Prone paper

Reviewer comments

Reviewer(s)' Comments to Author:

Reviewer: 1

Comments to the Author
(There are no comments.)

Reviewer: 2

Comments to the Author

Much improved manuscript

Background and aim:

All comments addressed.

Methods

1. Typo: Patients who were not fed enterally due to sig/span>nificant hemodynamic

Fixed. (This error is not seen in the manuscript)

2. Confirmation of feeding tubes is very different to current accepted practice in UK/Europe/USA: Feeding tube position was confirmed with a 20 ml gastric air inflation check auscultation once every six hours while on supine position. Additionally, tube position was noted and documented every time a chest X-ray was warranted.

In addition to the initial check X-ray, our institutional policy required a sixth hourly re-assessment of naso/oro-gastric tube patency and position by the treating nurse, by inflating the stomach with 10 to 20 ml of air with a syringe via the feeding tube and simultaneously auscultating for the gush of air entry over the epigastrium. Any resistance to inflation or lack of air entry on auscultation warranted immediate cessation of feeds and a repeat chest X-ray to confirm feeding tube position. Apart from this, feeding tube position was noted and documented every time a chest X-ray was done for any other reason

Even though this is not a fool proof method and has several limitations, many instances of NG tube displacement, coiling in the neck and blocks can be identified in practice. Therefore, this inexpensive maneuver is recommended by our institutional policy to reinforce the importance of correct NG tube positioning. Moreover, there are no other better and approved bedside means of checking position on a periodic basis.

We agree with the reviewers that this is not standard practice recommended by any guideline. However, in a resource limited set-up like ours, we had initiated this as a safety measure to pick up early feeding tube dislodgements and blockages.

3. Line 102: feeding guided by volume status, could the authors please expand on this. If a patient was fluid overloaded did that mean there was less volume available for feed? And if so, were they able to offer concentrated solutions of feed rather than these patients missing out on kcal/protein. Review 2: I'm still not clear on this – it seems to suggest feeds are prescribed by IBW yet calculations from SCCM/ASPEN are for actual weight or dry and usual weight in fluid overloaded patients. I think we need more detail on this protocol: "rate-based feeding protocol guided by patient's volume status was followed with provision for nocturnal catch-up where appropriate." Does this imply that patients that are fluid overloaded receive less nutrition or just less volume of feed? This is not clear.

Calorie (usually 25-30 Kcal/kg) and protein (1-1.5g/kg) prescriptions were made based on IBW or actual body weight depending on patient's nutrition risk and volume status. Devine's formula was used for calculating the ideal body weight (IBW). Total volume of enteral feeds per day was prescribed by the bedside clinician based on patient's physiology and volume status. The best combination of enteral scientific formula that could meet the calorie and protein goals within the volume prescribed for each patient was then used to deliver nutrition. Calorie density of feed used varied from 1 Kcal/ml to 2.1 Kcal/ml. Nasogastric or orogastric feeding was carried out as a continuous infusion. Feed infusion was started at a low rate and stepped up gradually based on tolerance to the desired rate

4. Statistical analysis has been added.

5. Other comments answered.

6. ***Results***

Fig 1 added.

7. ***Tables***

Table 1: revised with both means (SD) and median (IQR) where relevant.

Thank you

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