EtD 33. What is the recommended enteral fluid intake?

POPULATION:	Preterm infants receiving full enteral feeds
INTERVENTION:	Higher (≥180 mL/kg/day)
COMPARISON:	Lower enteral fluid intake (<180 mL/kg/day)
MAIN OUTCOMES:	**Critical for making a decision** Mortality Neurodevelopmental impairment Faltering growth / body composition Adverse effects (patent ductus arteriosus) Bronchopulmonary dysplasia Necrotising enterocolitis **Important but not critical** Fully breastmilk feeding at hospital discharge Fully breastfeeding at hospital discharge Duration of initial hospital stay Time to full enteral feeds Sepsis: proven or suspected Retinopathy of prematurity Anaemia of prematurity Cost: cost of intervention, cost of neonatal care and life-long cost **Of limited importance** Time to full sucking feeds
SETTING:	Any birth setting
PERSPECTIVE:	Clinical recommendation
BACKGROUND:	Establishing optimal enteral fluid intake in preterm infants is critical for maintaining fluid balance, supporting growth and preventing complications such as dehydration, electrolyte imbalances and oedema. After achieving full enteral feeding, recommendations for fluid volumes vary widely across neonatal units, reflecting uncertainty in the evidence and differing clinical practices. It is essential to balance the need for sufficient volume for optimal growth with the risk of fluid overload, which may exacerbate conditions such as patent ductus arteriosus, bronchopulmonary dysplasia and NEC. In the first week after birth, the postnatal physiological diuresis, insensible water losses, gestational age and clinical status of the infant influence fluid requirements. However, there is limited high-quality evidence to define precise daily fluid intakes by postnatal age during this transitional period. Current practices typically involve cautious advancement of enteral feed volumes based on the volume of expressed breastmilk that is available and the tolerance of feeds. Standardised recommendations for enteral fluid management could reduce practice variation and improve outcomes by supporting consistent clinical decision-making. This question seeks to determine the recommended enteral fluid intake once preterm infants are on full enteral feeds but also to identify evidence of appropriate fluid intake targets by postnatal day during the first week after birth, without increasing the

	risk of adverse outcomes.
CONFLICT OF INTERESTS:	The following ProVIDe cohort study (Reference 3) co-authors for this topic are on the Guideline Development Group: Barbara Cormack, Frank Bloomfield are co-authors of the and are on the Guideline Development Group.

Assessment

Desirable Effects

How substantial are the desirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know	We identified one Cochrane review [1] and a report of a randomised trial within the review [2]. **High versus standard volume of fortified human milk or preterm formula** (High defined as >180 mL/kg/day and standard as ≤180 mL/kg/day) **Mortality:** RCT: No significant effect on all-cause mortality before discharge for higher versus lower enteral fluid volume (10 fewer per 1,000; 14 fewer to 51 more) [Critical]. **Neurodevelopmental impairment:** RCT: No significant effect on neurodevelopmental impairment for higher versus lower enteral fluid volume (120 fewer per 1,000; 213 fewer to 210 more) [Critical]. **No faltering growth / body composition**: RCT: Higher enteral fluid intake was associated with significantly higher weight gain during hospital stay (MD 2.58 g/kg/day higher; 1.41 higher to 3.76 higher). There was no significant difference in linear growth (MD 0.05 cm/week higher; 0.02 lower to 0.13 higher) or head circumference growth (MD 0.02 cm/week higher; 0.04 lower to 0.09 higher) during hospital stay. There was no significant difference in the number of infants with weight (75 fewer per 1,000; 193 fewer to 288 more), length (163 fewer per 1,000; 230 fewer to 138 more) or head circumference (27 fewer per 1,000; 41 fewer to 296 more) <10th percentile at 12 months' corrected age [Critical]. **Adverse effects (patent ductus arteriosus)**: RCT: No significant effect on patent ductus arteriosus (11 fewer per 1,000; 36 fewer to 56 more) [Critical]. **Bronchopulmonary dysplasia**: RCT: No significant effect on bronchopulmonary dysplasia (1 more per 1,000; 49 fewer to 92 more) [Critical]. **Necrotising enterocolitis (NEC):** RCT: No significant effect on NEC (4 fewer per 1,000; 12 fewer to 48 more) [Critical]. **Duration of initial hospital stay**: RCT: No significant effect on duration of initial hospital stay (MD 1 days higher; 3.54 lower to 5.54 higher) [Important]. **High versus standard volume of unfortified human milk or term formula** (High	In a subgroup of 86 infants from a trial in the Cochrane review [2], there was no difference between high (180-200 mL/kg/day) versus standard (140-160 mL/kg/day) in fat mass, fat free mass or % body fat at 36 weeks postmenstrual age. The selection of these infants from the randomised sample was not clear. 160 mL/kg/day fortified expressed breastmilk 4 to 4.3 g/kg/day 160 mL/kg/day preterm formula 4.3 to 4.6 g/kg/day 160 mL/kg/day fortified expressed breastmilk 131 to 133 kcal/kg/day 160 mL/kg/day preterm formula 128 to 130 kcal/kg/day 180 mL/kg/day fortified expressed breastmilk provides 4.4 to 4.9 g/kg/day 180 mL/kg/day preterm formula provides 4.9 to 5.2 g/kg/day 180 mL/kg/day fortified expressed breastmilk provides 147 to 149 kcal/kg/day 180 mL/kg/day preterm formula provides 144 to 146 kcal/kg/day **Additional supporting data** **Aotearoa New Zealand:** Cohort analysis of ProVIDe RCT of 434 extremely low birthweight infants [3]. The study reported the relationship between higher

	defined as >200 mL/kg/day and standard as ≤200 mL/kg/day) **No faltering growth / body composition**: RCT: Higher enteral fluid intake was associated with significantly higher weight gain during hospital stay (MD 6.2 g/kg/day higher; 2.71 higher to 9.69 higher) [Critical]. **Necrotising enterocolitis (NEC):** RCT: No significant effect on NEC (1 more per 1,000; 30 fewer to 477 more) [Critical].	enteral/breastmilk volume intake in the first 4 weeks after birth and expected growth. Infants with mean week 4 total fluid intakes of 174-202 mL/kg/day were three times more likely (OR 3.0 [95% CI 1.3, 7.1, p=0.01]) to have *expected length growth* (defined as z-score change from birth to 36-week corrected age -0.8 to 0.8) than those with mean week 4 fluid intake in the 166-173 mL/kg/day range. Mean expressed breastmilk intake of 157-173 mL/kg/day in week 3 increased the odds of achieving *expected length growth* by 3.4 (CI 1.5-7.3, p=0.002) times compared with 115 to 156 mL/kg/day. Mean expressed breastmilk intake of 174-202 mL/kg/day in week 3 increased the odds of achieving *target growth* (defined as change in z-score from birth to 36 weeks' CGA of between -0.8 and 0.8 in all three of weight, length and head circumference) by 3 times compared with mean expressed breastmilk intake of 157 to 173 mL/kg/day.

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with lower enteral fluid intake (< 180 mL/kg/day)	Risk difference with higher enteral fluid intake (>/= 180 mL/kg/day)
Mortality: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: All-cause mortality before discharge	283 (2 RCTs)	⨁⨁◯◯ Low[a]	**RR 0.24** (0.01 to 4.71)	Study population	
				14 per 1,000	**10 fewer per 1,000** (14 fewer to 51 more)
Neurodevelopmental impairment: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Neurodevelopmental impairment at 12 months' corrected age	47 (1 RCT)	⨁⨁◯◯ Low[b,c]	**RR 0.52** (0.15 to 1.84)	Study population	
				250 per 1,000	**120 fewer per 1,000** (213 fewer to 210 more)
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Weight gain during hospital stay (g/kg/day)	271 (2 RCTs)	⨁⨁◯◯ low[a]	-	The mean faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula was **17.2 g/kg/day**	MD **2.58 higher** (1.41 higher to 3.76 higher)
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm	271 (2 RCTs)	⨁⨁⨁◯	-	The mean faltering growth / body composition: RCT: High versus standard	MD **0.05 higher** (0.02 lower to 0.13 higher)

formula assessed with: Linear growth during hospital stay (cm/week)		Moderate[c]		volume of fortified human milk or preterm formula was **0.77 cm/week**	
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Head growth during hospital stay (cm/week)	271 (2 RCTs)	⨁⨁⨁◯ Moderate[c]	-	The mean faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula was **0.71 cm/week**	MD **0.02 higher** (0.04 lower to 0.09 higher)
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Weight <10th percentile at 12 months' corrected age	47 (1 RCT)	⨁◯◯◯ Very low[a,b,]	**RR 0.70** (0.23 to 2.15)	Study population	
				250 per 1,000	**75 fewer per 1,000** (193 fewer to 288 more)
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Length < 10th percentile at 12 months' corrected age	47 (1 RCT)	⨁◯◯◯ Very low[a,b]	**RR 0.35** (0.08 to 1.55)	Study population	
				250 per 1,000	**163 fewer per 1,000** (230 fewer to 138 more)
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Head circumference < 10th percentile at 12 months' corrected age	47 (1 RCT)	⨁◯◯◯ Very low[b,d]	**RR 0.35** (0.01 to 8.11)	Study population	
				42 per 1,000	**27 fewer per 1,000** (41 fewer to 296 more)
Faltering growth / body composition: RCT: High versus standard volume of unfortified human milk or term formula assessed with: Weight gain during hospital stay (g/kg/day)	61 (1 RCT)	⨁⨁⨁◯ Moderate[b]	-	The mean faltering growth / body composition: RCT: High versus standard volume of unfortified human milk or term formula was **18.7 g/kg/day**	MD **6.2 higher** (2.71 higher to 9.69 higher)
Adverse effects (patent ductus arteriosus): RCT: High versus standard volume of fortified human milk or preterm formula	271 (2 RCTs)	⨁⨁◯◯ Low[a]	**RR 0.77** (0.28 to 2.12)	Study population	
				50 per 1,000	**11 fewer per 1,000** (36 fewer to 56 more)
Bronchopulmonary dysplasia (BPD) / chronic lung disease: RCT: High versus standard volume of fortified human milk or preterm formula	271 (2 RCTs)	⨁⨁⨁◯ Moderate[c]	**RR 1.01** (0.57 to 1.81)	Study population	
				113 per 1,000	**1 more per 1,000** (49 fewer to 92 more)
Necrotising enterocolitis (NEC): RCT: High versus standard volume of fortified human milk or preterm formula	283 (2 RCTs)	⨁⨁◯◯ Low[a]	**RR 0.74** (0.12 to 4.51)	Study population	
				14 per 1,000	**4 fewer per 1,000** (12 fewer to 48 more)
Necrotising enterocolitis: RCT: High versus standard volume of unfortified human milk or term formula	61 (1 RCT)	⨁◯◯◯ Very low[b,e]	**RR 1.03** (0.07 to 15.78)	Study population	
				32 per 1,000	**1 more per 1,000**

					(30 fewer to 477 more)
Fully breastmilk feeding at hospital discharge - not measured	-	-	-	-	-
Fully breastfeeding at hospital discharge - not measured	-	-	-	-	-
Duration of initial hospital stay: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Days	271 (2 RCTs)	⨁⨁◯◯ Low[a]	-	The mean duration of initial hospital stay: RCT: High versus standard volume of fortified human milk or preterm formula was **64.05 days**	MD **1 higher** (3.54 lower to 5.54 higher)
Time to full enteral feeds - not measured	-	-	-	-	-
Sepsis: proven or suspected - not measured	-	-	-	-	-
Retinopathy of prematurity (ROP) - not measured	-	-	-	-	-
Anaemia of prematurity - not measured	-	-	-	-	-
Cost: cost of intervention, cost of neonatal care and life-long cost - not measured	-	-	-	-	-
Time to full sucking feeds - not measured	-	-	-	-	-

a. Downgraded two levels for imprecision due to wide confidence intervals crossing the line of no effect and low event rates
b. Downgraded one level for indirectness as evidence based on a single study
c. Downgraded one level for imprecision due to confidence intervals crossing the line of no effect
d. Downgraded three levels for imprecision due to extremely wide confidence intervals crossing the line of no effect and low event rates

Desirable effects for Māori
No additional evidence available

Undesirable Effects
How substantial are the undesirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
● Trivial ○ Small ○ Moderate ○ Large ○ Varies ○ Don't know	None identified. **Undesirable effects for Māori** No additional evidence available	

Certainty of evidence
What is the overall certainty of the evidence of effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ● Low ○ Moderate ○ High ○ No included studies	Very low to high certainty of evidence overall	

Outcomes	Importance	Certainty of the evidence (GRADE)
Mortality: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: All-cause mortality before discharge	CRITICAL	⨁⨁◯◯ Low
Neurodevelopmental impairment: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Neurodevelopmental impairment at 12 months' corrected age	CRITICAL	⨁⨁◯◯ Low
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Weight gain during hospital stay (g/kg/day)	CRITICAL	⨁⨁⨁⨁ High
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Linear growth during hospital stay (cm/week)	CRITICAL	⨁⨁⨁◯ Moderate
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Head growth during hospital stay (cm/week)	CRITICAL	⨁⨁⨁◯ Moderate
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Weight < 10th percentile at 12 months' corrected age	CRITICAL	⨁◯◯◯ Very low
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Length < 10th percentile at 12 months' corrected age	CRITICAL	⨁◯◯◯ Very low
Faltering growth / body composition: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Head circumference < 10th percentile at 12 months' corrected age	CRITICAL	⨁◯◯◯ Very low
Faltering growth / body composition: RCT: High versus standard volume of unfortified human milk or term formula assessed with: Weight gain during hospital stay (g/kg/day)	CRITICAL	⨁⨁⨁◯ Moderate
Adverse effects (patent ductus arteriosus): RCT: High versus standard volume of fortified human milk or preterm formula	CRITICAL	⨁⨁◯◯ Low
Bronchopulmonary dysplasia: RCT: High versus standard volume of fortified human milk or preterm formula	CRITICAL	⨁⨁⨁◯ Moderate

Necrotising enterocolitis (NEC): RCT: High versus standard volume of fortified human milk or preterm formula	CRITICAL	⨁⨁◯◯ Low
Necrotising enterocolitis: RCT: High versus standard volume of unfortified human milk or term formula	CRITICAL	⨁◯◯◯ Very low
Fully breastmilk feeding at hospital discharge - not measured	IMPORTANT	-
Fully breastfeeding at hospital discharge - not measured	IMPORTANT	-
Duration of initial hospital stay: RCT: High versus standard volume of fortified human milk or preterm formula assessed with: Days	IMPORTANT	⨁⨁◯◯ Low
Time to full enteral feeds - not measured	IMPORTANT	-
Sepsis: proven or suspected - not measured	IMPORTANT	-
Retinopathy of prematurity (ROP) - not measured	IMPORTANT	-
Anaemia of prematurity - not measured	IMPORTANT	-
Cost: cost of intervention, cost of neonatal care and life-long cost - not measured	IMPORTANT	-
Time to full sucking feeds - not measured	NOT IMPORTANT	-

Certainty of evidence for Māori
No additional data

Values

Is there important uncertainty about or variability in how much people value the main outcomes?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability	Possibly important uncertainty or variability **Values for Māori** No additional research was identified.	

○ No important uncertainty or variability		

Balance of effects

Does the balance between desirable and undesirable effects favour the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favours the comparison ○ Probably favours the comparison ● Does not favour either the intervention or the comparison ○ Probably favours the intervention ○ Favours the intervention ○ Varies ○ Don't know	**High versus standard volume of fortified human milk or preterm formula - High certainty evidence** Increased weight gain during hospital stay **High versus standard volume of fortified human milk or preterm formula - Moderate certainty evidence** Uncertain effect on length and head circumference, bronchopulmonary dysplasia **High versus standard volume of fortified human milk or preterm formula - Low certainty evidence** Uncertain effect on mortality, neurodevelopmental impairment, patent ductus arteriosus, NEC, duration of hospitalisation **High versus standard volume of fortified human milk or preterm formula - Very low certainty evidence** Uncertain effect on weight, length or head circumference <10th percentile at 12 months' corrected age **High versus standard volume of unfortified human milk or term formula- Moderate certainty evidence** Increased weight gain during hospital stay **High versus standard volume of unfortified human milk or term formula- Very low certainty evidence** Uncertain effect on NEC **Balance of effects for Māori** No additional evidence	

Resources required

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	The resources required are minimal, especially if using breastmilk.	

Certainty of evidence of required resources

What is the certainty of the evidence of resource requirements (costs)?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ○ Low ● Moderate ○ High ○ No included studies	Reasonably certain **Certainty of evidence of required resources for Māori** No additional evidence available	

Cost effectiveness

Does the cost-effectiveness of the intervention favour the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favours the comparison ○ Probably favours the comparison ○ Does not favour either the intervention or the comparison ○ Probably favours the intervention ○ Favours the intervention ○ Varies ● No included studies	No studies were found. **Cost effectiveness for Māori** No additional evidence available	Using lower enteral feed volumes may increase the need for individualised nutritional supplementation to achieve adequate growth. This requires additional resources such as referral to a dietitian.

Equity

What would be the impact on health equity?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

○ Reduced ○ Probably reduced ○ Probably no impact ● Probably increased ○ Increased ○ Varies ○ Don't know	**Equity for Māori** Pēpi Māori experience higher rates of preterm birth and neonatal morbidity. Ensuring recommended enteral fluid intakes are applied consistently for pēpi Māori is essential to address these disparities. Culturally safe care and equitable access to appropriately resourced neonatal services must be prioritised to support optimal growth and developmental outcomes. **Equity for Pacific families** Pacific infants are at increased risk of preterm birth and face barriers to accessing high-quality neonatal care. Clear recommendations for enteral fluid intake during the first week and at full feeds must be implemented equitably. Care should reflect Pacific values, respect family involvement and ensure access to appropriate support across all settings. **Equity for underrepresented groups** Infants from Asian, migrant, rural or lower socioeconomic backgrounds may experience inconsistent neonatal care practices. Standardising recommended enteral fluid intake during early neonatal care is vital to promote equitable outcomes.	A 2025 survey in Aotearoa New Zealand neonatal units showed access to a neonatal dietitian was inconsistent [4]. Rural hospitals and lower-resourced units are less likely to have access to specialist neonatal dietitians. This means that if faltering growth occurs, it may not be consistently managed, so feeding strategies that minimise the risk of faltering growth will increase equity.

Acceptability

Is the intervention acceptable to key stakeholders?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	Probably acceptable as prescribing >180 mL/kg/day is common practice in some units. **Acceptability for Māori** No additional research available.	

Feasibility

Is the intervention feasible to implement?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ○ Probably yes ● Yes ○ Varies	Already occurring in some units, so it is feasible. **Feasibility for Māori** No additional research available.	

○ Don't know		

Summary of judgements

	JUDGEMENT						
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know
UNDESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know
CERTAINTY OF EVIDENCE	Very low	**Low**	Moderate	High			No included studies
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability			
BALANCE OF EFFECTS	Favours the comparison	Probably favours the comparison	**Does not favour either the intervention or the comparison**	Probably favours the intervention	Favours the intervention	Varies	Don't know
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know
CERTAINTY OF EVIDENCE OF REQUIRED RESOURCES	Very low	Low	**Moderate**	High			No included studies
COST EFFECTIVENESS	Favours the comparison	Probably favours the comparison	Does not favour either the intervention or the comparison	Probably favours the intervention	Favours the intervention	Varies	**No included studies**
EQUITY	Reduced	Probably reduced	Probably no impact	**Probably increased**	Increased	Varies	Don't know
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know
FEASIBILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know

Type of recommendation

Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
O	O	O	O	O

References

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