

# Balloon tamponade in variceal bleeding: use and misuse

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The efficacy of and complication rates associated with balloon tamponade have been reported from centres experienced in using the procedure.<sup>1-3</sup> This prospective survey was carried out to assess the value and complication rates of balloon tamponade when used in hospitals with limited experience of managing acute variceal bleeding.

## Patients, methods, and results

Over two years 30 patients were referred to this unit for the management of variceal bleeding with a balloon in position. Technical factors that we considered important for controlling bleeding were for the gastric balloon to be positioned close to the gastro-oesophageal junction and for it to be adequately inflated (in excess of 100 ml). Factors that we believed increased the risk of complications were: inflating the gastric balloon within the oesophagus (with the risk of oesophageal rupture); inadequately filling the gastric balloon (<100 ml allowed the tube to move upwards into the oesophagus, increasing the risk of occlusion of the larynx and pulmonary aspiration), inflating an oesophageal balloon at the level of the larynx; and using excessive mechanical traction (>1 kg) of the tube or applying inflation for prolonged periods (>36 hours).

In only 13 of the 30 patients was balloon tamponade effectively used to control bleeding. Failure to position the balloon correctly (13 cases) was the most common fault. In 15 cases the tube was used in such a way that there was a high risk of complications. The most common problem was underinflation of the gastric balloon (eight cases). In five cases excessive or prolonged traction was applied to the tube and resulted in severe ulceration of the gastro-oesophageal junction. In one case the gastric balloon was inflated in the oesophagus, but without serious consequences. Balloon tamponade was considered to be optimum—

that is, both effective and safe—in only 10 of the patients.

## Comment

We conclude that in most of these cases the balloon could not have stopped the bleeding and, furthermore, was likely to lead to complications. The most common error limiting the efficacy of tamponade was failure to position the gastric balloon correctly at the gastro-oesophageal junction. This procedure needs the firm retraction of an adequately inflated gastric balloon back to the cardia (we use 160-200 ml of a water-contrast mixture). The tube is then taped to the side of the face to provide skin traction and the position is checked radiologically. It is seldom necessary to inflate the oesophageal balloon if the gastric balloon is correctly positioned. Prolonged application of tamponade may cause severe mucosal ulceration, which can subsequently cause bleeding. This complication may be minimised by restricting the use of tamponade to less than 12 hours. Subsequent treatment should aim to prevent recurrent bleeding when the tube is withdrawn.

Guidelines for use cannot compensate for lack of experience, and our survey shows that without experience in its use balloon tamponade is of limited value. A pharmacological regimen<sup>4</sup> in conjunction with careful resuscitation offers more chance of controlling bleeding and has a lower risk of complications than inexperienced use of balloon tamponade.

Balloon tamponade is always a thoroughly unpleasant experience for the patient; this survey has highlighted major limitations in its use, and there is a high risk of complications.<sup>5</sup> These facts should lead hospitals to review their policy for managing variceal bleeding.

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(Accepted 30 December 1988)

# Old and unwashed: bathing problems in the over 70s

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Although bathing is an important aspect of self care, little information exists on the problems it causes in elderly people. We assessed the difficulties of bathing and identified what might be done to improve the provision of bathing for old people living at home.

## Patients, methods, and results

On each of 200 consecutive domiciliary visits carried out in Leeds Eastern district by this department we recorded age, sex, ability to bathe, whether help was required, whether the patient lived with someone and if so what help was provided, and frequency of bathing.

Altogether 175 questionnaires, on 116 women and

59 men with a mean age of 83 (range 70-94), were suitable for analysis. Eighty one patients lived alone, 64 with their spouses, 11 with their daughters, and 19 with another carer, such as a niece or sister.

All homes had baths; nine also had showers, only three of which were used. Ninety five people were able to have a bath, 46 requiring help. As an alternative to bathing 59 people had a standing strip wash, 42 requiring help. Twenty one people were unable to have a bath or a strip wash. The table shows who provided the help. Spouses provided the same proportion of help

Provision of help with washing and bathing for elderly people

Who provided help	People who had baths (n=46)	People who had standing strip washes (n=42)	Total (%) (n=88)
Family and friends:			
Spouse	13	11	24 (14)
Daughter	12	9	21 (12)
Other	11	5	16 (9)
Health and social services:			
Nurse	7	17	24 (14)
Care assistant	2		2 (1)
Home help	1		1 (<1)

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Br Med J 1989;298:1158-9