PURPOSE:
To define the protocol / procedure of nasogastric / orogastric tube insertion in the prehospital setting.
STAKEHOLDERS: All Aspirus MedEvac Transport Teams
PROVISIONS (POLICY / CONTENT / PROCEDURAL STEPS): PARAMEDIC / CRITICAL CARE PARAMEDIC / RN PROVIDER

Indications:

- Gastric Decompression secondary to bag-valve mask ventilation in patients with endotracheal intubation
- Gastric Decompression in setting of bowel obstuction

Contraindications

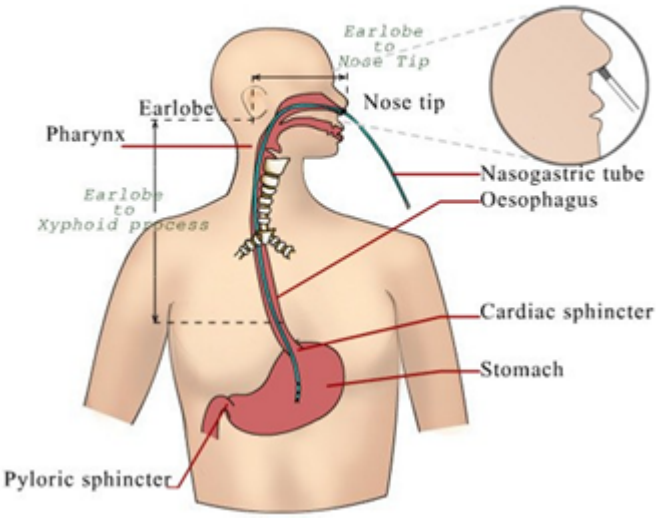
- Facial or neck trauma
- Head injury with concern for fracture of base of skull
- Caustic Ingestion
- Suspected esphageal perforation

Cautions

- Recent oral, facial, esophageal surgery
- History of gastric bypass surgery, especially initial 6 weeks post-operative

Procedure

1. Have emesis basin and tissues within reach.



2. Select appropriate sized NG/OG tube
3. Measure distance on tube for placement
    A. NG: Distance from from nose to ear to epigastrium
    B. OG: Distance from mouth to angle of jaw to epigastrium.
    C. For patients with history of gastric bypass surgery, reduce insertion length by 10 cm (4 inches)
4. Lubricate tube with water soluble gel, preferably benzocaine based.
5. Consider topical benzocaine spray to pharynx.
6. If no suspected spine injury, position patient with head in sniffing position.
7. Assess patency of nasal passages with a flashlight or by asking patient to breath through one nostril while occluding the other. **CONTRAINDICATION: DO NOT INSERT NASOGASTRIC TUBE IF SUSPECTED SKULL FRACTURE.**
8. Gently insert tube into nare guiding tube backward along floor of nasal passage (towards ear, not

up nose). If oral placement, insert tube with angle down throat.

9. Rotate tube toward opposite nare as you advance the tube steadily until it passes around the corner of nasopharyngeal junction.
10. If **no suspected C-spine injury**, have patient flex neck and instruct patient to swallow. Advance tube smoothly and quickly to desired length as patient swallows.
11. Remove tube if patient develops respiratory difficulty, gasping, or cyanosis.
12. Verify tube is in stomach by:
    A. Aspiration of gastric contents.
    B. Place stethoscope at epigastrium while injecting 5-10 cc of air. A rushing sound indicates that the tube is correctly placed.
    C. (Interfacility Transport) Confirmation of placement should be verified by x-ray and/or gastric contents aspiration.
13. Remove tube if unable to verify placement in stomach by clinical means or chest x-ray.
14. Tape correctly placed tube to nose.
15. Place tube on low intermittent suction. If low intermittent suction is not available, provide suction to NG tube from wall device for 1-2 minutes with 3-5 minutes between iterations.