**Marigold *(Calendula officinalis)*** is one of the most widely cultivated plants because it can grow easily in sunny locations in most kinds of soil. The flower heads of the marigold have been used as herbal medicine since ancient time for its wound healing and antiseptic properties. The bright colours of the flowers make them popular as dyes for fabrics and cosmetics. The florets of marigolds are edible and are often added to salad to give it colours. The petals of the flowers are used in lieu of the more expensive saffron. The flowers of marigold contain a high concentration of lutein, a compound that helps to reduce the risk of macular degeneration. Marigold is currently the main source of lutein supplement produced by the health industry.

Dr Sourabh Sharma – New Delhi, September 2017



Hello everyone, I gave my final FRCS examination in September 2017 and passed it in my first attempt. I thank my mentors in AIIMS and Singapore National Eye Center, family and friends for their continuous support in my journey.

**Structured Oral examination**

My oral 1st station was posterior segment

I was showed photo of left fundus with do/flame hemorrages with hard exudates.

I told signs and diagnosis. They asked what pattern – I said circinate

They asked stage then and asked what is the first sign in DR. I said microaneurysms. They asked me to show that. I also told differential radiation retinopathy to which they asked signs/stages.

They asked about pdr and macular edema, next steps, if it was pdr them tx, systemic as well. Number of shots in prp, thickness of retina.

Next pic was optic disc with nasalization of vessels and notching. They asked can I call this glaucoma. I said no, only if it corroborates with visual field. Then they asked what extra thing you will do. Role of oct, to which I told not important in this pt as it had peripapilary atrophy.

Next pic was of angiod streaks. I told systemic associations. Prognosis, prevention from trauma, complications.

Other fundus pic was of 4 yr old child with esotropia (scenario given). Macula had elevated lesion. I thought bests but later she gave hint and I said RB. Then discussion about stage, rx, Ix of RB. One extra question was of genetics percentage.

Another scenario was of myopia od -6 with vit hemorrhage – causes, mc cause, IX (USG if fundus not seen) and why – to r/o RD

2nd station was neurophthal and medicine

ist pic was u/l 30 yr old female with optic neuritis

discussion was on MS, signs, Ix (rapd, colour vision, contrast)

other causes at his age

then rx of MS - ONTT

next scenario was of 3rd nerve palsy – u/l ptosis with diplopia- acute onset

discussion was on types – anatomical and etiological

painful 3rd nerve palsy

3rd scenario was of u/l ptosis in chils – severe 5mm

what would be most imp thing – amblyopia

if chin up position – what does that mean

rx, cornea evaluation, lagophthalmous, bells, sling

medicine question was scenario of AION - GCA – diagnosis- ESR/CRP/temporal artery biopsy, rx

cx of steroids, dose

2nd scenario of what to do in atrial fibrillation

drugs – b blocker – amiodarone

Ix – if no ecg available

Causes, blood ix

Then, complications – embolus/pul edema

3rd scenario was of seizures – 1st step – call for help

then whether you will restrain the pt or not – I didn’t ans that

ABC – drugs

Benzodiazapines

3rd and last station was ant segment and oculoplasty

1st pic was PXF – hoarfrost sign – additional features in eye and systemically

what to do and during cataract surgery

2nd pic was inf PUK – ocular and systemic causes

specially about wegners, nasal congestion – doc – Ix

3rd scenario was of not improvement of vision after 1 mnth of cataract surgery

discussion went to refractive surprise, wrong iol power and mx

next was scenario of chemical injury – steps to do, mx

classification, limbal stem cell deficiency, mx

next pic was subluxation of lens sup

symptoms

mx

causes especially in children – classification of congenital subluxation

mx of subluxation, indicaton of treatment

**Clinical Examination**

My 1st clinical station was oculoplasty and eyelids

* 1st patient was b/e lower lid entropion. I told the diagnosis and grading by knap and Collins and other simple grading as well. I examined pinch and snap back test. Mct and lct laxity, lagophthalmous, dischitiasis

I was asked about etiology. I told involutional. I was asked what other causes. I told others like cicatricial, spastic. I was asked how do you see for cicatricial. I said by looking the conjunctiva. Then, I was asked about mechanisms of entropion. I quickly told overriding of pre septal, lid laxity, no support like in enophthalmous. The examiner asked whats that called. I didn’t know that.

Then, how will you treat. I told jones (plication of lid retractors)

Other options in case of lid laxity Weiss and quickert (if skin laxity)

He asked about quickerts – I said lid spitting in excess skin, rest I forgot.

* 2nd patient I was asked to do spot diagnosis in left lower eyelid

It was a small round mass with loss of lid architecture and madarosis with central ulcer. I said BCC.

* 3RD pt was u/l congenital ptosis

I started with all inspectory findings (face asymmetry, head posture, lid scarring, frontalis overation, absence of lid crease and all)

I was asked whats significance of chin posture – I said chin up in ptosis with clear pupil margin. Then I also told how we calculate the chin posture

I was asked to do demonstrate tests

As pt had frontalis overaction, I nullified its action by blocking it and measured vertical aperture, lid crease (though I told its ill defined but we look at most prominent one)

MRD1was negative, so for corneal reflex I asked for help. The examiner herself showed torch. I said mrd1 is negative. She asked to measure. I was getting difficulty in measuring as I had to block frontalis with ruler and had to lift lid too.

She said I know you know theory (she was there in my oral as well and I answered very well there), and asked to measure again. I did and told mrd 1 was -1mm.

Lastly she asked what other tests I would do. I said to check for lagophthalmous, bells, corneal sensation, tbut schirmer.

She asked me to do bells

I checked and said bells was fair.

I was very scared at this time as I expected me to answer and perform better

My 2nd station was anterior segment

I was asked to examine left eye on slit lamp.

I started telling signs, diffuse stromal edema, epi bullae, DM folds, Aciol, pi, sub ep scarring, 2 buried sutures sup, limbal scar – looked like PBK. I answered that. But examiner said why are sutures there, I couldn’t answer convincingly, then he told I missed another 6 o clock suture. I quickly said its optd lamellar graft (DSEK). I missed the graft.

-2nd patient left eye was going in phthisis with bsk – mostly post traumatic corneal perforation. I answered that.

-3rd elderly pt was fully dilated. Lens was cataractous with sup subluxation. I was also asked to look into iris in particular, superiorly. There was persistent pupillary membrane which I identified. The examiner looked satisfied.

He asked about causes of subluxation – I said age related zonular loss, pxf, trauma, and rest all systemic like marfans etc (unlikely in the pt)

He asked whats most common in this age – I said mostly age related. He asked which quadrant most common. I didn’t know that. He asked mx which I told going into cat op if pt wanted, ctr/cionni to keep in mind. Ant vitrectomy standby if vitreous comes in ac.

Last pt was young male with turban (sikh pt). everything was normal. Then I was looking into finer corneal details when examiner told to look cornea. There were prominent corneal nerves and thinning in center. I said that and told keratoconus. The bell rang. I was happy here that I didn’t miss this last bit.

Overall this station was ok for me. But still I couldn’t get that dsek graft.

3rd station was posterior segment.

I was asked to see left eye of the pt with 90d and slit lamp. I usually use my left hand only to hold 90d. the examiner asked me why not right hand, I said I use left hand only for both eyes. I don’t know whether it had a bad impression but this is what I have always done.

I examined and told that disc was large with large cup with diffuse chorioretinal degeneration with scar near fovea.

I told its myopic fundus with chorioretinal atrohy temporal to disc.

He asked me what are the ocular manifestations of myopia. I told from cornea to retina with choroidal NV, to which he asked what are types of CNV. I answered 3. Then I was confused with peri and parafoveal in between. He asked how to differenciate between active cnv from chronic. I answered FFA to which he said if that’s not available. I answered vaguely here. He asked what will OCT show. Lastly whats the rx. I said antivegfs. He asked any other treatment, which was used earlier. I thought and answered PDT.

Next pt was young with glasses. I was asked to examine 1 or both eyes. It was RP.

I told signs and diagnosis. He asked me what you will tell the pt. I asked I will take VA, full ophthalmic check up, syatemic work up to check if there are any associations. He quickly asked what all. I answered 5-6 of them. The erg and eog as well. He said why eog. Which condition will affect eog. I told rpe dystrophies like best, strargarts, fundus flavimaculatus, pattern etc. In RP, in later stages, both erg and eog are reduced. Early reduction is erg though, I said and b wave will decrease. He said why b. I said initially a as its due to rods/cones, then bipolar.

Then discussion went to genetics. I answered all 4 with prognosis. He said you still havent answered my question of what you will do to the pt. I think he wanted low visual aids as answer and I told that. He asked which ones. I told a few till end stage bionic eye too.

He asked to see the 3rd pt but told time will be less I guess. As the 3rd pt sat, bell rang

This station was ok for me.

Last and 4th station was neurophthal and ocular motility

I was asked to sit and examine a male pt.

On hirshberg, there was left esotropia, reflex was at pupil border, I said 15 deg esotropia. I asked whether I should do cover/uncover – examiner said no. asked me to test eye movements. I did versions first- looked fine except on dextroversion. I asked to check duction, and found right abduction deficit. Left was ok.

She asked me if I am done. I said one more time. I did movements again with alternate cover. She said no cover uncover here. She then said one more test is there, I said convergence. She then asked me to do cover uncover test.

I told about fixation and did the test. She asked whats the diagnosis.

I told left esotropia with right abduction deficit. She said why is there esotropia then, I told its overaction of left MR due to right LR underaction. She asked what is this law – I said herrings law of equal innervation.

She asked Mx, I asked h/o of dm/ht/trauma, examine rest cranial nerves. She said no dm, but trauma is there. I then said imaging. She said everything normal in imaging. I said conservative mx with prisms, if not corrected we can do sx like. I was about to say which sx but they told me to go to other pt.

2nd pt was right exotropia.

I was told to see the pt from far.

I told right exotropia. He asked which test is this. i told hirshberg. He asked how many degress of tropia. I said that its at pupil border, its 15 degress (I cant remember if I said 7 degree or not by mistake). He asked degree or PD, I said degree. He said how many PD then, I said double. He asked me to do confrontation test of left eye. I started with b/e central face testing and gross 4 quad testing, then I checked left eye. He asked whats importance of central testing before. I said to know about gross defects initials, he asked then why to do single eye then. I said to look into quadrant wise losses, he didn’t seem to get convinced.

3rd pt was a boy. I was asked to do pupil reaction testing. I asked whether I should check anisocoria also I dark and light. He said no need.

The mistake I did was not dim light. I performed testing with 2 torches and told about direct and consensual and rapd. It was left rapd with loss of direct and consensual in left. I told grade of rapd too. They asked grading and which is best test for rapd. I said neutral density filter. He said everything u did was ok but you did one mistake, think what. He said you didn’t dim light. I missed that.

He lastly asked what is the mc cause of rapd in this child. I said optic nerve tumour, trauma.

Books/Material to read-

Kanski is a must

Wong’s ophthalmology review is good

Prof Chua website is very handy in basic and clinical examination

I would recommend not to complicate by reading multiple books. These few are more than enough.

All the best to everyone.