Blakemore Placement

What you need

- Sengstaken-Blakemore Tube
- Salem Sump
- 60 ml Luer-lock Syringe
- 60 ml Slip-tip Syringe
- 2 christmas tree to male luer lock converters
- 3 three-way stopcocks
- 3 medlock caps
- Surgilube
- Roller-bandage (Kling)
- 1 one-liter bag of crystalloid
- Optional: 2 Hollister ETAD ET tube securing devices
- Possible Need: Laryngoscope, McGill Forceps, Hemostat

Gastric Port Set-Up
Esophageal Port Set-Up

How to Do It

1. Patient should be intubated and the head of the bed up at 45 degrees.
2. Test balloons on Blakemore and fully deflate. Mark salem sump at the 50 cm mark of the Blakemore with the tip 2 cm above gastric balloon and then 2 cm above esophageal balloon.
3. Insert the Blakemore tube through the mouth just like an NGT. You may need the aid of the laryngoscope and sometimes McGill forceps. Make sure the depth-marker numbers face the patient’s right-side.
4. Stop at 50 cm. Test with slip syringe while auscultating over stomach and lungs. Inflate gastric port with 50 ml of air.
5. Get a chest x-ray to confirm placement of gastric balloon in stomach.
6. Inflate with additional 200 ml of air (250 ml total)
7. Apply 1 kg of traction using roller bandage and 1 liter IV fluid bag hung over IV pole. Mark the depth at the mouth. The tube will stretch slightly over the next 10 minutes as it warms to body temperature.
8. After stretching, the tube may be secured to the ETAD tube holder.
9. Insert the salem-sump until the depth marked gastric is at 50 cm on the Blakemore. Suction both Blakemore lavage port and salem sump. You may need to wash blood clots out of the stomach with sterile water or saline.
10. If bleeding continues, you will need to inflate esophageal balloon:
11. Pull salem sump back until the esoph. mark is at the 50 cm point of the Blakemore. Attach a manometer to the second 3-way stopcock on the esophageal port of the Blakemore. Inflate to 30 mm Hg. If bleeding continues, inflate to 45 mm Hg.
12. Consider switching traction to Hollister ETAD Device.