Candidate Experience (Glasgow 2016)

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Alhamdullah , God will , I passed from first Attempt, Thank you my young Kid, who prayed for me a lot.

It is not a matter of Skills or much Knowledge, It's a matter of Practice, which will kill your stress and build up your trust.

It is not a matter of Study Sources, just master one book... that's all knowledge you need to pass questions efficiently… If you want me to say one source, I'll say past candidate experience, if you want to know no.2, I'll repeat again past candidate Experience, again and again….

Other sources include: Kanski, OR Oxford, Wong is excellent for Oral Exam, Chua book on website is greatly build your trust, try to test your voice loudly and presentable and slowly.

If you feel deficient, hesitating: join one of preparing Interactive courses for Exam, they will improve your interaction dramatically.

My advice never Rush to diagnosis, describe and describe and describe… Try to Relax as you can, you can't believe how much it helps .. Diagnosis never important, if you say signs and DD is more than enough!!!

And if you were deficient in one station, forget about it, you need to continue your Acrobatic way!!!

1st Day ORAL Exam:

Ophthalmic Medicine: English and Indian Examiner

English Examiner was an old man,

1- he started by showing me an anomalous suspected disc ,

My impression was optic disc pit, he was not happy… I got confused (disc was pink and healthy , good rim), with some prompt I said there's small cupping, mild nasal shift, there was small temporal crescent , may be due to peripapillay atrophy, **Glucoma Suspect**

Then discussion went for management: history, examination, investigation, ttt.

2- Scenario of young lady with slightly dilated left pupil, what is your impression?

I talked about anisocoria for DD till reach **Adie's Tunic Pupil,** Asked about clinical test: pilocarpin 0.125, what else? I said lost deep tendon reflex of Holmes Adies, he said what you can find on slit lamb? I said vermiform movement of light reflex.

3- A pictue of Adenxia and Anterior segment, he gave me history of 22 y old with no history of Atopy… Picture was unclear…. May be follicles or large papillae!!! Keratinization?? May be artifact. Narrow punctum and lost cruncle… I said may be OCP/ steven Jhonson , said what else? I got silent… he asked me about DD of papillary conj.

   Then he said could it be due to drugs?? I said may be **Drug toxicity**... bell Rang… I was not satisfied.

Second Indian Examiner:

1- Showed me Humphry Automated perimetry asked me in details and comment on it.
2- Picture of Infectious keratitis with hypopyon asked about management, He said supposed this corneal infiltrate not present, what is your impression? I said Endophthalmitis, what else? I said uveitis: infectious/ non infectious/ Masquarade syndrome.
3- A fundus picture with extensive exudate alone arcades: with macular edema
   I said DD: DM/ HTN/ RVO, macroaneurysm, capillary Hgioma, Vasculitis
   He said what else? I got silent!! He said what can make extensive exudate? I don't know!! Can it be coat's disease? I said yes, How can you manage, I talked about

history of young boy/ unilateral.. FFA/ OCT.. TTT according to visual potential, if poor and painless just observation, if good for laser/ peripheral cryo/ Anti VEGF.

Bell rang… I was not satisfied at all with this station

Ophthalmic surgery and pathology

1- picture of **full thickness macular hole** red free picture with adjacent OCT :total PVD

He asked about staging, how to manage

What complications of vitrectomy?

What is precaution after surgery (face down/ avoid air travel).

2- **graft with suture abcess ,hypopyon** discussion about management
3- Scenario of **postoperative refractive surprise.** Discussion about other causes of decreased vision.. How to manage this surprise?
4- Decreased vision 4 weeks after cataract surgery. Discussion about CMO (**Irvinn-Gass**).
5- **Rubeosis iridis** DD and management.

Neuro and general medicine

1- Scenario of FFA and fainting DD (Anaphylaxis/ hypoglycemic coma/ DKA/ Vasovagal attack/ cardiac arrest)and how to differentiate and how to manage
   Discussion was about **Anaphylaxis.**
2- scenario of patient 65 y old with recent history of headache and unilateral dilated pupil, causes and investigation
   Stress on **post communicating artery aneurysm** and other surgical cause
   However he was looking also for stroke!!!!

3- Picture of disc swelling in one eye, young female blurring of vision and headache, he want one diagnosis: **Optic neuritis , Multiple sclerosis**.

4- Ocular features of Rheumatoid Arthritis

What if this patient comes with absent marginal tear meniscus?

What investigations?

What differ between 1ry and 2ry schirmer ? Findings?

How can u manage?

5- middle age with CCT 590 um, IOP 17 bilateral cupping

DD??

Features of **normal tension glucoma**

What is neurological lesion associated?? I don't know.. i said MRI

Bell rang and still insists to know!!

2nd day, Clinical Exam

It was a greatly stress day, although I entered relaxed…It passed like a nightmare

And I forgot all systematic examination I learnt

They rush me in a very bad manner.

Posterior Segment:

1- Old man , Examine with 90 D , I saw very hazy view due to cataract and mid dilated pupil

   There were some vitreous strands; NVD inactive, mid periphery was laser marks periphery shows more extensive chorioretinal degeneration.

   Patient was so uncooperative

   He told me examine other eye, I didn't get view... Patient got back and said I am tired

   Examiner said ok ok

   If I told you other eye shows same picture, I said a case of **inactive PDR**

   HE said if other eye shows activity

   I was stressed from patient behavior… I said urgent PRP, + Anti VEGF if there's macular edema, tight control of blood sugar and stop smoking.

2- Middle age female, Examine with indirect Ophthalmoscope, surprise and shocking for me, it was not working, lost some time to adjust it…
   I got just central part view… I didn't gave comment, First Bell Rang
   Oh My God, what this station??!!! (I heared from my collegues later it is a case of **sector retinitis pigmentosa**)

3- Old Lady, Examine Anterior and posterior segment

There was **iris coloboma** and pc iol

Fundus shows large choroidal coloboma

He said examine other eye

There was same picture

He asked me if complete or incomplete coloboma and features of CHARGE syndrome.

Neuro and motility

1- There was a wheel chaired young man with exotropia ou with nystagmus

By motility limited adduction, Ataxic nystagmus in gaze ou

Bilateral INO

He said what you do next

I said optic nerve function as he is young for demyelinating disease

He said what else I said cerebellar signs, he said do it, there was abnormal finger to nose test

What u do for him?

MRI and refer to neurologist

2- Female middle age with left ptosis mild slight dilated pupil

He said do ocular motility

There was complete ophthalmoplegia only in left eye

He said what it can be I said CPEO but it is unilateral so less expected

He said what else I said myathenia

What else said **multiple cranial nerve palsies**

He said where the lesion is

I said cavernous sinus

Asked about causes

Then asked where else?

I said I don't know (I knew later he want Orbital Apex)

Bell Rang…

Oculoplasty

1- Examine middle age man,There was bilateral ptosis with deep upper sulcus

   Asked me what to do next I said measurement, he asked me to do

   Then motility there was limited elevation in abduction bilateral more severe in left eye, And some lagophthalmos

   I said may be congenital ptosis, He said it is recent onset, I said myathenia

   He said How to confirm? I said fatiguability, He said do it, I did I found slight dropping in left eye so i said +ve , He said are you sure?, I repeated again I said I am not sure

   He said what if it is **myotonic ptosis**

   I said yes may be

   He said what to do?? I said shake hand, I did and was +ve

2- A case with unilateral ectropion , he asked how to know diagnosis? I said check fascial nerve functions, it was normal..
   It is a case of **Unilateral Involutional Ectropion!!!**
   It was more medial With horizontal laxity, intact medial and lateral canthal tendon.
   Talked about conservative and surgery (medial conjuctivoplasty, lazy T procedure)

Anterior segment

Unfortunately he was known Aggressive Indian examiner

He asked me

1- Case 1 : She was a young lady said examine cornea

   There was criss cross linear opacities superficial, I said stromal, he was not happy with leveling!! He said examine other eye. There were opacities finer but different shape; I got confused I said may be atypical lattice

   He shouted why u think it is that deep?? I said ok then may be **REIS buckler or Cogan Dystrophy**

   He was still not happy

   Said what your management is, I said I ask about patient concern

   If visual for glasses

   He got angry; do u think she needs glasses with these fine opacities?

   I got silent

   He said what else

   I said if pain and photophobia then recurrent corneal erosions For PTK

   He said directly?

   I said first conservative

   He said like what? I said lubricants and bandage CL and antibiotic and cycloplegic

   He said why antibiotic and cyclo

   I said for 2ry bacterial infection and relieve spasm

   Was not satisfied!!

2- Case2 : Case with deep polygonal grayish opacities , I feel on endothelium

Said mostly fuchs endothelial dystrophy

He got angry, Said endothelium???

I searched hopeless for other things, Found small whitish ill defined lesions on deep stroma, I said may be macular dystrophy?

He said give me one diagnosis

I said **macular corneal dystrophy**

3- Case3 : lower Iris defect with ectropion uviae and dense cataract

He said examine other eye, Was normal

He said your diagnosis

I said coloboma he said if I ask you on phone what u said?

I said may be DD : trauma or surgical

He repeated the question and said it is a case of right eye.....?

I said **iris coloboma**

He said yea, He said complete or incomplete

I said I want to examine fundus

He repeated in aggressive way, Complete or incomplete???

I said incomplete because the lens is not affected, asked about complications during and after cataract extraction

4- Case 4 Unstable AC IOL with tilted to side,Diffuse iris atrophy with correctopa and pseudopolycoria

He said examine other eye

I found same picture but also AC IOL but stable

He said what it is

I said **<u>iridocorneal dysgenisis</u>**

Bell Rang

Never Lose Hope in GOD, he will help you, Exam easy or hard, Examiners Malignant or Benign, you answered one or more cases bad?? Just do your best

Trust in ALLAH….

I wish my experience was useful

Good luck in your Exam inshallah

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