EG032 Oesophageal-gastric tamponade tubes

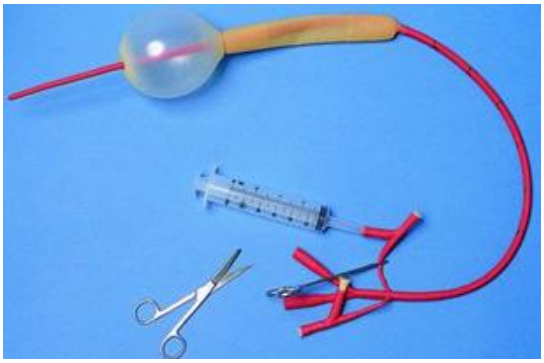
1. Key Recommendations for operational use
For use by: ScotSTAR teams. **Internet:** Yes

ENSURE YOU ARE USING THE CORRECT INSERTION GUIDE.

- There are two types of oesophageal-gastric tamponade tubes available in Scotland.

- **EMRS only carry the Cliny Sengstaken-Blakemore Type 42**

- **Some referring sites may have the latex Minnesota type tube.**
- **EMRS carry the ancillaries for this tube.**



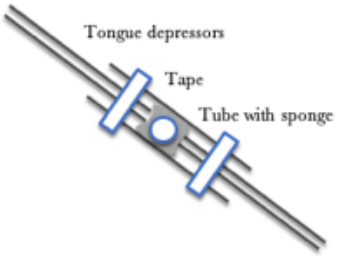
Oesophageal Tamponade: Cliny Sengstaken-Blakemore Type 42

1. Ensure patient is intubated

2. You need

- Eye Protection, Gloves
- Cliny Sengstaken-Blakemore Type 42
- Lubrication
- 20ml Luer slip syringe
- 50ml catheter tip syringe
- Aneroid Sphygmomanometer
- Spigots (2)
- Tongue depressors (6)
- Elastoplast tape
- Laryngoscope +/-Magills, NG drainage bag (SCRAM bag)
- pH testing strips

Once under tension use 6 tongue depressors taped to create an anchor at the mouth around the sponge.



3: Preparation

- Close both clamps.
- Inflate 50ml of air into the gastric balloon (blue port - red marker).
- Inflate 50ml of air into the oesophageal balloon (clear port - black marker).
- Check both balloons for leaks.
- Deflate both balloons ensuring 50ml of air is returned.
- Lubricate tube and guide wire.

4: Insertion and Inflation

- Insert tube through mouth to 60cm (20Fr mark) with laryngoscope and direct vision.
- **If there is significant resistance: stop, remove and reinsert.**
- Remove guide-wire.
- **If guide-wire cannot be removed easily, stop and consider removing tube.**
- Inflate gastric balloon (blue port - red marker) with 300ml of air.
- **If there is resistance, stop.**
- Tension the tube: pull hard until firm resistance is felt.
- Maintain tension with tongue depressors.

5: Post Insertion

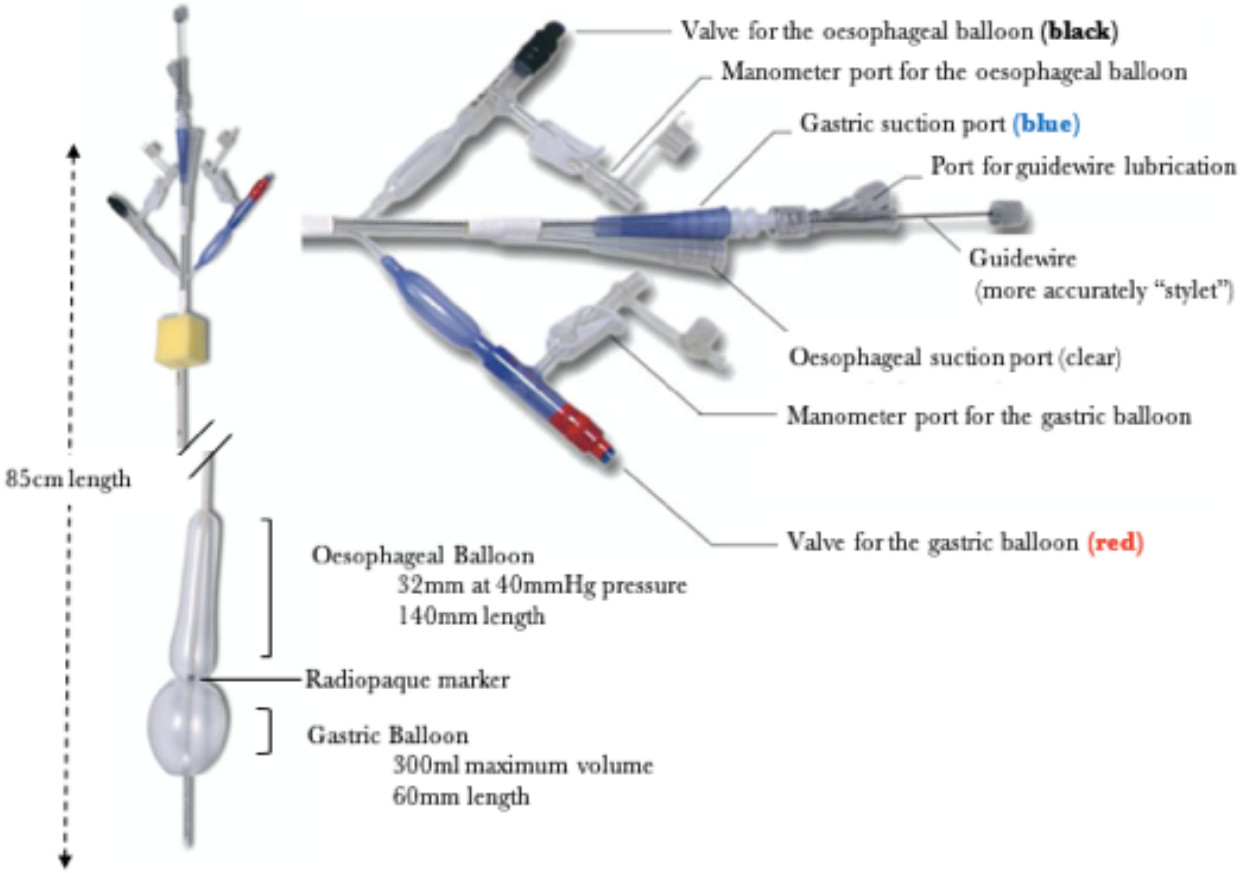
- Confirmation with CXR or pH optional.
- Suction gastric and oesophageal lumens with catheter tip syringe.
- Spigot oesophageal port.
- Free drainage from the gastric port with NG drainage bag.
- Document:
  - tube length at tongue depressor,
  - volume inflated,
  - time inflated.

6: If Continued bleeding

- Ensure gastric balloon is inflated and under tension.
- Discuss with gastroenterology.
- Inflate oesophageal balloon (clear port - black marker) to 30mmHg.

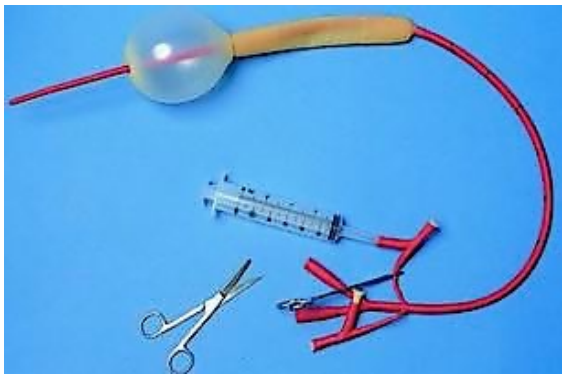
7: Air Transport

- Transfer at low altitude or King Air cabin pressurised to sea level.
- Monitor balloon pressure during flight.


Valve for the oesophageal balloon (black)
Manometer port for the oesophageal balloon
Gastric suction port (blue)
Port for guidewire lubrication
Guidewire
(more accurately "stylet")
Oesophageal suction port (clear)
Manometer port for the gastric balloon
Valve for the gastric balloon (red)
85cm length
Oesophageal Balloon
32mm at 40mmHg pressure
140mm length
Radiopaque marker
Gastric Balloon
300ml maximum volume
60mm length

Oesophageal Tamponade: Bard Minnesota Tube

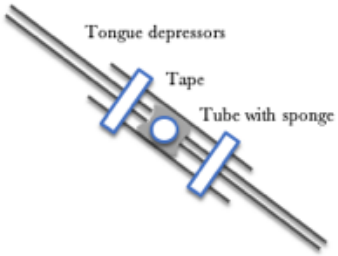
1. Ensure patient is intubated



2. You need

- Eye Protection, Gloves
- Bard Minnesota tube (red)
- Lubrication
- 2x50ml catheter tip syringes
- Aneroid Sphygmomanometer with plastic connector
- Spigots (6)
- Tongue depressors (6)
- Clamps with protected jaws (2)
- Elastoplast tape
- Laryngoscope +/-Magill's, NG drainage bag (SCRAM bag)
- pH testing strips

Once under tension use 6 tongue depressors taped to create an anchor at the mouth around the sponge.



3: Preparation

- Attach aneroid sphygmomanometer to the gastric port and the catheter syringe and clamp to other port.
- Inflate the gastric balloon with 500ml of air, noting the pressure every 100ml.
- Inflate the oesophageal balloon with 500ml of air, noting the pressure every 100ml.
- Check both balloons for leaks under water.
- Deflate both balloons ensuring 500ml of air is returned.
- Lubricate tube.
- Freeze tube or place in ice bath to stiffen.

4: Insertion and Inflation

- Insert tube through mouth beyond 50cm with laryngoscope and direct vision.
- Inflate gastric balloon to 500mls total, checking the pressure every 100mls.
- **If >15mmHg of preparation pressure, stop.**
- Tension the tube once clamped, pull hard until firm resistance is felt.
- Maintain tension with tongue depressors.
- Spigot all ports and ensure clamped.

5: Post Insertion

- Confirm with CXR or pH.
- Suction gastric and oesophageal lumens with catheter tip syringe.
- Spigot oesophageal port.
- Free drainage from the gastric port with NG drainage bag.
- Document:
  - gastric balloon pressures at 100/200/300/400/500mls pre and post insertion.
  - length at tongue depressor.
  - volume inflated.
  - time inflated.

6: If continued bleeding

- Ensure gastric balloon is inflated and under tension.
- Discuss with gastroenterology.
- Inflate oesophageal balloon 35-45mmHg.

7: Air Transport

- Transfer at low altitude or King Air cabin pressurised to sea level.
- Monitor balloon pressure during flight.

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Document History			
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		EMRS North	✓
		Paediatric	X
		Neonatal	X
	Tayside Trauma Team		X

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Scope and purpose	
• Overall objectives: The aim of this guideline is to describe the insertion of the Sengstaken-Blakemore Type 42 as an oesophageal-gastric tamponade tube for control of variceal bleeding not amenable to medical treatment prior to endoscopy. • Statement of intent: This guideline is not intended to be construed or to serve as a standard of care. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. Clinicians using this guideline should work within their skill sets and usual scope of practice. • Feedback: Comments on this guideline can be sent to: sas.cpg@nhs.scot • Equality Impact Assessment: Applied to the ScotSTAR Clinical Standards group processes.	
• Guideline process endorsed by the Scottish Trauma Network Prehospital, Transfer and Retrieval group.	