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## **NASOGASTRIC & OROGASTRIC TUBES**

### **PURPOSE**

To define the indication and use of nasogastric (NG) and orogastric (OG) tubes in critical patients when under cardiac or respiratory arrest.

### **AUTHORITY**

Health & Safety Code, Division 2.5, §§ 1797.220, 1798  
California Code of Regulations, Title 22, Division 9

### **POLICY**

Paramedics may place nasogastric or orogastric tubes in ventilated pediatric and adult patients under cardiac or respiratory arrest.

### **INDICATIONS**

Gastric distention during cardiac or respiratory arrest increases aspiration risk, decreases cardiac blood flow, and decreases respiratory expansion. Decompression of ventilated air or gastric contents from a ventilated pediatric or adult patient under cardiac or respiratory arrest utilizing a salem sump nasogastric or orogastric tube decreases these risks.

### **CONTRAINDICATIONS**

- I. Suspected basilar skull fracture
- II. Suspected mid-facial fractures
- III. Known or suspected actively bleeding esophageal varices

### **PROCEDURE**

- I. Select appropriately sized salem sump gastric tube (eight French [8 Fr], twelve [12 Fr], fourteen [14 Fr], eighteen [18 Fr]).
- II. Measure the insertion length of gastric tube from the midway between the xiphoid process and umbilicus, to the earlobe and over to the tip of the nose.
- III. For pediatric patients, use Broselow or equivalent length based tape to determine appropriate size gastric tube.
- IV. King Airway LTS-D placements, use size eighteen French (18 Fr) gastric tubes.
- V. Mark the measured length of gastric tube with a piece of tape.
- VI. Lubricate tube with water soluble lubricant if inserting nasally or through King Airway.
- VII. Nasal insertion: direct gastric tube along the floor of nostril to the posterior nasopharynx, then feed the gastric tube through the oropharynx down the esophagus and into the stomach, stopping when taped mark nears nostril.
- VIII. Oral insertion: direct gastric tube along tongue to posterior oropharynx, then feed the gastric tube down the esophagus and into the stomach, stopping when taped mark nears the lips.
- IX. Confirm correct gastric placement of gastric tube by:



# Yolo Emergency Medical Service Agency

## Field Policy

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### SKILLS

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- A. Injecting ten to twenty milliliters (10 to 20 ml) of air while auscultating over the stomach for a “swoosh” or “burping/bubbling” indicating the gastric tube tip lies within the stomach.
- B. Confirm absence of similar sounds in the lungs by auscultating in the mid-axillary line bilaterally while repeating the injection of small ml volumes of air.
- C. Aspirating gastric contents
- X. Tape the tube in place on the nose or around the mouth. Alternatively, some commercial types of endotracheal tube holders can be used to secure gastric tubes if passed orally.
- XI. Attach the gastric tube to low pressure suction twenty – one hundred and twenty millimeters (20 – 120 mm) and observe for gastric decompression.

### PRECAUTIONS

- I. Endotracheal intubation does not protect against tracheal placement of the gastric tube. Fogging or lack of gastric contents may indicate tracheal placement.
- II. If vomiting occurs, proceed with placement and suction around the gastric tube.
- III. Abandon gastric tube placement if unsuccessful after three (3) attempts.
- IV. Difficulty in placement may be eased by directing the chin posteriorly and performing a manual jaw thrust while inserting the gastric tube.

### CROSS REFERENCES

King Airway