Last Revised: May 18, 2012

Tubes and Lines Policy: Body

This is an incomplete list of the tubes and lines which require a phone call to the clinical service and documentation of that call.

Nasogastric (NG) tube:
This is usually a dual lumen catheter intended for decompression of the stomach. It consists of a main channel and a secondary sump channel. There is a thin radiopaque marker line along one side. The proximal sidehole is indicated by a short break in this line.

Ideal position: The tip and upper sidehole both located clearly between the GE junction and pylorus.

Phone call:

a) Tracheal or bronchial position. Use the carina as a clue as to the luminal course of the tube.
b) Not visualized. Make sure it has been removed and is not looped in the upper airway or head.
c) Tip and sidehole above the GE junction. This may also indicate the presence of a hiatal hernia, look at a lateral CXR or related CT scans
d) Sidehole above the GE junction, but tip below. Recommend advancing 5-8 cm to insure the tip is within the stomach.
e) Tip or sidehole beyond the pylorus with a distended stomach.

Dobhoff feeding tube:
A tube placed to one of three levels for delivery of nutritional feedings and medicine. The tube comes in one of three varieties, a large weighted tip placed by the clinical service, a small weighted tip placed by radiology, and a more lucent end-hole tip placed by endoscopy.

Ideal position: The desired position will depend on the clinical indication for the tube:

a) Within the stomach: Most inpatients with normal mental status, these patients are not at risk for aspiration.
b) Beyond the pylorus: Same category as above, furthest the weighted clinical tube will reach.
c) Beyond Treitz in the jejunum: Altered mental status, patients who are aspiration risks, pancreatitis patient (reduce pancreatic stimulation).

Phone call:

a) Not visualized.
b) Above the GE junction. This includes patients in whom you suspect a hiatal hernia as they are reflux and aspiration risks.

c) Within the stomach if this is a radiology or scope placed tube which has migrated or the patient is an aspiration risk or has pancreatitis.
d) Any tube which shows serial migration proximally from its original position, this may indicate a trend from tube management that will eventually result an incorrect position.
e) Kink, crimp, or acute angulation. Usually indicates a non-functioning tube.

Double J or ureteral stent catheter:
A catheter placed in the ureter with a flexible proximal loop to anchor it in the renal pelvis. Distal loop is in the bladder or in the drain bag if post cystectomy.

Ideal position: The preformed loops are in the expected position of the renal pelves and bladder.

Phone call: The loops are not where expected.

Ventriculoperitoneal (VP) shunt catheter:
A drainage catheter placed in the peritoneal space of the abdomen for drainage of CSF.

Ideal position: Widely coursing thru the abdomen.

Phone call:
a) Tight loop. Can indicate subcutaneous or extraperitoneal location (‘CSF-oma’).
b) Projection within the subcutaneous fat on tangential views.