FRCS GLASGOW JUNE 2016

I am Hani Mohamed Gharieb, Ophthalmology lecturer at Ainshams university, Egypt. Thanks God I had passed my final FRCS exam held in Glasgow in June 2016 from my first attempt. For colleagues planning to appear in the Glasgow center, try to travel 3 days before the examination to overcome the jet lag. I stayed in the Victorian house hotel which is suitable and relatively inexpensive as hotels in Glasgow are expensive, at the same time there is a nearby restaurant called "KRAVE" which prepare Halal food with a nice Egyptian working in it.

Regarding exam. Preparation I advice colleagues to study hard for the 2nd part exam. To concentrate on clinical and practical aspects before 3rd part.

Sources of studying:

1- **Kanski latest edition:** is the main source, try to mark the important points to help rapid revision before the exam. Remember every slide in Kanski.
2- **Will's eye manual**: Good for differential diagnosis, and management plans which are important for both part 2 and part 3 exam.
3- **Oxford handbook of Ophthalmology:** Very nice book, if you have enough time read it completely and add some points from it to Kanski, if you don't have time so at least read the differential diagnoses and clinical signs at the end of book, preoperative preparation, needle stick injuries, nystagmus which is very well covered in this book.
4- **Wong:** A must read book, mark the important points (as work up, classifications) to facilitate last minute revision.
5- **Chua eye page:** Amazing site, very important to pass, study past candidate experience (specially the experiences of exams held in your exam. center), common clinical cases, ocular pathology, examination videos, systemic diseases, clinical trials, solve cases as in viva challenge, Oxford eye page.
6- **Surgery:** Any good source, in addition to Collin oculoplastic surgery.
7- **Oxford handbook of general Medicine:** the last chapter on emergency Medicine, in addition to some other topics as infective endocarditis, hypertensive encephalopathy, subarachnoid hemorrhage, foreign body aspiration, needle stick injuries, anticoagulants, DVT, blood transfusion reactions, and any other emergency topics.
8- **OSCE books for revision:** e.g. Case reviews in Ophthalmology.
9- **FRCS cakewake:** Very nice book specially the part on clinical examination

which should be studied by heart.

In the viva exam. Every candidate will get a mark from each of the 6 examiners, one can still pass the exam. with up to 3 fail marks which must be compensated by high pass marks in other viva or clinical stations. In the clinical exam. every candidate will obtain a mark from each of the 8 examiners, one can still pass the exam. with up to 3 fail marks, which must be compensated with high pass marks in other clinical stations (viva high pass marks can't compensate for clinical fails). Every candidate can be allowed to achieve only one clear fail mark in the entire exam. More than one clear fail means exam. failure.

Clinical practice is so important for the few months before the exam. One should attend speciality clinics in subspecialities for which he is not familiar to practice the examination techniques and see different cases. One should train himself for answering viva questions while holding a stopwatch to control his answer with the available time.

Try to travel 2 or 3 days before the exam. to relieve stress. Also try to have short touristic tours in the city, this greatly relieve the stress. Be confident when you answer the examiner, all examiners are supportive. If you are not sure of the answer don't hesitate to say I don't know, it is much better than saying something wrong.

VIVA EXAMINATION 21st June (At Trade's Hall):

*** General Medicine and Neuro**

1st examiner (British examiner):

- Scenario of a lady in the ward after eye surgery developed hematemesis, she has osteoarthritis, pulse 110, systolic B.P. 100, ask about the emergency ttt including cross matching for blood, correlation with osteoarthritis (peptic ulcer complicating steroid ttt of osteoarthritis).

-Causes of transient visual loss, discussion. If the patient has palpitations (do 12 leads ECG, was happy after saying this), if ECG showed AF, discussion about AF treatment.

-Scenario of a patient35 years developed LR palsy followed by MR palsy, DD. Told myasthenia, what systemic disease else !! DM. If the patient comes with productive cough, ?! Myasthenic crisis or Lambert Eaton (told me this is one possibility).

2nd examiner (nice Indian examiner):

-Photo of scleromalacia perforans, asked description, difference between superficial and deep vessels, systemic associations (RA, SLE, Wegner's …..) and ttt (different immunosuppressives, mechanism of infliximab).

-Photo of swollen optic disc with a scenario of sudden drop of vision in old age, discussion about AION, GCA diagnosis, ttt, time for temporal artery biopsy.

-Adies pupil, how to differentiate which pupil is abnormal, diagnosis, pharmacological test, prognosis (good).

*** Ophthalmic Medicine:**

1st examiner (Indian examiner):

-Photo of NPDR, what is the most common causative disease of this appearance, what will you till the patient (including systemic control of DM, other comorbidities), management, investigations(FFA and OCT) , value of FFA (told first to show leakage but told me this can be demonstrated on OCT, when told ischemic maculopathy, he was impressed), ttt.

-Photo of unilateral proptosis, swollen erythematous lids, crusty disharge, orbital cellulitis, other proptosis DD including TED, work up (mainly that of orbital cellulitis and TED being the most common cause of proptosis), ttt.

-Photo with subretinal hge below the disc with macular pigmentary changes, very subtle lines around disc, I started to describe the lines when the examiner paid attention so I became sure, told angioid streaks, complications and causes of visual loss.

2nd examiner (British examiner):

-Photo of fundus pigmented lesion, DD CHRPE vs choroidal naevus, how to differentiate, associations of CHRPE, how to know in clinic (family history of

polyposis).

-Photo of atopic blepharitis, DD, ttt including ttt of ocular associations.

-Patient with intermittent variable diplopia, DD myasthenia, what else (he wants GCA), how to confirm myasthenia, history, exam., ice pack test, how to prepare ice pack?!! Tensilon test, EMG.

*** Ophthalmic surgery:**

1st examiner (Dr Mohan, Indian examiner):

-Picture of lower lid ectropion with punctum laterally displaced, with bilateral involutional ptosis, what type of ectropion(no scar or mass, if lid closure is normal so it is involutional), surgical ttt, how to do horizontal lid shortening, position of punctum after that(need to add MCT plication).

-Picture of huge choroidal melanoma with areas of hge, management, ultrasound findings, source of double circulation on FFA (I don't know, he smiled), ttt according to COMS (he objected on observation if small tumour).

-Photo of a swollen disc with a line of cotton wool spots radiating from it, I asked if it is bilateral, told me other eye normal. I gave initial diagnosis of purtscher retinopathy, he didn't commented but mostly wrong.

2nd examiner (British with very bad language):

-Scenario of drop of vision 4 days after phaco, what signs to search for (signs of endophthalmitis), ttt, what is the value of culture and microbiology as the patient already had injection (for reinjection if no improvement), if sensitivity results for gentamicin told him it can cause macular infarction, he accepted, if not improved after 2 days, call vitreoretinal surgeon for pars plana vitrectomy, told me and, I told and reinjection of antibiotics.

-Types of local anaesthesia, topical, subtenon, peribulbar and retrobulbar, disadvantages of each, complications of retrobulbar injection, happy when said brain stem anaesthesia.

-Photo of lid with ulcer at margin, BCC, histopathology and how it differs from SCC, treatment, excision with margin 4 mm told me what is the value of such large safety margin why not to excise at the edge of ulcer, I told him it may be infiltrating deep beyond the ulcer edge or be of morphoeic type, Moh's micrographic surgery and its

value. How to repair the resultant defect, started according to the size of the defect, he told me it will be large defect, source of tarsus, Hughes flap.

CLINICAL EXAMINATION 23rd June (At Caldonian university):

Orbit and lid station:

-Case of involutional lower lid medial ectropion in left side with bilateral dermatochalasis, asked me the cause of ectropion, by observation no skin scars, no lid masses, I asked to test for lid closure and the examiner allowed me, told him it is involutional, I asked to test for horizontal lid laxity and canthal tendon laxity and I demonstrated them. The examiner asked me about the non surgical treatment for ectropion, if the patient asked for surgery what types of surgery will be done, how to counsel the patient before surgery, what are the complications.

-Case of bilateral yellowish masses under the temporal conjunctiva, the examiner asked me to examine under the slit lamp, DD I told him orbital fat prolapsed, dermolipoma, lacrimal gland prolapsed which he felt it strange. I asked to feel the consistency and it was soft, he asked what is the most propable diagnosis I told him I suggest it is a fat prolapsed because dermoliopma have dermoid element as hair follicles and sebaceous glands. He asked me about the treatment, I replied I will refer the patient to oculoplastic surgeon for surgery, the examiner objected telling me the the condition is mils and may not require surgery so I told him to start with conservative treatment as artificial tears, what is the value, I replied for lubrication. The examiner asked me about the surgery details, I replied I don't know, then asked about the complications of surgery, I told him hemorrhage, infection, or recurrence. He asked why is hemorrhage important I told him it may compress the optic nerve. The bell rang.

Anterior segment station:

-Examiner (aggressive Indian) told me to examine the left cornea under the slit lamp, I found grayish patches with vesicular lesions at their center and Vogt limbal girdle, I

asked him to examine the fellow eye, he agreed, the right eye had a penetrating keratoplasty with aphakia, flat anterior chamber approaching grade 2, strand of iris attached to PKP wound at 6 o'clock, patch of iris atrophy and some Descemet's folds, He asked me what is the diagnosis in left eye I replied posterior polymorphous corneal dystrophy versus Fuch's dystrophy, he agreed. He asked about the cause of flat A.C. in right eye, I replied according to the IOP, he told me what do you think the IOP will be, I replied the Descemet's folds may indicate that the IOP may be soft, he became nervous and told me how low IOP lead to flat A.C. I replied if there is wound leak, he asked nervously do you see any signs of leak in this wound, I became blocked from his attitude and the bell rang *(my colleague in the following group told me that this examiner objected when he told him that the dystrophy in left eye is endothelial so he changed the diagnosis to deep macular dystrophy for which the examiner didn't agreed, I knew later that some colleagues complained him officially in previous exams and he is considered by the college as bad examiner but they replied they have no enough examiners, although he was nice in the viva exam).*

-An Arabic examiner (A. Kamal) asked me to examine the left eye I found peaked pupil with lower iridectomy and an A.C. IOL with limbal wound, he told me to examine the right eye, I found upper iris defect and pupil with coloboma, and an A.C. IOL. He asked me about the diagnosis, I thought of bilaterally complicated cataract surgery, or subluxation of lens, for which he didn't much agreed, then I got it, I told him may be iridocorneal dysgenesis, he immediately agreed, asked me about the different syndromes of dysgenesis, which one do you suggest here, I told him Rieger's anomaly (by exclusion of other syndromes). The bell rang but he asked me quickly what is the complaint of this patient, I replied monocular diplopia, he agreed and told me yes because of the decentered IOL.

I became stressed after this station but I tried to forget what happened to continue the exam. Which is an important advice.

Posterior segment station:

-A British examiner asked me to examine a lady's right eye with the indirect ophthalmoscope, the patient was not well dilated and she was tired and looking down, after insisting on her she looked up and I saw a small patch of bone spicule

pigmentation above the optic disc, the examiner asked me what is your diagnosis, I replied hereditary fundus dystrophy as retinitis pigmentosa, he asked about the other fundus signs of retinitis pigmentosa.

-The same examiner asked me to examine a patient with the 90 D lens, at first I saw a fibrous membrane at the disc, then I saw PRP scars, I also saw yellowish vitreous dots for which I gave DD of asteroid hyalosis versus synchysis scintillans. He asked me about the diagnosis and I replied regressed PDR after laser PRP, he asked me whewre to look for neovessels and if diabetic retinopathy could be asymmetrical or not. The examiner was very happy at the end.

-The Indian examiner was very nice, he asked me to examine the anterior segment of a patient, I found bilateral iris coloboma, pseudophakia, left eye showed retained lens matter on the anterior vitreous (he asked about its name but I don't know). I saw the fundus where I found bilateral choroidal colobomata. He asked me what had led to complicated left eye cataract surgery, I told him associated lens coloboma leading to zonular dialysis and he agreed. He asked me about the danger of cataract surgery in choroidal coloboma patient, I replied the risk of retinal detachment. He asked me the time in intrauterine life when coloboma occur, I replied very early in embryonic life. He inquired about the systemic associations, I told him CHARGE syndrome, he asked about its components. Finally he asked about congenital infection leading to CHARGE syndrome, I didn't remembered. The examiner was happy.

Ocular motility station:

-The first examiner (Dr Mohan) asked me to examine the motility in a young male, I found alternating exotropia, bilateral INO, with paralysis of convergence. He asked me what to do next, I told him to examine the visual acuity, pupil, fundus, he asked me to test for papillary reactions which I found normal. He asked me what to do for such patient, I replied I should consult the neurologist because the patient has a pontine lesion (mostly he wanted to prescribe prisms or do surgery).

-The second examiner asked me to test motility in a middle aged male, he has right

esotropia, the deviation on cover test is less with glasses, he asked me for the reason, I replied I should check the glasses, I found Fresnel prism on the right eye lens. The patient has limitation in right abduction. The examiner asked me what do you expect the right eye vision, I replied according to the duration of squint, he laughed and told me it 55 years duration, so I replied the right eye vision will be poor due to amblyopia. He asked me about other treatment options, I told him surgery or botulinum toxin injection, asked about surgery complications, I started talking about operative complications as slipped muscle or sclera perforation , he stopped me and asked me to examine a third case.

-The examiner told me this lady came to the clinic complaining of diplopia, I saw left severe ptosis, the eye was exotropic and slightly hypotropic. I started to do cover test and found no recovery movement of the left eye. The bell rang, the examiner told me you have 10 seconds to examine the ocular motility, I found limitation in left adduction, elevation and depression while abduction was intact, the examiner asked me about the diagnosis, I replied left third nerve palsy.

The results were announced on the website 4 weeks later during which I mwas stressed because of the anterior segment station in the clinical exam. when I saw my number in the pass list I was so happy. Good luck for all of you.

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