



STUDY PROTOCOL

A randomized multicenter open-label controlled trial to show that mucous fistula refeeding reduces the time from enterostomy closure to full enteral feeds
(**MUC**ous **F**istula **R**efeeding ("**MUC-FIRE**") trial)

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LIST OF ABBREVIATIONS

AE	adverse event
ALT	alanine transaminase
AST	aspartate transaminase
CVL	central venous line
DMC	Data Monitoring Committee
eCRF	electronic case report form
FIP	focal intestinal perforation
FTT	failure to thrive
FU	follow-up
GGT	Gamma-GT
HCTC	Hannover Clinical Trial Center
ICD	International Statistical Classification of Diseases and related Health Problems
IMC	intermediate care ward
ITT	intention to treat
MFR	mucous fistula refeeding
NEC	necrotizing enterocolitis
NG	nasogastric
NICU	neonatal intensive-care units
OR	operation room
PC	phosphatidylcholine
POD	postoperative day
SAE	serious adverse event
SBBO	small bowel bacterial overgrowth
SOP	standard operating procedure
TPN	total parenteral nutrition

STUDY SYNOPSIS

Title of Study	A randomized multicenter open-label controlled trial to show that mucous fistula refeeding reduces the time from enterostomy closure to full enteral feeds (MUCous FIstula REfeeding (“ MUC-FIRE ”) trial)
Short Term	MUC-FIRE
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Study Design	Randomized, multicenter, open-label, controlled, parallel group research study
Patient Population	Infants who underwent creation of an enterostomy receiving postoperative care and awaiting enterostomy closure
Participating Study Sites	n = 11
Sample Size	<p>To be assessed for eligibility: n = 201 To be assigned to the study: n = 106 To be analysed: n = 106</p>
Objectives	The primary objective of this study is to demonstrate that mucous fistula refeeding between enterostomy creation and enterostomy closure reduces the time to full enteral feeds after enterostomy closure compared to standard of care.
Endpoints	<p><u>Primary efficacy endpoint:</u> Time to full feeds (hours), defined as time to actual enteral intake of the age-dependent caloric requirements per day (defined as 120kcal/kg/24h)</p>

	<p>for at least 24h and a concomitant reduction of parenteral fluids to <20ml/kg/24h [Nutrition Committee, Canadian Pediatric Society; Committee on Nutrition, American Academy of Pediatrics].</p> <p><u>Key secondary endpoints:</u></p> <ol style="list-style-type: none"> 1) Estimated ratio of the diameter of the two bowel loops which are anastomosed. 2) Time to first bowel movement after enterostomy closure (mucous stool is considered a bowel movement), postoperative weight gain (g/d) (daily documentations recommended, minimum 2x per week), regular Z-Score (standard deviation score) documentation [WHO - weight-for-age] (daily documentations recommended, minimum 2x per week), days of postoperative total parenteral nutrition (> 20 ml/kg/24h) before and after the 2nd operation (=ostomy takedown) (TPN) 3) Laboratory parameters indicating cholestasis (conjugated bilirubin, GGT, ALT, AST). Time points for harvesting of blood samples : Baseline at the time of first MFR, then every 2 weeks until enterostomy takedown 4) Weight gain during the subsequent 5 days after reaching the primary endpoint 5) Central venous line (CVL) duration (days) and number of CVL infections (definition of infection: Neo-Kiss Guidelines) 6) Length of hospital stay 7) Reoperation <p><u>Assessment of safety:</u></p> <p>Assessment of possible (serious) adverse events (AEs/SAEs) after randomization (e.g. death, sepsis, bowel perforation)</p>
<p>Inclusion and Exclusion Criteria</p>	<p><u>Key inclusion criteria:</u></p> <p>Infants < 366 days, Ileostomy / Jejunostomy, double loop enterostomies and split enterostomies (with mucous fistula)</p> <p>Notice: All patients with meconium ileus are included. If later (required) diagnostics verify cystic fibrosis, the diagnostics as well as the diagnosis need to be documented in the eCRF and in further analysis subgroups will be established.</p> <p>Signed written informed consent obtained by parents/legal guardians and willingness of parents/legal guardians to comply with treatment and follow-up procedures of their child</p> <p><u>Key exclusion criteria:</u></p> <p>Resection of ileocecal valve, colostomy, small bowel atresia,</p>

	<p>Chromosomal abnormalities (if known at the time of randomization). Multiple ostomies (more than just an enterostomy and a mucous fistula).</p> <p>Reoperation (e.g. relaparotomy) prior to randomization is not an exclusion criteria, these patients may still be included in the study.</p>
<p>Intervention</p>	<p>All patients will receive standard care with standardized enterostomy creation and closure and will be treated according to a standardized feeding protocol.</p> <p><u>Experimental intervention:</u></p> <p>Perioperative mucous fistula refeeding between enterostomy creation and enterostomy closure.</p> <p><u>Control intervention:</u></p> <p>No perioperative mucous fistula refeeding between enterostomy creation and enterostomy closure.</p> <p><u>Follow-up per patient:</u></p> <p>3 months and 6 months postoperatively, following enterostomy closure (12-month follow-up only applicable for patients that are recruited early enough to complete this follow-up within the 48 month of overall study duration). Duration of intervention per patient of the intervention group: 6 weeks between enterostomy creation and enterostomy closure.</p>
<p>Study Duration</p>	<p><u>Recruitment:</u> approx. 41 months (176 weeks)</p> <p><u>Study duration per patient:</u> Maximum 58 weeks to minimum 32 weeks</p> <p><u>Duration of the entire study (first patient in to last patient out):</u> 48 months (208 weeks)</p>
<p>Statistical Analysis</p>	<p><u>Efficacy:</u> The type-one error rate is set to 5% (two-sided).</p> <p><u>Description of the primary efficacy:</u> The primary analysis is performed on the intention to treat population (ITT). The aim of this study is to demonstrate superiority of perioperative mucous fistula refeeding compared to standard care (no mucous fistula refeeding) in reducing the time to full enteral feeds after enterostomy closure. The treatment effect will be estimated with a Cox-regression adjusted for treatment, weight at birth (<1000g / ≥1000g) and center and will be assessed by the estimated hazard ratio (refeeding vs no refeeding) for reaching full enteral feeds. Superiority of the refeeding procedure will be concluded if the lower bound of the corresponding two-sided 95%-confidence interval for the treatment effect hazard ratio is greater than 1.</p> <p><u>Safety:</u> (Serious) adverse events (AEs/SAEs) will be compared between treatment groups with a chi-square test and other appropriate tests. P-</p>

	<p>values will be assessed descriptively.</p> <p><u>Secondary endpoints</u>: All secondary analyses will be explorative.</p>
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RESPONSIBILITIES

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1 SCIENTIFIC BACKGROUND AND STUDY RATIONALE

Enterostomies in infants may be created for different reasons. During the presence of an enterostomy the regular stool transfer is interrupted since the distal part of the bowel (the part following the enterostomy) does not participate in the processing of stool. Therefore it does not contribute to the resorption of enteral nutrients. As a consequence these infants need additional parenteral nutrition. Due to the negative side-effects of parenteral nutrition all patients should return to enteral nutrition as soon as possible. Consequently, many pediatric surgical centers worldwide routinely perform mucous fistula refeeding (MFR) into the former unused bowel after enterostomy creation because case reports and retrospective analyses show low complication rates and faster postoperative weight gain. Several providers, however, shy away from this approach because to date there is still no high quality evidence for the benefit of this treatment. The aim of this study is to assess the effects of mucous fistula refeeding in a prospective randomized trial. We hypothesize that MFR between enterostomy creation and enterostomy closure reduces the time to full enteral feeds after enterostomy closure compared to standard of care. Moreover, the side effects of parenteral nutrition may be reduced and the postoperative hospital care of infants undergoing ostomy closure shortened.

1.1 The Medical Problem

After creation of any enterostomy the bowel distal to the enterostomy is not in use. Therefore the physiologic passage of stool, nutrient uptake and growth of the bowel distal of the enterostomy are interrupted. At the time of enteral reanastomosis the surgeon often sees an enormous discrepancy in diameters of the proximal and the distal loops of bowel. In these cases the postoperative increase of enteral feeds and the dependence of the infant on parenteral nutrition may be prolonged. Furthermore it is well known that continuous parenteral nutrition is associated with several side effects including cholestasis and central line infections [1]. The physiological passage of stool through the bowel is important for enterohepatic circulation, resorption of fluids, electrolytes, vitamins, and enteral growth. Moreover, the passage of stool per rectum is important for developing a regular defecation reflex.

1.2 Evidence

Recently Gause et al. presented their results on MFR in neonatal patients [2, 3]. In their retrospective analysis of 28 patients (13 in the MFR group and 15 in the control group) a shorter duration of parenteral nutrition and a faster time to full enteral feeds in the MFR group were reported. In 2006, Richardson et al. performed a systematic review on case reports and small case series of MFR after enterostomy creation [4]. The authors concluded that MFR was safe, as no complications were identified in any of the cited publications. In conclusion, studies published so far showed a faster weight gain in the group of MFR compared to controls [2, 4, 5, 6, 7]. These promising results need to be confirmed by a randomized, controlled study, which is the intention of this proposal.

1.3 The need for a study

As suggested by Gause et al. [3] a multicenter study of MFR is warranted in order to address the limitations of retrospective studies carried out so far. The results of this randomized

controlled study may strongly influence the perioperative care of neonates within the pediatric surgical community. If our hypothesis is confirmed, the postoperative hospital stay of infants undergoing ostomy closure will be shortened. The benefits of MFR include a shorter duration and therefore less side effects of parenteral nutrition. Moreover, an economic benefit through lower costs for TPN and a shorter hospital stay may be reached.

1.4 Risk-Benefit-Assessment

Many pediatric surgical centers worldwide routinely perform MFR after enterostomy creation. However, due to a lack of prospective studies the level of evidence showing a benefit of this treatment strategy is low. Although the systematic review by Richardson et al. [4] showed no complications using this technique, MFR into the distal bowel loop may potentially cause complications such as bowel perforation. The risk for possible complications can be minimized by careful and standardized manipulation of the enterostomies. The local condition of the ostomy will be investigated twice daily.

If our hypothesis is confirmed, the postoperative hospital care of infants undergoing ostomy closure will be shortened. The benefits of MFR may include a shorter duration and therefore less side effects of parenteral nutrition. Moreover, an economic benefit through lower costs for TPN and a shorter hospital stay may be reached.

The results of the current study may influence the standard of neonatal intensive care. Therefore the potential benefits of MFR outweigh the possible risks of this study.

Results of data analyses including all data how to perform MFR will be published. If the results of this study will show significant differences between the intervention group and controls MFR will become the new standard of care for neonates with enterostomies.

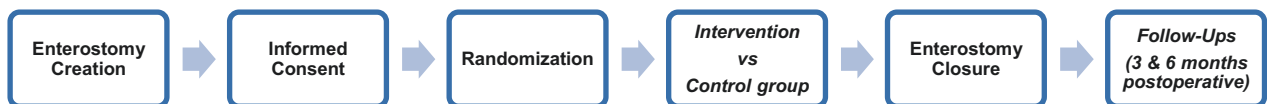
In Germany, the current national guideline for neonatal and surgical treatment of necrotizing enterocolitis (NEC) is currently in revision [Leitlinie 024-009: Nekrotisierende Enterokolitis (NEK)]. One of the principal investigators of the study (Prof. Dr. Martin Lacher) is coauthor of this guideline. If the current study proves the hypothesis that MFR is beneficial for these infants it may not only change the national guideline for the best treatment after enterostomy creation in Germany but in other countries too.

2 STUDY DESIGN, OBJECTIVES AND ENDPOINTS

2.1 Study Design

This is a randomized, multicenter (n=11), open-label, parallel group, controlled research study to demonstrate that mucous fistula refeeding between enterostomy creation and enterostomy closure reduces the time to full enteral feeds after enterostomy closure compared to standard of care.

Intervention scheme/Study flow



2.2 Study Objectives

The primary objective of this study is to demonstrate that mucous fistula refeeding between enterostomy creation and enterostomy closure reduces the time to full enteral feeds after enterostomy closure compared to standard of care.

2.3 Study Endpoints

2.3.1 Outcome measures

Time to full enteral feeds after enterostomy closure (hours) was chosen as the primary outcome parameter because of its clinical relevance representing the influence of MFR on the intestinal autonomy in the course of the disease. The endpoint is highly objective due to the strict and well-defined feeding protocol (see 3.1). In most of the referenced publications postoperative weight gain early after surgery was chosen as the primary outcome parameter. However, body weight is always affected by the shift of body fluids into the third space. Therefore postoperative weight does not always correlate with enteral/ parenteral caloric supplementation as a sign of enteral resorption. For this reason it was not selected as the primary outcome parameter but will be assessed as secondary outcome measure. Secondary outcome measures further include the number of days of postoperative total parenteral nutrition (TPN) and the cholestasis parameters (conjugated bilirubin, GGT, ALT, AST) as indicators for hepatotoxicity of parenteral nutrition. The “time to first bowel movement” (hours) which correlates to the postoperative transanastomotic passage of stool, will be another secondary outcome parameter. A bowel movement consisting of only mucous rather than stool is also considered a bowel movement. Finally, all outcome parameters including possible complications will be assessed during the follow-up 3, 6 and 12 months (12-month follow-up only applicable for patients that are recruited early enough to complete this follow-up within the 48 month of overall study duration) after enterostomy closure.

2.3.2 Determination of primary and secondary measures

Primary efficacy endpoint:

Time to full feeds (hours), defined as time to actual enteral intake of the age-dependent caloric requirements per day (defined as 120kcal/kg/24h) for at least 24h and a concomitant reduction of parenteral fluids to < 20ml/kg/24h [Nutrition Committee, Canadian Pediatric Society; Committee on Nutrition, American Academy of Pediatrics].

For determining the time to full enteral feeds, the feeding advancement will be carried out according to the predefined nutritional protocol after 6-8 tolerated feedings in 3-4 hour intervals (24 hours). "Full feeds" is therefore defined as 120kcal/kg/24h actual enteral intake [8, 9]. The nurses will document any increase and decrease of nutrition precisely and daily controls will be carried out by the responsible neonatologist and pediatric surgeon.

Key secondary endpoints:

- 1) Estimated ratio of the diameter of the two bowel loops which are anastomosed.
- 2) Time to first bowel movement after enterostomy closure (mucous stool is considered a bowel movement), postoperative weight gain (g/d) (daily documentations recommended, minimum 2x per week), regular Z-Score (standard deviation score) documentation [WHO - weight-for-age] (daily documentations recommended, minimum 2x per week), days of postoperative total parenteral nutrition (> 20 ml/kg/24h) before and after the 2nd operation (=ostomy takedown) (TPN)
- 3) Laboratory parameters indicating cholestasis (conjugated bilirubin, GGT, ALT, AST). Time points for harvesting of blood samples : Baseline at the time of first MFR, then every 2 weeks until enterostomy takedown
- 4) Weight gain during the subsequent 5 days after reaching the primary endpoint
- 5) Central venous line (CVL) duration (days) and number of CVL infections (definition of infection: Neo-Kiss Guidelines)
- 6) Length of hospital stay
- 7) Reoperation

Cleaning and changing of infants diapers will be performed according to a fixed schedule in order to uniformly document the time to first bowel movement following enterostomy closure. For determining postoperative weight gain (g/d) and calculating Z-Scores (standard deviation score) [WHO - weight-for-age] all infants are weighted regularly (daily recommended, minimum 2x week). This will be carried out according to a fixed schedule during morning rounds prior to feeding in an unclothed status.

Days of postoperative total parenteral nutrition (TPN) are counted, starting on the day of enterostomy closure and ending on the day of full enteral nutrition. The parenteral nutrition is manufactured by the hospital pharmacy on a daily basis, while considering the simultaneous enteral caloric intake.

Laboratory parameters for cholestasis (conjugated bilirubin, GGT, ALT, AST) are measured on a regular basis every 2 weeks starting at randomization and in cases of pathologic clinical signs (jaundice, acholic stools).

2.4 Study Duration

Recruitment:

Approximately 41 months (176 weeks)

Study duration per patient:

Maximum 58 weeks to minimum 32 weeks

Duration of the entire study (first patient in to last patient out):

48 months (208 weeks)

3 STUDY POPULATION

3.1 Study Population

Infants who underwent creation of an enterostomy receiving postoperative care and awaiting enterostomy closure:

to be assessed for eligibility: n = 201

to be assigned to the study: n = 106

to be analysed: n = 106

Duration of intervention per patient of the intervention group: 6 weeks between enterostomy creation and enterostomy closure

Follow-up per patient: 3 months, 6 months and 12 months post enterostomy closure, following enterostomy closure (12-month follow-up only applicable for patients that are recruited early enough to complete this follow-up within the 48 month of overall study duration).

3.2 Inclusion Criteria

1. Only infants younger than 366 days of age with status post ileostomy or jejunostomy creation (double loop enterostomies and split enterostomies (with mucous fistula)) will be included in the study to create a homogenous cohort of patients with similar diseases (e.g. necrotizing enterocolitis [NEC], focal intestinal perforation [FIP]). Also, infants of this age group are unique in several respects such as the response to parenteral nutrition and its hepatic toxicity resulting into neonatal cholestasis. The ostomy localization is restricted to the jejunum and ileum. Therefore, the cohort of patients shows a similar bowel length for fluid-, vitamin- and electrolyte resorption.
2. All patients with meconium ileus are included into the study. If later (required) diagnostics verify cystic fibrosis, the diagnostics as well as the diagnosis need to be documented in the eCRF and in further analysis subgroups will be established.
3. Signed written informed consent obtained by parents/legal guardians and willingness of parents/legal guardians to comply with treatment and follow-up procedures of their child.

3.3 Exclusion Criteria

1. The resection of the ileocecal valve is an exclusion criterion because of its association with extensive bowel resection and therefore prolonged parenteral nutrition [10]
2. Patients with small bowel atresia are excluded because of prenatally underdeveloped bowel distal to the atresia
3. Patients with chromosomal abnormalities (if known at the time of randomization) are excluded because of potential malabsorption and malnutrition due to an underlying syndrome.
4. Multiple ostomies (more than just an enterostomy and a mucous fistula), colostomy.

Reoperation (e.g. relaparotomy) prior to randomization is not an exclusion criteria, these patients may still be included in the study.

3.4 Feasibility of recruitment

In order to reach a total sample size of 106 patients during 36 months in 11 centers, every center will have to include 3.2 patients per year on average. The participating centers represent institutions treating a large patient volume and are located in different regions of Germany and Austria. All of them are University hospitals with large neonatal intensive-care units (NICU). When analyzing the center data over the last five years, each of the centers treated at least 6.1 infants per year that would fit our inclusion criteria (see 9.).

3.5 Achievability of recruitment rate

The center number was increased by new partners (university hospitals/ medical providers treating high patient numbers in specialized pediatric intensive care units). All centers have experience in adhering to scientific protocols and have participated in prospective studies. The necessary patient numbers (n=106) calculated by the power analysis will be achieved in the three year period according to patient numbers of the individual centers. The Hannover Medical School and University of Leipzig have participated in several (multi center) prospective studies without encountering problems with patient recruitment after proper counseling on study goals, protocols and the possible complications in relation to estimated benefits [11-25]. The recruitment of patients in this study will occur after enterostomy creation. As the patients should be clinically stable by this time, the parents will have enough time to make their decision on whether they want their infant to participate in the trial.

3.6 Discontinuation Criteria

The following reasons may lead to discontinuation:

1. Death
2. Bowel perforation due to intubation of a catheter into the distal bowel loop during refeeding

4 STUDY PROCEDURES

No study procedures are allowed to be conducted until parent’s written informed consent has been obtained (please also refer to chapter 9.1). The investigator is responsible for obtaining the parent’s written informed consent after adequate explanation of the aim, study assessments, potential risks and benefits and consequences of the study as well as alternative treatment options.

4.1 Study Calendar

	Enterostomy Creation	Screening	Pre Treatment Phase	Treatment Phase (Refeeding or Control)	End of Treatment (Enterostomy Closure)	Post Treatment Phase	FU 1 3 months	FU 2 6 months	(FU 3 12 months)*
			at least 1 week up to 6 weeks	at least 3 weeks up to 8 weeks	approx. 6 weeks after Enterostomy Creation	at least 2 weeks up to 8 weeks	3 months after Enterostomy Closure)	6 months after Enterostomy Closure)	12 months after Enterostomy Closure)
Data Assessment			daily	daily		daily	Outpatient clinic	Outpatient clinic	Outpatient clinic
Randomization			x						
Demographic data		x							
Informed consent		x							
In-/ Exclusion criteria		x							
Operation protocol		x							
Body weight			x	x		X **	x	x	x
Laboratory			x ***	X ***		X ***	x	x	x
Refeeding protocol				x					
Nutrition protocol						x			
Medical history			X						
Adverse events				x	x	x	x	x	x
Time to first bowel movement after enterostomy closure [hours]						x			

*only applicable for patients that are recruited early enough to complete the 12-month follow-up within the 48 month of overall study duration

**weight is measured during the subsequent 5 days after reaching the primary endpoint

***every 2 weeks starting at randomization and in cases of pathologic clinical signs (jaundice, acholic stools)

4.2 Standardized protocol for creation of a small bowel enterostomy (*all patients*):

- Exploratory laparotomy (transverse preferred)
- Possible resection of necrotic bowel
- Identification of bowel for the enterostomy
- Proximal and distal limbs of the bowel loop are pulled through the abdominal wall muscles and skin (Loop enterostomy) via the abdominal incision or separate incision (preferred).
- Measurement of the length of small bowel between a) the ligament of Treitz (or if malrotation the first mobile part of the duodenum) and the enterostomy and b) the enterostomy and the ileocecal valve [cm]. The measurement should be undertaken at the antimesenteric wall of the bowel.
- Closure of laparotomy:
 - Fascia with continuous suture Polyglactin 2-3/0
 - Subcutaneous interrupted sutures Polyglactin 4/0
 - Intracutaneous interrupted sutures Poliglecaprone 5/0
- Documentation of operative time (OR-Time in minutes).
- Daily documentation of the patient's weight recommended (minimum 2x per week).

4.3 Standardized protocol on perioperative mucous fistula refeeding (*MFR*):

Definition: Infants are considered capable for MFR after 2 weeks following enterostomy creation if no contraindications for MFR, like sepsis, are present.

- Start 14-42 days after enterostomy creation (modified according to Wong et al. [6])
- Content to be transferred: the infant's own stool
- Intervals of stool transfer: 6-8 hours as a bolus or continuously via a catheter introduced into the distal bowel loop (blocked with 0.5ml of Water)
- Amount of stool transfer: Initiation with 0,5ml/kg/h per day. Increase of 5ml/kg/d or as tolerated
- If the stool is too thick to be transferred, it may be diluted with normal saline 0,9%. (Or glucose 5% in case of hypernatremia)
- Maximum amount of stool transfer (goal): whole amount of own stool
- Documentation of time point and amount a) when the maximum amount of feeds are tolerated b) if and when the entire amount of stool is transferred
- Duration of refeeding: at least 3 weeks and until the infant's weight exceeds 2000g,
- Probiotics may be given as per protocol of the local institution
- Prokinetic agents are not allowed during the entire trial.

4.4 Standardized protocol for enterostomy closure (*all patients*):

- Timing of surgery: 6 weeks after enterostomy creation provided that the infant has a body weight of > 2000g
- If a patient is randomized to the MFR group the MFR should at least be performed for 21 days.
- Documentation whether the full amount of stool has been transferred (yes/no)
- Preoperative contrast study of the distal loop of the enterostomy to rule out stenosis is only necessary if the infants have not reached MFR of the total stool amounts of the preceding

24h. For all other infants preoperative contrast studies can be performed voluntarily. This study may be performed on the NICU by plain abdominal X-ray with enteral contrast (water-soluble isoosmolar)

- Central line placement if an adequate amount of calories cannot be provided via a peripheral line.
- No preoperative bowel preparation
- Placement of nasogastric (NG) tube in the operation room (OR)
- Size NG tube:
 - Premature infants up to 3 months of age: 6F catheter
 - 3 to 12 months of age: 8F catheter
- Small bowel anastomosis: Interrupted sutures with
 - 5/0 Polyglactin in infants below 6 months of age
 - 4/0 Polyglactin in infants above 6 months of age

4.5 Standardized protocol on the parenteral nutrition (all patients):

- using the recommendations in “Neugeborenenintensivmedizin” by Rolf Maier and Michael Obladen (9th edition, 2017) on nutrition:
- fluid (ml/kg body weight/ day) 110 – 180
- energy (kcal/kg body weight/ day) 80 – 160
- amino acid (g/kg body weight/ day) 2 – 4
- lipid (g/kg body weight/ day) 2 - 3

4.6 Standardized protocol for management after enterostomy closure (all patients):

- Calories of the parenteral nutrition [8, 9] if there is no hyperglycemia (> 200mg/dl), sepsis, hemodynamic instability that require a different caloric intake.
 - Day of surgery: 50 - 90cal/kg/day
 - POD (postoperative day) #1: 80-120kcal/kg/day
 - POD #2: 80-120kcal/kg/day
 - POD #3: 80-120kcal/kg/day
 - POD #4: 80-120kcal/kg/day
- Trophic feeding of <3ml x 8 (max 24ml/d) is allowed
- Initiation of enteral nutrition: POD #2
- The initiation of enteral nutrition may be delayed until the gastric residuals (as indicated by the amount of drainage via the nasogastric tube) are below 3ml/kg/nursing-shift or 10ml/kg/day.
- Perioperative antibiotic therapy: type and length based on bacteria profile have to be documented. Suggestion: Perioperative single shot antibiotic treatment. Different antibiotic regimes, adjusted to microbe profiling is possible, but should be documented precisely.
- Standardized feeding source
 - In all infant´s age-specific feeding sources will be used
 - Breast milk (if available) as there is a general consensus that breast milk (70kcal/100ml) is the most effective protection against the development of necrotizing enterocolitis (Good et al.[26]) (document amount used each day)
 - Alternative 1: donor breast milk (document amount used each day)

- Alternative 2: Formula for preterm infants (name, manufacturer, the kcal/ml and the amount should be documented in the eCRF)
- Caloric enhancement of the milk: pure human milk or preterm formula is given until a feeding amount of 100ml/kg/d is tolerated, then the energy content of human milk can be enhanced – type and extent of caloric enhancement should be documented precisely

Notice: As a large variety of institutional protocols on the fortification of the milk exist, the type of fortification is left to the discretion of the institution but should be documented.
- Documentation of the selected fortifiers, their amount and the caloric content of the milk
- The aspirate of the gastric tube (gastric residual) is continuously measured prior to the next feeding
- Feeding protocol (modified protocol of Bohnhorst et al [27])
 - Initial amount of enteral nutrition: 20ml/kg/d (in intervals of 3 or 4 hours)
 - Increase by 30ml/kg/d, when 8 (or 6, depending on feeding intervals) consecutive feedings were accepted

Example (infant's weight 2000g):

POD # 3: 8 x 5ml	= 40 ml	(20ml/ kg/d)
POD # 4: 8 x 12,5ml	= 100 ml	(50ml/ kg/d)
POD # 5: 8 x 20ml	= 160 ml	(80ml/ kg/ d)
POD # 6: 8 x 27,5ml	= 220 ml	(110ml/ kg/ d)
POD # 7: 8 x 35ml	= 280 ml	(140ml/ kg/ d)

- Gastric residuals prior to the feeding of over 20% of the previous feeding volume are considered pathologic. For the consecutive feeding 20% of the preceding feeding volume (=accepted gastric residual) is added to the current volume while the previous gastric residual (>20%) is subtracted of the total volume:
 feeding-volume + 20% of the preceding volume – whole amount of previous gastric residuals

1. Example:

Enteral intake 6 x 60ml; gastric residuals 20-50%

Gastric residual e.g. 21ml

Calculation:

60 ml (feeding)

+ 12 ml (20% of the previous feeding)

– 21 ml (gastric residual prior to the feeding) → 53 ml

2. Example:

Enteral intake 6 x 72ml; gastric residuals 20-50%

Gastric residual e.g. 30ml (ca. 40%)

Calculation:

72 ml (feeding)

+ 14 ml (20% of the previous feeding)

– 30 ml (gastric residual prior to the feeding) → 56 ml

- The next feeding is continued regularly and the feeding volume is then again increased after six consecutive accepted feeds
- If gastric residuals exceed 50% of the previous feeding volume or infant's vomiting one feeding is skipped

4.7 Further documentations after enterostomy closure (*all patients*):

1. Duration (minutes) of operation (enterostomy closure)
2. Postoperative duration of assisted respiration (hours) prior versus post extubation
3. Daily documentation of morphine use (influencing bowel movement and therefore our primary outcome)
4. Documentation of analgesia type (especially peridural anaesthesia catheters, influencing postoperative bowel motility)

4.8 Additional treatments

The additional treatment of the patient (intervention) group involves the MFR (see 3.2 „standardized protocol on perioperative MFR“) with daily introduction of a catheter into the distal bowel loop followed by stool transfer.

Despite the standardized MFR no additional surgical or drug therapy is planned.

4.9 Control(s)/Comparator(s)

Infants of the control group will receive the current perioperative care.

4.10 Frequency and scope of study visits

All patients will be continuously monitored on the intensive care unit (NICU) or intermediate care ward (IMC) by neonatologists, pediatric surgeons, and nursery staff. Medical records will be analyzed including vital signs, weight, oral intake, and medications.

All participating centers will be visited by the coordinating investigators before the start of the study. In the course of the study investigators of all centers will meet in the local medical institution twice a year and exchange feedback on the feasibility of the protocols, especially on complications and serious adverse events. In addition to these meetings, the study coordinator will be constantly available by email and phone to address questions regarding the study. In the course of the study medical information will be electronically exchanged monthly via encrypted email, telephone, and Fax).

4.11 Assessment of safety

Assessment of possible (serious) adverse events (AEs/SAEs) after surgery (e.g. intestinal bleeding, bowel perforation) from randomization until reaching the primary endpoint or 12 months post enterostomy closure.

AEs and SAEs have to be reported in the eCRF. Serious adverse events will be reported to the Ethics Committee according to the Declaration of Helsinki.

4.12 Timeframe complete study

Year 1		Year 2	Year 3	Year 4	Year 5
Completing all preparations					Publication
	Recruitment of patients				
	„Follow-ups“ 3, 6 (and 12) months following enterostomy closure				
	First pat. in			Last pat. in	
		50% pat. recruited		100% pat. recruited	
	Annual meetings of all recruiting centers at the German Surgical Congress Annual meetings of all recruiting centers at the German Pediatrician Congress				

5 ADVERSE EVENTS

Current data suggests a low complication rate in mucous fistula refeeding. Lau et al. [28], with the up to date largest study population (n=77), documented no major complications. However, a retrospective analysis by Haddock et al. [25] with an inhomogenous population reported on the risk of bowel perforation, bleeding and death associated with mucous fistula refeeding. Therefore, these criteria are adverse events during the study period.

Postoperative complications are classified, using the Clavien-Dindo classification and assessment of complications on daily basis. However, when not associated to MFR these complications are not considered adverse events [23, 24].

6 STATISTICAL ANALYSIS

The primary analysis will be performed on the ITT population, i.e. all randomized patients will be analyzed in the treatment group to which they have been initially allocated. The treatment effect will be assessed by the Hazard Ratio for reaching full enteral feeds estimated with a Cox regression adjusted for center, weight at birth and treatment, and the respective 95% confidence interval. Superiority of the refeeding procedure will be concluded if the lower bound of the two-sided 95%-confidence interval for the Hazard Ratio (refeeding vs no refeeding) is greater than 1. In case of missing information on the time to full feeds, patients will be censored at the last known status before full feeds. All secondary analyses will be exploratory and will be conducted on the ITT population.

6.1 Methods against bias

This is an open-label study. Blinding is not possible because active refeeding of stool in the intervention group is obvious to any person participating in the medical care of the patient. Randomization will be performed centrally (with variable block length) and stratified by center and weight at birth (<1000g / ≥1000g), as this is an important prognostic factor for primary endpoint. Randomization will take place after enterostomy creation in order to reduce the amount of missing values due to patient exclusion after surgery (e.g. due to unforeseen need for resection of ileocecal valve). The primary analysis will be performed on the ITT population as this is an open study and parents may have preferences not outspoken before randomization. A per protocol analysis will be conducted as a sensitivity analysis. Consistency between the findings in the ITT population and the per protocol population will be examined as it is an important pre-requisite for a successful interpretation of the study. Drop-Outs are not expected because all patients will constantly undergo neonatal intensive care and will therefore not be lost to follow-up. If parents withdraw their infant from study participation they will be asked to allow data collection at a final analysis in order to avoid that information would be wasted. Nonetheless, if missing values should occur (e.g. due to death, or parents' refusal of data collection) observations will be censored at the last timepoint with known enteral feeding status. Since this censoring may be informative, missing values for time to full feeds will be replaced by the worst observation in each group in a sensitivity analysis in order to check how censoring may have influenced the results. If any death should occur before the respective patient reaches full enteral feeds a sensitivity analysis will be performed on all surviving patients.

6.2 Proposed sample size/Power calculations

The literature of MFR is scarce and information on the primary endpoint “time to full enteral feeds” is limited [4]. A recently published retrospective analysis of 24 patients [3] of which 13 received refeeding of stool to the mucus fistula and 11 did not receive refeeding of stool showed a median time from reanastomosis to enteral feeds of 7 days in the control group and 4 days in the refeeding group. The data presented for the control group is in line with retrospective data of 42 patients collected at Hannover Medical School. These 42 patients are all patients fulfilling the inclusion criteria who were treated at Hannover Medical School between 2005 and 2015. They did not receive refeeding of stool and had a median time to full enteral feeds of 7 days. According to Gause et al. [3] a survival analysis is appropriate. In their respective publication, median times are reported corresponding to a hazard ratio of 1.751 for time to enteral feeds (4 days vs 7 days), 2.331 for parenteral nutrition discontinuation (6 days vs 14 days) and 2.667 for goal feeds (7.5 days vs 20 days). Because time to enteral feeds in this publication is in line with our retrospective data of time to full feeds, a hazard ratio of 1.751 is assumed for the treatment effect. In order to show a treatment effect with a power of 80% and a two-sided type I error probability of 5 % with a logrank test a total of 100 events (full enteral feeds) is required, if the hazard ratio for the treatment effect is 1.751. Since patients will be in neonatal intensive care, every patient is expected to reach full enteral feeds. Nonetheless, to account for possible deaths, the sample size was increased by 6 patients, resulting in a total of 106 patients. Sample size was estimated in nQuery Advisor 7.

6.3 Compliance/Rate of loss to follow up

Multiple retrospective data analyses show low complication rates related to MFR. During 14-years of MFR a group of the University of Hong Kong observed no major complications associated to the refeeding in 77 patients with necrotizing enterocolitis [28].

All centers participating in the current study have experience on MFR and recorded no major complications in any of the centers. This observation is well in line with data on 13 patients undergoing MFR at the Department of Pediatric Surgery at Johns Hopkins University School of Medicine in Baltimore. The authors documented no major complications associated to refeeding but observed benefits of the intervention [3].

We are very confident that there will be almost no loss of follow-up in this study. Due to the severe course of the diseases parents of patients with neonatal surgical conditions have an intense emotional relationship with the treating surgeons and neonatologists. Almost all parents prefer follow-up appointments at the treating hospital after their infants have been discharged from the hospital. We therefore do not expect any loss of follow-up. However, as a precaution the patient recruitment was increased to 11 centers with 201 expected patients.

7 DATA MANAGEMENT

All study data will be collected by the investigator and/or other study personnel. A validated clinical trial data base (electronic case report form) is provided in which the data are entered. These data includes further relevant diagnosis, using the International Statistical Classification of Diseases and Related Health Problems (ICD 10 coding system). In particular because of the risk of comorbidities in preterm infants (e.g. bronchopulmonary dysplasia, retinopathy of prematurity, intraventricular haemorrhage). Authorized and trained staff of the study sites will enter the data in the eCRF in a timely manner. Only SAEs will be documented and reported on paper forms. Verification of the data in the eCRF occurs by risk-based monitoring as well as via range, validity and consistency checks programmed in the system. Additionally, manual queries can be raised in the system if discrepancies are detected. Based on the queries, the investigator can review the data and resolve the discrepancy or justify the entered data directly in the system. All changes of data entered in the eCRF are documented in an audit trail. A quality control will be performed before the database is closed. This procedure is documented. Finally, data transfer takes place for statistical evaluation.

The data management plan contains further details about data management processes.

8 QUALITY ASSURANCE AND MONITORING

All initiation visits, onsite monitoring visits, close-out visits and in-house monitoring will be conducted by monitors of Hannover Clinical Trial Center (HCTC). HCTC SOPs will be utilized. Before beginning of the study pre-study visits by the primary investigators will be conducted to be able to instruct the local investigators in how to follow the study protocol and documentation of data. Initiation visits will be done in each study centre prior to patient recruitment to ensure adherence with all study procedures by the monitor of HCTC. To assure high data quality and patients safety regular on-site monitoring visits will be performed by HCTC monitors. Checking of signed informed consents and source data verification will be carried out according to a risk adapted approach. At the end of the study close out visits will be performed at all study sites. Project managers, monitors and PIs will be in close and regular contact throughout the study and with all study sites.

Monitoring details will be summarized in a monitoring plan which will be prepared by the project manager (HCTC). The monitoring plan will be reconciled with the coordinating investigator and members of the clinical project management. It will serve as guiding document for all monitors and will contain details on monitoring activities, responsibilities and interfaces between study team, data management, source data and adverse events. In-house monitoring will assure high data quality. Data capture will be achieved by electronic data capture (electronic CRF). On-site source data verification will be done according to a risk adapted monitoring afterwards. In total, 3 monitoring visits are planned per study site.

8.1 Data Monitoring Committee

An independent Data Monitoring Committee (DMC) will be implemented to detect possible harms and to assure continuous risk/benefit assessment. A DMC is a group of independent experts external to the study assessing the progress, safety data and, if needed, critical efficacy endpoints. Details of the definition of DMC, its composition and its roles and responsibilities can be found in the separate DMC charter.

9 ETHICAL AND LEGAL CONSIDERATIONS, ADMINISTRATION

The study will be conducted in accordance with the principles of ICH-GCP (as far as possible for this kind of study) and the Declaration of Helsinki.

Study protocol and patient consent form will be submitted to ethics committees before start of the study. No amendment to the protocol may be made without consideration by the Ethics Committee.

9.1 Patient Information and Informed consent

The investigator is responsible for obtaining the parent's written informed consent after adequate explanation of the aim, study assessments, potential risks and benefits and consequences of the study as well as alternative treatment options. Parents will have sufficient time to ask questions before deciding on whether to participate in the study or not. The patient information/informed consent form has to be signed in duplicate by the patient's parents and the investigator. One document will be given to the parents, the other one will be kept at the participating study sites. No study procedures are allowed to be conducted until parent's written informed consent has been obtained.

The patient information/informed consent form has to be revised whenever important new information becomes available that may be relevant to the parent's consent.

Participation in this clinical trial is voluntary. Withdrawal from the study at any time and for any reason is without any disadvantages to the patient's further treatment.

9.2 Patient Insurance

The trial will be covered by a participant insurance in case the trial site (clinic) does not cover the study by its liability insurance (Haftpflichtversicherung). All subjects (parents) will be informed about their rights and obligations in regard to insurance policies before participating in the study. A copy of the insurance policies will be handed out to each patient (parents).

9.3 Data Protection

Data will be collected, handled, stored and analysed in accordance with national regulations. All study staff have to give due consideration to data protection and medical confidentiality.

If the participant withdraws the previously given informed consent, the participant has the right to demand the deletion of all data collected so far. If the participant withdraws and does not demand the deletion of data, these so far collected data will be anonymised and used for the statistical analysis.

9.4 Registration

The study will be registered at a public study register (ClinicalTrials.gov) prior to the start of recruitment.

9.5 Record Retention

The original study documents will be stored in an archive of the participating study site for at least 10 years after the final study report.

9.6 Financing

The clinical trial is funded by public funds through the German Research Foundation.

10 HANDLING OF BIOMATERIAL

Biomaterials in the main study include the analyses of sera and the use of enterostomy stool for MFR. Sera will be collected and analyzed using the current concepts of each department. Therefore, no additional trauma will be present.

Enterostomy losses will be collected in strict intervals [1x (continuous refeeding) – 3x (separated refeeding every 8 hours) daily] for the refeeding. Stool will not be stored for the MFR. The necessary amount will be transferred and the surplus will be thrown away.

11 PUBLICATION

After completion of the trial, data analyses will be performed by the Institute of Biostatistics (MHH). Results will be published and the study protocol including all data how to perform MFR. If the results of this study will show significant differences between the intervention group and controls MFR will become the new standard of care for neonates with enterostomies.

In Germany, the current national guideline for neonatal and surgical treatment of necrotizing enterocolitis (NEC) is currently in revision [Leitlinie 024-009: Nekrotisierende Enterokolitis (NEK)]. One of the principal investigators of the trial (Prof. Dr. Martin Lacher) is coauthor of this guideline. If the current trial proves the hypothesis that MFR is beneficial for these infants it may not only change the national guideline for the best treatment after enterostomy creation in Germany but in other countries too.

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13 SIGNATURES

This document has been approved by the following persons. The following signatures document their approval.

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Date

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