**Title:** Optimal outcome measures for a trial of not routinely measuring gastric residual volume in neonatal care: a mixed methods consensus process

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Dr Chris Gale reports grants from Medical Research Council and the National Institute for Health Research during the conduct of the study; grants from National Institute for Health Research, Mason Medical Research Foundation, Rosetrees Foundation and from Canadian Institute for Health Research outside the submitted work. He reports grants and personal fees from Chiesi Pharmaceuticals outside of the submitted work; the grant is for a research study and the personal fee was to support attendance at an educational meeting. Chris Gale is vice-chair of the NIHR Research for Patient Benefit London Regional Assessment Panel and has sat on the panel since 2016.

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Dr Frederic Valla reports personal fees from BAXTER, personal fees from NUTRICIA, outside the submitted work.

Lyvonne Tume is an NIHR HTA panel member.

**Selection of outcome measures for a trial of not routinely measuring gastric residual volume in neonatal care: a mixed methods consensus process**

**Abstract (250 words)**

**Background:** Routine measurement of gastric residual volume to guide feeding is widespread in neonatal units but not supported by high-quality evidence. Outcome selection is critical to trial design.

**Objective:** To determine optimal outcome measures for a trial of not routinely measuring gastric residual volume in neonatal care.

**Design:** A focused literature review; parent interviews; modified two-round Delphi survey and stakeholder consensus meeting.

**Participants:** Sixty-one neonatal healthcare professionals participated in an eDelphi survey; 17 parents were interviewed. 19 parents and neonatal healthcare professionals took part in the consensus meeting.

**Results:** Literature review generated 14 outcomes and parent interviews contributed eight additional outcomes; these 22 outcomes were then ranked by 74 healthcare professionals in the first Delphi round where four further outcomes were proposed; 26 outcomes were ranked in the second round by 61 healthcare professionals. Five outcomes were categorised as ‘consensus in’, no outcomes were voted ‘consensus out’. ‘No consensus’ outcomes were discussed and voted on in a face-to-face meeting by 19 participants, where four were voted ‘consensus in’. The final nine consensus outcomes were: mortality, necrotising enterocolitis, time to full enteral feeds, duration of parenteral nutrition, time feeds stopped per 24 hours, healthcare associated infection; catheter associated bloodstream infection, change in weight between birth and neonatal discharge and pneumonia due to milk aspiration.

**Conclusions and relevance:** We have identified outcomes for a trial of no routine measurement of gastric residual volume to guide feeding in neonatal care. This outcome set will ensure outcomes are important to healthcare professionals and parents.

**250words**

**Introduction**

Heterogeneity in outcome selection limits evidence synthesis and is a problem in neonatal care1 where meta-analyses rarely provide conclusive recommendations2. Neonatal trial outcomes are often not meaningful to parents and patients3,4; selection of clinically relevant outcomes that are important to parents and patients is key to improving uptake of research into practice5. A solution is the development and application of core outcome sets, important outcomes identified by key stakeholders using robust consensus methods6. The Core Outcomes In Neonatology (COIN) set has been identified7 and should be the minimum8 standard for neonatal effectiveness trials, however research questions often measure additional specific outcomes; selection of these should also involve key stakeholders and robust methodology.

This study is part of a larger National Institute for Health Research (NIHR) funded mixed methods feasibility study (GASTRIC) to determine whether it was possible to conduct a future trial comparing no routine gastric residual volume measurement with routine gastric residual volume measurement to guide feeding in neonatal care9.

**Methods**

A four stage mixed method study followed established methodology for identification of core outcomes for trials6, March 2018 - April 2019:

1. A focused literature review of outcomes reported in clinical trials and observational studies of gastric residual volume measurement in critically ill adults, children or neonates: Databases were searched (Medline, CINAHL, Proquest) in March 2018 by LNT using the search terms: ‘gastric residual’ and ‘gastric aspirate’ in critically ill patients. Outcomes were extracted from identified studies.

2. Parent interviews: Qualitative researchers (LR and ED) recruited English-speaking parents of children that received neonatal care in the last three years via social media, national networks, word of mouth and a newspaper advertisement. A participant information sheet listing potential outcomes identified from the focused literature review was emailed to parents to read prior to interview. Based on previous research10 it was anticipated that 10-15 parents would be recruited to reach data saturation point11. Interviews explored views on the proposed GASTRIC trial and which outcomes parents felt would be important. Content analysis12 was used to identify outcomes to inform the subsequent Delphi study.

3. Delphi Study: A modified 2-round Delphi13 e-survey was developed from the literature review and the parent interviews (Supplementary File 1) and pilot tested for clarity and face validity with ten healthcare professionals and the study team, and input into DelphiManager14. Nurses, doctors, pediatric surgeons and dietitians working in neonatal units were invited to take part via email through professional networks. The target number of respondents was 100 to ensure representation from key stakeholder groups with understanding of relevant issues, and consistent with previous core outcome sets6; automated reminders were sent weekly.

Round 1 summarised previous trial designs and outcomes used, and listed a set of outcomes to score using a 9-point Likert scale as recommended by the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group15, 1–3 signifying ‘not important’, 4–6 ‘important but not critical’ and 7–9 ‘critical’. Participants were able to comment and asked to suggest additional relevant outcomes. Outcomes were listed alphabetically to avoid bias due to the order displayed. After Round 1 the study management group reviewed additional suggested outcomes and added distinct outcomes to the second round. In Round 2, participants were presented with descriptive statistics and histograms of Round 1 scores for each outcome by stake-holder group, asked to re-score these outcomes, to score additional outcomes suggested in Round 1, and to specify a single primary outcome.

The Round 2 scores were used to formulate consensus statistics for each outcome overall and by stakeholder group, using pre-defined cut-offs for ‘Consensus In’ (≥70% participants scoring 7 to 9 AND <15% participants scoring 1 to 3 in each stakeholder group), ‘Consensus Out’ (≥70% participants scoring 1 to 3 AND <15% participants scoring 7 to 9 in each stakeholder group), ‘No consensus’ (anything else). Consensus thresholds were defined *a priori* consistent with published guidance and previous studies6.

4. Face-to-face consensus meeting: Parents, clinical trial methodologists and neonatal healthcare professionals were invited to review the results of the mixed-methods study, vote on outcomes that did not reach consensus in the Delphi survey and discuss future trial feasibility and design. An independent facilitator led the meeting. Voting results were summarised using the same methodology as described for the Delphi.

Ethics approval: University of the West of England, April 2018 (REF HAS.18.04.144).

**Results**

**Literature review**

The focused literature review identified six studies, one in children16, three in adults17-19 and two in preterm neonates20,21. Reported outcomes were summarised (Table 1). Incidence of ventilator associated pneumonia was not reported in the neonatal studies and therefore not included in the neonatal Delphi, gastrointestinal morbidity was separated into vomiting and diarrhea, generating 14 items from the literature review. Figure 1 shows the generation of outcomes across the study.

**Parent-important outcomes**

Seventeen parents of 19 children (two mothers had twins) who received neonatal care in 21 hospitals were interviewed. Interviews took place on average 11 months (range 0.8 - 37 months) after neonatal admission. Reasons for neonatal care were preterm birth (n=18) and meconium aspiration syndrome (n=1). Parents split ‘long-term neurodevelopment’ into long-term hearing loss, problems with vision, problems with cognition and motor problems (such as cerebral palsy), and proposed four further outcomes: time from birth to nasogastric tube removal, total length of time on any respiratory support, brain injury on imaging, and healthcare associated infections.

**Delphi Study**

In November 2018, healthcare professionals at all 184 neonatal units in England, Scotland and Wales were contacted via email; 76 individuals registered for the survey, 74 went on to score 22 outcomes in Round 1, and of these, 61/74 (80%) went on to complete Round 2. Four additional outcomes were suggested by respondents in Round 1: change in head circumference, incidence of pneumonia due to aspiration of feeds; incidence of catheter associated bloodstream infection, time to oral feeding; 26 outcomes were included in Round 2. 76% (46/61) of respondents changed their score for at least three outcomes from Round 1 to Round 2. There was no evidence of attrition bias between rounds; the 13 healthcare professionals that only took part in Round 1 had similar views to those who took part in both rounds (supplemental figures). After Round 2 ‘consensus in’ was achieved for five outcomes: mortality; incidence of necrotising enterocolitis; time to full enteral feeds; duration of parenteral nutrition; time feeds stopped per 24-hour period. No outcomes were voted ‘consensus out’. Outcomes scored in Round 2 are shown in Table 2 with the outcome source and consensus status.

Respondents were asked their choice of primary outcome for a future trial: 48/61 (79%) respondents suggested at least one; the most common were incidence of necrotising enterocolitis (24/61; 39%) and time to full enteral feeds (18/61; 30%).

**Consensus meeting**

Nineteen participants (1 charity representative; 1 clinical trialist/methodologist; 2 neonatal dietitians; 5 neonatal doctors; 7 neonatal nurses; 1 paediatric surgeon; 2 parents) attended the consensus meeting on 1st April 2019, representing 14/184 (8%) of UK neonatal units, three universities and the charity Bliss. Some had participated in the Delphi study. At this meeting there was discussion and voting on the 21 outcomes that did not reach consensus in the Delphi. Using the same scoring criteria as the Delphi survey, four items were voted ‘consensus in’, four were voted ‘consensus out’ and 13 failed to reach any consensus (Table 3). Nine consensus outcomes for a future trial are presented in Table 4.

**Discussion**

This study reports a set of outcomes identified as important by healthcare professionals and parents for a trial comparing no routine measurement of gastric residual volumes in neonatal care to routine measurement. This study-specific outcome set was developed following a robust process with involvement of key stakeholder groups. This is one of the few studies to apply such methods to outcome selection in neonatal or paediatric care. Poor outcome selection is increasingly recognised as a source of research waste1,22. The use of study-specific outcome sets in conjunction with relevant Core Outcome Sets, such as COIN7, will ensure trials support evidence synthesis, are relevant to parents and inform clinical practice.

Gastric residual volume is a measurement of the volume of the entire stomach contents from aspirating with a syringe, and is distinct from the aspiration of a small volume of gastric fluid for pH testing to confirm gastric tube position. Routine measurement of gastric residual volume commonly informs feeding decisions in neonatal units in the UK23 and internationally. The rationale underpinning this is to assess ‘feed tolerance’ and to predict, and potentially prevent, necrotising enterocolitis by withholding enteral feeds24,25. However, there is minimal evidence to support routine measurement of gastric residual volumes in neonatal care. A recent single-centre trial found that avoiding routine measurement of gastric residual volumes may be beneficial, leading to higher weight gain and shorter length of stay26, however trials to date have not had power to evaluate the relationship between gastric residual measurement and necrotising enterocolitis26,27. Despite potential harms such as mucosal injury, and evidence that gastric residual volume is an inaccurate measure of gastric contents28, routine assessment of gastric residual volumes is engrained in neonatal care29. This study was commissioned by the United Kingdom NIHR as part of a wider piece of work to evaluate the feasibility of a multi-centre trial examining no routine measurement of gastric residual volumes. This study identifies a set of outcomes for such a trial which comprise uncommon but severe events (mortality, necrotising enterocolitis, pneumonia secondary to milk aspiration and infection) and nutritional outcomes (time to full enteral feeds, days of parenteral nutrition, number of times that feeds are stopped, change in weight). While there is some overlap with core outcomes identified for neonatal research generally7, this study specific outcome set more closely targets nutritional outcomes – highlighting the importance of using general core outcome sets in conjunction with trial specific consensus processes that involve parents and patients.

Previous neonatal trials have targeted nutritional outcomes (time to achieve full enteral feeds) as the primary outcome. Although these studies have reported necrotising enterocolitis, event rates have been low. Healthcare professionals are highly concerned about adverse events30 and may fear these more than they value improved outcomes. This study confirms that the adverse outcome necrotising enterocolitis is key across all stakeholder groups for this clinical question. The incidence of necrotising enterocolitis is low among all but the most preterm infants31 and therefore any trial seeking to demonstrate superiority or non-inferiority for such an outcome will require high numbers and multiple sites. Previous trials have not had sufficient size to detect differences in necrotising enterocolitis, which may in part explain why routine measurement of gastric residuals remains entrenched in neonatal practice single-centre trials that indicate it is detrimental.

Strengths include a pre-registered approach that identified trial outcomes for the Delphi survey and consensus meeting from both previous research and parents with experience of neonatal care. Limitations include the incomplete participation of UK neonatal units in the Delphi survey, although the response rate of 40% is in keeping with other surveys. The consensus process was deliberately limited to UK neonatal professionals and parents to determine the feasibility of a UK trial, which limits generalisability to other healthcare settings. Some identified outcomes overlap or are not well defined in neonates, and will require refinement prior to any future trial. We had only limited participation in the Delphi from neonatal dieticians, however this group was well represented in the final consensus meeting. We did not include parents in the Delphi survey as asking for parental views on outcomes at interview and involving them in the final consensus meeting were felt to be the most appropriate ways to gain meaningful input from this group.

**Conclusions**

We describe development of an outcome set for a trial comparing no routine gastric residual volume measurement with routine measurement to guide feeding in neonatal care. This was identified though a consensus approach involving parents and neonatal clinical stakeholder groups. The use of such outcomes increases the likelihood that future trial results are both meaningful to parents/patients and are implemented in clinical practice.

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**Statement of authorship**

L Tume, C Gale and J Dorling equally contributed to the conception and design of the research; H Hickey, K Woolfall, E Deja, L Roper, A Beissel, F Valla, B Arch contributed to the design of the research; H Eccleson, J Preston, I Andrzejewska, N Pathan, L Latten, B Arch and E Deja contributed to the acquisition and analysis of the data; E Deja and L Roper conducted qualitative interviews; E, Deja, B Arch, AP Jones, L Tume, C Gale and J Dorling contributed to the interpretation of the data; and C Gale, B Arch and L Tume drafted the manuscript. All authors critically revised the manuscript, agree to be fully accountable for ensuring the integrity and accuracy of the work, and read and approved the final manuscript.

**Figure 1: Generation of outcomes across different stages of the study**

**Table 1: Outcomes identified in previous studies of gastric residual volume measurement**

|  |  |
| --- | --- |
| **Outcome** | **Patient population** |
| 1. Intensive care unit length of stay | All  |
| 2. Hospital length of stay | All |
| 3. Length of invasive ventilation | All |
| 4. Occurrence of ventilator associated pneumonia  | Adult and paediatric |
| 5. Achievement of predicted energy goals using various definitions:Proportion of patients achieving 100%Cumulative calorie deficit over 7 daysRatio of prescribed/achieved energy targetEnteral feeding ‘adequacy’Median daily volume of feed given Percentage of predicted energy requirement achieved per dayTime to achieve full feeds for preterm neonates (120ml/kg and 150ml/kg/day) | Adult, paediatric and neonatal |
| 6. Occurrence of necrotising enterocolitis | Neonatal and paediatric  |
| 7. Incidence of gastro-intestinal intolerance: vomiting, diarrhea, abdominal distention, feed intolerance, gastro-esophageal reflux  | Adult and paediatric |
| 8. Nursing time spent measuring gastric residual volumes | Adult |
| 9. Change in weight from admission to discharge | Neonatal and paediatric |
| 10. Change in length from admission to discharge | Neonatal |
| 11. Days of parenteral nutrition  | Neonatal |
| 12. Days with a central venous catheter in place to deliver parenteral nutrition | Neonatal  |
| 13. Time feeds stopped per 24-hour period | Adult  |
| 14. Survival | All |

Table 2: Percentage of participants that scored 7, 8 or 9 for each outcome scored in Round 2 of the Delphi study, by stakeholder group

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Outcome source**  | **Doctors** | **Nurses** | **Dietitians** | **All** | **Consen-sus status** |
| **Outcome** | **(n=40)** | **(n=18)** | **(n=3)** | **(n=61)** |
| Mortality | LR | \*100% | \*100% | \*100% | \*\*100% | In |
| Incidence of necrotising enterocolitis | LR | \*100% | \*94.4% | \*100% | \*\*98.4% | In |
| Time from start of enteral feeding to achieve full (150ml/kg/day) enteral feeds | LR | \*92.5% | \*88.9% | \*100% | \*\*91.8% | In |
| Healthcare associated infections | Parents | \*87.5% | \*88.9% | 66.7% | \*86.9% | None |
| Days on parenteral nutrition | LR | \*77.5% | \*94.4% | \*100% | \*\*83.6% | In |
| Incidence of catheter-associated blood stream infection | DR1 | \*85% | \*70.6% | 66.7% | \*80% | None |
| Time feed stopped per 24 hour period | LR | \*70% | \*83.3% | \*100% | \*\*75.4% | In |
| Change in weight (growth) between birth and neonatal unit discharge | LR | \*75% | \*77.8% | 66.7% | \*75.4% | None |
| Days of central venous line access | LR | \*75% | \*72.2% | 66.7% | \*73.8% | None |
| Length of stay in hospital | LR | 45% | \*72.2% | \*100% | 55.70% | None |
| Incidence of pneumonia due to milk aspiration | DR1 | 37.5% | \*76.5% | 66.7% | 50% | None |
| Length of stay neonatal unit | LR | 35% | \*72.2% | 66.7% | 47.5% | None |
| Long term outcomes: Problems with mobility like cerebral palsy  | Parents | 45% | 50% | 33.3% | 45.9% | None |
| Long term outcomes: Problems with cognition | Parents | 35% | 38.9% | 33.3% | 36.1% | None |
| Gastro-intestinal morbidity: Vomiting | LR | 30% | 61.1% | \*100% | 42.6% | None |
| Change in head circumference between birth and neonatal unit discharge  | DR1 | 42.50% | 23.50% | \*100% | 40% | None |
| Change in length (growth) between birth and neonatal unit discharge | LR | 42.50% | 27.80% | 66.70% | 39.30% | None |
| Brain injury on imaging | Parents | 25% | 33.30% | 33.30% | 27.90% | None |
| Time to oral feeding | DR1 | 27.50% | 23.50% | 33.30% | 26.70% | None |
| Length of time invasive ventilation | LR | 12.5% | 50% | 66.7% | 26.2% | None |
| Long term outcomes: Hearing loss | Parents | 15% | 27.80% | 33.30% | 19.70% | None |
| Long term outcomes: Problems with eyesight | Parents | 15% | 27.80% | 33.30% | 19.70% | None |
| Nursing time spent measuring gastric residual volumes  | LR | 5% | 27.80% | 66.70% | 14.80% | None |
| Gastro-intestinal morbidity: Diarrhoea | LR | 5% | 27.80% | 33.30% | 13.10% | None |
| Total length of time respiratory support (invasive and non-invasive) | Parents | 2.50% | 27.80% | 0% | 9.80% | None |
| Time to nasogastric tube removal | Parents | 10% | 5.60% | 0% | 8.20% | None |

\* ‘Consensus in’ criteria were met: ≥70% scored 7, 8 or 9 and <15% scored 1, 2 or 3;

\*\* ‘Consensus in’ criteria met in all groups;

† ‘Consensus out’ criteria were met: ≥70% scored 1, 2 or 3 and <15% scored 7, 8 or 9 [NB: None found];

†† ‘Consensus out’ criteria met in all groups;

Source of outcome: LR Literature review; DR1 Delphi Round 1

Table 3: No-consensus items voted on at consensus meeting

|  |  |
| --- | --- |
| **Outcome** | **Consensus status** |
| Healthcare associated infections | In |
| Incidence of catheter-associated blood stream infection | In |
| Change in weight between birth and neonatal unit discharge | In |
| Incidence of pneumonia due to milk aspiration | In |
| Change in head circumference between birth and neonatal unit discharge | No Consensus |
| Brain injury on imaging | No Consensus |
| Gastrointestinal morbidity: Vomiting | No Consensus |
| Length of stay hospital | No Consensus |
| Length of stay neonatal unit | No Consensus |
| Length of time receiving invasive ventilation | No Consensus |
| Long term outcomes: Hearing loss | No Consensus |
| Long term outcomes: Problems with vision | No Consensus |
| Long term outcomes: Problems with cognition | No Consensus |
| Long term outcomes: Brain injury on imaging | No Consensus |
| Long term outcomes: Motor problems  | No Consensus |
| Time to oral feeding | No Consensus |
| Total length of time receiving respiratory support (invasive and non-invasive) | No Consensus |
| Change in length (growth) between birth and neonatal unit discharge | Out |
| Gastrointestinal morbidity: Diarrhoea | Out |
| Nursing time spent measuring gastric residual volume | Out |
| Time to nasogastric tube removal | Out |

**Table 4: Final nine outcomes gaining consensus for a trial of no gastric residual volume measurement**

|  |
| --- |
| Mortality |
| Incidence of necrotising enterocolitis |
| Time from start of enteral feeding to achieve full (150ml/kg/day) enteral feeds |
| Days on parenteral nutrition |
| Time feed stopped per 24 hour period |
| Healthcare associated infections |
| Incidence of catheter-associated blood stream infection |
| Change in weight between birth and neonatal unit discharge |
| Incidence of pneumonia due to milk aspiration |

**What is already known on this topic**

1. Routine measurement of gastric residual volume to guide feeding is widespread in neonatal units worldwide, but not supported by high-quality evidence
2. Adequately powered and methodologically robust randomised trials would provide evidence about risks and benefits of routine measurement of gastric residual volume in neonatal care
3. Selection of trial outcomes that are relevant to health professionals, parents and patients is key to improving the quality and implementation of research

**What this study adds**

1. We have identified outcomes for a trial of no routine measurement of gastric residual volume to guide feeding in neonatal care.
2. Consensus outcomes included: mortality, necrotising enterocolitis, time to full enteral feeds, duration of parenteral nutrition, time feeds stopped per 24 hours, healthcare associated infection
3. Use of this outcome set in trials of no routine measurement of gastric residual volume will ensure outcomes are important to clinicians and parents.

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