Gastric Tube Insertion (≥ PL4)

Clinical Indications:

1. Adult and pediatric cardiac arrest or comma following placement of advanced airway.
2. Patients who are vomiting or at risk for aspiration due to altered mental status.

Contraindications:

1. Actual or suspected laceration or perforation of the esophagus.
2. Suspected fractures of the cribiform plate as evidenced by severe maxillofacial trauma for nasal gastric tube placement.
3. Ingestion of a caustic substance.

Notes/Precautions:

1. Anticoagulant use (e.g. coumadin/warfarin) or disorders of coagulopathy (hemophilia) is a relative contraindication.

Procedure:

1. Select appropriately sized tube according to patient size and measure the correct length for insertion.
   a. To measure length: While holding the distal end of the tube, measure the distance from the patient's earlobe to the bridge of his/her nose, and from there to a point just below the xiphoid process
   b. Mark this length with a piece of tape to serve as a future guide point
2. In the unconscious or arrested patient with an advanced airway in place, the orogastric route of insertion may be preferred.
3. If an iGel is used the appropriate size gastric tube must be inserted through the gastric lumen of the iGel airway.
4. Lubricate distal 3 to 6 inches of the tube (preferably with Lidocaine jelly) and select the most widely patent nostril.
5. Support the back of the patient's head and gently advance tube straight back along the floor of the nasal cavity (in an anterior-to-posterior direction, not cephalad). If resistance is felt, rotate tube slightly to help advance it into position.
6. Continue to insert the tube past the glottic opening into the esophagus. Continue to insert the tube into the nose until the pre-measured mark reaches the front edge of the nostril.
7. After reaching the predetermined mark confirm that the tube has not curled up into the oropharynx or pharynx. While listening over the epigastrium, inject 20-30 mL of air into the tube and listen for "gurgling" to indicate proper placement. Aspirate and observe for gastric contents (may not always be present).
8. If no sounds are heard over the epigastrium, and you notice fogging or misting in the tube, or patient cannot cough or speak, immediately withdraw the tube and oxygenate the patient.
9. If tube placement has been confirmed, securely tape the proximal end where it enters the nostril to the bridge of the nose.
10. After tube is firmly secured, connect the proximal end to suction device and suction as needed.