

highly predictive of free lung. The presence of visceral thickening on TUS may also predict NEL, although there was only limited data to support this finding.

**Conclusion** In-depth TUS assessment can be delivered and interpreted quickly in the day-case setting using widely available portable ultrasound equipment, with potential implications for patient care and non-invasive diagnosis of NEL. Further research is needed to evaluate the ability of M-mode and other TUS parameters to predict NEL and symptom response prior to invasive intervention.

**REFERENCE**

1 Salamonsen MR, *et al.* Novel use of pleural ultrasound can identify malignant entrapped lung prior to effusion drainage. *Chest* 2014;**146**(5):1286–93.

**P3 THORACIC ULTRASOUND EXPERIENCES AMONGST RESPIRATORY TRAINEES – A NATIONAL SURVEY**

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10.1136/thoraxjnl-2016-209333.146

**Introduction** Level 1 proficiency in thoracic ultrasound is a mandatory curriculum requirement for respiratory speciality trainees in the UK. Guidance on attaining and maintaining this competency is outlined by The Royal College of Radiologists (RCR).<sup>1</sup> This has been a focus of the GMC survey specialty specific questions.

**Aims** To further evaluate thoracic ultrasound competencies and training experiences amongst respiratory registrars in England.

**Methods** We invited all respiratory trainees in England to complete an online survey. Responses were collected between October 2015 and June 2016.

**Results** 202 (of approximately 600) respiratory trainees completed the survey from 14 deaneries.

65.8% (131/199) trainees are level 1 accredited with 20.6% (22/107) of these performing fewer than 20 ultrasounds in the past year. Figure 1 illustrates the self-reported confidence in identifying pathology.

59% (107/171) of all respondents are never or rarely supervised. 60% (102/169) of queries are answered by real time evaluation or review of stored media. The remaining 40% reported that advice was based on verbal descriptions.

29.2% (50/171) of trainees reported that access to an ultrasonographer for advice was either “not easy” or “impossible”. 9% (15/167) reported that there were no level 1 or level 2 accredited consultants at their current hospital.

**Conclusion** Most trainees are level 1 accredited, but many do not perform the minimum 20 scans/year to maintain their competency.<sup>1</sup> Access to supervision is also limited. Though not a requirement, trainees are less confident in identifying pathology pertinent to acute and respiratory medicine, particularly pulmonary oedema and pneumothorax.

Encouragingly ultrasound training has evolved considerably in recent years, but ongoing work needs to focus on improving supervision and training. There is a case for reviewing current guidance and to consider tailoring training and expectations to align with the specific needs of respiratory registrars.

**REFERENCE**

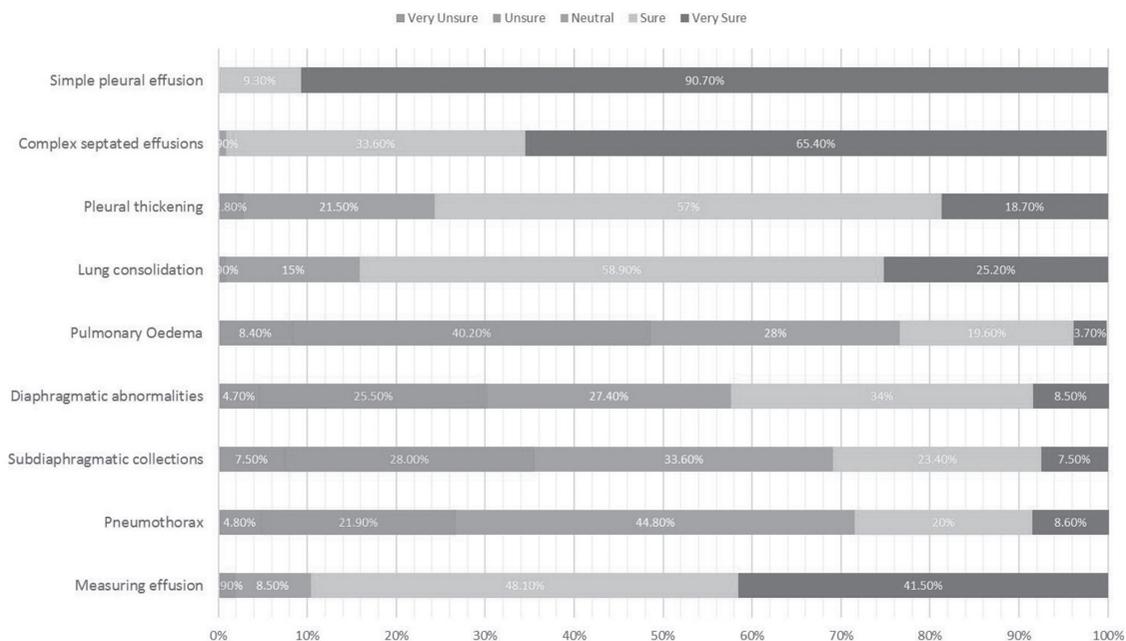
1 The Royal College of Radiologists. Ultrasound training recommendations for medical and surgical specialties. 2nd edn. London: The Royal College of Radiologists, 2012.

**P4 A PROSPECTIVE ASSESSMENT OF THE CLINICAL UTILITY OF INTERCOSTAL ARTERY IDENTIFICATION IN PLEURAL INTERVENTION**

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10.1136/thoraxjnl-2016-209333.147

**Background** Respiratory Specialists perform an increasing number of complex pleural procedures. With this comes a greater focus on patient safety and risk reduction. There is strong evidence that ultrasound guidance in procedure site selection for pleural effusion reduces organ puncture and pneumothorax, but



**Abstract P3 Figure 1** Confidence in identifying thoracic pathology amongst level 1 accredited trainees