table we assumed 5 meetings at $t= 0.10, 0.25, 0.50, 0.75$ and 1.0. This function $a(t)$ was extended to a smooth function of t using a cubic spline\textsuperscript{e6} and at each DSMB meeting the actual stopping boundary was calculated so that the probability of stopping at or before that meeting was $a(t)$. Similarly the futility boundary was defined by the beta-spending function $b(t)$. The number $b(t)$ represented the cumulative probability that the results would be below the futility stopping boundary given the alternative hypothesis of a 2.25 day increase in VFD with a standard deviation of 10.5. At each DSMB meeting a futility stopping boundary was calculated so that the probability of futility stopping at or before that meeting was $b(t)$ at this alternative hypothesis.

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The overall one-sided significance level of the study was 0.025 which is equivalent to a two-sided p=0.05 significance level. Five analyses were planned after 100, 250, 500, 750, and 1000 patients. Under the assumption that there were five equally spaced interim analyses the power of the study was 90·7%. Changes in the number or spacing of the interim analyses would have a minor effect on the power. With this design, assuming that the pattern of deaths and extubations was similar to the FACTT fluid study, there was an 82% chance that the study would show both a significant effect of VFD and a nominally positive benefit in mortality.

The DSMB was advised to consider mortality differences in deciding whether to stop the trial. They might decline to stop the trial for efficacy if the mortality difference would make the positive benefit in VFDs difficult to interpret and they might decline to stop the trial for futility if there is a positive mortality benefit. For example, if there was no difference in VFDs but a trend towards a survival benefit the DSMB might continue past a futility boundary. The stopping rules were set up so that this would not invalidate the trial if such judgments were made. The efficacy boundary was developed without regard to the futility boundary. Thus if the futility boundary was crossed but the trial was not stopped, the trial can still achieve a 0.025 one-sided significance level.

<table>
<thead>
<tr>
<th>No. of Patients</th>
<th>P Value for Efficacy, 2-sided</th>
<th>Difference</th>
<th>Error Spending</th>
<th>Probability of Stopping</th>
<th>CI When No Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Efficacy</td>
<td>Futility</td>
<td>Type I, 1-Sided</td>
<td>Futility, Efficacy</td>
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<td></td>
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<tr>
<td>100</td>
<td>1.5 E-6</td>
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<td>-0.50</td>
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<td>0.0021</td>
<td>0.0232</td>
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<td>1.3</td>
<td>0.46</td>
<td>0.0104</td>
<td>0.0287</td>
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<td>1000</td>
<td>0.0429</td>
<td>0.95</td>
<td>0.46</td>
<td>0.0250</td>
<td>0.0923</td>
</tr>
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</table>

Table Legend: Stopping Boundaries: The table shows the characteristics of this boundary if we had the interim reports described above. The second column is the nominal p-value to stop for efficacy; the third and fourth columns are the difference in VFD to stop for efficacy and futility. The next columns are the error spending functions. The type I error spending function is the probability that the upper boundary will be exceeded under the null hypothesis. The type II error spending function is the probability that the statistic will be below the lower boundary at an interim analysis or under the upper boundary at the final analysis under the alternative hypothesis. The probability of stopping for futility is given in the seventh column and the probability of stopping for efficacy in the eighth column. The final column shows the confidence interval for the difference in VFD if the trial stopped for efficacy at that look and the treatment effect just exceeded the stopping boundary.
eReferences


### eTable. Ventilator-Free Days and 60-Day Mortality by Subgroups

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trophic Feeding</th>
<th>Full Feeding</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ventilator-free days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entry in shock</td>
<td>210</td>
<td>204</td>
<td>.36</td>
</tr>
<tr>
<td>Entry not in shock</td>
<td>298</td>
<td>288</td>
<td>.58</td>
</tr>
<tr>
<td>PaO2/FIO2 &lt;200</td>
<td>356</td>
<td>351</td>
<td>.48</td>
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<tr>
<td><strong>BMI category, kg/m²‡</strong></td>
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</tr>
<tr>
<td>&lt;18.5</td>
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<td>10</td>
<td>.29</td>
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<tr>
<td>18.5 to &lt;25</td>
<td>144</td>
<td>142</td>
<td>.75</td>
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<tr>
<td>25 to &lt;30</td>
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<td>.20</td>
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<td>≥30</td>
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<td><strong>60-d mortality</strong></td>
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<tr>
<td>Entry in shock</td>
<td>210</td>
<td>204</td>
<td>.43</td>
</tr>
<tr>
<td>PaO2/FIO2 &lt;200</td>
<td>356</td>
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<td><strong>BMI category, kg/m²‡</strong></td>
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<td>&lt;18.5</td>
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<tr>
<td>≥30</td>
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<td>.83</td>
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</tbody>
</table>

Ventilator-free days and 60-day all-cause mortality for subgroups of patients entering the study in shock, entering with P/F ratio ≤ 200, and patients by BMI category. ‡ BMI was unknown in one patient in the trophic group and two in the full-feeding group. Values are mean with 95% CI or Number (%) (95% CI).
eFigure 1. Specific Gastrointestinal Intolerances by Group

Percentage of enteral feeding days through day 12 patients experienced each specific gastrointestinal intolerance by randomization group. Patients receiving full-feeding (Black bars) experienced more days with vomiting, elevated residual volumes, regurgitation, and constipation compared to those receiving trophic feeds (Gray bars). Only patients still receiving mechanical ventilation and enteral feeding on each specific day are included. Overall, patients in the full feeding group had 3983 feeding days and the trophic group had 4050 feeding days. Error bars represent 95% CI.
The full-feeding group (Black bars) had significantly more daily total fluid intake for days 2 through 7 compared to the trophic feeding group (Gray bars). Day 0 represents time from randomization to 7AM the next morning. Only patients still receiving mechanical ventilation on each specific day are included. Values represent means and error bars represent 95% CI. *P<0.001; †P=0.01
The full-feeding group (Black bars) had significantly more daily total fluid output for days 2 through 7 compared to the trophic feeding group (Gray bars). Day 0 represents time from randomization to 7AM the next morning. Values represent means and error bars represent 95% CI. *P<0.001; ‡P=0.02
Heart rates were similar between trophic and full-feeding groups through day 7. Values represent means with error bars as 95% CI. Day 0 represents the day of randomization.
Both groups had similar systolic blood pressures through day 7. Values represent means with error bars as 95% CI.
eFigure3C. Daily Central Venous Pressure by Group

Central Venous Pressures were similar in both groups through day 7 except day 1 where the full-feeding group had a higher CVP. Values represent means with error bars as 95% CI. *P=0.03
Vasopressor use was similar and decreased in both groups over the first 7 days. Values represent percentage of patients receiving vasopressors that day.
eFigure 4. Daily Respiratory Physiology and Support

eFigure 4A. Daily Tidal Volume by Group

Tidal volumes were similar between groups over the first 7 days. Values represent means with error bars as 95% CI. Day 0 represents the day of randomization.
Higher levels of PEEP were used in the full-feeding group at baseline and days 1 and 2. Values represent means with error bars as 95% CI. *P=0.02
Plateau pressures were similar between groups for the first 7 days. Values represent means with error bars as 95% CI.
P/F ratios were similar between groups for the first 7 days. Values represent means with error bars as 95% CI.
Oxygenation index did not differ between groups over the first 7 days. Values represent means with error bars as 95% CI.
Minute ventilation was similar between groups over the first 7 days. Values represent means with error bars as 95% CI.
The full-feeding group had higher PaCO₂ values on days 1, 2, and 3. Values represent means with error bars as 95% CI. †P=0.01; ‡P=0.02; *P=0.05
eFigure 5. Daily Laboratory Values

eFigure 5A. Daily Serum Sodium by Group

Serum sodium values were similar in both groups for the first 7 study days. Values represent means with error bars as 95% CI. Day 0 represents the day of randomization.
The trophic group had lower serum potassium levels on days 4 through 7. Values represent means with error bars as 95% CI. *P<0.001; ‡P=0.01
Both groups had similar serum magnesium levels through day 7. Values represent means with error bars as 95% CI.
eFigure5D. Daily Serum Phosphorous by Group

Both groups had similar serum phosphorous levels through day 7 except for day 2 where levels were higher in the trophic group. Values represent means with error bars as 95% CI. *P=0.03
The full-feeding group had slightly higher serum bicarbonate on study day 3. Values represent means with error bars as 95% CI. *P=0.04.
Serum Total Protein increases slightly over the 7 days in both groups, but does not differ between trophic and full-feeding groups. Values represent means with error bars as 95% CI.
Serum albumin does not change or differ by group over the first 7 study days. Values represent means with error bars as 95% CI.