FRCS Glasgow Part 3 Candidate Experience- Glasgow 2018

My name is Ryan Ramoutar and I'm from Trinidad and Tobago. I sat the Part 3 exam in June 2018 in Glasgow and passed. It was my 2nd attempt having been unsuccessful in New Delhi 2017.

I'd like to thank my parents, Emmanuel and Maureen Ramoutar, for their support and my mentors and teachers in Ophthalmology; Dr. Krishna Mahabir and Dr. Vishwamitra Ramdath. I'd also like to thank all my colleagues at the San Fernando General Hospital who assisted and facilitated my preparation for this exam.

The exam was held on two consecutive days in Glasgow. The oral was held at the Royal College and the Clinical at Caledonian University. Glasgow is a relatively small city so a taxi/Uber isn't generally more than 20 minutes from either centre. There was some excitement as the exam coincided with the fire that destroyed the iconic Art School.

Oral/Viva

First station was the **posterior segment** station:

Photo of Moderate Non Proliferative DR. Asked to describe the photo and point out venous beading. Questions on management including Laser and Anti VEGF

Photo of a sub retinal lesion. Asked to describe and estimate the size of the lesion (in DD). Gave Dx of Choroidal Melanoma, Choriodal Nevus and Osteoma. Discussion on investigation and management of choroidal melanoma.

Photo of a CRAO with a perfused cilioretinal artery. Asked to describe photo and identify what the perfused area means (patent cilioretinal artery). Asked what investigations I'd want to order (ECG/Echo/Carotid Doppler/Lipid Profile) and what systemic association I'd be concerned about. (Giant Cell Arteritis). Asked diagnostic criteria of GCA.

Scenario of a patient with posterior and intermediate uveitis. Gave Dx of TB, Sarcoid and ARN. Discussion on ARN including management (drugs and route of administration)

The second station was the **neuro/motility/medicine** station:

Scenario of a patient who presents with Atrial Fibrillation. Questions on Electric and Medical Cardioversion (monophasic/biphasic/amiodarone), rate control (amiodarone/beta blocker/digoxin) and anticoagulation (warfarin). Asked about preop management of a patient on warfarin (admit, refer to cardiology and convert to LMWH). Asked if conversion to LMWH is necessary (no, patient can have surgery if INR is 1.5-2.0)

Scenario of a patient who presents with GCA. Asked about diagnostic criteria (3 or more of: Age>50, new onset temporal headaches, ESR>50, tender or absent temporal artery pulse, positive temporal artery biopsy) and management (refer to rheumatology, pulsed IVMP with long oral taper monitored by serial CRP and ESR). Specifically asked if patient can be treated in the absence of a positive temporal artery

biopsy. (Yes, diagnosis can be made on clinical grounds only and TAB can have skip lesions). Asked what systemic features patient can present with (fever and PMR) and what other meds I'd want to consider (Gastroprotection and bone protection)

Given a Humphrey VFT of both eyes. Started by giving demographic data and commenting on the false positive/negative/fixation losses before describing the field. Field showed a bitemporal hemianopia denser superiorly (on first glance it could have been mistaken for a quadrantopia but it didn't obey the horizontal meridian). Gave diagnosis of pituitary adenoma. Asked management. (refer to neurosurgery and endocrine. Imaging including MRI and CT and serum hormone levels)

Given scenario of a patient with NF-1 who has a son. Son is now 8 years old and has never been evaluated. Is it necessary to evaluate and what for? This question was pretty open ended. I started by saying I would like to investigate since NF-1 is AD and son has a 50% chance of inheriting the disorder. Would look for small neurofibromas and café-au- lait spots (pre-pubertal criteria), in addition to lisch nodules and freckling (axillary and inguinal). Would be specifically concerned about amblyopia in the presence of a plexiform NF and optic nerve gliomas. Would want to perform a full refraction, fundal exam and imaging if index of suspicion is high for ON glioma. Failed to mention risk of pheochromocytoma, but they didn't prompt for it and moved to the next question.

Asked about the ocular and systemic features of sarcoidosis. Listed ocular from anteriorly to posteriorly and gave systemic including skin lesions, CNS granulomas, hilar adenopathy, salivary, paroid and submandibular swellings and CNVII palsy. Asked about treatment (refer to rheumatology, steroids initially, then (named) steroid sparing agents…asked which would be my drug of choice- methotrexate)

Scenario of bilateral CNIV palsy and how patient will present. (chin down, mild to no head tilt). Causes of CNIV palsy and how I would investigate. Asked what test I'd like to perform; said double Maddox rods or Maddox wing (for evaluation of cyclotorsion). Asked what else…simpler…said Parks 3 step…asked to go through how I'd perform it clinically. Just about got in the full explanation when the bell rang.

The third station was the **anterior segment** station:

Photo of a dendritic ulcer. Asked to describe. Discussion on HSV keratitis including presentation and management (HEDS, cycloplegia, pain management)

Photo of Ectropion. Asked to describe and classify (involutional). Asked examination (lid distraction test), management. (symptomatic including lubricants and taping if lagophthalmos present. Surgical including lateral tarsal strip with or without wedge resection with or without blepharoplasty (KZ procedure).

Shown a photo of a lower lid lesion. Asked to describe. Discussion on basal cell carcinoma including risk factors and management (incisional/excisional biopsy, topical imiquimod, vismodegib) and reconstruction (Direct <1/3, Tenzel 1/3-1/2, Hugh's >1/2)

Shown a photo of a conjunctival lesion. DDx of CIN and squamous cell conjunctival ca. Asked about viruses associated with the presentation (HIV and HPV) and management (excision with clear margins)

Shown a photo of a cornea with a central opacity and inferior thinning. Dx of hydrops. Management (Hypertonic NaCl and PKP). Asked to describe the steps of PKP.

Asked how I would pre op a patient to reduce risk of PC tear intraop. Went through full history and examination (trauma/drugs/PXE/Aniridia etc etc), ensuring proper dilation. Use of hooks/rings to ensure proper dilation and careful phaco technique especially on final quadrant.

Clinical/OSCE

The first station was **neuro/motility**.

Elderly male with CNVI palsy and a Fresnel prism. Asked to evaluate the specs (to say that there was a Fresnel) and perform ocular motility. Elicited the findings and gave dx. Asked causes, what investigations and management I'd like to do. (microvascular, trauma, cavernous sinus lesions, false localizing sign. Ix include none if clear cause or CT/MRI brain and orbits if no underlying cause or present >6/12. Management include advice on driving if diplopia, hess charting, Fresnel and surgical options if >6/12 unresolving)

The second station was a young male in a wheelchair. Asked to perform motility. Presented with failure of adduction bilaterally with abducting nystagmus. Asked what other test I'd like to perform; said pupils which was normal and confrontational VF. Asked where the lesion was- MLF, investigations- MRI, dx- WEBINO and cause- MS (I said demyelination)

The second station was **Oculoplastics and Lids.**

Elderly female with bilateral ptosis. Asked to perform a full ptosis examination followed by a discussion of causes (involutional/neurogenic). Discussion centred on MG in full details. (pt. dx was involutional ptosis, not MG however)

Middle aged female with unilateral ptosis. Asked to examine, including lid distraction. Asked if I wanted to find out anything more. Asked on what side she slept on (ipsilateral to the ptosis). Dx of Floppy eyelid syndrome and mechanical ptosis. Discussion on management. (refer to dietician, weight loss, refraction and surgical management)

The third station was **Anterior Segment.**

Female with bilateral, asymmetrical map-dot fingerprint dystrophy. Asked genetic inheritance and management. (symptomatic, lubricants, CL, as for RCES)

Elderly male with trab, subluxed IOL and pseudoexfoliation syndrome. Asked the complications of cataract surgery as a result of PXE (poor dilation, ZD) and if subluxation could occur after surgery (yes) and how to prevent or minimize complications.

The final station was **Posterior Segment.**

First patient was a young female. Asked to examine the right fundus using SL and 90D. Patient had a macular scar with an associated peripheral macular circinate scar extending from the superior to inferior arcade. Gave dx of choroidal rupture. Asked ddx and gave laser scar and toxo. Discussion centred on toxo (it clearly wasn't a toxo scar). Asked if a patient could have toxo bilaterally. (yes, rare simultaneously, but could occur consecutively and congenitally). Asked what management can be offered in this case with unilateral low vision. Said refer to orthoptist, refraction, patching. Counsel on poor prognosis in that particular eye and refer to appropriate social services.

Second patient was a middle aged female. Asked to use indirect to examine retina. Patient had PRP scar and a pale ON. Asked ddx, said PRP as a result of DM II, RP, ON eg. Toxic/nutritional/glaucoma. Asked what Ix, I said VF +/- CT/MRI. Any advice?- counsel on driving.

Resources

My preparation consisted primarily of Clinical Experience and practicing the correct techniques and management in the clinical setting. Practise with the Indirect Ophthalmoscope is essential.

Theoretical resources included Kanski (8th ed) and Oxford Handbook of Ophthalmology (3rd ed). OHCM (9th ed) for the Medicine Viva station is essential. In house lectures by the consultants as well as online resources for surgical procedures (YouTube) were also very helpful.

Practising with another candidate, if possible, is a great asset; otherwise, practicing by speaking out loudly to yourself and taking the time to look at and describe pathology can be just as useful.

Best of luck to all candidates!