

## Balloon Tamponade in variceal haemorrhage (insertion of Sengstaken Blakemore tube) – Full Clinical Guideline

Reference no.:CG-GASTRO/2017/16

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.

- Note distance to GOJ if following endoscopy
- Lubricate Sengstaken tube
- Pass into the stomach via the nose or mouth - if performed at time of endoscopy then pass the scope to confirm gastric balloon beyond GOJ before inflation)
- 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- The tube should be withdrawn gently until the balloon is opposed to the gastric cardia and then weighted with 1 litre bag of IV fluids and a note made of the tube's position relative to the incisors/gums/nares.
- The oesophageal balloon should not be inflated initially (and ideally not at all)
- 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 and removed at that point in the endoscopy room.

All patients who have a Sengstaken placed must be admitted to ITU and intubated to secure the airway and prevent aspiration.

The probability of survival at 1 year following an episode of SBP is 30-50%. SBP should trigger referral for transplant assessment where appropriate.

**Documentation Controls** (these go at the end of the document but before any appendices)

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