NURSING SERVICE GUIDELINES
GENERAL

Guideline: **Blakemore Esophagogastric Tamponade Tube**

Policy Number Superseded:

Purpose of Guidelines: To provide guidelines to the RN in preparing for insertion and maintaining a Blakemore esophagogastric tamponade tube.

Effective Date:
February 16, 2026

Initial Effective Date:
July 2019

Procedure:

Used for: Esophageal variceal bleeding (emergent)
Inserted by: ICU/ED/GI/Endoscopy/OR Physician

Locations where used:

- MICU/SICU
- ED
- Endoscopy/Operating Room

Supplies needed:

(1) Blakemore Kit (Lawson #90046) from Central Supply X3884 or OR X3900
(2) Water based lubricant
(3) IV pole
(4) Liter bag of saline for traction
(5) Open canister or basin
(6) Nasogastric Tube

(A) The RN is responsible for preparing and arranging supplies. This is a clean, not sterile, procedure.

(B) Obtain a Blakemore kit (Lawson #90046) , water-based lubricant, and a canister/basin of water.

(C) Kits are available from Cental Supply (x3884) or OR (x3900).

(D) Requisitions for a Blakemore kit can be made online via the supply chain website. Pick-up is required.

(E) Pre-procedure:

(1) Gather supplies.

(2) Attach stopcocks to both the gastric and esophageal balloon lumens, pressure gauge.

(3) Test balloon:

Using a 50ml luer lock syringe inflate gastric balloon with 50ml of air, submerge in water to check for leaks, after check is completed deflate gastric balloon.

(4) Using a 50ml luer lock syringe inflate esophageal balloon with 50ml of air, submerge in water to check for leaks, after check is completed deflate esophageal balloon.Replace all caps on stopcocks.

(5) Mark nasogastric tube for reference.

Align tip of gastric tube with top of gastric balloon and mark a “G” on gastric tube at the 50cm mark of the Blakemore.

Align tip of gastric tube with top of esophageal balloon and mark a “E” on gastric tube at the 50cm mark of the Blakemore.

(F) Insertion: gastric balloon inflation.

(1) Place head of bed at 45 degrees.
(2) Tube is inserted orally to the 50cm mark at the gums.
(3) Assist provider by injecting 30ml of air into gastric aspiration port of Blakemore and listening for an air bolus.
(4) If air bolus is heard, inflate gastric balloon with 50ml of air and clamp.
(5) Confirm placement with x-ray and once confirmed, fill ballon with an additional 200ml of air and clamp.
(6) Retract Blakemore tube until resistance is felt and mark the tube at gum line.
(7) Apply traction using kerlix to tie around Blakemore and a liter bag of saline, hanging bag of saline on the iv pole.

(G) Monitoring and care.

(1) Tube may shift. If shift is greater than 2cm notify physician and reconfirm placement.
(2) Aspirate stomach content and lavage every 30 minutes with 50 ml of water to prevent clotting.
(3) Apply low continuous suction through the gastric aspiration port for the first 12 unless ordered differently.
(4) Document color of aspirate. If aspirate continues to be bright red. Report findings to physician and prepare to inflate esophageal balloon.

(H) Inflating esophageal balloon.

(1) Insert gastric tube to the "G" mark, connect to suction to check for bleeding.
(2) If bleeding persist, provider may inflate esophageal balloon, if so, move gastric tube to the "E" mark.
(3) Attach the manometer to the esophageal balloon port using the stopcock, open valve to patient and inflate slowly to 35-40mmHg. Close valve to patient and replace cap on stopcock.
(4) Clamp esophageal balloon lumen at least 3cm from opening.
(5) Continue lavage every 30 min with warm water.
(6) If bleeding persists, esophageal balloon pressure can be increased to a max of 45mmHg.
(7) Check esophageal balloon pressure at minimum every 2 hours to assess for leaks or overinflation.

(I) Documentation

(1) Document placement of Blakemore in EMR.
(2) Assess status of drain at a minimum of every 4 hours.
(3) If esophageal balloon is inflated document pressure with each assessment.
(4) Lubricate Blakemore tube with water soluble lubricant.
(5) The provider will insert the Blakemore tube orgastrically so that the 50cm mark on the tube is at the gum line.
(6) Connect the catheter tip syringe to the 20 Fr. gastric aspiration port and inject 30ml of air while listening over the gastric region.
(7) If air sounds are heard, inflate the gastric balloon with 50ml of air and clamp the port.
(8) Confirm placement by x-ray and unclamp the port; insert an additional 200ml of air and re-clamp the port.

(9) Retract the Blakemore tube until resistance is felt and mark the tube at the gum line.
(10) Use the liter bag of normal saline to apply traction.

(J) The tube may migrate out as it warms but should not migrate more than 2cm. If it does, suspect hiatal hernia and re-evaluate position with x-ray.

(K) Aspirate all stomach contents through the 20 Fr. Port. Lavage frequently with 50ml tap water to prevent clots from plugging the tube.

(L) Attach low continuous suction to the 20 Fr. Port during the first 12 hours, only per IFU.

(M) Irrigate and aspirate the Blakemore tube every 30 minutes with 50ml warm tap water and document the color of the aspirate. If the aspirate is bright red, the physician may consider inflating the esophageal balloon.

(N) Insert the Salem sump tube to the depth that lines up with the "G" mark and apply suction to check for bleeding. If there is continued bleeding, the physician may choose to inflate the esophageal balloon. If so, reposition Salem sump so the "E" mark is at the 50cm line on the Blakemore tube and secure it.

(O) With Christmas tree or Lopez valve (with small white connector). Open the valve to the patient. Inflate slowly to 35-40 mmHg and close the valve to the patient. Remove the gauge and replace the cap.

(P) Clamp the esophageal balloon port approximately 3cm from the opening.

(Q) If bright red bleeding continues after 30 minutes of lavaging the stomach, increase the esophageal balloon pressure to 45mmHg (maximum pressure).

(R) Frequent pressure checks should be made to guard against undetected air leaks in the system.

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