# Nestlé Compleat Paediatric

## Competitor analysis



November 2025

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# AIM OF THE DOCUMENT

This document is intended for INTERNAL use only. It can serve as a base for the training of your careline and sales teams, providing them with more background and detailed information for discussions with HCPs. None of the content should go external as such. If used for any assets that will go external, please ensure local CVM approval.

It starts with a topline overview and summary of Nutrini's superiority followed by a deep dive of Nutrini MF range versus Nestlé Compleat Paediatric, looking at the nutritional composition, list of ingredients, clinical evidence and communication & claims. At the end, an overall summary and conclusion will be provided.


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# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
- Compleat Paediatric activation overview
  - Topline conclusion
  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


## CONTENT



**1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE**



**2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC**



**3. OVERALL SUMMARY AND CONCLUSION**

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1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

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- Nutritional & compositional overview
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  - Detailed analysis
- Evidence overview
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  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
- Compleat Paediatric activation overview
  - Topline conclusion
  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


# 1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE



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  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
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  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


# NUTRINI'S SUPERIORITY KEY MESSAGES



**Strong credibility built on 30+ years of clinical heritage**



**Delivering complete care combining feeding solutions, our own Flocare®Infinity medical devices and services (homecare, careline, etc.)**




**Widest and most tailored portfolio (age-adapted and energy-specific solutions)**



**Scientifically proven tolerance and long-term health outcomes**



**Clinically precise in line with ESPGHAN guidelines**




**Providing unique ingredients (whey protein dominant and MF6 fibre mix)**

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  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
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3. OVERALL SUMMARY AND CONCLUSION


# EXECUTIVE SUMMARY: NUTRINI'S RANGE SUPERIORITY IN PAEDIATRIC TUBE FEEDING




## Philosophy

- Strong leadership and established credibility among HCPs.
- Built on its heritage of more than 30 years of clinical experience.
- Offering complete care with nutritional solutions, medical devices and services.
- Rooted in science and suitable for a wide range of clinical conditions.

### Portfolio & Composition

- **Tailored nutrition: Age- and energy-specific** formulations, aligned with **ESPGHAN guidelines.**
- **Unique ingredients & clinical precision:**
  - **Fibre quantity: With or w/o fibre.**
  - **Fibre quality: Unique MF6 fibre blend** closely resembling fibre intake of a healthy/varied diet and proven benefits on bowel health.
  - **Protein quality: Whey dominant** for better tolerance.
  - **Fat quality: With DHA** supporting cognitive development during critical growth phases.

### Clinical evidence

- **Evidence strength:** 4 studies with prospective, crossover, and retrospective designs— with data up to 12 months usage
- **Growth outcomes:** Proven catch-up growth, improved BMI, and body composition over 6–12 months.
- **GI tolerance:** Evidence for reduced constipation, improved stool consistency, and decreased laxative use.
- **Nutritional rehabilitation:** Focus on long-term recovery, not just symptom relief.
- **Micronutrient safety:** Proven long-term micronutrient stability and safety across multiple studies.

### Communication & Activation

- HCP-focused activation, with evidence-based messaging.
- High credibility among HCPs with long history.

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- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
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3. OVERALL SUMMARY AND CONCLUSION


# EXECUTIVE SUMMARY: KEY POINTS FOR COMPLEAT PAEDIATRIC

## Philosophy

- Innovative and first to market in the naturality segment.
- Built on strong perception and growing body of clinical experience around mild GI tolerance and real food ingredients.
- Appeals to HCPs due to tolerance benefit and parental preferences, emphasizing familiarity and naturality.




### Portfolio & Composition

- Available in one SKU: 1.2 kcal/ml, suitable for children aged 1+.
- Represents a **one-size-fits-all approach** with limited customization.
- Contains **14% real food ingredients** (chicken, vegetables, fruit).
- **Fibre & protein** partially coming from real-food ingredients whey content is not declared.

### Clinical evidence

- Supported by 8 studies (varying quality), primarily focused on:
  - Short-term GI symptom relief (retching, constipation, diarrhea).
  - Quality of life improvements.
  - Healthcare cost reduction (based on U.S. real-world data).
- Lack of long-term nutritional rehabilitation - limited data on growth outcomes and no data on nutritional adequacy or micronutrient stability.

### Communication & Activation

- Consistent, single-minded messaging targeting both HCPs and parents.
- Leverages real patient stories, recipes, and naturality cues.
- Maintains a high share of voice, driven by emotional appeal and strong presence across different channels.

**In conclusion, Compleat Paediatric provides an emotionally resonant solution for tube-fed children with mild GI tolerance issues, emphasizing real food ingredients and caregiver appeal. However, its clinical evidence base is variable in quality and primarily mainly focused on short-term symptom relief.**

**In contrast, Nutrini is grounded in science with a strong credibility built over 30+ years of clinical heritage. It offers a wide, tailored and comprehensive range of solutions supported by robust, peer-reviewed data demonstrating good tolerance, catch-up growth, and long-term nutritional health outcomes—making it suitable for a wide range of clinical needs.**

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
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3. OVERALL SUMMARY AND CONCLUSION


# EXECUTIVE SUMMARY: COMPARATIVE ANALYSIS OF NUTRINI RANGE VERSUS COMPLEAT PAEDIATRIC

| EQUITY | NUTRINI RANGE | COMPLEAT PAEDIATRIC |
|---|---|---|
| **Clinical philosophy** | Clinical precision, tailored nutrition, ESPGHAN-aligned | One-size-fits-all, naturality-focused |
| **Target group** | Suitable for broad range of clinical conditions | Patients with GI tolerance challenges or lifestyle needs |
| **Age adaptation** | 1–6 yrs, 7–12 yrs | 1+ yrs |
| **Evidence** | Focus on long-term growth & safety | Focus on short-term GI symptom relief |
| **Micronutrient tracking** | Present | Absent |
| **Energy options** | 0.75, 1.0, 1.5 kcal/ml | 1.2 kcal/ml only |
| **Protein source** | Whey/casein blend | Chicken, vegetables, milk (whey unspecified) |
| **Fibre options** | MF6: a mixture of non-soluble and soluble fibres with clinically proven benefits | From peas, arabic gum, inulin, FOS (51% from fruits & vegetables) |
| **Activation strategy** | HCP-focused, evidence-based | HCP and Parent-focused, emotional storytelling |

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  - Detailed analysis
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  - Topline comparison & conclusion
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3. OVERALL SUMMARY AND CONCLUSION

# 2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC



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  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
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3. OVERALL SUMMARY AND CONCLUSION

# PRODUCT COMPARISONS BETWEEN NUTRINI MF RANGE AND COMPLEAT PAEDIATRIC

As Danone has a very wide tube portfolio, but no innovation specifically in the naturality segment yet to directly compare Nestlé Compleat Paediatric with, we felt it makes most sense to **compare Compleat Paediatric versus our core range tube products Nutrini Low Energy MF 0.75, Nutrini MF 1.0, Nutrini Energy MF 1.5 kcal** as these are closest to Compleat Paediatric 1.2 kcal composition.




In the following slides, the comparison has been made on:

- **Nutritional composition incl list of ingredients**
- **Evidence**

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

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  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
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3. OVERALL SUMMARY AND CONCLUSION

# NUTRITIONAL & COMPOSITIONAL OVERVIEW

- Topline comparison & conclusion
- Detailed analysis

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
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  - Topline conclusion
  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


# TOPLINE COMPARISON OF THE KEY NUTRITIONAL & COMPOSITIONAL DIFFERENCES BETWEEN NUTRINI MF RANGE VS. COMPLEAT PAEDIATRIC

| Category | Nutrini MF range (Nutricia) | Compleat Paediatric (Nestlé) | |
|---|---|---|---|
| **Energy variety** | Multiple: 0.75, 1.0, 1.5 kcal/ml | Single: 1.2 kcal/ml | |
| **Protein source** | Whey/casein blend (up to 60% whey) | 33% from chicken & vegetables, remaining protein likely caseinate | |
| **Protein-energy ratio (PE%)** | 9.7–10.7% (age-appropriate) | 12.3% (higher, but not age-specific) | |
| **Fat profile** | Lower saturated fat (3.6–4.8% E) | Higher saturated fat (12.3% E) | |
| **DHA/EPA** | Present and declared | No levels declared, but does contain fish oil | |
| **Carbohydrates** | Lower sugar content | Higher sugar (from fruit/veg) | |
| **Lactose** | <0.025 g/100 kcal (lactose-free claim possible) | <0.05 g/100 kcal | |
| **Fibre blend** | MF6: mix of non-soluble and soluble fibres with clinically proven benefits | From peas, arabic gym, inulin, FOS (51% coming from fruits & vegetables) | |
| **Micronutrient density** | Varies, higher density in LE version | Higher density for some nutrients | |
| **Real food ingredients** | No real food ingredients added, but it provides safe, effective, and well-tolerated nutritional support for children in a similar way | 14% (chicken, peas, fruit) | |
| **Viscosity** | Lower (6–18 mPa.s) – suitable for Ch6 tubes | Higher (70 mPa.s) – requires Ch8 | |
| **Osmolality** | 210–405 mOsm/kg | 340 mOsm/kg | |
| **Packaging** | 200 & 500 ml, pump-compatible, suitable for bolus feeding | 250 ml (ENFit) & 500 ml (SmartFlex, suitable for bolus feeding) | |
| **List of ingredients** | Nutrini MF range and Compleat Paediatric are highly processed foods with comparable list of ingredients. No objective conclusion can be drawn since they are meeting legal requirements. | | |

## Colour code explainer

- **Nutrini MF range shows superiority**
- **Nutrini MF range and Compleat Paediatric are comparable**
- **Attributes are different and may/may not be a benefit (depends on HCP view)**
- **Nutrini MF range does not demonstrate superiority**

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  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
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3. OVERALL SUMMARY AND CONCLUSION


# TOPLINE CONCLUSION

- Both Compleat Paediatric and Nutrini MF range offer distinct nutritional profiles tailored to paediatric needs.
- Compleat Paediatric contains real food ingredients (13.8%), providing a more 'natural' option in a single formulation suitable across age groups 1> years.
- Nutrini MF range formulations contain the **unique MF6 fibre mix,** are **whey-based,** and are **enriched with DHA.** The range offers age-adapted formulations (Nutrini for 1-6 years, Nutrinimax for 7-12 years) with various **energy-specific options** (0.75, 1.0 and 1.5 kcal/ml), enabling precise nutritional support tailored to individual needs.
- Its energy-specific solutions are aligned with ESPGHAN guidelines.

**Conclusion:** With its broad selection of age- and energy-specific options, the Nutrini MF range **delivers tailored nutrition that better supports the unique needs of paediatric patients.**






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- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
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3. OVERALL SUMMARY AND CONCLUSION


# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 1. ENERGY




| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **ENERGY kcal/ml** | 0.75 | 1.0 | 1.5 | 1.2 | **The Nutrini MF range offers greater flexibility and a more tailored, patient-centric approach compared to Compleat Paediatric, which follows a one-size-fits-all model.**<br>• Nutrini MF range includes a variety of products designed to meet diverse patient needs, **with different energy densities**—0.75, 1.0, and 1.5 kcal/ml—to support low, normal, and high energy requirements. The range is also available **with or without fibre,** enabling more precise nutritional support based on individual clinical needs.<br>• All energy densities in the Nutrini MF range—0.75 kcal/ml (Nutrini Low Energy), 1.0 kcal/ml (Nutrini), and 1.5 kcal/ml (Nutrini Energy)— **are supported by ESPGHAN guidelines for paediatric malnutrition and for children with neurological impairment (NI) (1,2).** In contrast, the 1.2 kcal/ml energy density used in Compleat Paediatric is neither referenced nor recommended in current clinical guidelines. | |

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- **Nutrini MF range does not demonstrate superiority**


1. ESPGHAN Committee on Nutrition:, et al. "Practical approach to paediatric enteral nutrition" J. Pediatr. Gastroenterol. Nutr. 51.1 (2010): 110-122; 2. Romano, Claudio, et al. "ESPGHAN guidelines for the evaluation and treatment of gastrointestinal and nutritional complications in children with neurological impairment." J. Pediatr. Gastroenterol. Nutr. 65.2 (2017): 242-264.

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- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
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3. OVERALL SUMMARY AND CONCLUSION


# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 2. MACRO-NUTRIENT DIFFERENCES: PROTEIN

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **PROTEIN g/100 kcal (PE %)** | 2.0 (10.6%) | 2.4 (9.7%) | 2.7 (10.7%) | 3.1 (12.3%) | **Nutrini MF and Nutrini Energy MF are designed to meet the increased protein needs of children with disease - related malnutrition (DRM)**. They provide 10–11% protein energy (PE), aligning with the estimated needs of wasted or moderately malnourished children (9–12% PE) depending on the desired rate and composition of weight gain (3-5).<br><br>**While Nutrini MF and Nutrini Energy MF are specifically designed for children aged 1–6 years, Compleat Paediatric is formulated for a broader age range, starting from 1 year onward.** This broader target group may explain the relatively lower protein levels in the Nutrini products. However, their protein-energy (PE) ratios are appropriate for the intended age group. For older children (7–12 years), Nutricia offers the **NutriniMax range—a unique offering that bridges the gap between paediatric and adult nutritional needs.** NutriniMax provides 3.3 g of protein per 100 kcal, corresponding to a 13% PE.<br><br>Children with NI may have 30–50% lower energy needs than healthy peers, but their protein requirements remain unchanged. **Nutrini Low Energy MF is formulated to meet these needs in line with ESPGHAN guidelines (2),** which highlight that when energy needs are low, it can be challenging to meet protein targets. In such cases, a higher-protein formula – like Nutrini Low Energy- is recommended to avoid undernutrition. | |
| **PROTEIN QUALITY (SOURCES)** | 60% whey & 40% casein | 60% whey & 40% casein | 40% whey & 60% casein | 33% from rehydrated chicken, green peas and green beans & 67% from milk (most probably "casein") | Nutrini MF range uses a blend of dairy-based proteins—specifically whey and casein—which play complementary roles in supporting growth. Whey-based formulas, in particular, are associated with faster gastric emptying and improved feeding tolerance (6). According to ESPGHAN guidelines (2017), whey-based enteral nutrition has been shown to signifi-cantly reduce acid gastroesophageal reflux episodes in children with severe neurological impairment (NI), and formulas containing 50% whey have demonstrated reductions in gagging and retching (2). Due to these benefits, **ESPGHAN recommends whey-based formulas for children with NI, underscoring a key advantage of the Nutrini range, and especially Nutrini Low Energy, in managing tolerance-related challenges.**<br><br>In contrast, Compleat Paediatric sources its protein from natural foods such as chicken, vegetables (e.g., peas and green beans), and milk. While milk protein is listed among the ingredients, the proportion of whey is not specified. Therefore, we assume that **Compleat Paediatric contains casein in addition to these natural protein sources.** | |

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2. Romano, Claudio, et al. "ESPGHAN guidelines for the evaluation and treatment of gastrointestinal and nutritional complications in children with neurological impairment." J. Pediatr. Gastroenterol. Nutr. 65.2 (2017): 242-264; 3. WHO/FAO/UNU, E.C., Protein and amino acid requirements in human nutrition. Technical. Report Series No 935. 2007, Geneva: WHO; 4. Golden, M., Proposed recommended nutrient densities for moderately malnourished children. Food Nutr Bull 2009. 30(3): p. S267-342; 5. Pencharz, P. et al, Protein and energy requirements for 'optimal' catch-up growth. Eur J Clin Nutr 2010. 64(1): p. S5-7; 6. Brun AC, S.K. et al.,The effect of protein composition in liquid meals on gastric emptying rate in children with cerebral palsy Clin Nutr 2012. 31: p. 108-12.

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2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
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  - Topline conclusion
  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION

# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 3. MACRO-NUTRIENT DIFFERENCES: FATS

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **FAT g/100 kcal** | 3.3 | 4.4 | 4.4 | 4.27 | **Nutrini MF range and Compleat Paediatric contain similar amount of fat,** with the exception of Nutrini Low Energy which contains lower level of fat in line with the ESPGHAN guidelines for children with NI (2). | |
| **Saturated fat g/100 kcal (% E)** | 0.4 (3.6%) | 0.53 (4.8%) | 0.52 (4.7%) | 1.37 (12.3%) | **Nutrini MF range contains less than half the amount of saturated fat compared to Compleat Paediatric, offering a more balanced fat profile.** Nutrini MF range's saturated fat levels are **in line with WHO guidelines,** which recommend less than 10% of total energy intake from saturated fatty acids for children over 2 years of age (7). In contrast, Compleat Paediatric exceeds this recommendation. | |
| **DHA mg/100 kcal EPA mg/100 kcal** | 34.8 8.19 | 35.3 8.31 | 35.1 8.35 | Unknown | Long-chain polyunsaturated fatty acids (LCPs), particularly DHA, play a critical role in brain and retinal development, membrane function, and immune regulation in children. Supplementation with DHA has been associated with improved cognitive performance, visual acuity, motor coordination, and reduced incidence of infections, especially in children with restricted diets or developmental challenges (8,9). **Nutrini MF range has added DHA and EPA by design, providing 43 mg of n-3 long-chain polyunsaturated fatty acids (LCPs) per 100 kcal**, in line with expert recommendations on n-3 LCP intake in children, as summarized by Sijben (8). In contrast, it is unclear whether Compleat Paediatric contains added DHA or EPA, and if so, at what level—making Nutrini MF range a more transparent and targeted choice in this regard. (7) | |
| **LA mg/100 kcal (%E) ALA mg/100 kcals (%E)** | 950 (8.5%) 207 (1.8%) | 979 (8.8%) 211 (1.8%) | 974(8.7%) 212 (1.8%) | 735(6.6%) 103 (0.9%) | The EFSA Adequate Intake (AI) recommendations for essential fatty acids are set at >4% of energy for linoleic acid (LA) and >0.5% for alpha-linolenic acid (ALA). Both the Nutrini MF tube range and Compleat Paediatric meet these requirements. The IOM (US) sets slightly higher AIs for children, further supporting the value of Nutrini MF range's formulation. | |
| **MCT fat g/100 kcal (% E)** | 0 (N/A) | 0 (N/A) | 0 (N/A) | 0.6 (5.4%) | Nutrini MF range does not contain added MCT oil, intentionally formulated to maintain a lower saturated fat content. While MCT levels above 40–60% of total fat have been shown to support tolerance in children with intestinal failure—particularly in semi-elemental formulas—such high levels are not necessary for standard paediatric use (10).<br><br>In contrast, Compleat Paediatric contains very low levels of MCT, **which are not considered clinically significant in terms of tolerance or nutritional advantage.** Therefore, while MCTs can be beneficial in specific clinical contexts, their inclusion at low levels does not offer a meaningful benefit in general paediatric formulations. | |

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6. ESPGHAN Guidelines for children with NI - Romano, Claudio, et al. 2017; 7. WHO updates guidelines on fats and carbohydrates; 8. Sijben JW, G.A.,et al., Is it prudent to add n-3 long-chain polyunsaturated fatty acids to paediatric enteral tube feeding? Clin Nutr 2011. 30: p. 273-81; 9. Uauy, R.wt al., Essential fatty acids in early life: structural and functional role. The Proceedings of the Nutrition Society, 2000. 59(1): p. 3-15; 10. Goulet, O., et al. "Neonatal short bowel syndrome as a model of intestinal failure: physiological background for enteral feeding." Clin. Nutr. 32.2 (2013): 162-171.

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
  - Topline comparison & conclusion
  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
- Compleat Paediatric activation overview
  - Topline conclusion
  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION

# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 4. MACRO-NUTRIENT DIFFERENCES: CARBS

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **CARBS g/100 kcal** | 12.2 | 12.4 | 12.2 | 12 | **Nutrini MF range and Compleat Paediatric contain similar amount of carbs** with no clinically relevant differences. | |
| **Sugars g/100 kcal** | 0.7 | 0.8 | 0.7 | 1.11 | Nutrini MF range contains a lower total amount of sugars compared to Compleat Paediatric. This difference is expected, as Nutrini does not include fruits or vegetables—common natural sources of sugars found in Compleat Paediatric. While Nutrini's absolute sugar content is lower, it primarily uses maltodextrin, whereas Compleat Paediatric contains more fructose derived from its fruit and vegetable ingredients.<br><br>Given these differences in both quantity and source, **no definitive conclusion can be drawn regarding the superiority of sugar levels or types between the two products.** | |
| **Lactose g/100 kcal** | <0.025 | <0.025 | <0.025 | <0.05 | Nutrini MF range and Compleat Paediatric contain similar amount of lactose with no clinically relevant differences. However, Nutrini has a slightly lower lactose content and meets the criteria for **a "lactose-free" claim—an advantage that could support a superiority positioning.** | |

**Colour code explainer**

- **Nutrini MF range shows superiority**
- **Nutrini MF range and Compleat Paediatric are comparable**
- **Attributes are different and may/may not be a benefit (depends on HCP view)**
- **Nutrini MF range does not demonstrate superiority**

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

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  - Detailed analysis
- Evidence overview
  - Topline comparison & conclusion
  - Detailed analysis
    - Compleat Paediatric evidence
    - Nutrini MF range evidence
- Compleat Paediatric activation overview
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3. OVERALL SUMMARY AND CONCLUSION

# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 5. MACRO-NUTRIENT DIFFERENCES: FIBRES

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **FIBRES g/100 kcal** | 0.7 | 0.8 | 0.8 | 0.85 | **Nutrini MF range has a slightly lower level of fibre than Compleat Paediatric, however, there are no clinically relevant differences.** | |
| **Sources & types of fibres** | 67% soluble fibre (inulin, oligofructose, arabic/acacia gum, soya polysaccharides) 33% insoluble fibre (cellulose, resistant starch) | | | Peas, arabic gum, inulin, fructo-oligosacchahrides 51% from V&F | Nutricia's unique MF6 blend combines 6 different soluble and insoluble fibres, which closely resembling the fibres found in a normal diet.<br><br>MF6 has been evaluated in multiple studies across both paediatric and adult populations, demonstrating benefits such as improved stool consistency and GI tolerance, reduced incidence of constipation and diarrhoea, and enhanced gut microbiota in children. (11-17)<br><br>In comparison, Compleat Paediatric also contains fibre and highlights **that half of its fibre content comes from natural sources** (e.g. fruits, and vegetables), which aligns with its inclusion of 14% real food ingredients. However, the exact ratio of soluble to insoluble fibre in Compleat Paediatric is not disclosed, limiting direct comparison. As such, **no definitive conclusion can be drawn regarding the superiority of MF6 versus naturally sourced fibres.** | |

**Colour code explainer**

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3. OVERALL SUMMARY AND CONCLUSION

# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 6. MICRO-NUTRIENT DIFFERENCES

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **Micronutrients per 100 kcal** | | | | | Nutrini MF and Nutrini Energy MF provide a solid nutritional foundation for paediatric use, aligned with international standards (FSMP, EFSA, US IOM). While some growth-related micronutrients (e.g., vitamin D) could be optimized, these formulas remain suitable for general paediatric support.<br><br>Nutrini Low Energy Multi Fibre (LE) offers higher micronutrient density per 100 kcal, ideal for children with low energy needs but standard micronutrient requirements (e.g., neurological impairment). Additionally, Nutrini High Energy is beneficial for patients with volume restrictions (e.g., due to medication use or underlying conditions).<br><br>**In contrast, Compleat Paediatric is more micronutrient-dense, designed for children 1+ years and as a base for homemade blends, ensuring nutritional adequacy.** This explains its higher micronutrient levels compared to the Nutrini MF range.<br><br>Overall, Compleat Paediatric offers an alternative option and does not replace the well-established, evidence-based Nutrini MF range in standard paediatric care. | |
| **Iron mg/100 kcal** | 1.36 | 1.0 | 1.0 | 1.2 | | |
| **Zinc mg/100 kcal** | 1.31 | 1.0 | 1.0 | 0.60 | | |
| **Magnesium mg/100 kcal** | 14.4 | 11 | 11.2 | 16.2 | | |
| **Calcium mg/100 kcal** | 78.7 | 59.3 | 59.5 | 98.3 | | |
| **Vit D µg/100 kcal** | 1.31 | 1.0 | 1.0 | 1.45 | | |
| **Vit C mg/100 kcal** | 13.1 | 9.9 | 9.9 | 4.4 | | |
| **Carotenoids mg/100 kcal** | 0.13 | 0.10 | 0.1 | Unknown | Carotenoids provide powerful antioxidant protection and, in some cases, serve as provitamin A, supporting immune function, vision, and cellular health. Higher dietary intake and plasma levels of carotenoids have been associated with a reduced risk of chronic diseases, including cancer and cardiovascular conditions. Patients receiving nutritional support may have increased requirements for carotenoids and other antioxidants because of infection, injury or illness (18). Therefore, the **inclusion of carotenoids in the Nutrini MF range is a logical step to help meet the increased needs of this vulnerable population.** | |

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COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

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3. OVERALL SUMMARY AND CONCLUSION


# NUTRITIONAL & COMPOSITIONAL COMPARISON: NUTRINI MF RANGE VS COMPLEAT PAEDIATRIC

## 7. OVERALL PRODUCT & PACK CHARACTERISTICS

| Nutrients | Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Nutrini MF range vs Compleat Paediatric | Superiority rating |
|---|---|---|---|---|---|---|
| **Real food ingredients (%)** | 0 | 0 | 0 | 14% | **Nutrini MF range does not contain real food ingredients; however, it provides safe, effective, and well-tolerated nutritional support for children in a similar way.** (Please refer to the evidence sections for more details). | |
| **Proportion F&V (%)** | 0 | 0 | 0 | 6.9% | **Nutrini MF range does not contain real food ingredients; however, it provides safe, effective, and well-tolerated nutritional support for children in a similar way.** (Please refer to the evidence sections for more details). | |
| **Viscosity (mPa.s)** | 6 | 7 | 18 | 70 | **Ch 6 feeding tubes, with their smaller diameter, are generally more comfortable for patients**—especially for long-term or nasal use—and are **suitable for low-viscosity** nutritional products like the Nutrini MF range. However, their narrow lumen increases the risk of clogging and limits the flow rate, making them less ideal for thicker formulas. **In contrast, Ch 8 tubes accommodate higher-viscosity products such as Compleat Paediatric more effectively, reducing the risk of blockage and allowing for faster administration.** | |
| **Osmolality mOsm/kg** | 210 | 240 | 405 | 340 | The osmolality of Compleat Paediatric falls between the osmolality ranges of Nutrini MF range products, which is expected given its higher energy density. In general, isotonic formulas—those with an osmolality around 300 mOm/kg—are best tolerated, particularly in patients with impaired gastric emptying or those at risk of diarrhea. | |
| **Age indication** | 1-6yrs | 1-6 & 7-12 yrs | 1-6 & 7-12 yrs | 1-13 yrs | Nutrini MF range is **more specifically tailored** than Compleat Paediatric, offering **age-appropriate solutions and dedicated formulations for both tube feeding and oral nutritional supplementation (ONS)**. In contrast to Compleat Paediatric's more standardized approach, Nutrini MF range avoids a one-size-fits-all model by providing specialised SKUs designed to meet the distinct needs of different paediatric age groups—such as the Nutrini tube range for children ages 1-6 years, the NutriniMax tube range for ages 7–12 years, and the Fortini ONS range for children over 1 year. | |
| **Pack and connection** | 0.13 | Available in 200 and 500 ml, compatible with Infinity pump | Available in 200 and 500 ml, compatible with Infinity pump | Available in two formats: 500ml SmartFlex® and 250ml with ENFit compatible | Although both Compleat Paediatric and Nutrini MF range offer similar packaging formats (200 ml / 250 ml and 500 ml), Compleat Paediatric's holds an advantage in terms of bolus feeding compatibility—thanks to its **EN-Fit-compatible SimpLink®** format. However, Nutrini MF range offers added **benefits through its OpTri®** bottle, which performs better on some aspects of usability (e.g. flip top cap, transparent bottle and big hanging eye) safety & hygiene, recyclability, and compatibility with standard enteral feeding systems. | |

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# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# PRODUCT COMPARISON – LIST OF INGREDIENTS













| Nutrini LE MF 0.75 kcal | Nutrini MF 1.0 kcal | Nutrini Energy MF 1.5 kcal | Compleat Paediatric | Main differences between Nutrini MF range vs Compleat Paediatric |
|---|---|---|---|---|
| Water, maltodextrin, vegetable oils (rapeseed oil, sunflower oil), whey protein concentrate (from cow's milk), dietary fibres (soy polysaccharides, resistant starch, inulin, arabic gum, cellulose, oligofructose), sodium caseinate (from cow's milk), acidity regulator (citric acid), di potassium hydrogen phosphate, emulsifier (soy lecithin), fish oil, sodium chloride, calcium hydroxide, potassium hydroxide, sodium L-ascorbate, carotenoids (contains soy) (β–carotene, lutein, lycopene), choline chloride, magnesium hydroxide, sodium citrate, taurine, ferrous lactate, zinc sulphate, L-carnitine, nicotinamide, retinyl acetate, copper gluconate, DL-α tocopheryl acetate, cholecalciferol, Dbiotin, sodium selenite, manganese sulphate, calcium D-pantothenate, thiamin hydrochloride, riboflavin, pyridoxine hydrochloride, potassium iodide, sodium fluoride, cyanocobalamin, chromium chloride, pteroylmonoglutamic acid, sodium molybdate, phytomenadione. | Water, maltodextrin, vegetable oils (rapeseed oil, sunflower oil), whey protein concentrate (from cow's milk), sodium caseinate (from cow's milk), dietary fibres (soy polysaccharides, resistant starch, inulin, arabic gum, cellulose, oligofructose), emulsifier (soy lecithin), fish oil, acidity regulator (citric acid), dipotassium hydrogen phosphate, sodium chloride, tri calcium phosphate, potassium chloride, calcium hydroxide, potassium citrate, sodium L-ascorbate, carotenoids (contains soy) (B-carotene, lutein, lycopene oleoresin from tomatoes), choline chloride, potassium hydroxide, magnesium hydroxide, taurine, ferrous lactate, zinc sulphate, L-carnitine, retinyl acetate, copper gluconate, nicotinamide, sodium selenite, cholecalciferol, manganese sulphate, calcium D-pantothenate, D-biotin, thiamin hydrochloride, DL-a-tocopheryl acetate, riboflavin, pyridoxine hydrochloride, pteroylmonoglutamic acid, chromium chloride, potassium iodide, sodium fluoride, cyanocobalamin, sodium molybdate, phytomenadione. | Water, maltodextrin, vegetable oils (rapeseed oil, sunflower oil), sodium caseinate (from cow's milk), whey protein (from cow's milk), dietary fibres (soy polysaccharides, cellulose, resistant starch, inulin, arabic gum, oligofructose), fish oil, emulsifier (soy lecithin), tricalcium phosphate, potassium chloride, acidity regulator (citric acid), sodium chloride, dipotassium hydrogen phosphate, potassium citrate, carotenoids (contains soy) (B-carotene, lutein, lycopene oleoresin from tomatoes), choline chloride, potassium hydroxide, magnesium hydroxide, sodium L-ascorbate, calcium hydroxide, taurine, ferrous lactate, zinc sulphate, L-camitine, copper gluconate, nicotinamide, manganese sulphate, calcium D-pantothenate, DL-a tocopheryl acetate, thiamin hydrochloride, sodium fluoride, riboflavin, pyridoxine hydrochloride, retinyl acetate, pteroylmonoglutamic acid, potassium iodide, chromium chloride, D-biotin, sodium selenite, sodium molybdate, phytomenadione, cholecalciferol, cyanocobalamin. | Water, maltodextrin, rehydrated chicken (6.9%), rehydrated vegetables (4.3%: peas 3.8%, green beans 0.54%), vegetable oils (rapeseed, sunflower oil), milk protein, peach puree (1.4%), orange juice from orange juice concentrate (1.2%), dietary fibres (pea fiber, acacia gum, fructooligosaccharides, inulin), emulsifier (E472c, E471), medium chain triglycerides, minerals (potassium phosphate, calcium chloride, calcium lactate, calcium phosphate, sodium chloride, potassium chloride, magnesium oxide, magnesium citrate, iron lactate, zinc sulfate, copper gluconate, manganese sulfate, sodium fluoride, potassium iodide, sodium molybdate, chromium chloride, sodium selenite), fish oil, choline bitartrate, vitamins (vitamin C, niacin, vitamin E, pantothenic acid, vitamin B6, riboflavin, thiamine, vitamin A, folic acid, vitamin K, biotin, vitamin D, vitamin B12), stabilizer (E407), taurine, l-carnitine, antioxidant (E304). | • Compleat Paediatric includes meat-based protein, whereas Nutrini MF range purely relies on dairy-based proteins.<br>• Nutrini MF range has a broader fibre blend, while Compleat Paediatric has a simpler one.<br>• MCTs (medium-chain triglycerides) are only present in Compleat Paediatric (but very low amounts, therefore no clinically relevant benefits expected for patients with fat malabsorption).<br>• Compleat Paediatric contains Carrageenan (E407) as thickener, while Nutrini MF range prefers to avoid this thickener (due to negative publications on possible risk of affecting the immune system). |

**Both Nutrini MF range and Compleat Paediatric are highly processed food solutions.**
**No objective conclusion can be drawn since both products are meeting the legal FSMP requirements.**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

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  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION

# EVIDENCE OVERVIEW

- Topline comparison & conclusion
- Detailed analysis
  - Compleat Paediatric evidence
  - Nutrini MF range evidence

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# TOPLINE COMPARISON OF CLINICAL EVIDENCE: COMPLEAT PAEDIATRIC VERSUS NUTRINI MF RANGE (1)

| | COMPLEAT PAEDIATRIC | NUTRINI MF RANGE | COMMENTS |
|---|---|---|---|
| **Evidence volume & design** | 8 studies (7 articles + 1 abstract)<br>4 real-world data studies on Organic Blend (US) (1 article & 3 abstracts).<br>• **Prospective studies:** 2 studies (O'Connor et al. 2024, Thornton-Wood et al. 2020)<br>• **Retrospective studies:** 4 studies (O'Connor, 2025, 2023, 2022, 2021)<br>• **Case studies:** (Siddiqui, 2020)<br>• **Survey:** (Boston, 2020)<br>• **Real-world data:** (Steel et al. 2023, Herikson et al.2023, Desai et al. 2022, Hopkins et al. 2022) | 4 studies (2 articles & 2 abstracts).<br>• **Prospective studies:** 2 studies (Vernon-Roberts et al., 2010, Grogan et al., 2006)<br>• **Retrospective study:** (Valeria et al., 2018)<br>• **Double blind cross-over study:** (Trier et al., 1999) | While the volume of publications supporting Compleat Paediatric is greater, the clinical relevance and robustness of the evidence are more important than quantity alone. Both Compleat Paediatric and Nutrini MF range are supported by a variety of study designs, contributing to the overall strength of their evidence bases. However, several limitations in the Compleat Paediatric studies should be taken into account:<br>1. **Lack of randomization and control groups** Most studies are retrospective or single-arm prospective, **lacking randomization and control groups**—limiting the ability to establish causality and clinical comparability.<br>2. **Lack of comparative data** There are **no head-to-head studies or alternative formula comparators** available between Compleat Paediatric and standard pediatric polymeric formulas (e.g., Nutrini MF range), making it impossible to determine relative superiority in terms of GI tolerance, nutritional adequacy, or growth outcomes.<br>3. **Unclear baseline feed descriptions** Many studies fail to adequately describe the formula used prior to switching to Compleat Paediatric, **omitting key formula characteristics** such as fibre content, protein source, or degree of hydrolysis. This lack of transparency limits the ability to interpret outcomes accurately and undermines meaningful comparisons between Compleat Paediatric and standard paediatric formulas.<br>4. **Data overlap across studies** Several studies originate from the **same research group and reuse similar patient cohorts** (e.g. RICIMIX and Feeding Mode studies), reducing the uniqueness and generalizability of findings.<br>5. **Short study duration** Several studies span only **7–14 days,** which is insufficient to evaluate long-term outcomes such as growth or sustained tolerance.<br>6. **Sku-specific evidence** Many real-world data studies are based on the U.S. SKU (Compleat® Pediatric Organic Blends), which may not reflect the EU version of Compleat Paediatric. |

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# TOPLINE COMPARISON OF CLINICAL EVIDENCE: COMPLEAT PAEDIATRIC VERSUS NUTRINI MF RANGE (2)

| | COMPLEAT PAEDIATRIC | NUTRINI MF RANGE | COMMENTS |
|---|---|---|---|
| **Growth & nutritional rehabilitation** | ✗ Growth outcomes are secondary and assessed in only 2 studies.<br><br>✗ Often not clinically significant or not reported.<br><br>✗ Limited anthropometric tracking. | ✓ Growth is consistently prioritized and central in all Nutrini MF range study designs.<br><br>✓ Robust data from multiple studies (e.g., Vernon-Roberts, Dipasquale).<br><br>✓ Significant improvements in weight, BMI, height (esp. cerebral palsy). | Nutrini MF range demonstrates a strong evidence base for supporting paediatric growth, with multiple studies **showing statistically and clinically significant improvements in anthropometric measurements (e.g. weight, BMI, MUAC etc).** Its formulations are tailored to meet the needs of children with varying energy requirements, including those with neurological impairment, and growth is a central outcome in its clinical evaluations.<br><br>In contrast, Compleat Paediatric primarily focuses on GI tolerance and symptom relief. While some studies mention growth, it is not consistently measured or prioritized, and the available data lacks clinical significance. |
| **GI tolerance** | ✓ All Compleat Paediatric studies primarily target symptom relief in children with GI complications.<br><br>✓ Consistent improvement in GI symptoms: retching, constipation, diarrhea, nausea.<br><br>✗ Focused on symptom relief, without addressing nutritional rehabilitation* or measurable recovery outcomes such as growth or improved nutritional status.<br><br>*Nutritional rehabilitation refers to the process of improving the nutritional status of malnourished children by addressing undernutrition through structured enteral feeding. | ✓ GI tolerance is not the primary outcome, is evaluated as part of a broader clinical goal: nutritional recovery and growth support.<br><br>✓ Consistent improvements in GI symptoms: stool consistency, constipation reduction, reduced laxative use.<br><br>✓ Nutrini MF range Studies are designed to support growth outcomes and benefits in nutritional rehabilitation* including:<br>• Growth tracking (weight, BMI, height).<br>• Nutritional adequacy even at reduced energy intake.<br>• Micronutrient stability and safety. | Compleat Paediatric is supported by a substantial number of studies demonstrating **valuable symptom relief and good short-term tolerance,** particularly in children with GI complications. These studies consistently report improvements in symptoms such as retching, constipation, diarrhea, and nausea. However, the evidence base **lacks depth in nutritional rehabilitation and long-term outcomes.** Most studies do not assess or report on growth metrics (e.g., weight gain, BMI, height), nutritional adequacy, or micronutrient status over time. Structured tracking of recovery in malnourished children is absent.<br><br>Nutrini MF range offers **robust, long-term evidence of GI tolerance,** alongside benefits in **nutritional rehabilitation and growth outcomes.** Its formulations are specifically designed to support catch-up growth, maintain micronutrient stability, and **ensure safe long-term use—making them well-suited for nutritional recovery.** Specifically, GI improvement is supported by consistent findings across multiple study designs:<br>• Trier et al., 1999 (double-blind, crossover): ↓ constipation days<br>• Grogan et al., 2006 (prospective): Improved stool consistency, ↓ laxative use<br>• Vernon-Roberts et al., 2010 (prospective, 6 months): No GI intolerance, 25% ↓ laxative use<br>• Dipasquale et al., 2018 (retrospective, 12 months): No feeding intolerance, stable micronutrient status. |

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3. OVERALL SUMMARY AND CONCLUSION

# TOPLINE COMPARISON OF CLINICAL EVIDENCE: COMPLEAT PAEDIATRIC VERSUS NUTRINI MF RANGE (3)

| | COMPLEAT PAEDIATRIC | NUTRINI MF RANGE | COMMENTS |
|---|---|---|---|
| **Micronutrient & safety** | ✗ Rarely reported.<br><br>✗ No long-term safety or micronutrient tracking. | ✓ Stable levels reported across study periods & no adverse complications (e.g., Vernon-Roberts, Dipasquale).<br><br>✓ Detailed assessments included. | Compleat Paediatric **lacks consistent reporting on micronutrient status,** with no long-term safety data or tracking available.<br><br>In contrast, Nutrini MF range **includes detailed micronutrient assessments across study** periods, demonstrating stable levels and no adverse complications even in severely malnourished children, supporting its suitability for long-term nutritional management. |
| **Quality of life & health economics** | ✓ Positive impact on caregiver and patient QoL.<br><br>✓ Health economic benefits - reduced healthcare resource utilization (HCRU) and costs. | — Not primary focus, but improved outcomes (e.g. growth, GI symptoms) suggest better feeding experience and reduced caregiver burden. | Compleat Paediatric shows **a direct positive impact on patient and caregiver quality of life,** along with reduced healthcare resource use and costs. While Nutrini does not primarily focus on QoL or health economics, its **improved GI outcomes and growth suggest a better feeding experience and reduced hospital burden.** This is supported by:<br>• Sullivan et al. (2005), who reported fewer hospital admissions due to reduced chest infections in children fed with Nutrini after gastrostomy, highlighting its potential to lower healthcare costs.<br>• Real-world data studies based on the U.S. SKU (Compleat® Pediatric Organic Blends), where GI symptom relief is similarly linked to decreased healthcare utilization and economic burden. |
| **Clinical philosophy** | ✓ GI improvement is primary focus.<br><br>✓ Focuses on naturality through real food ingredients. | ✓ Growth and structured nutritional rehabilitation are primary focus.<br><br>✓ Tailored formulas for varying tolerance and energy needs (e.g., Peptisorb, Low Energy 0.75 kcal/ml for reduced energy requirements and High Energy variants 1.5 kcal/ml for increased caloric support). | Compleat Paediatric takes a **naturality focused approach,** aiming to improve **GI tolerance and support patient and caregiver quality of life,** with evidence—especially from U.S. real-world data—suggesting reduced healthcare resource use and economic benefits.<br><br>Nutrini, developed by Nutricia, is rooted **in clinical precision.** It offers a range of nutritionally complete formulas **tailored to different tolerance and energy needs** (e.g., Peptisorb, Nutrini Low Energy, Nutrini High Energy), **designed to support catch-up growth, micronutrient stability, and long-term safety.** While not primarily focused on QoL or cost outcomes, Nutrini MF range consistent improvements in GI symptoms and growth indirectly reduce hospital burden and enhance feeding experiences.<br><br>Together, Compleat Paediatric and Nutrini MF range represent complementary philosophies in paediatric nutritional care—**one emphasizing natural ingredients and real-world impact, the other clinical precision and targeted nutritional rehabilitation.** |

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# CONCLUSION ON CLINICAL EVIDENCE: COMPLEAT PAEDIATRIC VS NUTRINI MF RANGE













| | Evidence volume & design | Growth & nutritional rehabilitation | GI tolerance | Micronutrient & safety | Quality of life & health economics | Clinical philosophy |
|---|---|---|---|---|---|---|
| COMPLEAT PAEDIATRIC | 8 studies + 4 real-world (US); varying quality - mostly retrospective, short-term, no head-to-head comparisons with standard formulas (Nutrini). | Limited growth data; not consistently tracked. | Focus on GI symptom relief (retching, constipation, diarrhea); mild tolerance focus. | No long-term safety or micronutrient tracking. | Positive caregiver feedback; reduced healthcare resource use (US data). | One-size-fits-all, naturality-focused & GI tolerance focused. |
| NUTRIINI MF RANGE | 4 studies incl. retrospective, prospective & crossover; focused on growth and long-term outcomes. | Strong evidence for catch-up growth, BMI, and micronutrient stability. | Part of broader goals; good tolerance with improved stool consistency, reduced laxative use. | Stable micronutrient levels; no adverse events. | Improved outcomes suggest reduced burden (not directly measured). | Tailored nutritional support, clinically precise, ESPGHAN-aligned. |

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
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3. OVERALL SUMMARY AND CONCLUSION


# CLINICAL EVIDENCE OVERVIEW: COMPLEAT PAEDIATRIC




This section summarizes the current body of evidence on **Compleat Paediatric® 1.2 kcal/ml,** including:

- **8 studies** (incl 7 peer-reviewed journal articles and 1 abstract).
- **6 studies** on other Compleat Paediatric variants (incl 3 real-world data posters on **Compleat® Paediatric Organic Blends (US).**

## Key findings:

Offers a concise overview of the most important takeaways across studies for quick reference and strategic use.

## Table of study parameters:

Captures key study parameters such as design, sample size, population, baseline feed, transition, duration, and purpose.

## In-depth evidence summary:

Provides a narrative synthesis including study aim, key findings, clinical relevance, and an assessment of evidence strengths and limitations.

## Sources of information:

The studies and reports were collected from the following sources:

- Nestlé Health Science Compleat® – Real Food Tube-Feeding Solutions Compleat® - Real Food Tube-Feeding Solutions
- Nestlé Commercial Websites
- ESPGHAN 2025 – Clinical evidence | Linktree
- Independent Literature Search (conducted July 2025)

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

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3. OVERALL SUMMARY AND CONCLUSION

# KEY FINDINGS FROM COMPLEAT PAEDIATRIC PUBLICATIONS (LAST 5 YEARS)



## 1. Gastrointestinal (GI) tolerance

- **Improved stool consistency and frequency**
  - **O'Connor et al., 2024:** Switching to Compleat Paediatric in PICU patients led to improved stool consistency and frequency, alongside increased short-chain fatty acid (SCFA) levels.
  - **Thornton-Wood et al., 2020:** Children with complex needs experienced firmer stools and reduced reflux and retching after transitioning from standard or peptide feeds to Compleat Paediatric.
  - **RICIMIX & Feeding Mode Study:** A reduction in GI symptoms such as vomiting and constipation was observed following a switch from standard enteral formulas (whole protein, peptide, amino acid) to Compleat Paediatric.
  - **HND Study:** Patients demonstrated improved stool consistency and frequency, with a notable reduction in symptoms including reflux and retching after switching to Compleat Paediatric from standard enteral formulas (whole protein, peptide, amino acid).
- **Well Tolerated Across Diverse Populations**
  - **JHND Study:** Compleat Paediatric was well tolerated across a diverse pediatric population previously receiving standard enteral formulas.



## 2. Weight and growth outcomes

- **Weight gain observed in:**
  - **RICIMIX:** Modest weight improvements after 1 month.
  - **Feeding Mode Study:** Weight gain varied by feeding method (bolus vs continuous).
- **No significant weight change in short-term studies:**
  - **Thornton-Wood et al., 2020:** No weight change over 7 days.
  - **O'Connor et al., 2024:** Focused on tolerance, not growth.

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# KEY FINDINGS FROM COMPLEAT PAEDIATRIC PUBLICATIONS (LAST 5 YEARS)



## 3. Quality of life

- **RICIMIX:** Parental feedback indicated children were "more comfortable" after switching to the food-derived formula.
  - One child was able to successfully toilet train due to improved bowel habits.
  - 4% saw changes in schooling patterns, with improved attendance and participation.
  - 16% of children showed positive changes in mood or behavior, described as "more happy and settled."
  - 28% experienced simplified feeding routines, allowing families to feel confident enough to go on holiday.
- **Feeding mode study:** Children fed via intermittent bolus reported the greatest weight gain, which is a positive health outcome.
  - The study notes that feeding mode flexibility (e.g., bolus feeding) is better suited for mobile children and families seeking less time connected to pumps —this supports daily life convenience and autonomy.
- **Boston et al 2020:** CRFCF (commercial real-food containing formulas) were seen as convenient and nutritionally consistent, though caregivers desired more real-food ingredients.
- **Siddiqui et al 2021:** Improved quality of life of patients and parents.



## 4. Health economic outcomes*

- **Desai et al.,2022:** CBTF(commercial blenderised tube formula) was associated with substantial reductions in healthcare resource utilization (HCRU) and economic burden compared to plant-based TF in paediatric post-acute care.
- **Herikson et al., 2023:** CBTF led to fewer inpatient, outpatient & emergency visits, translating into significant cost savings in paediatric patients with chronic conditions.
- **Steel et al., 2022:** The study suggests potential cost savings through improved tolerance and reduced symptom burden.

* All the health economic outcomes are based on real-world data studies done on the US SKU - Compleat Paediatric Organic Blends.

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3. OVERALL SUMMARY AND CONCLUSION

# COMPLEAT PAEDIATRIC STUDIES: TABLE OF KEY STUDY PARAMETERS (EU)




| Study | Design | Sample size | Population | Baseline feed | Transition | Duration | Purpose | Key outcomes |
|---|---|---|---|---|---|---|---|---|
| **O'Connor et al., 2024** | Prospective, repeated-measures, single-arm | 20 | Critically ill children in PICU | Not specified (PICU admission) | Initiated Compleat® Paediatric formula | 14 days | Monitor SCFA levels, stool outcomes, feed tolerance | SCFA levels maintained; feed well tolerated |
| **Thornton-Wood & Saduera, 2020** | Prospective, multicentre, single arm | 19 | Children (1–14 yrs) with GDD, epilepsy, CP, Down's syndrome | Standard or peptide formula | Direct switch to Isosource® Junior Mix | 7 days | Assess tolerance and acceptability of food-derived formula | Well tolerated; positive acceptability |
| **O'Connor et al., 2025 (JHND)** | Retrospective, single-centre | 70 | Medically complex children, primarily with neurological impairments (53%) | Standard enteral formulas (52%whole protein, 23% peptide, 25% amino acid) | Switched to Compleat® Paediatric EFI | 7 days to >1 year | Monitor EFI implementation, GI symptom improvement | 82% improved GI symptoms; 60% discharged on EFI |
| **O'Connor et al., 2021 (RICIMIX)** | Retrospective, multicentre chart review | 43 | Children with GI symptoms on various formulas | Standard, hydrolyzed, amino acid, or blended | Switched to Compleat® Paediatric | 1 month | Assess GI symptom improvement and weight change | Improved GI symptoms; monitored weight change |
| **O'Connor et al., 2023 (Feeding Mode Study)** | Retrospective, multicentre chart review | 43 (same cohort as RICIMIX) | Same cohort as RICIMX; feeding mode comparison | Same as RICIMIX | Maintained feeding mode (bolus/continuous) on Compleat® Paediatric | 1 month | Compare GI tolerance and weight gain by feeding mode | No difference in GI tolerance or weight gain |
| **Boston et al., 2022** | Cross-sectional caregiver survey | 41 caregivers | Caregivers of tube-fed children (mean age: 7y) | Home-blended or commercial real-food formulas | Not interventional | N/A | Understand caregiver perceptions of HBTF vs CRFCF | Caregiver-reported benefits of real-food formulas |
| **Siddique et al., 2021** | Case series / practical experience | N/A | Pediatric patients in clinical settings | Not specified | Initiated food-derived enteral formulas | Case -dependent | Share practical experience with EFI use | Reported improvements in GI tolerance and caregiver satisfaction |

**Classification based on strength of the evidence**

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3. OVERALL SUMMARY AND CONCLUSION

# COMPLEAT PAEDIATRIC STUDIES: TABLE OF KEY STUDY PARAMETERS (US)




| Study | Design | Sample size | Population | Baseline feed | Transition | Duration | Purpose | Key outcomes |
|---|---|---|---|---|---|---|---|---|
| **Steel et al., 2022 Nut Clin Pract** | Retrospective real - world data analysis | 231 (180 children, 51 adolescents/adults) | Paediatric and adult patients post-acute care | Not specified in detail; assumed standard enteral formulas | To CBTF (Compleat® Paediatric/Adult Organic Blends) | ≥14 days (most ≥28 days) | Assess real-world use and GI tolerance of CBTF | Significant reduction in GI symptoms (constipation, nausea, vomiting) and visits for GI issues; no increase in GI medication use; high formula retention (≥28 days) |
| **Desai et al., 2022 NASPGHAN Poster** | Retrospective comparative study | 469 paediatric patients | Children with malnutrition, digestive diseases, cerebral palsy, seizures | Standard enteral formulas | To CBTF (Compleat® Paediatric Organic Blends) | 28, 84, 168 days post-discharge | Evaluate clinical and economic outcomes of CBTF in chronic pediatric conditions | Significant reductions in GI symptoms and healthcare resource utilization (HCRU); cost savings across all conditions |
| **Henrikson et al., 2023 ASPEN Poster** | Retrospective claims analysis | 469 (CBTF) vs. 595 (STD-TF) | Paediatric patients (1–14 years) post-acute care | Plant-based standard tube feeding (STD-TF) | To CBTF (Compleat® Paediatric Organic Blends) | 84 days post-discharge | Compare HCRU and costs between CBTF and STD-TF | CBTF group had significantly fewer healthcare visits and lower adjusted costs across all service types vs plant-based TF |
| **Hopkins P100 Poster ASPEN 2022** | Retrospective real-world claims analysis | 180 paediatric patients | Children (1–13 years) post-hospital discharge | Not specified; assumed standard enteral formulas | To CBTF (Compleat® Paediatric Organic Blends) | ≥14 days (81% used ≥28 days) | Describe demographics and GI tolerance of CBTF in community setting | Significant reduction in GI symptoms (nausea, vomiting, diarrhea, constipation, distension); well tolerated across diverse diagnoses; high retention rate |

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (1)




| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **O'Connor 2025** | O'Connor, Graeme, Angela Camacho Velandia, and Zoltan Hartfiel Capriles. "The impact of an enteral formula with food-derived ingredients on dietetic practice at a specialist children's hospital in the UK: Retrospective study." Journal of Human Nutrition and Dietetics 38.1 (2025): e13374. | **Aim:** Monitor the implementation of an enteral formula with food-derived ingredients (EFI) by dietitians in a specialist children's hospital.<br><br>**Highlights:** The most common symptom before starting EFIwas loose stools (38%). Within 7 days of starting EFI, there was an improvement in gastrointestinal symptoms in all categories, with over 80% improvement in vomiting, loose stools, and constipation.. Long term usage: 42/70 children were discharged on an EFI, 33% had been on EFI for 1-6 months, while 20% had been on it for more than a year. | Yes | No | No | No | In a specialist children's hospital, Compleat Paediatric is primarily implemented by dietitians in children who are already established on an enteral formula displaying gastrointestinal symptoms. However, dietitians are increasingly implementing an food derived enteral feeds (EFI) as their first-line formula and as a compromise to a blended diet when requested by parents. | **+ Reasonable sample size:** 70 children (NI in 47%)<br><br>**+** Data collected from **15 dieticians from several different specialties** within a tertiary paediatric center.<br><br>**- Single-centre retrospective study** |
| **O'Connor 2024** | O'Connor, Graeme, et al. "An open-label pilot single- subject study to monitor the impact of a Food-Based enteral formula on faecal short-chain fatty acid concentrations in children admitted to intensive care with sepsis." Clinical Nutrition Open Science 53 (2024): 1-10. | **Aim:** Assess the impact of an enteral formula with food-derived ingredients on feed tolerance and fecal SCFA concentrations in children admitted to ICU with sepsis.<br><br>**Highlights:** Despite receiving multiple antibiotics, both stool consistency and frequency improved in first week with feed in PICU ie. Reduction in diarrhoea. SCFA concentration- Faecal butyrate and prioponate maintained. | Yes | No | No | No | Children admitted to ICU with sepsis tolerated a Food-Based formula. Faecal butyrate and propionate concentrations were maintained whilst feeding on a high fiber Food-Based formula. Further research is warranted to assess whether a Food-Based formula is superior to a standard enteral formula in preserving the intestinal microbiota, thereby mitigating gastrointestinal complications associated with antibiotic-related dysbiosis. | **+ Clinical relevance is strong,** linking feed tolerance to SCFA in critically-ill children<br><br>**- Small sample size** (N=20 children with sepsis)<br><br>**- No control group** (open label, UK center over 14 days) |

**Classification based on chronological order**

# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (2)




| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **O'Connor 2023** | Tolerance and Impact on Intestinal Short Chain Fatty Acids of a High Fibre 'Enteral Formula With Food Derived Ingredients' in Children Admitted to Intensive Care (PICU): Prospective Pilot Study. | **Aim:** Assess the impact of a high fibre enteral formula on feed tolerance and intestinal SCFA in children admitted to PICU with enteral feed intolerances.<br><br>**Highlights:** Overall stool consistency and frequency improved within one week after switching formula. SCFA concentrations reduced in relation to children's length of stay and length of time on antibiotics. No correlation between SCFA concentration and stool consistency/frequency. | Yes | No | No | No | Children admitted to PICU may benefit from a high fibre enteral formula with food derived ingredients to minimise feed intolerance and thereby optimise nutrient absorption. In this pilot study the improved gastrointestinal tolerance of enteral formula with food derived ingredients did not relate to intestinal SCFA concentration. Future research should monitor the effectiveness of enteral formulas with food derived ingredients capacity to support post intensive care gut microbiota restoration of SCFA production. | POSTER ABSTRACT, 20 PICU subjetcs |

**Classification based on chronological order**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

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  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (3)




| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **O'Connor 2022 and O'Connor 2023 1 study 2 publications** | O'Connor, Graeme, Zoltan Hartfiel-Capriles, and Sharan Saduera. "Intermittent bolus versus continuous feeding in children receiving an enteral formula with food derived ingredients: a national multicentre retrospective study." Clinical Nutrition ESPEN 54 (2023): 175-179. | **Aim:** Evaluate the tolerance of different feeding modes, in children who had switched to an 'enteral formula with food derived ingredients'.<br><br>**Highlights:** Children continuously fed saw the greatest reported improvement in retching, abdominal pain and loose stools. Children who were fed intermittent bolus reported the greatest increase in weight. | Yes | Yes | Yes | No | Enteral formulas with food derived ingredients are well tolerated and effective in achieving weight gain and meeting dietetic goals whether delivered continuously or as intermittent bolus feed. The clinical situation will determine the most appropriate and effective feeding mode and should be guided by the dietitian and medical team.<br><br>Intermittent Bolus Feeding: Preferred for its flexibility and suitability for mobile children. Continuous Feeding: Often used in clinical settings for better tolerance. | **+ National, multicenter design:** The study included data from multiple centers (across 4 UK centres), enhancing the generalizability of findings.<br><br>**+ National, multicenter design:** The study included data from multiple centers, enhancing the generalizability of findings.<br><br>**+ Practical relevance:** The study provides real-world data on the use of enteral formulas with food-derived ingredients.<br><br>**+ Positive clinical outcomes:** Consistent improvements in GI symptoms and QoL.<br><br>**- Small sample size:** Study included only 43 children, which may limit the generalizability of the results.<br><br>**- Short trial period:** The study monitored outcomes for only 1 month, not addressing long-term effects.<br><br>**- Retrospective design:** The study design may introduce biases and does not establish causation. |
| | O'Connor, Graeme, et al. "Monitor gastrointestinal tolerance in children who have switched to an "enteral formula with food-derived ingredients": A national, multicenter retrospective chart review (RICIMIX study)." Nutrition in Clinical Practice 37.4 (2022): 929-934. | **Aim:** Collect data relating to feed tolerance in children who had switched to an 'enteral formula with food derived ingredients'.<br><br>**Highlights:** Significant improvement in GI - reduction in retching, flatulence , loose stools & constipation. Changes observed with 1 week of switching. Improvements in weight & in children's behavior were observed. | Yes | Yes | Yes | No | Beneficial outcomes have been observed in medically complex children who switched to enteral formulas containing food-derived ingredients. These data should encourage healthcare professionals to consider recommending enteral formulas with food-derived ingredients. | |

**Classification based on chronological order**

# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (4)




| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Siddiqui 2021** | Siddiqui, A., V. Steele, and M. Van Der Linde. "Benefit of including food-derived ingredients in enteral nutrition formulas: Practical experience from clinical cases." Journal of Neonatology and Clinical Pediatrics 8 (2021): 066-067. | **Aim:** Evaluate the impact of enteral nutrition formulas containing food-derived ingredients on gastrointestinal tolerance and overall well-being in children with various medical conditions. The study seeks to provide practical insights through real-world clinical cases, demonstrating the potential benefits of these formulas in improving symptoms of feed intolerance and enhancing the quality of life for both children and their families.<br><br>**Highlights:** Significant improvements in GI symptoms were reported following a change to Compleat Paediatric which resulted in improved quality of life for children and their families. | Yes | No | No | No | Compleat offers a solution to enterally fed chiildren who are experiencing symptoms of feeding intolerance. It can also offer reassurance to parents and caregivers as well as dietitians in the transition from commercial formula to a homemade BD as it has a predictable nutritional content and is compatible with enteral feeding equipment. It provides an alternative to a homemade BD in hospital and school settings as well as when travelling. Reduced symptoms of intolerance (including constipation and vomiting ) and a significant impact on the QOLfor the children and their families were observed. Compleat Paediatric may be considered as a sole source of nutrition or in conjunction with a blended diet when children are experiencing feeding intolerance with their current formula. | **Clinical relevance:** The study provides practical insights from real clinical cases, making the findings highly relevant for healthcare providers.<br><br>**+ Diverse case studies:** It includes a range of medical conditions, demonstrating the formula's broad applicability.<br><br>**+ Positive outcomes:** Consistent improvements in symptoms and quality of life across different cases highlight the formula's effectiveness.<br><br>**- Sample Size:** The study is based on a limited number of case studies (#4), which may not be representative of the broader population.does not establish causation. |

**Classification based on chronological order**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (5)




| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Thornton-Wood, 2020** | Thornton-Wood, C., and S. Saduera. "Tolerance and acceptability of a new paediatric enteral tube feeding formula containing ingredients derived from food: A multicentre trial (in the United Kingdom)." J. Neonatol. Clin. Pediatr 7 (2020): 50. | **Aim:** Evaluate the gastrointestinal tolerance and acceptability of a new pediatric enteral tube feeding formula containing ingredients derived from food. The study sought to provide a safer and nutritionally adequate alternative to homemade blended diets, addressing the needs of children requiring long-term tube feeding while ensuring the formula met clinical standards for safety and nutrition.<br><br>**Highlights:** The new tube feed containing ingredients derived from food was well tolerated by the majority of participants, with minimal adverse effects. It supported improved GI symptoms and beneficial changes in stool type in a number of participants. | Yes | No | No | No | The new tube feed containing ingredients derived from food was well tolerated by the majority of participants; it supported improved GI symptoms and beneficial changes in stool type in a number of participants. Based on the outcome of this study, we would recommend a change in the current policy documents and guidelines to allow the use of this new tube feed formula within the acute and community setting.<br><br>Moreover, additional research is warranted to further document the health impact on GI symptoms, nutritional status, quality of life and to better understand the mechanisms underlying the benefits of food-based tube feed formula. | **+ Multicenter design:** The study was conducted across 5 NHS centers, enhancing the generalizability of the findings.<br><br>**+ Intervention study:** The study provides practical insights into the use of a new pediatric enteral tube feeding formula in real-world clinical settings.<br><br>**+ Positive clinical outcomes:** The formula was well tolerated by the majority of participants, with improvements in GI & stool consistency.<br><br>**- Small sample size:** The study included only 19 participants (16/19 completed), which may limit the generalizability of the results.<br><br>**- Short duration:** The study included only 19 participants (16/19 completed), which may limit the generalizability of the results.<br><br>**- Parental reporting:** The study relied on parental recording of symptoms, which may introduce reporting bias. |

**Classification based on chronological order**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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  - Detailed analysis

3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC (6)

| Author name | Title, journal & link to the publication | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Boston, 2020** | Boston, Michelle, and Heather Wile. "Caregivers' perceptions of real-food containing tube feeding: A Canadian survey." Canadian Journal of Dietetic Practice and Research 81.4 (2020): 193-197. | **Aim:** Understand caregivers' perceptions and experiences with home-blenderized tube feeding (HBTF) and commercial real-food containing formulas (CRFCF) for children requiring tube feeding. The study sought to identify the factors influencing caregivers' choices, the challenges they face, and their overall satisfaction with these feeding methods.<br><br>**Highlights:**<br><br>Challenges:<br><br>HBTF: Difficulty preparing away from home (70%) and need for special blenders (56%).<br>CRFCF: Lack of variety (53%) and cost (47%).<br><br>Perceptions:<br><br>CRFCF: Viewed as convenient (85%) and nutritionally consistent (61%), but lacking in real-food ingredients (63%).<br>HBTF: Seen as natural (95%), nutritionally balanced (93%), and providing a good variety of food ingredients (93%). | Yes | No | Yes | No | Usage Patterns: 54% of caregivers used home-blenderized tube feeding (HBTF), 34% used commercial real-food containing formulas (CRFCF), and 12% used both.Key factors for choosing a formula: presence of whole foods, nutritional completeness, and natural ingredients.<br><br>Caregivers desire formulas that are nutritionally complete and made of whole foods. **CRFCF offers convenience and consistency, yet caregivers prefer more real-food ingredients.** | **+ Comprehensive insights:** Provides detailed insights into caregivers' preferences, challenges, and perceptions regarding HBTF and CRFCF.<br><br>**+ Practical relevance:** Offers valuable information for dietitians to support caregivers in making informed choices about tube feeding.<br><br>**+ Diverse perspectives:** Includes a range of caregiver experiences and opinions, enhancing the study's applicability.<br><br>**- Small sample size:** The study had a limited number of participants (41 caregivers), which may affect the generalizability of the findings.<br><br>**- Language and recruitment bias:** The survey was available only in English and recruited participants from a specific Facebook group, potentially limiting the diversity of responses.<br><br>**- Survey:** study design |

**Classification based on chronological order**

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC ORGANIC BLEND IN US (1)



| Author name | Link to the publication | Note for relevance (SKU) | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Steel, 2023** | Steel, Cindy, et al. "Understanding the use and tolerance of a pediatric and an adult commercial blenderized enteral formula through real-world data." Nutrition in Clinical Practice 38.2 (2023): 449-457. | This study uses Compleat Pediatric® Organic Blends plant-based enteral formula for pediatric patients (aged 1–13 years). | Yes | No | Yes due to the reduction of GI complications | Yes | These Commercial blenderized enteral formulas, based on real-food ingredients, were prescribed to diverse patients in the community and were well tolerated. These formulas offer an alternative to standard polymeric formulas and an alternative or adjunct to homemade blenderized formulas. | **+ Real-world data - practical insights from a diverse patient population** (N=231).<br>**+ Comprehensive analysis:** Includes detailed demographic and clinical data.<br>**- Retrospective design:** Relies on existing medical claims data, which may have inherent biases.<br>**- Short follow-up:** Limited to 28 days post-discharge, not addressing long-term outcomes. |
| **Henrikson, 2023** | Real-World Evidence on Clinical and Health Economic Outcomes among Pediatric Patients in Post-Acute Care Receiving Commercial Blenderized Tube Feeding Formulas.<br>Conference paper | This study used Compleat® Paediatric Organic Blends US. | Yes | No | Yes due to the reduction of GI complications | Yes | Use of a Commercial Blenderized Tube Feeding formula among post-acute care children diagnosed with malnutrition, diseases of the digestive system, cerebral palsy and seizures was well tolerated and associated with significant reductions in GI intolerance symptoms. Significant reductions in HCRU and associated costs were observed, demonstrating the potential role of CBTF in improving clinical and health economic outcomes in children with chronic conditions. | **+ Large sample size & diverse group of patients:** 469 pediatric patients, with chronic conditions (malnutrition, digestive diseases, cerebral palsy, seizures) which enhances the reliability and generalizability of the findings.<br>**+ Real-world data:** Uses nationally representative US claims data, providing insights into clinical practice & outcomes.<br>**+ Longitudinal design:** Assesses outcomes at multiple time points (28, 84, and 168 days post-discharge), allowing for evaluation of sustained effects.<br>**- Retrospective design:** it is subject to biases such as confounding and cannot establish causality.<br>**- Lack of control group:** No comparison with patients receiving other types of enteral nutrition (e.g., standard formulas), limiting the ability to attribute outcomes solely to CBTF. |

**Classification based on chronological order**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF COMPLEAT PAEDIATRIC ORGANIC BLEND IN US (2)



| Author name | Link to the publication | Note for relevance (SKU) | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Desai, 2022** | Desai, A., et al. "Health economic benefits of real food tube feeding formulas compared to standard tube feeding formulas in post-acute care adult patients." Clinical Nutrition ESPEN 54 (2023): 704-705.<br><br>Conference report | The patients of this study received either CBTF (Compleat® Paediatric Organic Blends, Nestlé) or plant-based STD-TF (Kate Farms® Pediatric Standard 1.2, Kate Farms, US). | No | No | No | Yes | The use of CBTF containing a variety of real food was associated with significant reductions in HCRU and costs compared to plant-based STD-TF in post-acute pediatric care. | **+ Real-world data** from a large U.S. claims data-base covering 98% of health plans (~500 patients in each group).<br><br>**+ Comparative analysis** of two commercially available formulas.<br><br>**- Retrospective design:** The study's retrospective nature may introduce biases r elated to data collection and interpretation.<br><br>**- Short follow-up:** Outcomes were assessed only up to 84 days post- discharge, limiting the understanding of long-term effects. |
| **Hopkins, 2022** | Commercial Blenderized Tube Feeding Formula: Real-World Data on Use and Tolerance among Pediatric Patients in the Community.<br><br>Poster | This study used Compleat® Paediatric Organic Blends US. | Yes | No | No | Yes | This CBTF formula was prescribed for and well tolerated by a diverse group of children in the post-acute care community setting and was typically used for ≥28 days, indicating that it was efficacious and accepted by patients. The diversity in the diagnosis of children prescribed this CBTF formula suggests the ability to generalize the results to a larger real-world population. These findings contribute to the growing body of literature CBTF formula use. | **+ Diverse & big sample size** (=180 children from various regions of the US).<br><br>**+ Clinical relevance** (Focused on real-world use of a commercial blenderized tube feeding formula in a post-acute community setting, providing practical insights).<br><br>**+ Real-world evidence.**<br><br>**- Retrospective design:** Study's retrospective nature may introduce biases related to data collection and interpretation. |

**Classification based on chronological order**

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF DIFFERENT VARIANTS OF NESTLÉ COMPLEAT IN US




| Author name | Link to the publication | Note for relevance (SKU) | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|---|
| **Minor, 2025** | Minor, Gerard, et al. "Reductions in Gastrointestinal Intolerance, Healthcare Resource Utilization and Cost Associated with a Plant-Based Peptide Enteral Formula with Fruit and Vegetable Ingredients: Retrospective Analysis of Children and Adults in Post-Acute Care." Nutrition and Dietary Supplements (2025): 63-72. | This study uses pediatric plant-based peptide enteral formulas with fruit and vegetable ingredients; Compleat® Pediatric Peptide 1.5 | Yes | No | No | Yes | Use of a plant-based peptide enteral formula with fruit and vegetable ingredients was associated with significant reductions in GI intolerance symptoms, HCRU and associated costs in children and adults post hospital discharge. This retrospective analysis of real-world national-level data supports the use of a plant-based peptide enteral formula with fruit and vegetable ingredients as a well-tolerated option for EN in children and adults requiring EN support in a post-acute care setting. | **+ Large dataset:** Utilized nationally representative US claims data, providing robust evidence across a wide demographic.<br><br>**+ Comprehensive analysis:** Included detailed patient characteristics, comorbidities, and longitudinal data on GI symptoms.<br><br>**+ Positive outcomes**: Demonstrated significant reductions in GI.<br><br>**- Retrospective design:** Potential biases related to retrospective data collection and interpretation may affect results.<br><br>**- No Control Comparator Group:** Lacks a contemporaneous comparator arm using standard polymeric or animal protein formulas, making it harder to attribute benefits solely to the plant-based peptide formula. |
| **Minor, 2021** | Minor, Gerard, Shinobu Yamamoto, and Sarah S. Cohen. "Meeting Nutritional Needs of the Enterally Fed Child with Neurological Impairment." Journal of Clinical Nutrition & Dietetics (2021). | This study was used 1.0 kcal/ml Paediatric formula containing ingredients from foods (tomatoes, peas, green beans, peaches, chicken and cranberry juice). It provided 15%, 51% and 34% of calories from protein, carbohydrate and fat, respectively, and 2 g fiber per 250mL of formula (Compleat® Paediatric). | Yes | No | No | No | The commercially-made, food-based formula tested was a safe, convenient, and nutritionally-balanced enteral feeding for children with Neurological Impairment and associated feeding disorders. Calorie and protein goals were achieved without notable intolerance and no reports of serious adverse events. | **+ Diverse sample:** Included children with various neurological impairments and feeding disorders.<br><br>**+ Comprehensive data collection:** Detailed recording of daily formula intake, GI symptoms, and adverse events. |

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3. OVERALL SUMMARY AND CONCLUSION

# CLINICAL EVIDENCE OVERVIEW: NUTRINI MF RANGE

This section summarizes the current body of evidence on **Nutrini MF** range, including:

- **2 articles** (Vernon-Roberts et al., 2010 & Dipasquale et al., 2018).
- **2 abstracts** (Trier et al., 1999 & Grogan et al., 2006).

## Key findings:

Offers a concise overview of the most important takeaways across studies for quick reference and strategic use.

## Table of study parameters:

Captures key study parameters such as design, sample size, population, baseline feed, transition, duration, and purpose.

## In-depth evidence summary:

Provides a narrative synthesis including study aim, key findings, clinical relevance, and an assessment of evidence strengths and limitations.

## Sources of information:

For more detailed information regarding our evidence for Nutrini MF range, please visit FG/Paediatric Malnutrition Evidence Directory in the link below.

Asset Details Page

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3. OVERALL SUMMARY AND CONCLUSION

# KEY FINDINGS FROM NUTRINI MF RANGE PUBLICATIONS



## 1. Growth outcomes

**Nutrini MF range formulas have consistently supported significant catch-up growth in children with neurological impairment,** particularly those with CP. Improvements were observed in weight, BMI, and triceps skinfold thickness, with no evidence of excessive fat gain.

- **Dipasquale et al., 2018:** Significant improvements in triceps skinfold thickness, weight, and BMI in CP group over 12 months. Less pronounced in metabolic/genetic groups.
- **Vernon-Roberts et al., 2010:** Significant increases in weight, mid-upper arm circumference, and leg length over 6 months. No excess fat gain.
- **Trier et al., 1999:** Satisfactory weight gain in both fibre & non-fibre feeds.



## 2. Gastrointestinal (GI) tolerance

**Nutrini MF range formulas, especially those enriched with fibre, consistently demonstrated good GI tolerance,** with improvements in bowel function and minimal adverse symptoms.

- **Dipasquale et al., 2018:** No feeding intolerance.
- **Vernon-Roberts et al., 2010:** No feeding intolerance, no adverse effects, 25% laxative use.↓
- **Grogan et al., 2006:** Fibre-enriched formulas well tolerated; reduced GI symptoms (nausea, vomiting, abdominal pain), ↓laxative use.
- **Trier et al., 1999:** Both feeds well tolerated; multifibre feed ↓ constipation days.



## 3. Nutritional intakes

**Nutrini MF range provided adequate energy and nutrient intake,** including protein, even at reduced volumes, aligning with dietary reference intakes.

- **Dipasquale et al., 2018:** Nutrini (1.0 kcal/mL) provided age-appropriate energy and nutrient intake based on DRI; well tolerated and effective.
- **Vernon-Roberts et al., 2010:** Micronutrient levels remained within reference ranges despite lower energy intake.
- **Grogan et al., 2006:** Fibre-enriched formulas did not compromise nutrient intake.
- **Trier et al., 1999:** Both feeds supported adequate energy and protein intake for growth.

COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS

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3. OVERALL SUMMARY AND CONCLUSION


# NUTRINI MF RANGE: TABLE OF KEY STUDY PARAMETERS

| Study | Design | Sample size | Population | Baseline feed | Transition | Duration | Purpose / Key outcomes |
|---|---|---|---|---|---|---|---|
| **Vernon-Roberts et al., 2010** | Prospective, longitudinal feasibility | 14 | Children with SQCP | Pre-gastrostomy baseline | Post-gastrostomy→ Nutrini Low Energy Multi Fibre | 6 months | Evaluate growth, body composition, micronutrient status |
| **Grogan et al., 2006** | Prospective, single-arm, pre-post | 14 (7 on each formula) | Children on long-term enetral nutrition | 1-week baseline on non-fibre formula | Switched to Nutrini Low Energy or Energy Multi Fibre | 4 weeks | Improved stool consistency; reduced laxative use; well tolerated |
| **Dipasquale et al., 2018** | Retrospective, 5-year cohort study | 38 (from 110 screened) | Malnourished NI children (mostly CP) | N/A | PEG feeding with Nutrini standard polymeric formula | 12 months | Improvement in triceps SFT, body weight, and BMI in NI children, especially those with CP |
| **Trier et al., 1999** | Double-blind, randomized crossover trial | 16 | Tube-fed children (CP and other diagnoses) | Fibre-free formula (Nutrini) | Switched to Nutrini Multifibre | 2 × 14 days | Reduction in constipation days; well tolerated |

**Classification based on strength of the evidence**

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF NUTRINI MF RANGE (1)

| Author name | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|
| **Dipasquale et al, 2018** | **Aim:** The primary aim was to assess the nutritional outcomes of exclusive gastrostomy tube feeding with standard polymeric formula in malnourished NI children. The secondary aim was to investigate gastrostomy complications and the impact of the underlying NI-associated disease on the nutritional outcomes.<br><br>**Highlights:**<br>Nutritional improvement:<br>• Significant increases in triceps skinfold thickness in all patients.<br>• Significant increases in body weight and BMI in children with cerebral palsy (CP), but not in those with metabolic or genetic conditions.<br><br>Safety:<br>• No serious complications related to gastrostomy or feeding were reported. | Yes | Yes | No | Yes | The standard polymeric formula via gastrostomy tube represents a safe and efficient long-term nutritional intervention in children with NI and malnutrition. | **+ Real-world clinical data over a 5-year period.**<br><br>**+ Focus on a vulnerable population** (38 NI children with malnutrition).<br><br>**+ Clear nutritional outcomes.**<br><br>**+ Follow-up period** (12 months)<br><br>**- Retrospective design:** Limits ability to establish causality.<br><br>**- No control group:** Lacks comparison with other feeding strategies (e.g., blenderized or elemental formulas).<br><br>**- Small sample size for the malnourished subgroup** (n=38).<br><br>**- Limited diversity in diagnoses** — majority had cerebral palsy. |
| **Vernon-Roberts et al, 2010** | **Aim:** Investigate whether weight gain could be achieved without an adverse effect on body composition by using a low-energy feed in gastrostomy-fed children with SQCP.<br><br>**Highlights:**<br>• Significant increases in weight, mid-upper arm circumference, and leg length.<br>• No significant increase in fat mass or percentage.<br>• Micronutrient status: Adequate, with most levels within reference ranges.<br>• Fibre intake remaned below recommended levels despite high-fibre formula. | Yes | Yes | No | Yes | Children with spastic quadriplegic cerebral palsy (SQCP) who are fed a low-energy, micronutrient-complete, high-fibre feed continue to grow even with energy intakes below 75% of the estimated average requirements. This was not associated with a disproportionate rise in fat mass or fat percentage, and the majority of micronutrient levels remained within the reference range. | **+ Prospective design:** The study followed patients over time, allowing for direct observation of changes in growth and body composition.<br><br>**+ Targeted population:** Focused on children with spastic quadriplegic cerebral palsy (SQCP), a group with high nutritional vulnerability and feeding challenges.<br><br>**+ Follow-up period:** Outcomes were assessed for over 6 months.<br><br>**- Small sample size**: Only 14 children were included, limiting statistical power and generalizability. |

**Classification based on chronological order**

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# IN-DEPTH EVIDENCE SUMMARY OF NUTRINI MF RANGE (2)

| Author name | Aim & key highlights | Improved GI tolerance | Improved intake / weight changes | Acceptance / improved QofL | Health economics | Conclusion | Strength (+) and limitation (-) of evidence |
|---|---|---|---|---|---|---|---|
| **Grogan et al, 2006 (conference abstract)** | **Aim:** Measure the GI effects of Nutrini Low Energy Multi Fibre and Nutrini Energy Multi Fibre in children on long-term enteral nutrition (vs nonfibre containing baseline formulas).<br>**Highlights:**<br>• Improved stool consistency, especially in children with loose stools.<br>• Some children reported reduced nausea, vomiting, and abdominal pain.<br>• 2 of 10 children on regular laxatives were able to stop. | Yes | No | No | Yes | Fibre-enriched formulas were well tolerated and showed positive trends in stool consistency and GI symptoms. However, the small sample size limits generalizability, and further research is needed. | **+ Direct comparison:** Evaluated both low- and high-energy fibre formulas.<br>**+ Objective measurements:** Stool frequency and consistency were recorded systematically, providing clear and objective data on gastrointestinal function.<br>**- Small sample size:** only 14 children completing the study (7 on each formula) which limits the generalizability of the findings.<br>**- Short duration:** 4-week intervention may not capture long-term effects.<br>**- No control group:** Baseline comparison only; no parallel non-fibre group. |
| **Trier et al, 1999 (conference abstract)** | **Aim:** determine the effects of a multifibre supplemented enteral feed (Nutrini MF) on GI function vs to a fibre-free isocaloric formula (Nutrini).<br>**Highlights:**<br>• Both formulas were well tolerated.<br>• Weight gain was satisfactory across both groups.<br>• Significant reduction in constipation days with the multifibre formula ($p < 0.05$).<br>• No significant differences in other GI symptoms. | Yes | No | No | Yes | The multifibre - supplemented formula was:<br>• Well tolerated.<br>• Effective in reducing constipation.<br>• Suitable for children aged 13–125 months requiring tube feeding. | **+ Double-blind cross over design:** This design minimizes bias and allows each child to serve as their own control, enhancing the reliability of the results.<br>**- Small sample size** (N=16 children).<br>**- Short intervention period:** Each formula was administered for only 14 days, which may not reflect long-term effects or tolerance.<br>**- Homogeneity of the sample:** The majority of the children had cerebral palsy, which may limit the applicability of the results to children with other conditions. |

**Classification based on chronological order**

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  - Topline conclusion
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3. OVERALL SUMMARY AND CONCLUSION

# COMPLEAT PAEDIATRIC ACTIVATION OVERVIEW

- Topline conclusion
- Detailed analysis

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION


# TOPLINE CONCLUSION ON CLAIMS AND COMMUNICATION COMPLEAT PAEDIATRIC



## 1. Focus on tolerance & naturality

- Real food ingredients
- Family moments imagery



## 2. Supports patients' & parents' needs, linked to improved quality of life

- Familiar ingredients



## 3. Credibility through real experiences

- Stories, recipes, word of mouth



## 4. Messaging integrity

- Most claims justified
- Some stretching messages linked to blenderized diet (BD) implying that Compleat Paediatric can be classified as BD as well



## 5. Localized secondary messages

- Sustainability (Nordics)
- BD comparison (Poland)
- Child-friendly cues (France)

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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3. OVERALL SUMMARY AND CONCLUSION

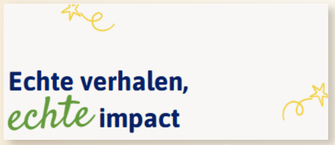

# KEY MESSAGES COMPLEAT PAEDIATRIC FROM GLOBAL AND LOCAL WEBSITES FOCUSED ON NATURE AND FAMILIARITY




**Reinforcing clinical evidence + whole food benefits (balance of medical precision + natural nutrition).**

**Compleat Paediatric provides realiable and complete nutritional solutions made familiar food ingredientes and plant protein options to increase patien satisfaction while meeting ther nutritional needs and dietary preferences.**

**'Real stories, real impact'**




**Emotional appeal focusing on patient-centered approach**




**Smart link to BD, stating 'Neutral products that can be used as good base for BD or consumed next to it'**

**'Products developed with experts like dieticians, chefs and HCPs'**

As the only feed in the UK&I to contain food-derived ingedientes*, Compleat® paediatric is ofetn considered by dietitians for families waiting to explore or who are following a blended diat. It can be used flexibly:

- As a base to homemade blends to provide a know nutritionak value and reduce the amount of work that goes into preparing blends.
  Recipes are available for dietitians to provide to their patients.
- As a base to homemade blends to provide a know nutritionak value and reduce the amount of work that goes into preparing blends.
- As a bridge or stopping stone for those wanting to expore blended diets. The BDA Practice Toolkit The Use of Blended Diet with Enteral Feeding Tubes (2021) can be views **here**


1. Compleat® - Real Food Tube-Feeding Solutions
2. Compleat.info | Compleat® Nestlé Health Science
3. Compleat® paediatric for professionals | Nestlé Health Science

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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# EU COUNTRY EDUCATION AND PROMOTION

Simple and consistent  messaging on tolerance, using naturality cues and real patient stories, built on strong perception of having one solution that meets all patients' needs with tolerance challenges.

## COUNTRY MATERIALS - FRANCE

KOL mini videos (x10) published on Linkedin



1. Parents' expectations regarding enteral nutrition for their child
2. HCPs' expectations regarding enteral nutrition solutions in pediatrics.
3. Main issues in pediatric enteral nutrition.
4. Advantages and disadvantages of "homemade" enteral nutrition in pediatrics.

https://www.linkedin.com/posts/nestle-health-science-france_compleat-400-gastu-sont-les-parametres-ecl4vte-7291660795728633792-mcE?utm_source=share&utm_medium=member_desktop&rcm=ACoAAB-0904BYgCA78-YRTVCLFdFbF1wCQ#Nmd

HCP Session JFN congress (dec 24)



KOL Webinar (feb 25)




Symposium GFHGNP congress (march 25)



Newsletter widely sent to HCPs



Launch video
https://youtu.be/NWC_hJy5dss






HCP leaflet

NHS website communication




## COUNTRY MATERIALS – ITALY AND POLAND










## COUNTRY MATERIALS – SWEDEN AND NORWAY













## CONFERENCE COMMUNICATION

ESPGHAN, 2023



ESPEN, 2023



ESPGHAN, 2024



ESPGHAN, 2025



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# OVERVIEW OF COMPLEAT'S PAEDIATRIC CLAIMS JUSTIFICATION BASED ON THEIR STUDIES - GENERAL




Compleat® pediatric

| Compleat Paediatric justified claims / messages | Substantiation / validation |
|---|---|
| Reduced constipation. | Yes, O'Connor 2025, Steel 2023, O'Connor 2022, Siddiqui 2021 |
| Improved overall GI tolerance with increased gut microbiota diversity and supported beneficial changes in stool type. | Yes, O'Connor 2024, where SCFA concentration (Faecal butyrate and prioponate) maintained – stool consistency & stool frequency improved in the first week in PICU. |
| Particularly well tolerated in long-term care, for children with disabilities, rehabilitation, vegetative state and neurological diseases. | Yes, Steel 2023, Thornton-Wood 2020, Siddiqui 2021....but there is no data on long-term health outcomes. |
| Evidence less strong and pretty stretching.<br>Benefits of natural food ingredients with proven improvement in gastrointestinal symptoms such as belching, vomiting and constipation compared to a standard formula. | Not fully justified – even though some evidence shows improvements in GI symptoms, there are no 2-arm studies (except Desai, 2022) so they compare the results of Compleat vs other SIF. |

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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# OVERVIEW OF COMPLEAT'S PAEDIATRIC CLAIMS JUSTIFICATION BASED ON THEIR STUDIES - FRANCE




| Claims | Substantiation | Review |
|---|---|---|
| Product name – Nature mix | Quite a stretch implying that some ingredients come right out of a garden. | To be reviewed by local French authorities how 'Nature' is being interpreted. |
| Nestlé innovates in Paediatrics: because nature offers the best, Nestlé Health Science offers the first enteral nutrition solution based on everyday foods* | *First formula based on everyday foods: rehydrated chicken meat (6.9%), rehydrated vegetables (4.3%) (peas 3.8%, green beans 0.54%), peach puree (1.4%), orange juice from concentrate (1.2%) among Paediatric enteral nutrition formulas on the French market. | This message is justified – perhaps a bit of an exaggerated message, but they are indeed the first launcing this type of product. |
| 1/3 of the recommended daily portions of fruits & vegetables | From 2 times 500 ml pouches of Compleat® Paediatric Nature Mix. High Council of Public Health, June 2020. Opinion on the revision of dietary guidelines for children aged 0-36 months and 3-17 years. | Based on UK dietary references, this statement is not accurate.* Please see the relevant explanation and calculation below:<br>• 1000 mL × 6.9% (F&V) = 69 g of real food ingredients in the full product.<br>• This means 69 g per 1000 mL, or 6.9 g per 100 mL.<br>• When compared to the UK recommended daily intake of fruits and vegetables (400 g/day, based on 5 portions of 80 g), the contribution is: 9/400=17.25%<br>So, 17% is not equivalent to one-third of the daily intake, based on UK guidelines. |
| And in addition, good tolerance | O'Connor G et al. Monitor gastrointestinal tolerance in children who have switched to an "enteral formula with food-derived ingredients": A national, multicenter retrospective chart review (RICIMIX study). Nutr Clin Pract. 2022 Aug;37(4):929-34. | This message is justified – it is supported by multiple studies, including the one referenced, demonstrating proven outcomes on tolerance. Please refer to the relevant evidence section for further details. |
| We partner with organic farmers to source the fruits and vegetables for our Compleat® Paediatric Organic Blends formulas, providing wholesome nutrition from farm to feeding tube | No reference. | This is only applicable to the US SKUs, specifically the Organic blend. |
| Based on everyday foods | First formula based on everyday foods: rehydrated chicken meat (6.9%), rehydrated vegetables (4.3%) (peas 3.8%, green beans 0.54%), peach puree (1.4%), orange juice from concentrate (1.2%) among Paediatric enteral nutrition formulas on the French market. | This message is justified– they are first launching this type of formula. |
| Coverage of recommended intakes of EPA, DHA | Apports Energétiques Totals. | We cannot confirm the validity of this claim. Although "fish oil" is listed among the ingredients, the label does not specify the levels of DHA and EPA, which are essential for assessing its nutritional contribution. |

* Where available, please apply local dietary reference values, using the following calculations as a basis.

1. EXECUTIVE SUMMARY SUPERIORITY OF NUTRINI'S RANGE

2. DEEP DIVE NUTRINI MF RANGE VERSUS COMPLEAT PAEDIATRIC

- Nutritional & compositional overview
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  - Detailed analysis
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3. OVERALL SUMMARY AND CONCLUSION

# OVERVIEW OF COMPLEAT'S PAEDIATRIC CLAIMS JUSTIFICATION LINKED TO BLENDERISED DIET - FRANCE




| Claims | Substantiation | Review |
|---|---|---|
| Low GI. | - | It is referring to low gycemic index – no evidence about it, it should be relevant due to low level of sugars and the presence of complex carbs. Nutrini also has low GI. |
| Provides similar benefits as self-mixed tube nutrition while being a nutritionally complete and safe option for tube-fed patients. | Bennett K, Hjelmgren B, & Piazza J. Blenderized tube feeding: health outcomes and review of homemade and commercially prepared products. Nutrition in Clinical Practice 2020;35(3), 417-431. | This statement is indeed taken from this publication. However, several study limitations should be considered:<br>• Limited sample sizes & study designs: Many studies referenced in the review are small-scale, observational, or retrospective. This limits the generalizability of findings and makes it difficult to draw definitive conclusions about equivalence between commercialised blenderized tube feeding (CBTF) and homemade blenderized tube feeding (HBTF).<br>• Lack of long-term data: There is limited evidence on the long-term health outcomes of CBTF compared to HBTF, especially in diverse patient populations (e.g., adults vs. pediatrics, chronic vs. acute conditions).<br>• Variability in cbtf formulations: Not all CBTF products are created equal. Nutritional profiles, ingredient quality, and processing methods vary significantly across brands, which can affect tolerance and outcomes.<br>• Real food perception & psychosocial impact: Some caregivers and patients perceive HBTF as more "natural" or aligned with family meals, which may contribute to improved psychosocial well-being—something CBTF may not replicate. |
| Self-mixed tube feeding effectively mitigated GI symptoms in head and neck cancer patients who were tube fed for 6 weeks. | Spurlock AY, Johnson TW, Pritchett A, Pierce L, Hussey J, Johnson K, Carter H, Davidson SL, Mundi MS, Epp L, Hurt RT. Blenderized food tube feeding inpatients with head and neck cancer. Nutr Clin Pract. 2022 Jun;37(3):615-624. doi: 10.1002 ncp.10760. Epub 2021 Aug 31. | This statement is indeed taken from the referenced publication. Based on its findings, the publication supports the declared claim: "For most patients, QOL and oral intake increased and GI symptoms decreased over the 6-week period, particularly during weeks 3 and 4, when the impact of treatment is particularly exacting on patients with HNC."<br>Aknowldegments: Hurt RT is a consultant for Nestlé Nutrition and Lisa Epp is a consultant for Abbott Nutrition, Nestlé Nutrition, and Halyard Avanos. Manpreet S. Mundi has received research grant funding from Nestlé, Fresenius Kabi, and Real Food Blends. All others report no conflicts. |
| Self-mixed tube feeding (home-made blenderized food) can reduce the incidence of diarrhoea in critically ill heart surgery patients. | Fabiani A, et al. Impact of a natural versus commercial enteral- feeding on the occurrence of diarrhea in critically ill cardiac surgery patients. A retrospective cohort study. International Journal of Nursing Studies 2020;108, 103605. | This statement is indeed taken from the referenced publication. Based on its findings, the publication supports the declared claim: "Administration of a blenderized diet based on natural food for enteral feeding can reduce the incidence of diarrhea in cardiac surgery critically ill patients." |

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3. OVERALL SUMMARY AND CONCLUSION

# 3. OVERALL SUMMARY AND CONCLUSION



# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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# COMPLEAT PAEDIATRIC SUMMARY OVERVIEW

## PRODUCT RANGE AND PRESENCE



One tube formulation
1.2 kcal
250 and 500 ml
Smartflex bottle
Age: 1+



Available in 13 EU markets & Turkey




ONS expected to launch end of 2025

## BENEFIT, TARGET GROUP AND EVIDENCE



**BENEFIT**

Mild tolerance/GI symptom reflief as main entry point and benefit. Linked to the addition of real food ingredients.

**TARGET GROUP**

All tube patients 1+ with mild GI tolerance challenges with focus on neurological patients.

Strategy – one size fits all.

**EVIDENCE**

Various studies showing:

- Short-term GI symptom relief.
- Improved QoL and health care costs (based on US real-world data).

Limited data on growth & long-term benefits.

## OVERALL COMMUNICATION STORY

**Simple & consistent messaging**



Usage of naturality cues




Real and recognisable ingredients




Story on familiar food that bonds, creating sense of togetherness and normalcy linked to better QoL for the whole family

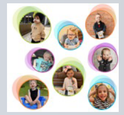



Inspiration by nature



IWholesome choice

Products developed with experts like dieticians, chefs and HCPs



Real patient stories

## ACTIVATION ACROSS TARGET GROUPS





- Many HCP activities - education (conferences, events, materials, promotion and evidence sharing etc.).
- Promotion of Compleat Paediatric in blenderized diets.
- Focus on bolusfeeding, ENFit compatible SimpLink® connection for 250 ml variant.
- Compleat Paediatric has its own consumer website containing real patient stories, blogs and recipes.

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# SUMMARY & CONCLUSION

Both Compleat Paediatric and Nutrini MF range are nutritionally complete FSMP formulas with proven tolerance in clinical use. However, they differ in positioning, evidence strength, and clinical breadth.




## ✓ Compleat Paediatric

- **Core Strength:** Focused positioning on mild tolerance and real food ingredients.
- **Positioning:** Appeals to parents seeking natural, food-derived solutions.
- **Clinical Role:** Offers one-size-fits-all approach for tube-fed patients with **mild GI tolerance challenges.**
- **Evidence Base:** Supported by a broad, though **variable-quality, dataset**— primarily focused on short-term relief of GI symptoms.




## ✓ Nutrini MF range

- **Core Strength:** Established **leadership and credibility among HCPs,** rooted in science and aligned with expert guidelines.
- **Positioning:** Offers a comprehensive, **tailored tube-feeding portfolio** including medical devices and services.
- **Clinical Role:** Suitable for a **wide range of clinical conditions,** effectively supporting complex nutritional needs.
- **Evidence Base:** Supported by robust, peer-reviewed data demonstrating:
  - **Good GI tolerance.**
  - **Catch-up growth.**
  - **Positive long-term health outcomes** (beyond GI symptom relief).

In conclusion, Compleat Paediatric provides an emotionally resonant solution for tube-fed children with mild GI tolerance issues, emphasizing real food ingredients and caregiver appeal. However, its clinical evidence base is variable in quality and primarily mainly focused on short-term symptom relief.

In contrast, Nutrini MF range is gounded in science with a strong credibility built over 30+ years of clinical heritage. It offers a wide, tailored and comprehensive range of solutions supported by robust, peer-reviewed data demonstrating good tolerance, catch-up growth, and long-term nutritional health outcomes —making it suitable for a wide range of clinical needs.

# COMPLEAT PAEDIATRIC COMPETITOR ANALYSIS


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# END