



EMS System for Metropolitan Oklahoma City and Tulsa 2026 Medical Control Board Treatment Protocols



Approved 9/17/25, Effective 1/15/26, replaces all prior versions

PROTOCOL 9L - Nasogastric/Orogastric Tube – Adult & Pediatric

EMT

EMT-INTERMEDIATE 85

ADVANCED EMT

Indications:

1. I-gel™ placement only.
2. Decompression of ventilated air in stomach (reduction of gastric distension) in the cardiac arrest patient.
3. Decompression of ventilated air in stomach (reduction of gastric distension), compromising oxygenation/ventilation in the unconscious, I-gel™ patient.

Technique:

1. Choice proper NG tube size from chart in protocol 2E.1 (page 2E.2).
2. Lubricate NG tube prior to insertion into I-gel™ NG tube portal.
3. Place NG tube through the I-gel™ NG tube portal into the stomach.
4. Confirm correct gastric placement of gastric tube by injecting 10 to 20 mL of air while auscultating over the stomach for a “swoosh” or “burping/bubbling” indicating the gastric tube tip lies within the stomach. Confirm absence of similar sounds in the lungs by auscultating in the mid-axillary line bilaterally while repeating the injection of small mL volumes of air.
5. Attach gastric tube to low pressure suction and observe for gastric decompression.

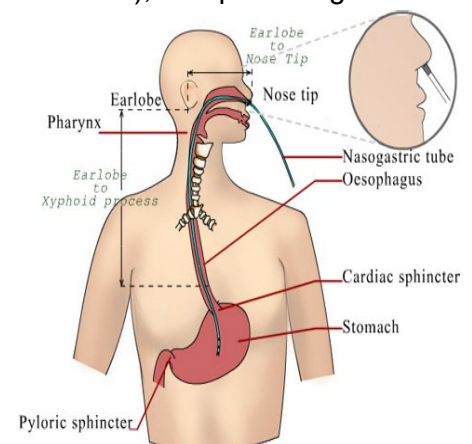
PARAMEDIC

Indications:

1. Decompression of ventilated air in stomach (reduction of gastric distension) in the cardiac arrest patient. (may be placed pre or post intubation)
2. Decompression of ventilated air in stomach (reduction of gastric distension), compromising oxygenation/ventilation in the unconscious, intubated patient.

Contraindications:

1. Suspected basilar skull fracture
2. Suspected mid-facial fractures
3. Known or suspected actively bleeding esophageal varices





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PROTOCOL 9L - Nasogastric/Orogastric Tube – Adult & Pediatric cont.’

Technique:

1. Select correct size gastric tube. Adult patients typically require size 16 to 18 French gastric tubes.
2. Measure length of gastric tube to pass by starting with tip just at xiphoid process, then using distance to earlobe and over to tip of nose (Figure).
3. Mark the measured length of tube with a piece of tape.
4. Lubricate tip of tube with water soluble lubricant if inserting nasally.
5. Nasal insertion: direct gastric tube along the floor of nostril to the posterior nasopharynx, then feed the gastric tube through the oropharynx down the esophagus and into the stomach, stopping when taped mark nears nostril.
6. Oral insertion: direct gastric tube along tongue to posterior oropharynx, then feed the gastric tube down the esophagus and into the stomach, stopping when taped mark nears lips.
7. Confirm correct gastric placement of gastric tube by injecting 10 to 20 mL of air while auscultating over the stomach for a “swoosh” or “burping/bubbling” indicating the gastric tube tip lies within the stomach. Confirm absence of similar sounds in the lungs by auscultating in the mid-axillary line bilaterally while repeating the injection of small mL volumes of air.
8. Tape the tube in place on the nose or on around the mouth. Alternatively, some commercial types of endotracheal tube holders can be used to secure gastric tubes if passed orally.
9. Attach gastric tube to low pressure suction and observe for gastric decompression.

Troubleshooting:

1. Abort gastric tube passage attempts if unsuccessful in three attempts.
2. Repetitive coughing indicates the gastric tube is erroneously passing down the trachea. Tracheal/bronchial stimulation in gastric tube passage will typically provoke strong coughing reflex. Promptly withdraw tracheally placed gastric tubes to avoid aspiration. An endotracheal tube will not prevent inadvertent passage of a gastric tube down the trachea.
3. Avoid lavage or medications via gastric tube. Use is for gastric decompression.