Sengstaken Tube - Summary Clinical Guideline

Reference No: CG-GASTRO/2017/016

A Sengstaken tube should be passed by a person experienced in its use. This will usually be a consultant gastroenterologist after endoscopy has failed to stop bleeding, or if access to endoscopy is delayed.

Patients who require a Sengstaken tube to control bleeding are at great risk of aspiration and should be intubated to secure the airway and prevent aspiration prior to insertion of the Sengstaken tube.

Most patients will have a Sengstaken tube inserted following a gastroscopy that has failed to achieve adequate control bleeding when endotracheal intubation has already been undertaken for general anaesthesia.

Occasionally a patient will require insertion of a Sengstaken tube prior to endoscopy in a clinical area due to life threatening variceal haemorrhage. This should only be done as a bridge to emergency endoscopy in general theatres or transfer to ICU and will require airway protection as above.

- Note distance to GOJ if following endoscopy
- Lubricate Sengstaken tube
- Pass into the stomach via the mouth
- If being inserted following endoscopy, the endoscopist should if able, repass the endoscope to confirm the gastric balloon is in the stomach before inflation step.
- Inflate the gastric balloon with 300ml air and clamp
- The tube should be withdrawn gently until the balloon is opposed to the gastric cardia and then weighted with 500ml bag of IV fluids and a note made of the tube's position relative to the incisors/gums.
- Inflation of the oesophageal balloon is rarely, if ever needed and should certainly not be inflated initially. Must only be inflated after discussion with consultant gastroenterologist
- Confirm tube position with chest x-ray
- The position of the tube should be recorded hourly.
- The gastric and oesophageal aspirate ports should be left on free drainage and aspirated hourly.

Within 24 hours arrangements should be made for a repeat gastroscopy and the balloon deflated immediately prior to the endoscopy.