

SMOFlipid formulation

Newborn use only

2023

Alert	SMOFlipid should always be a part of a complete parenteral nutritional treatment including amino acids and glucose.			
Indication	As part of parenteral nutrition			
Action	SMOFlipid compounded formulation provides essential fatty acids, non-carbohydrate energy, fat and water-soluble vitamins. SMOFlipid contains soybean oil (30%), medium chain triglyceride (30%), olive oil (25%) and Fish oil (15%).			
Drug type	Lipid emulsion.			
Trade name	SMOFlipid compounded formulation – supplied by Fresenius-Kabi.			
Presentation	SMOFlipid compounded formulation prepared by Fresenius-Kabi:			
	1. 45 mL syringe FKS 045V			
	2. 50 mL syringe FKS050V			
	2. 151 mL bag FKC PLV1.			
	Contents	45 mL syringe For ≤1 Kg	50 mL syringe For ≤1 Kg	151 mL bag For >1 Kg
	SMOFlipid 20%	32.5 mL	36 mL	109 mL
	Soluvit N	2.5 mL	2.8 mL	8.4 mL
	Vitalipid N Infant	10 mL	11.2 mL	33.5 mL
FK code	FKS045V	FKS050V	FKCPLV1	
Stability	13 days at 2 ⁰ -8 ⁰ C	13 days at 2 ⁰ -8 ⁰ C	12 days at 2 ⁰ -8 ⁰ C	
There are other strengths of compounded formulations available. Please check with your local facility.				
Dose	1-3 g/kg/day			
	Equates to the volumes of the compounded formulation that contains 80% of water*			
	Lipid, g/kg/day	SMOFlipid volume, mL/kg/day		Water content
	1 g/kg/day	6 mL/kg/day		5 mL/kg/day
	2 g/kg/day	12 mL/kg/day		10 mL/kg/day
3 g/kg/day				
18 mL/kg/day				
15 mL/kg/day				
*Due to the significant water content, SMOFlipid can be counted in the total volume of fluid intake.				
Dose adjustment	consider reducing the dosage of lipid emulsions, if triglyceride levels >3.0 mmol/L, ¹ but consider continuing at least 0.5g/kg/day to prevent essential fatty acid deficiency.			
Maximum dose	3 g/kg/day			
Route	IV			
Preparation	No preparation is required for compounded formulation. Syringes and bags are supplied in light protected packaging.			
Administration	Continuous IV infusion over 24 hours. Protect from light. DAILY volume may also be administered over 20 hours. Maximum hang time at room temperature is 48 hours.			
Monitoring	IV site for extravasation. Serum triglycerides - once at 24 hours after the completion of 1,2 and 3g/kg/day and then, weekly or if baby is ill until the infusion is ceased. blood glucose, electrolytes, liver and renal function, full blood count as routine laboratory monitoring during complete parenteral nutrition.			
Contraindications	Hypersensitivity to fish-, egg-, soya- or peanut protein or to any of the active substances or excipients. Severe hyperlipidaemia. Severe liver insufficiency. Severe blood coagulation disorders. Severe renal insufficiency without access to hemofiltration or dialysis. Acute shock. General contraindications to infusion therapy: acute pulmonary oedema, hyperhydration, decompensated cardiac insufficiency.			
Precautions	Hepatic impairment Impaired lipid metabolism which can occur in sepsis, renal or hepatic impairment. Unstable conditions (e.g. severe metabolic acidosis, severe sepsis and hypotonic dehydration).			

SMOFlipid formulation

Newborn use only

2023

Drug interactions	The addition of medications other than water- and fat-soluble vitamins as compounded in these formulation should be avoided.																																																													
Adverse reactions	Hypertriglyceridemia. Fat overload syndrome – Not reported in neonates. In adults, it is characterised by hyperlipemia, fever, fat infiltration, hepatomegaly with or without icterus, splenomegaly, anaemia, leukopenia, thrombocytopenia, coagulation disorder, haemolysis and reticulocytosis, abnormal liver function tests and coma. The symptoms are usually reversible if the infusion of the fat emulsion is discontinued.																																																													
Compatibility	These recommendations are extrapolated from 4 studies^{3-5,11} and the SMOFlipid formulations used in those studies may differ from our formulations. If there is any existing incompatibility between a medication and a pure soybean-based ILE, then it would remain incompatible with SMOFlipid.³ However, one cannot assume that compatibility with intralipid equates compatibility with SMOFlipid as SMOFlipid contains mixed lipids, not pure soybean oil. Fluids: Mixing SMOFlipid compounded formulation with other solutions should be avoided. Sodium chloride 0.9%, amino acid-glucose solution. Y-site: <table> <tr> <th>Drug</th><th>Drug concentration</th><th>Y-site compatibility</th></tr> <tr> <td>Amoxicillin</td><td>100 mg/mL</td><td>Yes</td></tr> <tr> <td>Ampicillin</td><td>30 mg/mL; 100 mg/mL</td><td>Yes</td></tr> <tr> <td>Benzylpenicillin</td><td>100 mg/mL</td><td>Yes</td></tr> <tr> <td>Caffeine (base)</td><td>10 mg/mL</td><td>Yes</td></tr> <tr> <td>Dexmedetomidine</td><td>4 mcg/mL</td><td>Yes</td></tr> <tr> <td>Fentanyl</td><td>50 mcg/mL</td><td>Yes</td></tr> <tr> <td>Furosemide</td><td>10 mg/mL</td><td>Yes</td></tr> <tr> <td>Heparin</td><td>500 units/mL</td><td>Yes</td></tr> <tr> <td>Hydromorphone</td><td>2.5 mg/mL</td><td>Yes</td></tr> <tr> <td>Ibuprofen</td><td>1.25 mg/mL; 5 mg/mL</td><td>Yes</td></tr> <tr> <td>Ibuprofen lysine</td><td>4 mg/mL</td><td>Yes</td></tr> <tr> <td>Indometacin</td><td>200 mcg/mL</td><td>Yes</td></tr> <tr> <td>Ketamine</td><td>10 mg/mL</td><td>Yes</td></tr> <tr> <td>Midazolam</td><td>0.5 mg/mL</td><td>Yes</td></tr> <tr> <td>Milrinone</td><td>200 mcg/mL</td><td>Yes</td></tr> <tr> <td>Morphine hydrochloride</td><td>500 mcg/mL</td><td>Yes</td></tr> <tr> <td>Morphine sulfate</td><td>500 mcg/mL; 1 mg/mL</td><td>Yes</td></tr> <tr> <td>Paracetamol</td><td>10 mg/mL</td><td>Yes</td></tr> <tr> <td>Sildenafil</td><td>0.8 mg/mL</td><td>Yes</td></tr> </table> Y site - Other⁷ Aminophylline, ampicillin, aztreonam, calcium gluconate, cefazolin, cefoperazone, cefotaxime, ceftazidime, clindamycin, cloxacillin, dexamethasone sodium phosphate, digoxin, dobutamine, enalaprit, erythromycin lactobionate, fentanyl citrate, fluconazole, hydrocortisone sodium phosphate, insulin, regular, isoproterenol, lidocaine, magnesium sulfate, meropenem, methylprednisolone sodium succinate, metronidazole, miconazole, nitroglycerin, norepinephrine bitartrate, octreotide acetate, penicillin G potassium (not sodium), pentoxifylline, piperacillin-tazobactam, potassium chloride, sodium bicarbonate, sodium nitroprusside, tacrolimus, ticarcillin disodium, trimethoprim-sulfamethoxazole, vancomycin HCL, zidovudine. Uncertain: Alprostadil 20 mcg/mL in D5W approaches the incompatibility threshold with SMOFlipid.		Drug	Drug concentration	Y-site compatibility	Amoxicillin	100 mg/mL	Yes	Ampicillin	30 mg/mL; 100 mg/mL	Yes	Benzylpenicillin	100 mg/mL	Yes	Caffeine (base)	10 mg/mL	Yes	Dexmedetomidine	4 mcg/mL	Yes	Fentanyl	50 mcg/mL	Yes	Furosemide	10 mg/mL	Yes	Heparin	500 units/mL	Yes	Hydromorphone	2.5 mg/mL	Yes	Ibuprofen	1.25 mg/mL; 5 mg/mL	Yes	Ibuprofen lysine	4 mg/mL	Yes	Indometacin	200 mcg/mL	Yes	Ketamine	10 mg/mL	Yes	Midazolam	0.5 mg/mL	Yes	Milrinone	200 mcg/mL	Yes	Morphine hydrochloride	500 mcg/mL	Yes	Morphine sulfate	500 mcg/mL; 1 mg/mL	Yes	Paracetamol	10 mg/mL	Yes	Sildenafil	0.8 mg/mL	Yes
Drug	Drug concentration	Y-site compatibility																																																												
Amoxicillin	100 mg/mL	Yes																																																												
Ampicillin	30 mg/mL; 100 mg/mL	Yes																																																												
Benzylpenicillin	100 mg/mL	Yes																																																												
Caffeine (base)	10 mg/mL	Yes																																																												
Dexmedetomidine	4 mcg/mL	Yes																																																												
Fentanyl	50 mcg/mL	Yes																																																												
Furosemide	10 mg/mL	Yes																																																												
Heparin	500 units/mL	Yes																																																												
Hydromorphone	2.5 mg/mL	Yes																																																												
Ibuprofen	1.25 mg/mL; 5 mg/mL	Yes																																																												
Ibuprofen lysine	4 mg/mL	Yes																																																												
Indometacin	200 mcg/mL	Yes																																																												
Ketamine	10 mg/mL	Yes																																																												
Midazolam	0.5 mg/mL	Yes																																																												
Milrinone	200 mcg/mL	Yes																																																												
Morphine hydrochloride	500 mcg/mL	Yes																																																												
Morphine sulfate	500 mcg/mL; 1 mg/mL	Yes																																																												
Paracetamol	10 mg/mL	Yes																																																												
Sildenafil	0.8 mg/mL	Yes																																																												
Incompatibility	Fluids: Mixing SMOFlipid compounded formulation with other solutions should be avoided. Y-site:⁷ Aciclovir, Alprostadil (uncertain-check compatibility section), amikacin sulfate, amphotericin B, ceftriaxone, dopamine, doxycycline, famotidine, ganciclovir, gentamicin, lorazepam, midazolam, phenobarbital, rocuronium. <table> <tr> <th>Drug</th><th>Drug concentration</th><th>Y-site compatibility</th></tr> <tr> <td>Alprostadil</td><td>20 mcg/mL</td><td>Approaches incompatibility threshold</td></tr> <tr> <td>Caffeine citrate</td><td>20 mg/mL</td><td>No</td></tr> <tr> <td>Dopamine</td><td>3.2 mg/mL</td><td>No</td></tr> </table>		Drug	Drug concentration	Y-site compatibility	Alprostadil	20 mcg/mL	Approaches incompatibility threshold	Caffeine citrate	20 mg/mL	No	Dopamine	3.2 mg/mL	No																																																
Drug	Drug concentration	Y-site compatibility																																																												
Alprostadil	20 mcg/mL	Approaches incompatibility threshold																																																												
Caffeine citrate	20 mg/mL	No																																																												
Dopamine	3.2 mg/mL	No																																																												

	Famotidine	2.5 mg/mL	No
	Gentamicin	2 mg/mL; 10 mg/mL	No
	Rocuronium	10 mg/mL	No
Stability	45 mL syringe: 13 days at 2-8°C; 151 mL syringe: 12 days at 2-8°C		
Storage	Compounded formulations are to be stored in refrigerator once they arrive the NICU.		
Excipients	Glycerol, Egg Lecithin, dl-alpha-Tocopherol, Sodium Hydroxide, Sodium Oleate, Water for injections		
Special comments	Due to the significant water content, SMOFlipid can be counted in the total volume of fluid intake.		
Evidence	Background Intravenous lipid emulsions (ILEs) are an indispensable part of paediatric parenteral nutrition (PN). ILE provides a noncarbohydrate source of energy delivered as an iso-osmolar solution in a low volume (2.0 kcal/mL with 20% ILEs, or 1.1 kcal/mL with 10% ILEs). Generally, a lipid intake of 25-50% of non-protein calories is recommended in fully parenterally fed infants. Lipids provide essential fatty acids (EFAs) and help with the delivery of the water- and fat-soluble vitamins. Efficacy Recent meta-analyses and RCTs provide evidence that the initiation of lipids within the first two days of life in very preterm infants appears to be safe and well tolerated. No signs of increased respiratory impairment, chronic lung disease, sepsis, patent ductus arteriosus, necrotising enterocolitis, intraventricular haemorrhages, retinopathy of prematurity, or mortality could be demonstrated. Observational studies also suggested that early initiation of ILE influences later neurodevelopment. To date there is no evidence that gradual increments in the infusion rate of lipids improve fat tolerance. ESPGHAN 2018 recommendations: 1. In preterm infants, lipid emulsions can be started immediately after birth and no later than on day two of life and for those in whom enteral feeding has been withdrawn, they can be started at time of PN initiation. 2. In preterm and term infants, parenteral lipid intake should not exceed 4 g/kg/day. 3. In children, parenteral lipid intake should be limited to a maximum of 3 g/kg/day. 4. In order to prevent essential fatty acids (EFA) deficiency in preterm infants a lipid emulsion dosage providing a minimum linoleic acid (LA) intake of 0.25 g/kg/day can be given. This equates to 1 g/kg/day of SMOFlipid as a minimum. 5. In order to prevent EFA deficiency in term infants and in children a lipid emulsion dosage providing a minimum LA intake of 0.1 g/kg/day can be given. This equates to 0.5 g/kg/day of SMOFlipid as a minimum. 6. Pure soybean oil (SO) ILEs (e.g. Intralipid) may provide less balanced nutrition than composite ILEs (e.g. SMOFlipid). 7. For PN lasting longer than a few days, pure SO ILEs should no longer be used and composite ILEs with or without fish oil (FO) should be the first choice treatment. SMOFlipid is a composite ILE with fish oil. 8. In preterm infants, ILEs should be protected by validated light-protected tubing. 9. 20% ILEs (e.g. SMOFlipid 20%) should be the first choice treatment. 10. In newborns including preterm infants, routine use of ILEs should be continuous over 24 hours. If cyclic PN is used, for example for home PN children, ILEs should usually be given over the same duration as the other PN components. 11. In paediatric patients, heparin should not be given with lipid infusion on a routine basis. (LoE 3e4, GPP, conditional recommendation for) 12. In paediatric patients with sepsis, more frequent monitoring of plasma triglyceride concentration and dose adjustment in case of hyperlipidaemia are recommended. ILE dosage may be reduced but lipid supply may generally be continued at least in amounts supplying the minimal EFA requirements. 13. In patients with severe unexplained thrombocytopaenia, serum triglyceride concentrations should be monitored and a reduction of parenteral lipid dosage may be considered. 14. As part of measures to reverse IFALD in paediatric patients, a discontinuation of SO ILE, (e.g. Intralipid), a reduction of other ILE dosage and/or the use of composite ILE with FO (e.g. SMOFlipid), should be considered along with the treatment and management of other risk factors.		

15. The use of pure Fish oil ILE (e.g. omegaven) is not recommended for general use in paediatric patients but may be used for short-term rescue treatment in patients with progression to severe Intestinal failure associated liver disease, based on case reports.
16. Markers of liver integrity and function, and triglyceride concentrations in serum or plasma should be monitored regularly in patients receiving ILEs, and more frequently in cases with a marked risk for hyperlipidaemia (e.g. patients with high lipid or glucose dosage, sepsis, catabolism, extremely low birth weight infants).
17. Reduction of the dosage of ILEs can be considered if serum or plasma triglyceride concentrations during infusion exceed 3 mmol/L (265 mg/dL) in infants.

Safety

A systematic review suggested that the ILEs initiated within the first 2 d of life in VLBW infants appears to be safe and well tolerated.⁸ In this meta-analysis, type of lipid also did not show any significant difference in growth during hospital admission, death, bronchopulmonary dysplasia, duration of respiratory support and supplemental oxygen, necrotising enterocolitis, hypertriglyceridemia, and hyperglycemia.⁸ ILEs do not seem to affect platelet number or platelet function.¹ However, some concerns were raised regarding the effect of ILEs on platelet aggregation. ESPGHAN 2018 recommendation: In patients with severe unexplained thrombocytopenia, serum triglycerides should be monitored and a reduction in lipid dosage may be considered.¹

Fat overload syndrome: Characterized by fever, jaundice, hepatosplenomegaly, respiratory distress, and spontaneous haemorrhage. Other symptoms include anaemia, leukopenia, thrombocytopenia, low fibrinogen levels and coagulopathy. Although this was most often reported with rapid infusion of pure Soy oil ILEs, it was also reported with accidental, rapid infusion of SMOFlipid in a 2-year old girl, suggesting the rate of infusion is responsible. The patient was successfully treated with supportive care combining fluid infusion, transfusion of platelets, and substitution of serum albumin (0.5 g/kg/d) and fresh-frozen plasma (10 mL/kg). In the next couple of days, she received extra platelets, erythrocyte transfusion, and filgrastim (Neupogen; 5 µg/kg/d) due to a very low leukocyte count.⁹

Hypertriglyceridemia: Hypertriglyceridemia (HT) is common in extreme preterm infants. A retrospective review of 195 infants <29 weeks gestation showed HT in 33% in 23-25 weeks and 16% in 26-28 weeks. Severe HT (Plasma triglyceride >4.5mmol/L) was noted in 10% in 23-25 weeks and 4.5% in 26-28 weeks gestation. In this study, there were no overt signs of fat overload directly attributable to LE, however, 2 infants developed transient mild thrombocytopenia and 1 infant developed transient pancytopenia, coinciding with the severe HT. There were no episodes of liver dysfunction or cholestasis associated with severe HT. The number of infants who developed HT at 1 g/kg/day, 2 g/kg/day and 3 g/kg/day were 1.5%, 3.6% and 14.4% respectively.¹⁰

Practice points

Estimated vitamin intakes in **preterm** neonates with 3 g/kg/day of SMOFlipid formulation

Unit/kg/day	ESPGHAN 2018 Day 0	ESPGHAN 2018 Growing	3 g/kg/day of lipid formulation
Vit A, IU	700-1500	700-1500	920
Vit D, IU	80-400	80-400	160
Vit E, IU	2.8-3.5	2.8-3.5	2.8
Vit K, µg	10	10	80 [#]
Thiamine, µg	350-500	350-500	310
Riboflavin, µg	150-200	150-200	360 [#]
Niacin, mg	4.0-6.8	4.0-6.8	4
Pyridoxine, µg	150-200	150-200	400 [#]
Folate, µg	56	56	40 [*]
Vit B12, µg	0.3	0.3	0.5 [#]
Pantothenate, mg	2.5	2.5	1.5 [*]
Biotin, µg	5-8	5-8	6
Vit C, mg	15-25	15-25	10 [*]

Estimated vitamin intakes in **term** neonates with 3 g/kg/day of SMOFlipid formulation

Nutrient, Unit/kg/day	ESPGHAN 2018	3 g/kg/day of lipid formulation
Vit A, IU	462-989	920

	Vit D, IU	40-150	160
	Vit E, IU	2.8-3.5	2.8
	Vit K, µg	10	80 [#]
	Thiamine, µg	350-500	310
	Riboflavin, µg	150-200	360 [#]
	Niacin, mg	4.0-6.8	4
	Pyridoxine, µg	150-200	400 [#]
	Folate, µg	56	40 [*]
	Vit B12, µg	0.3	0.5 [#]
	Pantothenate, mg	2.5	1.5 [*]
	Biotin, µg	5-8	6
	Vit C, mg	15-25	10 [*]
References	1. Lapillonne A, Mis NF, Goulet O, van den Akker CH, Wu J, Koletzko B, Braegger C, Bronsky J, Cai W, Campoy C, Carnielli V. ESPGHAN/ESPEN/ESPR/CSPEN guidelines on pediatric parenteral nutrition: Lipids. Clinical Nutrition. 2018 Dec 1;37(6):2324-36. 2. Fresenius-Kabi SMOFlipid formulations. 3. Herrera OR, Caviness LA, Helms RA. Emergence of new injectable lipid emulsions in the USA: guidance for pediatric clinicians. Food and Nutrition Sciences. 2019 Jul 30;10(07):823. 4. Ross EL, Salinas A, Petty K, Her C, Carpenter JF. Compatibility of medications with intravenous lipid emulsions: effects of simulated Y-site mixing. American Journal of Health-System Pharmacy. 2020 Dec 1;77(23):1980-5. 5. Garcia J, Garg A, Song Y, Fotios A, Andersen C, Garg S. Compatibility of intravenous ibuprofen with lipids and parenteral nutrition, for use as a continuous infusion. PLoS One. 2018 Jan 3;13(1):e0190577. 6. Cober, M.P., Gura, K.M. and Plogsted, S. (2018) Challenges in Pediatric Nutrition: What's up with Lipid Emulsions? New Products, Dosing Strategies and Potential for Fatty Acid Deficiency. 27th PPAG Annual Meeting & 2018 Pediatric Pharmacy Conference , Salt Lake City, 26 April 2018. 7. Mirtallo JM. Parenteral Nutrition Therapy: Assessment Tools and Guidelines. Policy. 2023 Jun 21. 8. Vlaardingerbroek H, Veldhorst MAB, Spronk S, van den Akker CHP, van Goudoever JB. Parenteral lipid administration to very-low-birth-weight infants—early introduction of lipids and use of new lipid emulsions: a systematic review and meta-analysis. Am J of Clin Nutr 2012;96:255-268. 9. Hojsak I, Kolacek S. Fat overload syndrome after the rapid infusion of SMOFlipid emulsion. J Parenter Enteral Nutr 2014;38:119e21. 10. Sinclair R, Schindler T, Lui K, Bolisetty S. Hypertriglyceridaemia in extremely preterm infants receiving parenteral lipid emulsions. BMC pediatrics. 2018 Dec;18(1):1-7. 11. Senarathna SMDKG, Strunk T, Petrovski M, Woodland S, Martinez J, Chuang VTG, Batty KT. Physical compatibility of lipid emulsions and intravenous medications used in neonatal intensive care settings. Eur J Hosp Pharm 2023; In press; doi:10.1136/ejhpharm-2023-003870.		

VERSION/NUMBER	DATE
Original 1.0	30/11/2023
Current 1.0 (minor errata)	13/02/2025
REVIEW	30/11/2028

Authors Contribution

Primary author/s	Srinivas Bolisetty, Pramod Pharande, Girish Deshpande
Evidence Review	Srinivas Bolisetty, Pramod Pharande, Girish Deshpande
Pharmacy expert review	Prof Kevin Batty (Director of Pharmacy, Curtin Medical School, Perth, Western Australia)
Nursing Review	Eszter Jozsa, Denise Coll, Eloise Deibe, Charlotte Walter, Bryony Malloy
Pharmacy Review	Michelle Jenkins
ANMF Group contributors	Sarah Allworth, Nilkant Phad, Bhavesh Mehta, Mohammad Irfan Azeem, Rebecca O'Grady, Thao Tran, Susanah Brew, Benjamin Emerson-Parker, Simarjit Kaur, Helen Huynh, Martin Kluckow, Stephanie Halena, Karel Allegaert
Final editing	Srinivas Bolisetty
Electronic version	Cindy Chen, Ian Callander
Facilitator	Srinivas Bolisetty

Citation for the current version

Bolisetty S, Pharande P, Deshpande G, Batty K, Jozsa E, Coll D, Deibe E, Walter C, Malloy B, Jenkins M, Azeem MI, Allworth S, Phad N, Barzegar R, Brew S, Mehta B, O'Grady R, Kluckow M, Tran T, Huynh H, Halena S, Chen C, Kaur S, Gengaroli R, Emerson-Parker B, Callander I, Allegaert K. SMOFlipid formulation. Consensus formulary by the Australasian Neonatal Medicines Formulary group. Version 1, dated 30 November 2023. www.anmfonline.org