the artery. The puncture needle was inserted at the identified point 30-45° and advanced 1-3mm until the needle tip was visualized center to the artery on the SA-OOP view. The ultrasound probe was then rotated 90° to visualize the LA-IP view with the needle in full profile and centered within the artery. The guidewire was inserted, and the cannula threaded over the guidewire.

**Results** This sequential approach of ultrasound guided SA-OOP followed by LA-IP resulted in a successful first pass radial arterial cannulation using Seldinger technique and a total catheterisation time of seven minutes.

**Conclusions** Doctors can benefit from the advantages of each approach while minimizing its respective limitations. Further studies should be done to assess the overall procedural and patient outcomes.

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**Application for ESRA Abstract Prizes:** I don’t wish to apply for the ESRA Prizes

**Background and Aims** Normally, the nerves arising from the brachial plexus are placed around a single axillary artery (AA) in different positions.[1,2] At axilla, two arteries can occur in 2.6%-2 to 9.2%[1] of population. Double AA in ultrasonographic image has already been described, but in the published images,[1] the two arteries were neither equal in caliber nor equidistant from the axillary vein (AV). They were described as either larger superficial and smaller deep axillary arteries combination or defined as an accessory artery.[1,2] The double AA of equal caliber is described only in a cadaver.[3]

**Conclusions** The ultrasound image showed two axillary arteries of equal caliber, equal depth, and equidistance from a single AV at the center. The vein indented due to the mild pressure exerted by the probe which helped to differentiate it from arteries. The brachial plexus was identified by the ultrasonographic appearance as bunch of small round hypoechoic structures. The brachial plexus was seen between the axillary arteries and it was closer to the medial AA [figure 1]. The nerves arising from the brachial plexus were not seen separately as median, ulnar, radial, and musculocutaneous nerves, but as a single mass within a single sheath. There is a compelling similarity of this ultrasound image with the face of an owl. We emphasize the appearance of brachial plexus as a single mass within a single sheath in case of a double AA of equal caliber. This knowledge is important to give a successful brachial plexus blockade at the axilla in this anatomic variant.

**Conclusions** Intersecalene brachial plexus block and erector spinae plane block for axillary dissection: a successful approach

**Background and Aims** The sensory innervation of the axilla is achieved by the brachial plexus and the intercostobrachial
nerve. Hence, in patients regarded as high risk for general anesthesia, surgical interventions in the axilla require combined regional anesthesia techniques. Two previous cases describe the combination of intercostobrachial with supraclavicular brachial plexus block for axillary surgery. Others report the use of erector spinae plane block (ESPB) as postoperative analgesic approach to axillary dissection. Nevertheless, no study combines ESPB and interscalene brachial plexus block (IBPB) as anesthetic technique. This abstract aims to demonstrate their effectiveness in anesthesia and analgesia, for axillary surgery.

**Methods**
A 68 years old woman, ASA IV, was proposed for left axillary dissection. She was regarded as high risk for general anesthesia, because she had two meningiomas, one that caused compression of the pontobulbar parenchyma and near collapse of the fourth ventricle and another that shaped the left parietal convexity. We performed an ultrasound-guided left IBPB, with 8 mL ropivacaine 0.75%, and a left ESPB at T4 level with 20 mL ropivacaine 0.375%, 50 µg of fentanyl and 1mg of midazolam were administered for sedation.

**Results**
Fifteen minutes after ESPB, we obtained sensory block in dermatomes T1 to T8. The surgery was performed with no complications and no other anesthetics were required. The patient had no pain postoperatively and was discharged home 24h later.

**Conclusions**
The combination of IBPB and ESPB is an effective anesthetic approach for axillary dissection. It provided complete anesthesia and long-lasting postoperative analgesia.

**NEURAXIAL ULTRASOUND TEACHING PROGRAMME**

Dairshini Sithambaram*, Tammar Al-Ani. Anaesthetics, Glasgow Royal Infirmary, Glasgow, UK

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**Application for ESRA Abstract Prizes:** I don’t wish to apply for the ESRA Prizes

**Background and Aims**
There is growing evidence for using preprocedural neuraxial ultrasound (PNU) to improve the safety and efficacy of neuraxial blocks. However, there are currently no standardised training pathways for this technique. This quality improvement project introduces a neuraxial ultrasound teaching programme for anaesthetic trainees.

**Methods**
We surveyed anaesthetic trainees covering obstetric and general theatres in a large tertiary hospital on their use of preprocedural neuraxial ultrasound. The survey results helped structure the neuraxial ultrasound teaching programme within our department.

**Results**
The results of the survey are summarised in the table 1 below

**SONOCLUB: IMPROVING ANAESTHETISTS’ ABILITY TO IDENTIFY THE KEY ANATOMY OF THE PLAN-A BLOCKS**

Nicholas Weston Smith*, Olivia Ward, Stuart Wade. Anaesthetics, Swansea Bay University Health Board, Swansea, UK; Anaesthetics, University Hospitals Sussex NHS Foundation Trust, Worthing, UK

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

**Background and Aims**
The adoption of the ‘Plan A’ blocks concept reflects a move towards a standardised approach to regional anaesthesia training in the UK. To improve consistency in the approach to these procedures an international consensus of anatomical structures to identify has been produced. Set up locally in 2021, ‘Sonoclub’ is a biweekly teaching programme involving a demonstration of sonoanatomy, practice scanning, and guidance on performing a specific Plan A block. Anaesthetists were observed at four Sonoclub sessions to determine whether teaching improved their ability to identify the key structures described in the international consensus.