

## Nasogastric Tubes: AN10.05, AN10.15, AN11.05, AN11.15



AN10.05 Nasogastric Tube

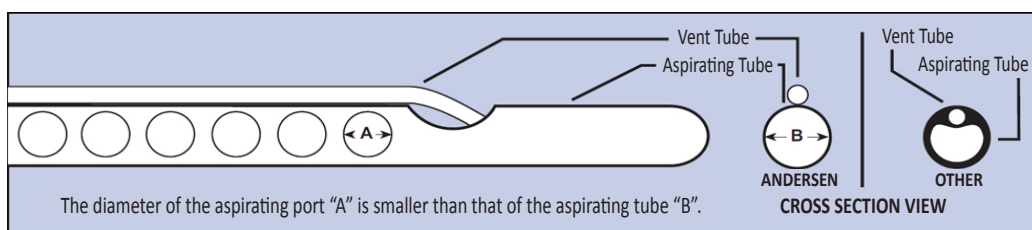
Dr Andersen invented the biluminal tube as a way to provide a simple, visual check that the tube is working correctly.

*“If it’s bubbling, it’s working”*

Andersen’s range of vented (biluminal) nasogastric tubes are designed to keep the stomach completely empty - continuously. Aspirate is constantly lifted up the aspirating tube by air that has gone down the vacuum control tube.

### Features of Nasogastric Tubes

- **Separate vent tube controls vacuum preventing** high suction causing **tissue damage** of the gastric mucosa.
- **Burr free edges** to aspirating ports help prevent mucous or particulate matter from becoming trapped.
- Round **aspirating ports have slightly smaller diameter than the aspirating tube**, so that particles too large to pass through the aspirating tube are screened by aspirating ports.
- **24 aspirating ports**; smaller percentage reduction in drainage if a port does become blocked.
- Vent tube is attached to aspirating tube by a slender web: maximises cross sectional area of aspirating tube, to **outperform conventional tubes** many times its size.
- 0.5 micron **antibacterial filter** prevents airborne contaminants from entering the system.
- **Constant wash action** of bacteria-free air through the system removes aspirate quickly.
- **Soft vinyl material** reduces pressure necrosis.
- **Marks** at 40, 50, 60, and 70 cm from the proximal end from the aspiration port, to **aid placement**. Paediatric tubes also have multiple markers to aid positioning in children.
- **Distal end is moulded** into a gently rounded tip **for atraumatic passage** and extended patient tolerance.
- **No latex**, avoiding allergic reactions.
- **Phthalate free**.
- **Radio-opaque vent tube**, allowing x-ray to confirm positioning.
- **Clear aspirating tube** allows positive visual evidence that the vacuum source and drain are working: **“If it’s bubbling, it’s working.”**
- A unique **anti-reflux filter prevents reflux** up the vent tube.
- Each tube is **sealed in a tyvek pouch**. Ten pouches are placed in an Andersen Sterijet package, **vacuum-sealed and sterilised**. A glance at the package gives visual confirmation that it has not been damaged in handling. If it is vacuum-tight, it is still sterile.
- **Stylet option available**, facilitating intubation in an anaesthetised, unconscious or uncooperative patient.



# Andersen Nasogastric Tubes

## Optional Stylet



Andersen has the only nasogastric tube with a Stylet to improve intubation in the anesthetised, unconscious or uncooperative patient. By preparing the nasal cavity with aqueous jelly, intubation can be performed in a normal manner, without removing the plastic stylet from the gastric tube, so that it is stiff when you pass it. Once proper placement is confirmed, the stylet may be removed by grasping the loop in one hand and the white tubing connector in the other hand and pulling out the stylet.

Code	Description	Quantity
AN10.05	16 Fr. 122cm standard tube.	10/box
AN10.15	16 Fr. 122cm standard tube with stylet.	10/box
AN11.05	10 Fr. 122cm paediatric tube.	10/box
AN11.15	10 Fr. 122cm paediatric tube with stylet.	10/box

## Nasogastric Tube Placement

Proper nasogastric tube positioning places the tube tip in the cardia of the stomach. Even if the tube is only being used for drainage, placement in the lungs can cause pneumonia.

The three generally accepted methods of determining tube position are:

- Stethoscope auscultation
- Aspirate fluid colour
- Aspirate fluid pH
- X-ray

Auscultation involves blowing air down the tube and listening for the bubbling sound coming from the correct place.

Fluid from the stomach is typically clear or cloudy. Fluid from the lungs may be clear, cloudy and frequently tinged with blood. Fluid from the intestine is generally green to greenish-yellow.

The pH of gastric fluid will be 0 - 4.0, pH of fluid from the upper intestine (Duodenum) will be 7.5 – 8.0, and pH of fluid from the lungs will be above 6.0. Any testing of pH should wait for at least one hour after the patient has received any medication or feeding through the tube.

X-ray is certainly the most reliable method, though it is not practical for frequent assessments. The vacuum control tube on Andersen biluminal tubes is opaque to X-rays (i.e. visible on X-ray scans).