

A simple method to prevent devastating complications

Sir,

We read with interest the letter to editor by Soni *et al.*^[1] in the October – December 2011 issue, on the problem of air leak around endotracheal tube due to malposition of nasogastric tube (NGT) in the trachea. As an intensive care physician, we routinely place gastric tube via oral or nasal route blindly in ventilated or non-ventilated patients. It is common for the nasogastric or orogastric tube (NGT/OGT) to slide in the trachea, also by the side of endotracheal or tracheostomy tube.^[2]

Malpositioning of NGT/OGT feeding tube in the trachea results in devastating complications, which are usually preventable.^[3] As NGT/OGT tube insertion is a routine procedure in ICUs, operation theatres, wards and emergency area, it does not seem practical to check for NGT/OGT position with fiberoptic bronchoscopy in all the patients.

We are using a simple 4-step method for a long time now to prevent this avoidable complication:

- Insert NGT/OGT with recommended method.
- Check by auscultation of air insufflation with 20 ml syringe in the epigastrium.
- Keep the proximal end open for one minute to allow injected air to come out.



Figure 1: ICU nurse feeling for expiration over her cheek in spontaneously breathing patient

- Bring the proximal end of NGT/OGT close to the cheek and feel for the movement of air [Figure 1]. In spontaneously breathing patient movement of air will be felt on the cheek during expiration while in patients on mechanical ventilation or non-invasive ventilation continuous flow of air is felt on cheek.

We always follow these simple steps while inserting NGT/OGT blindly, thereby avoiding the most devastating complications in a simple way. Moreover, if this final step is not fulfilled then we remove and reposition the NGT/OGT. Since, this is an usual practice in our department we have rarely encountered any complication or ventilator malfunction in our ICUs and wards during insertion of NGT/OGT.

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