

Dr. Babar Anwar Khan's FRCS 3 (Ophthalmology) Glasgow UK Exam Experience --- Muscat Center



PID NO= 39102

Candidate No= 0001

Candidate Name = Dr. Babar Anwar Khan

FRCS(Ophthalmology) Part 3 Glasgow UK

Exam Center= Muscat

Test Date: Viva ---3rd Dec 2016, Clinical ---5th Dec 2016

Aaoozubillahiminashaitanirrajim. Bismillahirrahmanirrahim.

Its truly Said, " The surest way not to Fail is to Determine to Succeed".

Alhamdulillah ,my name is Dr. Babar Anwar Khan .I am working at Adam Hospital,AI-Dakhliyah Region,Sultanate of Oman for the past 6 years as Specialist Ophthalmologist and Head Of the Eye Department in a Government Job since December 2010 .I basically belong to Karachi ,and my homeland ,The Islamic Republic Of Pakistan.

I passed the FRCS (Ophthalmology)Part 3 from the first attempt mashallah and topped among the list of 15 candidates out of total 40 who passed.In my opinion ,it was an easy andvery well organized exam . I took The Jeddah Course of Final FRCS Arranged by Magrabi Hospital Doctors.I offer Special thanks to Dr .Waleed Bader,Dr Tarreq Najjar and the team which gave me tips and tricks to tackle the exam . I think course is very important before appearing in the exams .

I dedicate my success to whole my family members who believed in my efforts always.They include the living legends which are my parents including the role model my Father Professor Dr.Mohammad Anwar Khan(Tamgha-I-Imtiaz) who is very famous Consultant Eye Specialist and Surgeon I my country himself and my belated mother Dr Mrs Tanvir Anwar Khan, my darling,loving and caring Wife Ruqayya Babar Khan and my three little angel daughters Aatirah Babar Khan ,Aroush Babar Khan and Eshaal Babar Khan and my angel nephew Mohammad Taha Azam Khan.

Also my the credit and special thanks go to my only Elder and Caring Sister Dr. Rahat Anwar Khan working as Consultant Obstetrician and Gynecologist at NHS Trust Hospital and is a British National herself who really made an effort to get me the Exam center of Muscat. She went personally with my application from London to submit my Application of the aforementioned Exam directly to RCPSCG

early in the morning and delivered it right on time for acceptance. I would also like to thank my younger brother Mr Azam Anwar Khan(BA,MBA) in Accounts and Finance and his wife Farya Azam Khan who always believed in my potentials as an ophthalmologist and used to encourage me. I would like to Thank my teachers including Dr Vas Dev Hirani ,Madam Razia and my Collegues in Oman including Dr Aftab Ahmed Naser X MOIC Adam Hospital ,Dr Osama the Present MOIC of Adam Hospital ,Dr Omar,Dr Eslam,Dr Moawad,Dr Obaid ,Dr Hanif,,Ahmed Kutti, Haroon,Ali Musallimi ,Dr Najmul Hasan ,Dr Muhammed Jamilurrahman ,Dr Muhammad Idrees, Dr Mudassir ,Ritesh Kumar Gupta, William,John ,Sarfaaraz who always encouraged me . I would like to also thank my neighbors including Mr Afraz,Mr Shahzad,Mr Faisal,Mr Farhatullah ,Mr Asif, Imran for believing in my efforts and endeavours in Studies. My In laws also prayed for me a lot for my success including Ghayasuddin ,Moeenuddin ,Ziauddin,Zaheer Brother,Zahida Sister,Quratul Ain Sister ,Shakeela Sister,and Salauddin Brother.

Special thanks to my very dear colleague Dr .Dinesh who shared Accommodation with me and provided me the peaceful atmosphere so I could study silently at the Accommodation like a library.

Atlast But not the least ,I am grateful to the Head Of the Eye Department of Al-Nahda Tertiary Care Hospital Dr Mariam Al-Wahabi ,Consultant Eye Specialist and Surgeons Dr Rikin Shah FRCS ,Dr Rajeev FRCS, Dr Chandrashekhar MS and Vitreoretinal Surgeon, Dr Abdul Latif Al-Raeesi Chairman Oman Ophthalmic Society,and Madam Farida Al-Baloshi in Neuroophthalmology who focused my preparation in limited periord of time according to the Syllabus and directly monitored my progress and trained me precisely how to perform in the Exam of FRCS and kept retifying my mistakes. They are All leading Surgeons and specialist And nest in the Country of Oman and Master in their respective Fields.

Now I will share my Experience of Viva and Clinical Exam With you people inshallah.

Before I entered Viva or Clinical Exam I read Surah Alam Nashra of Quran Kareem ,Nasrumminallahei Fathun Qareeb,Summussabeela Yassarahu. I am Punctual In Namaz and Read After Fajr Lohe Qurani regularly and Allah Sunbhanaotallah Made This Exam a piece Of Cake For me.

1st Day Exam 3rd December 2017 VIVA:

1st Station 10.00 -10.20 AM OPHTHALMIC MEDICINE:(1st Badge)

First Examiner Britisher:

Case 1: Picture of a white child with pigmented lesions over the face and Blepharitis bilateral.

Whats your diagnosis Dr tell after seeing this picture. I answered its Atopic Dermatitis with Blepharitis

What else it could be . I answered Ichthyosis, Contact Dermatitis,Xeroderma Pigmentosum.Then asked what do you think it could be associated within the eyes . I answered It Can be associated Shield shaped corneal ulcer,Anterior subcapsular shield shaped cataract ,,Vernal Keratoconjunctivitis keratoconus . Mostly what causes keratoconus in this case. I answered Constant Eye Rubbing. What treatment you will give doctor. I will refer to the Dermatologist for skin problem , I will give this patient local antihistaminic eyedrops,Sodium Cromoglycate,steroids for allergy and after ruling contraindications but will do counseling to stay away from allergens ,and not to rub the eyes . I will also tell the patient that although its difficult to totally eliminate this condition but will have to followup with time as it comes and I will try to arrange it . I will also give leaflets and the information to join the internet site on the patients having same disease.

Case 2: Right side mid lateral view of the proptosed left eye of young female patient with chemosis and congestion and also periocular swelling .

What do you think it could be ? I said it looks like Gross pronounce proptosis in the left eye with congestion . Give your Differentials ??Orbital Cellulitis,Thyroid eye disease,Glioma , Meningioma ,Cavernous Hemangioma ,Malignancy. If secondaries would Cause proptosis what are the most common Cancer involving the eye in metastasis.Sir Its Lung Carcinoma in Males and Breast Cance in Females. Do you think Thyroid eye disease could be unilateral ?? Yes dear Sir it can be bilateral as well as unilateral as in this case .Tell me any life threatening complication of orbital cellulitis and vision threatening also. Sir it can cause Meningitis and Cavernous Sinus Thrombosis. Do you thing can it compromise the visual acuity also . Yes Sir in my opinion it can cause mainly too problems in form of either Exposure Keratopathy or By Compression of Optic Nerve . Tell me what Examination or Tests you will do to check Optic Nerve Function Specifically. I said Colour Vision ,Contrast Sensitivity,Pupillary Reactions ,Fundoscopy,Fields Test If Possible.

Case 3: Picture of Right Fundus with a black Round Flat Lesion Above the Superior Arcade of about the Dic Diameter in Size:

Tell me the Differentials:It Could be Choroidal Nevus ,Congenital Hypertrophy Of Retinal Pigment (CHRPE)Epithelium,Choroidal Melanoma,Old Macular Hemorrhage. Tell me about (CHRPE) why you say it this . I said because its flat and overlying vessels are seen passing well. There is also Hypopigmentation at the border. What type of the same disease you can see. Classify it?? IT can be Typical or Atypical CHRPE. Is there any systemic Association Of it. Yes Sir I can remember 4 ,Turcot SYndrome ,Familial Adenomatous Polyposis Syndrome and Neurofibromatosis,Gardeners .Why it cant be Melanoma in this case.Because Sir there is no Pigment like Lipofuscin in it and Its not raised too. But we will have to illicit history Do examination Ocular Exam and Systemic exam and run investigations like Liver Biopsy US etc before coming to the conclusion. Excellent

Thank you for your Co-operation . Thank to you Sir.

Second Examiner Indian:

Case 1: A colored stereo Fundus picture of Left eye

What you think it is?? This is left side Coloured Stereophotograph with good resolution.Whats your diagnosis?Sir its Moderate NPDR with CSMO.Ok .What is CSMO?? I said there are three

definitions. Hard Exudates within 500um of the centre of the macula, if associated with retinal thickening. Retinal Thickening within 500 um of the centre of the macula. Retinal Thickening of one disc diameter (1500um), any part of which is within one disc diameter of the centre of the macula.

Then they asked which type of hard exudate here you see in the macula. I answered these are circinate exudates because they surround the microaneurysms. How you will treat the CSMO. I said that the treatment will be tailored based on FFA findings and OCT. What these will do. I said if FFA we will rule out the ischemic maculopathy and the capillary drop out. Because if it's there it will preclude Grid Laser treatment and prognosis of vision will be already poor and I don't do grid laser then. Examiner was nodding his head and seemed convinced. He then asked how you do the laser and gave me a pen from back side to tell how I will do it. I answered in my practice I will do grid by first lining the boundaries one burn apart causing greyish white burns under the arcade and avoid hitting fovea and will use the chart given in the manual for the appropriate spot size, duration and power. Spot size will be kept at 50 um near fovea and should avoid the papillomacular bundle and the fovea directly. What you will do with circinate exudates. I will burn microaneurysm with focal laser. They didn't ask unnecessary questions as they mostly keep giving hints and ask simple questions and we should avoid landing ourselves in trouble by extra answering.

Case 2: Fundus Fluorescein Angiography picture with only the anomaly showing above the upper arcade.

What is this Doctor?? It is Hyperfluorescence. Which type of hyperfluorescence doctor. I said it's the leakage from new vessels. What else you see? There are saccular pouches seen which denote microaneurysms. Good. What else??? I cannot see any other abnormality in it Sir. Which phase you think it is. This is late Venous phase Sir. Fine.

Case 3: Coloured Stereo Fundus Photo with Disc Hemorrhage and lines emanating like spokes of wheel from the disc. There was a semilunar tear in on the lateral side of the macula perpendicular to the line arising from the lateral disc and reaching the macula with hemorrhage.

What you see in the picture?? Sir this is subretinal hemorrhage near the disc. How you know its subretinal or Subretinal Pigment Epithelium hemorrhage. I answered former is bright red and latter is dark red. I explained that these are the angioid streaks and they are prone to develop break in the Bruch's membrane and so the bleeding could be possible. Yes but this whitish sclera seen through scar is not following the streaks what do you think could be. It was a bit tough case. I answered well its possible that the patient had a choroidal rupture due to blunt trauma or Road Traffic Accident and the lesion near the disc is bright red due to optic disc avulsion and vessels avulsion, whereas that dark red near the macula could be due to rupture of the Bruch's from the fragile angioid streaks already plus the choroidal rupture laterally to the macula. No. Quickly give me some differentials: Pseudoxanthoma Elasticum, Ehlers Danlos Syndrome, Paget's Disease, Sickle Cell Disease, Idiopathic, High Myopia, Acromegaly. Examiner said Excellent. I had great courage and feeling after my first station. The bell rang and I thanked the examiners. They were smiling and happy Alhamdulillah.

5 minutes break - British Co-ordinator Asked all Candidates to come out of Hall and wait and then enter when they tell.

2nd Station 10.25 -10.45 AM OPHTHALMIC SURGERY AND PATHOLOGY:

First Examiner Indian:

Case One: He gave me the scenario of a 55 years old Male 4 days ago underwent Cataract Surgery develops pain and redness with discharge and blurring his vision ??What do you think it could be ?? It can be Post Operative Uveitis ,Retained Toxic Lens Material,Post operative Endophthalmitis. How Will you manage Post Operative Endophthalmitis ??I will Take History and Check Notes Of Previous Cataract History ,Duration Of Operation,Any Complication or Inadvertent event if Happened. I will Do the Complete Visual Assessment including the VA,Pupil Reactionand Slit Lamp Examination. I will Check For Loose Sutures ,Conjunctiva, Cornea for interface and AC for Cells and Hypopyon ,Vitreous Show,Rented Posterior Capsule Capsule. I will check for Vitreous Show OR Wick all to rule out other possibilities.Then I will do IOP Check and will try to do fundoscopy if Possible.I will check corneal Sensitivity. I will try to find any leakage with Seidel's Test and also any corneal Surface Problem and will Check TBUT. I will Run some important Tests like Conjunctival Swab for Gram Staining, Culture and sensitivity. I will do Aqueous and Vitreous Tap and Take Samples FOR Gram staining Culture and Sensitivity. All Cases you will do this or is there any line of Action . I said That Basically there is a study Known as Endophthalmitis Vitrectomy Study . According to it if the Vision IS PL Vitrectomy is Indicated . Rest of the case with Hand Movement and better vision is for Earlier stated Line Of Action Until the Results OF the Test Specify the Particular Organism to focus On its treatment . Which antibiotics are Given . We give intaviteal antibiotics Like Vancomycin for Gram Positive ,Amikacin and Ceftazidime for Gram Negative Cover. Examiner Nodded Head and was please.

Case 2: There was Anterior Segment Photograph With a mass over Greater than half of the lower lid in the Patient's Left eye.

Yes Doctor describe What this Is?? Sir this is the colored Anterior Slit Lamp Biomicroscope Picture Showing a mass in the lower lid with the cater in the middle and rolled edges with Surface Vessles. Its Involving greater than half of the Lid and lower punctus is spared. There is colour Changes and also Madarosis .The Crows Feet Indicate that Patient is Elderly . Whats your Diagnosis So doctor. The Picture gives Diagnosis Of Basal Cell Carcinoma . How Will you Treat it and What's the principle. Sir 4 mm of Extra Margin will be taken and Surgical Excision with Biopsy will be done .Per Operatively Frozen Sections may be seen or Moh'ss Micrographic Surgery to Ensure Complete removal Of the Tumor . But Doctor Then what you will do of the Defect created After its. I explained as its Greater than Half Defect is there so Anterior And Posterior Lamellar Reconstruction should be done with one side as a graft or and the other Flap ensuring Not to Compromise the Blood supply. In my Clinical Setting I will do the Cutler Beard procedure . The Examiner seemed Convinced and didn't ask Further Question .They Always try to help you rather than asking indepth Questions as time is short .

Second Examiner Britisher:

Case 1: Can You Tell me type Of Local Anesthetics Available for Ophthalmology??

I said Intracameral,Topical,Subconjunctival,Subtenons,Epibulbar,Retrobulbar,Regional like Facial Block and Infiltration Anesthesia.What are the Complications ?? I said Heart Block And Respiratory Depression.Does Hemorrhage Occur ??? If Retrobulbar Anesthesia is given it causes Retrobulbar Hemorrhage which is Managed with Lateral Cantholysis and Intraocular pressure reducing medications and some times Honan's Baloon or Tennis Ball with Sterilized Cap is Used Surgery Postponed . Which Type of Anesthesia You use In the Cataract surgery in your Setting . I told That I give facial Block with O'Brien's Technique and Vanlind Infiltration Anesthesia and Epibulbar as I am more Good at doing Extracapsular Cataract Extraction rather than Phacoemulsification .So please

Don't Try to Play With them . Say What you Know . We Cannot fool the Examiners Around. They Are Clever.

Case 2: An Anterior Segment Coloured Slit Lamp Photograph With Left Eye Severe Ptosis And and Lower Lid Ectropion. Patient's Age was 60 Years they told . Whats the Lesion??

I said It the Coloured Anterior Segment Slit Lamp Photo with showing Abnormality in the left eye .What Dignosis in the lower lid tell fast .Its Ectropion Sir? What are the methods to Diagnose and treat ectropion.

I said there a many Procedures. Basically there is problem with the lower lid Laxity and Medial or lateral Canthal Tendon Laxity . So some Tests are done by Pulling Away Lid From the Globe and by seeing the position of lower Canaliculus with respect to limbus or pupil and then according to the Severity the Surgeries are offered. Also Tarsal Atrophy is checked by Palpation and Lower lid retractors are checked by askingn the patient to look down.Name Some Procedures?? Medial Conjunctivoplasty, Bitz procedure, Kuhnt Zymenowsky Procedure, Blepharoplasty, Lateral Tarsal Strip , Tarsorrhaphy , Plication OF medial Canthal Tendon etc. Whats Bitz procedure. Sir I havent Done it myself but I know that we do Horizontal Lid Shortening . What you will do of this Lid then?? Sir I will opt For Frontalis Brow Suspension With Fascia Lata sling. Examiner looked Satisfied with my Answer.

Case 3 : Colored Fundus Photo with a dark Mass from behind the pupil covering from 12 to 4 o'clock Obscuring the view of the Macula and Exudate On the surface on corrugated smooth surface It Seemed anterior to the Equator and too far from the Disc.

What is Differential? Melanoma , Retinoblastoma, Suprachoroidal Hemorrhage? What is the Diagnosis ?? Sir two Questions only I want to Ask. Whats the Age and IS there any history of drug use or Intraocular or Extraocular Surgery Done or History OF trauma . Age is 55 years and is male . No History as you said . Sir the diagnosis is Choroidal Melanoma pigmented . Which Tests you do to Dignose . FFA for Dual Circulation . Whats is Dual Circulation . The Feeding Vessels Of the Tumor Will interrupt with the normal phases of Angiogram and with will not follow the Normal Pattern . What else Test. A and B scan Ultrasound . He didn't Ask ABOUT what you See in it . HE asked What Else Tests are required for Choroidal Melanoma . I said Sir Liver Biopsy and LFTS as its primary Site Metastasis . PET or Bone Scans could be done too. HE was nodding his head. HE asked me about Treatment . I said the Treatment will depend on site and Size OF the Tumor and patient Wishes and Fears . What are Options then ?? Brachytherapy , External Beam Radiotherapy, Transpupillary thermotherapy with Adjunctive Chemotherapy, Enucleation . Whats Brachytherapy. I answers that radioactive Iodine is used with the plaques which are attached to the episclera to produce internal affect and tumor Shrinks . But near macula Not Done. What else is there, the treatment the bell rang he said common tell me . I at last said Anterior Choroidal Resection (Choridectomy) which I will do in this Case as the tumor is anterior to the equator. I thanked the Examiner as the Station Finish . I became More Confident Now . As there was only Last Hard Nut To crack Left for me Alhamdulillah .

5 minutes break-British Co-ordinator Asked all Candidates to come out of Hall and wait and then enter when they tell.

3rd Station 10.50 -11.10 AM GENERAL MEDICINE AND NEUROLOGY:

First Examiner Britisher:

Case 1: Hello Good Morning I am going to give you Scenario and this is the piece of paper and pencil . You can write it down not to let you forget the information I provide you.

The patient almost 24 years old came with complaining of noticing in the mirror of his right eye deviated externally for the past 4 weeks . But now he has also noticed deviation in the left eye what do you think has happened to him?? Give Differentials? Myasthenia Gravis, Orbital Myositis, Eaton Lambert Syndrome. Just think some endocrinological cause doctor. Yes Sir Thyroid Eye Disease Or Thyroid Related Orbitopathy causing Restrictive Myopathy.

Case 2: A patient is awaiting for DCR surgery 55 years old male with Osteoarthritis History on Oral Medications. A nurse Reports You That the patient all of a sudden has hematemesis and vomited blood. The nurse tells you the vitals as Pulse rate 110 and Systolic blood pressure under 100. Tell me what's happening to the patient and how you will manage ??

Sir the patient is under Hypovolemic shock due to Loss of blood and Upper GI bleeding. As patient may be using NSAIDs could cause perforated peptic ulcer . Without Wasting Time I will Notify the Emergency response Team at the Hospital at provided number . I will rush towards the patient taking an assistant nurse. I will assess the airway Breathing and Circulation . I will Ask the Nurse to attach Patient to the monitors including ECG, Pulse Oximetry, and arrange 2 wide bore cannulae in the arm and run some important investigations like FBC, Electrolytes, Clotting Profile, INR levels, FBS and start giving crystalloids almost 2 liter instantly without delay. I will also order for cross matching 6 units of Blood and Will keep Fresh Frozen Plasma and Vitamin K at hand to be used after consulting the Medical Internist or A and E doctor. I will ask nurse to pass catheter and maintain Urine output at 30 ml /hour and CVP lines adequately as mentioned in the chart. By this time the competent medical Internist or Emergency Response team may have arrived and at All times I will be carrying BNF in order to check the proper dosage of medications as required. I will try to shift the patient with team doctors and Nurse to the Intensive Therapy unit and will also Refer to the Vascular Surgeon about the Bleed as it could be a major Bleed. I will hand over my patient in safe hands of the expert A and E department team and will keep taking feedback from them and will postpone the surgery

Case 3: The patient with Myasthenia Gravis has started Gaspings and breathless difficulty like choking is there with changes in voice what causes this affect ?? The bulbar Palsy.

Case 4: Patient has transient Loss of vision for some minutes in one eye and is young patient . What is this called?? Amaurosis Fugax . What History You Would Like to Elicit in this patient and in eye what can be the complication . I answered we will look for valvular heart disease and It could be related to Arrhythmia . Complication can be like retinal Embolism .

Case 5: Patient is a heavy truck driver diabetic since two days is having binocular diplopia and the right eye noticing is exotropic. Diplopia is disturbing him now . He comes to you Complaining . When you examine his 6/6 vision Both eyes . How will you treat and What Advice you Give . Give one solution . Its Patching or Occlusion of the Deviating eye and informing the DVLA (Driving Vehicle Licensing Authority). Examiner Nodding his head and shifted me towards other examiner . I thanked him .

Second Examiner Indian:

Case 1: A coloured anterior segment photo of the eye with elevated upper lid in the right eye and a bulge over the upper conjunctiva adjacent to the cornea

Describe this Picture for me : Its the coloured Anterior Segment Photo Taken with slit Lamp Camera in the right eye showing thickening of the superior conjunctiva and having Anterior Staphyloma due to Bulge. We can see through the Ciliary Body . Whats your Diagnosis . Its a rare entity and comes in the category of Anterior Necrotizing Scleritis .Its called Scleromalacia Perforans.Whats is cause Dr. Its cause is Vascular Occlusion Sir. What Treatment you will give . I may give Systemic Steroid But will avoid Periocular Steroids as it may lead to melting and perforation of the globe. Which other complications can occur in the eye ?Dry eyes and Phthisis .What else you could give . We can give immunosuppressive therapy like methotrexate,cyclosporine,mycophenolate Mofetil etc. What will you do at the place where this defect is causing staphyloma . Sir We can use Scleral Patch Graft. Tell me three disease which include collagen Vascular disorders and can cause Scleritis.Wagners Granulomatosis ,Relapsing Polychondritis,Polyarteritis Nodosa.

Case 2 : A patient has unilateral Anisocoria and has noticed that the right pupil is larger than the left . What Could be the causes?? Third Nerve Palsy,Cyloplegic eye,Adies Tonic Pupil,Traumatic. How will you Diagnose the Adies Tonic Pupil. Sir I will Light and Dark test in Ambient Illuminated room Facility .The Adies Pupil is Dilated in the Dark as well as when we shine torch light over it. I will Check for Light near Dissociation By Asking Patient to look Far and then towards the near target held at 35 cm . I will do slit lamp exam to check the Vermiform Movement of the Iris . If knee jerk reflex is absent it will be Holmes Adies Syndrome . I will Pharmacologically Test the Adies Pupil with 0.125% Pilocarpine the Adies Pupil will Constrict due to Denervation Supersensitivity.

Case 3:Coloured Fundus Picture with the Pale Optic Disc Swelling and blurred margins ,Splinter Hemorrhage ,Macula Not Shown ,Tortuous Vessels

Quickly tell the Differentials. I said Arteritis or Non Arteritis Anterior Ischemic Optic Neuropathy,Toxic Optic Neuropathy Due to Medications ,Alcohol Or Nutritional Amblyopia,Space Occupying Lesion Like Tumor,Drusen if the splinter hemorrhage wasn't there .Bell rang.I thanked the Examiner and left

So that's how it went . I was Satisfied with my Performance Mashallah.

On 4th it was off

2ND Day Exam 5TH December 2017 CLINICAL:

There were interpreters available in each room and they said that if you want to give command to the patient please tell us . SO even if you know Arabic its useless because you will become dependent Inevitably .

1st Station 10.00 -10.12 AM ANTERIOR SEGMENT DISORDERS: (1st Badge)

Case One : Slit Lamp Examination of the Patient with the Right eye Keratoplasty Done and the Left eye Keratoconus .

The Indian Examiner asked me to examine Right eye first and comment what I see at every time . I checked the Eye piece and illumination system first and then put the magnification to 6x to have a broad view. I started seeing and telling The conjunctival is normal . There is a corneal Graft in the right eye and there are 360 degrees interrupted stitches in the graft. There is no rejection nor the cells in AC Pupil is regular round and reactive . I took permission to evert lid but examiner said its ok no need . Then He asked me to Examine his other Eye . I with Oblige Illumination say Vogt's stria there was a pipe attached with all slit lamps with which they were monitoring our technique. I checked for Reizittis Sign which was also Positive . I asked I would examine with blue light . Why doctor?? . I will check for the Fleischer Ring which are iron lines at the base of the cone . I could not appreciate any and told the examiner . He said Its ok. Now quickly he asked me questions as to which tests I will do to confirm that its Keratoconus. I said Oil Droplet Reflex with Ophthalmoscopy, Scissor reflex with Retinoscope. Munson's sign from behind the head standing and observing the bulge over the lower lid Autorefractometer or Keratometer for K1 and K2 reading. Corneal Topography which will establish it . Placidos Disc to see the mires. Specular Microscopy and Pachymetry. Very Good.

Case Two: Slit Lamp Exam of the patient with failed trabeculectomy and a valve implanted inferonasally . I asked to look down to observe the Bleb . It was of moderate Height but Diffused. I couldn't appreciate the PI . I kept explaining it to the examiner. I asked the patient to look up and mentioned to him that this patient's footplate of the valve is buried under conjunctiva . The lower lid was actually covering his valve apparently so if I wouldn't have asked him to look up or pulled the lower lid down I may have missed it as it was subtle at 5.30 o'clock. No other problem in this patient. Only one eye had to be examined .

Case Three : Asked to examine on slit lamp Both eyes of the patient only anterior segment

Right eye there was AC IOL implant with rented posterior Capsule and left eye there was Pseudophakia with PC. IOI Implant The British Examiner Asked me the Reason Why had to Place the AC IOL in the right IOL . I said That there may have been any iatrogenic Complication while placement of the Lens into the bag and like posterior capsule may have become rented . What other possibility ?? Also its possibility that the IOL previously placed may have been dislocated because of the trauma into the vitreous and posterior capsule may become rented . So in either case then removal of PC IOL and according to the suitable lens formula the secondary IOL placement was done . The examiner got happy.

Case Four: It was a young short statured girl and the examiner Britisher gave me his command to just do the Anterior Segment Slit Lamp Examination:

I saw that Both lenses are subluxated Superiorly and are cataractous too . Pupil was mid dilated and vertically oblong in both eyes . What Else you see doctor. I see the Zonules . HE confirmed in the Pipe attached to slit lamp I focussed through slit lamp and pinpointed so he could know what I am seeing. What Diagnosis you think . I said its Weil Marchesani Syndrome but IN this case the subluxation is superior rather than inferior or anterior. He asked why is subluxation . I told Sir because Zonular Apparatus . There was also Iridodonesis and I told him . He appreciated . He further said that this case is due for surgery . Which type of cataract surgery options you think be available. I said Phacemulsification with capsular tension ring , Intercapsular cataract extraction if capsule intact or Lensectomy through Pars plana vitrectomy or through corneal incision and Extracapsular cataract extraction with Scleral Fixation Lens or other option is the after removal of the lens Contact lens could

be placed to address inisekonia . ok . Nodded head and bell wrang. I thanked the Examiners. And left the cabin

Agin the first station build my confidence and I prepared fot the next station .

2 minute break only

2nd Station 10.14 -10.26 AM POSTERIRO SEGMENT DISORDERS: (1st Badge)

Case 1:

A smart young Britisher Standing already and with indirect wireless Ophthalmoscope in his hand greeted me and asked me whether I know how to operate it and then commanded me that see the patient s inferiro retina of the right eye only . I asked only Inferiro Sir or am I allowed to see the disc first as a rule .Ok Go ahead as you feel. I picked up the 20 D lens and asked patient to look down. Here please watch out the candidates need not to remove their vision glasses to see the fundus through this instrument . Keep wearing the specatacles and place the indirect head mount over it.adjust its eye piece.I lowered the illumination and saw the optic disc. Inerionasal to it was a punched out scar looking like coloboma but I didn't say . There were blackish Scars there inferiroly and . He asked me common tell what you saw. I say Peripheral black Marks . What if could be ? its possiblity that repair of the retinal Break has been done and Barricade tretmanet scars are these which I have seen . What else . It Could be Long standing retinal detachment with subretinal hemorrhage and is hemosiderin deposit. What else. Its could be Peripheral Retinal Degenerations .Tell the other last one . I said could be marks of Cryotherapy done previously for RD . You have seen the disc. What is whitish lesion near it?? I said it Looks like Choroidal Coloboma .IS it related to any anterir segment defect . I said yes it may cause inferionasal Iris Key hole defect like,Coloboma of the iris,coloboma of of the lens and ciliary body too. He then asked how histologically you would distinguish between the coloboma and the Staphyloma. I said in staphyloma the tissue will not be absent and will only bethinned out due to bulging at the posterir pole and location may vary whether involvement of optic disc alone ,macula alone or both together at the posteriro pole . Whereas the Uveal Coloboma the tissue will only be absent and will be lack of retina and choid with sparing and non bulging of the sclera.

Thats perfect . Doctor please give some differentials of the Chorioretinitis . Ok Sir it can be Histoplasmosis ,Toxoplasmosis , Birdshot chorioretinopathy ,Cytomegalovirus retinitis ,Laser induced or cryo induced.Thank you and passed me on to the Britisher Examiner who was waiting with two patients over the slit lamp.

Case 2: The patient was young male adult with divergent squint in the right eye . The examiner asked me to see the fundus of the Right eye quickly and do commentary and then the left eye also.Starting with the 90 D Condensing Lens Present over there I Started saying with respect to the right eye that the disc is pale and there is a flame shaped hemorrhage near the inferiro margin of the disc. There are PRP old scars ,Ghost vessels seen and vascular attenuation . Macular reflex was obliterated too and there was Epiretinal Membrane also . At some places still I could see new dot and blot Hemorrhage but over all fundus was pale. Whats the Diagnosis?? I said is the Post Laser status of High Risk Proliferative Diabetic Retinopathy ?? He Asked in the Macula which type of Epiretinal Membrane is this . I said the picture is Hazy I tried to look for tortous vessels or Pseudohole Formation also but I couldn't appreciate. Then he told me to move to the left eye of the same squinted male adult . While

trying to adjust the slit lamp I quickly saw the Anterior segment until Lens through dilated Pupil to Have an Idea what may Be expected. I am mostly very good at 90 D so in no Time I was able to Judge that there is nothing I could see. Examiner asked me what to you see. I said I am unable to see the fundus . SO now Whats your Diagnosis .I said its Type 1 Diabetes. I said It Could be Advance Proliferative Diabetic Retinopathy with Vitrous Hemorrhage or Vitreous Hemorrhage with Tractional Retinal Detachment. How will you Know in the Left eye about the Stage . I said I will check any previous Notes of the patient and if the Serial Exam Followup report is there it will tell whether any treatment earlier was done or not . Also I will do B-scan Ultrasound to Look For Vitrous Hmeorrhage and subtle Tractional Retinal Detachment .Do you think the Diabetes is Controlled. I said Looking at the Condition Of the Squint and Status OF fundus Looks as uncontrolled but I would Like to Elicit Complete Clinical History From the Patient and It wil depend on the risk factors of the patient also. The Examiner didn't Ask me which Test you will do to Confirm that the Diabetes is controlled or not . So I myself didn't say HBA1c therefore. We have to be precise as to what they are asking . We cannot beat about the bush.

Case 3: An Obese Male about 35 years of age with His Posteriro Segment to Examine with 90 D. When I saw his fundus There was Gross tenting going from the Dis Towards the Macula and inferirly there was Preretinal Hemorrhage . Macula was off. I couldn't see any Break nor Vitreous Hemorrhage . There were no LAser mark in this left eye . He then Asked me can you compare this case with the patient earlier seen . I said that this Fundus its obvious that There is TRD and High Risk Changes are also there SO I will Stage it also as Advance Proliferative Diabetic Retinopathy But of course in Type 2 Rather than type 1 . In the Earlier Case in the Fundus As I said Because of the Vitreous Hemorrhage whther surely its only Hisght Risk Or their May be occult RD which need to be rules by History Tests like B scan or Old records.The Examiner Became Impressed and Nodded His Head with a good gesture as he was convinced . Thanks to Allh Second Station Also Smoothly Went Away.I was more happy by now.

2 minutes Break

3rd Station 10.28 -10.40 AM NEUROOPHTAHLMIC AND OCULAR MOTILITY DISORDERS: (1st Badge)

Case 1: There was a young form 13 to 14 years age female Teenager . The Examiner Commanded me to Observe first and then do Commentary . The PAteints there wasn't need for talking as they were pre-consented for permission to Examine . SO I started sayin This is the Young Teenager and Has her head Tilted towards the right side. The Examine then made Her head staright so I said well now its staright I don't See any abnormality from 2 metres distance Ecept that she was using very thick Glasses which I asked the Examiner I would Like to see. The PATient then handed over her Glass quickly and I over the Edge Of the Table Saw that the Image of the Eye was Moving Against In both eye Glasss and they were Heavy And thick Also .I also Saw which I told On removing the Eye Glasses that there Was a gross Convergent Squint Of the Right Eye . But with Glasses was becoming Better . There was a chair on which he offered me to Sit and get closer to about a hand distance or One metre. Then I saw that the Patient and told That there is bilateral Horizontal Pendular Nystagmus . I said I would like to see in the slit Lamp to Confirm the Direction ,Amplitude and Frequency Of the Nystagmus BUt the Examiner said not needed . Do extarocular Motility Test. I did it with the Glasses on as time Was short the Thick Glasses gave me clue that almost the vision both eyes may be the same and it will never be 6/6 . On Extraocular Movements I only Checked for Versions and no time I had for Ductions . ON the Extreme Gazes the Pendular Nystagmus was becoming Jerky in Both Eyes and there was also restriction In Dextro and Levo Elevation and Dextro and Levo Depression.I kept Telling What I was seeing. Then I said I will check for Saccades and Persuits. I took two Pens out of my Pocket and Placed Up and down Right and left and asked the Interpreter to tell the Patient to Switch the eye from one target to the Other It was disturbed Saccade . Then I asked the Patient to try to keep the eye fixed to a target the BAcK Top Of my pen and Made the Circle Infront of Him And me In Air

and the Plus Also to mention to the Examiner that Pursuit Is Disturbed Too. I said Ideally I would Like to rule this Out With the Catford Drum . There wasn't Any. Then He asked What you Think IS the reason For Nystagmus . I said Could BE Congenital Cataract Which HAS been Operated and so using Aphakic Glasses but without atleast Torch Light or Slit Lamp I wont Confirm It . In the Context of the Thick Glasses and Right eye without Glasses Convergent and With Glasses No Squin I would think of Accomodative Refractive Esotropia . Why you say this . Because The Picture without torch Light Exam and Slit Lamp In the Context of the Right eye without Glasses Gives a clue that There may be Good ,Moderate vision or Poor Vision in One eye ,Which Only After Seeing the History of Previous Checkups and Maternal History and Childhood History and After Detailed History Orthoptic Assessment and Visual Examination Will lead to Conclusion . OK How you will Treat the Nystagmus ?? We will refract the Patient and Give the Glasses and It will be tailored according to the needs . We will Counsel that the Vision Will remain Compromized For Ever and may not reach until Last Line .We will Give the address of the Site OF the Internet and useful . If the Vision IS low Will Give the patient the Address of Low Vision Aid Department and will arrange Followup For Him . Doctor You you Know Any surgery done for Nystagmus . Yes I have read About Kestenbaum's Anderson Procedure . Thank you so much Doctor and Then Shifted me towards Other Indian Examiner .Tall and Having Beard.

Case 2: An obese young Lady . The Indian Examiner Commanded me to Do the Pupil Examination . I took Two Pen Torch Light . I checked for Anisocoria in Light and Dark . There Wasn't Any . I checked for Direct and Consensual Light Test in the Dark light . Direct and Consensual Light Reflex was Positive . I kept doing Commentary Like Wise. I checked for Light Near Dissociation . Also There Wasn't Any BY asking the Patient to Look at the Snellens chart ahead and then Bring Before the Patient the Target at 35 cms .There Wasn't Any. The Examiner Asked Me what Else you wil check For . I said I would Like to do Swinging Light Test to Check for RAPD. There is moderate RAPD in the Right eye Sir. SO now what you will Do. I said in no time I would Like to see Fundus With 90 D condensing lens . Both Examiners were very respectful and one turned the Slitlamp Towards me to let me do funduscopy . I couldn't ever Imagine that the Examiners will be so cooperative Giving Clues and Willing to pass if as Dr Waleed Bader in the FRCS Comprehensive Jeddah Course Exam aid Until We are ourselved Landing into the trouble . I Justify it was very right . I did funduscopy of the involved right eye when they said look in the fundus of the right eye . There was Otic Disc Edema and Blurred Margins with Tortous and Dilated Vessls . Macula was Clear. I magnified the Slit Lamp to have more closer look and found Loss of Venous Pulsation on the Disc. I told Him There is Disc Edema . He Said to me Try to look at the left eye also . As I am used to see the Fundus with the constricted Pupil . Very soon I was able to see that the left eye disc also Sectorially was raised . Venous Pulsations I couldnt Appreciate . So Doctor, What You Saw and what are Differentials . I said It could be Pseudotumor Cerebri (Idiopathic/Benign Intracranial Hypertension), Could be tumor, Non Arteritis Anterior Ischemic Optic Neuropathy, Nutritional or Toxic Amblyopia ,Pipillitis ,Neuroretinitis, Systemic etc. The bearded examiner Smiled. By that time Bell rang and I Thanks to Allah More in my Heart By Now 3 Stations I did Well If Last One Also I perform Well I may Pass inshallah . I had this Feeling.

2 Minutes Break ---I was Reciting Holy Quran AlmanAshraLaka Sadrak and Summussabila Yassarahoo and Nasrumminallahe Fathun Qareeb. I say One Middle Aged Man having on his left eye Abnormal Mass with left eye completely shut because of it entered the room I was going to go finally.

4rd Station 10.42 -10.54 AM OCULOPLASTIC AND LID DISORDERS: (1st Badge)

Case one ----- Indian Examiner

After Introduction instructed me to Observe at 2 meters and Examine the Left eye of a young Girl. Also Told me to do the Commentary as what I see. I said that there is ptosis of the left eye on Observation and Palpebral Fissure Narrow . Eye Look Phtysical But I would like to Examine in slit lamp and open the eye and see inside the Eye Ball. He then Let me Examine the Left eye . I open the eyelids gently and Could See that small eyeball is there without Cornea. There was Orbital Volume atrophy and small extraocular Muscles attached to the Globe . Movements I checked to See if it was there and the eyeball was moving back and forth although restricted . Then Examiner Asked That what you think It is Phthisis or Atrophy or Enucleated What It is. I said that It could be either But He didn't let me do the Slit Lamp Exam Neither there was any adjacent Prosthesis I could see. HE gave me a clue that you said that there is no cornea right see it again so what it could be . Sir Can I ask two simple Questions . Is there any History Of childhood Penetrating Injury OF the Glabe and Has she ever been operated in the Eyes . HE said Yes to Both . I got the clue and Said that It is possible that the Evisceration was done and the Surgeon Implanted the Implant In the Eye ball . He BEcame Happy and Nodded His Head . It was a strange Case. What Is your Diagnosis Then . I said Post Enucleation Socket Syndrome . There Is shortening Of Fornix . Ptosis ,Deep Sulcus and I further palpated the eye over the lids to check for Tarsal Atrophy. I didn't Discuss about the peg as in Evisceration as a suspect I thought better not to mention this word peg to let examiner annoyed. The Examiner didn't twist me unnecessarily. He asked for the Left eye which question will you ask and what suggestion you will give. I said for the eviscerated and implanted eye I would like to counsel that the vision may never come back however we can help her with the prosthesis and there is the special Department for this where it may be possible the Oculoplastic Surgeons will have to do different surgeries for Cosmesis . The Eye Colour And Size will be ,matched with the normal Eye and we will refer to the patient educationist to teach her that how will have to clean the eye prosthesis regularly so there is no infection in the Socket. I also said that I will ENSure whether if already Any Conformer was placed in the eye or she has already been using it and now for examination has removed. I will also Ask the PATient to demonstrate How she takes care of it and Places in the eye and will also with Artificial Cosmetic eye in place with Check Ocular Movement palpate from over the Lid . I will Give her Website Useful Address and arrange followups for her and Register her for Unilateral Blindness . Also I said That when she is eligible for License will have to Notify Driving Vehicle Licensing Authority .

Ok Doctor Tell Quickly What Advice you will give for the Right eye. I will Inform the patient With Sympathy and Empathy and to his family that As she is now only eyed . through life she need to wear Protective Glasses as she has to save the normal eye from Sharp injury or any sports which may injury her eye too and to refrain from it. I also counseled that there is remote Chance that she can Have Reaction in the Normal Eye due to the Previous Injury in the left eye but Not Necessarily and that if at any time she see floaters in front of the Normal Eye or Pain Or Unusual Symptoms In vision . Immediate come back to us in emergency so we could take care of her because it can Cause Sympathetic Ophthalmitis . I will Thank the Patient and satisfy the parents and Arrange the followup for patient and leave her satisfactorily > the examiner Happily Nodded the Head as a wise Man and Then Guided me towards the next examiner and my last Case

Case 2 : There was a British Examiner which Gave me command to Observe the middle Aged man without touching having in the left eye complete Ptosis and and the growth over the lateral side of the lid. He said at first to do Commentary. I answer Sir the left eye of the Patient has severe Ptosis and there is a mass over the upper lateral side of the lid and the warty like lesion on the surface of lateral lids. Although there was fullness or swelling over the upper lid too. What do you think it Could be . Tell me the Differentials. Sir In this site we find Lesions like Dermoid, Plexiform Neurofibroma, Orbital Varices, Lacrimal Gland Tumors. He asked OK If Plexiform Neurofibroma which type . I said Diffused. Which Disease you think OF . I said Neurofibromatosis Type 1 OR Von Rocklinghausens Disease. What Else you look For. I said I, will look For Cafe A lait Spots and Axillary Freckles and do Systemic Examination and also refer to the Dermatologist and to Medical Specialist. I will See the Lish Nodule with the Slit Lamp and will do Fundoscopy to Look For Optic Nerve. I will

Arrange CT to see if there is lacking Orbital Bone and also will Refer to Neurologist If Proptosis and Glioma is suspected and Visual acuity and Colour Test are abnormal. Moreover I will Ask for First Degree Relatives Screening For future Counseling of the Patient .

Ok But the patient is not Happy With this LEft eye and What will you do about this Mass . Do two Measurements which are Most Improtant. I checed for MRD 1 = -10 mm(1cm) ----Severe Ptiosis .Also I said I will Check For Levator Function . I placed My Right Thumb Over the Medial Right Eye brow Asking the patient to look Down and Negated frontalis muscle and asked the patient to look Up . LF(ULE) was coming 3 mm. So what you will do doctor?? I said I will so Frontalis Brow Supension With Facial Lata Sling .Any Other Options . I said Debulking or Blepharoplasty could BE thought about . But will do Counselling of te Patient that the Diffused one sometimes recurs and will have to see with time . I atleast mentioned the Examiner that recently I recieves One child of 6 years girl In the EYE OPD with her mom with Having NF type 1 .Alll documents and Multilple Surgeries done for Bilateral Rare Congenital Plexiform Neurofibroma and they have been consulting the Moorfield Eye Hospital Branch In Dubai .The Documents I read her Mother Had with her it was written that Debulking 4 to Five times they did at several sittings and that it has to be seen with time and cannot fully eradicate it . The examiner was Happy to Listen to the Answer and thanks to Allah It was over. I thanked the Examiner and came out of the room and was Positive About my result since then .

Advice About Courses and Books.

1. Comprehensive Eye Course Of Magrabi Eye Hospitals Jeddah Arranged By Tarreque Najjar and Waleed Badr an their Collegues it helped Me.
2. I did Clinical Attachment At the Tertiary Care For About Two Weeks at Al-Nahda Tertiary Care Its very important taht before exam for atleast 2 weeks we should be attached with seniors in order to brush up the clinical Skills and for Proper Exposure.
3. You tube Videos Of Oculoplastics,Glaucoma ,Catarct and Refractive surgeries. Its the Sea of Knowledge
4. Books I read were Only 3 + Chua Site
 - a)Kanski New Edition As an Atlas and
 - b)Oxford Hand Book OF Ophthalmology
 - c) FRCS Cake Walk
 - d)Chua Site Is very Extensive and Best. From This I studies the Past Candidates Experience which is very useful and indeed its a Gold Mine . Without Studying it we cannot Pass Truly.
5. I did not study Wong,Wills Eye Manual,Myron Yanoff Neither American Academy For Exam Preparations .
6. My advice to the Cadidates is to Keep One Book As Basic And Makes Notes at the sides OF the Book. Because Studying Big Books Will Fail a person instead and not pass certainly . My Basic Book Was the Cake walk which Only I studied Found It very Useful.Rest OF it I Relied On FRCS Course I did IN Jeddah Magrabi Eye Hospital And the Notes were Outclass. The Vivas Mock Exam was very Educative .

An Inspirational Poem Which Will Boost Up Moral of Those Going For Exam Inshallah

If you think you are beaten, you are;
If you think you dare not, you don't.
If you'd like to win, but think you can't
It's almost a cinch you won't.
If you think you'll lose, you've lost.
For out in the world we find
Success begins with a fellow's will:
It's all in his state of mind.
If you think you're outclassed, you are:
You've got to think high to rise,
You've got to be sure of yourself before
You'll ever win that prize.
Life's battles don't always go
To the stronger or faster man,
But sooner or later the man who wins
Is the one who thinks he can.

If You Have any Other Questions Brothers and Sisters I will be glad to help you in giving Advice About the Muscat Center Specially ,Travel and Preparation IN more Detail.

My Contact Details Are As Under:

Dr.Babar Anwar Khan
MD. FRCS(Ophthalmology)Glasgow UK
Specialist Ophthalmology
Head Of the Eye Department
Adam Hospital
Adam Willayat
Al-Dakhliyah Region
Po.Box 76
Post Code 618
Email: drbabanwar@yahoo.com
Mobile Numbers: +96896534614, +96898444794,+96893915639

Best Of Luck To All Who Are Taking The Exam . Be Punctual In Salaat .Obey Your Parents . Be Caring For your Spouses and Children. Be Nice to the relatives and honest friends and forgive all In Life. Be Motivated and Be determined . Inshallah ,its nothing in the world which man cannot achieve with determination and strong will. My Hard Work OF 17 years after my Graduation Has paid Me off eventually mashallah.

Woods are Lovely , Dark And Deep
But I have Some Promises To Keep
And Miles to go Before I sleep
And Miles to Go Before I sleep.