FRCS GLASGOW PART 3
MUSCAT CENTRE
YEAR 2018

1ST DAY: STRUCTURED ORAL EXAMINATION

1st STATION: NEUROLOGY, MOTILITY & GENERAL MEDICINE

1st EXAMINER (GENERAL PHYSICIAN)

What are the causes of Grand Mal Petit Epilepsy? (Especially Drugs & Toxins)

Management of a patient if he suffered from fits.

What are the causes of Amaurosis fugax?

How will you investigate and manage a patient of Amaurosis fugax?

About carotid Doppler U/S, how it will help? Then he asked about the management of carotid stenosis.

How it affects eye?

They showed a picture of pale optic disc and asked to describe the picture.

50 year old male suffered from sudden vision loss and have above findings. What could be differentials?

Causes of Ischemic Optic Neuropathy

2ND EXAMINER (NEURO-OPHTHALMOLOGIST)

A picture of Optic Disc Drusen (A solitary Drusen at nasal disc margin)

What could be differentials? How would you confirm your diagnosis? What ocular complications he may develop? What kind of field defect he may have?

Then he gave me a scenario and told me to write it down on paper. Scenario of Left Hypertropia of PD (I forgot) in a young child with head tilt on right.

What could be possible diagnosis? Any cause other than Lt Superior oblique palsy?

How would you confirm? Asked about Parks three step test? Possible findings in this patient

Management (Refraction, Amblyopia therapy and Surgery)

If patient has no complains, only head tilt then…. Will you do something?

A patient with hemiplegia now complaining of left homonymous hemianopia (macula sparing). What could be the possible cause? Why macula sparing?

On recovery patient is now complaining of total blindness. What could be the causes?

Then he gave me another complain or scenario of above patient (sorry I forgot) and asked about the cause. I said temporal crescent (He was happy by listening that).

2nd STATION: LIDS, OCULOPLASTIC & ANTERIOR SEGMENT

1st EXAMINER

A picture of Squamous cell carcinoma of conjunctiva. Diagnosis? Treatment options?

Any drug other than MMC?

A picture of BCC. Diagnosis? Treatment options?

He gave me a pencil and asked me to draw that how will you excise this? He was looking for 3mm of normal margins.

A picture of Acanthamoeba keratitis (picture was too blurred, just a central stromal haze along with peripheral haze which surrounds the cornea in circular pattern). I was totally confused. That peripheral haze was of radial keratoneuritis I guessed. Investigations? Non-invasive investigation in clinics (he was asking about corneal sensitivity, I realized later). Difference between acanth and herpes keratitis. Specifically he was asking about the pain.

2nd EXAMINER

A picture of PKP (he told me) and asked me to describe the findings in central cornea.

Picture was too blurred. That was rejection with folds and stromal edema. I said stromal rejection. He said what else. Then I realized it was endothelial rejection (Pics were too blurred so don't get stuck to one diagnosis. Examiners usually helping you so just speak up).

How will you treat a patient of rejection in your clinics? Asked me which steroid, frequency and what else?

Causes of rejection? Any infection which can cause rejection (Asking about viral keratitis). Then how will you treat?

A very blurred picture of Cicatricial entropion, Trichiasis and corneal opacity. Describe the picture? What could be the cause? Treatment of trachoma? Organism of trachoma? Other causes of Cicatricial conjunctivitis.

A scenario of Aniridia. Then he asked about the ocular complains and ocular findings (every word from kanski). Why its necessary to know the inheritance pattern of anridia? How will you treat?

3rd STATION: POSTERIOR SEGMENT

1st EXAMINER

He asked me about anti-glaucoma medications. Then side effects of beta-blockers (ocular and systemic)
Systemic side-effects (specifically in males)
Side effects of prostaglandin. Where you should not prescribe prostaglandins

Then he showed a picture of NPDR+CSME. Describe the picture. Causes & Treatment.
Definition of CSME

Picture of BRVO. Asked to describe the picture especially the findings in veins.
Causes treatment.

2nd EXAMINER

Picture of Retinitis Pigmentosa. Ocular complaints, investigation and treatment.

Picture of OCT of macular hole. Describe the findings, causes and stage on OCT. Treatment

Picture of CMV retinitis. Describe the findings, differentials and treatment options.

2nd DAY: CLINICAL EXAMINATION

1st STATION: OCULOPLASTICS & LID DISORDERS

1ST PATIENT: Male patient around 60yrs old with left Proptosis. Examiner asked me to do

General inspection

Proptosis examination

Pupillary reactions

Then he asked about the differentials and possible diagnosis

2nd PATIENT: Male boy around 15yrs old with Right Ptosis with good lid crease. Examiner asked me to do

General inspection

Ptosis examination (I measured MRD, PFH, LF, Lid Crease). After that Jaw winking and Bell's (examiner was looking for this). I asked to do EOM but he refused (although during examination I had noticed obvious lid lag)

Then he asked about the possible diagnosis. I said he might be a patient of Post ptosis surgery

2nd STATION: ANTERIOR SEGMENT

1ST PATIENT: Young male on slit lamp. He has left vascularized central corneal opacity. What could be the possible causes? Then he asked me to examine left eye (I was confused whether that was DMEK or LASIK FLAP). I realized later that he might be a patient of keratoconus with earlier hydrops causing secondary vascularized CO.

2nd PATIENT: Old patient with Flat Bleb in Right eye and PEX + P.P in Left eye

Examiner asked me the cause and further treatment. If this patient has 0.8 cupping with IOP 25 with maximum tolerated medication what will you do? I said laser trabeculoplasty and then TRAB. He asked one tell me one option whether ALT or TRAB? I said TRAB. What you should tell to the patient before TRAB? Vision loss may occur after TRAB. He asked what that phenomenon is.

3rd STATION: POSTERIOR SEGMENT

1st PATIENT: Indirect Ophthalmoscopy

Patient has myopic fundus with inferior laser marks. Examiner asked me the cause for laser & about retinal degeneration.

2nd PATIENT: On slit lamp with 78D (That lens was not cleaned and I realized by seeing the fundus as I was unable to see from that lens. I quickly took out my 90D. So bring your 90D with you)

Patient has extensive laser marks with few dot hemorrhages and hard exudates on macula.

Examiner asked me about the findings, cause, investigation and treatment.

3rd PATIENT: On slit lamp with 90D

Patient has extensive laser marks with Macular Hole. Examiner asked me about the findings and one condition that fits with these findings.

4th STATION: NEURO-OPHTHALMOLOGY & OCULAR MOTILITY

1st PATIENT: Examiner asked me to perform direct ophthalmoscopy, then pupillary reactions then confrontation. Patient has left RAPD and left facial asymmetry due to trauma.

2nd PATIENT: Middle aged male. Examiner asked me to do EOM. Vision was very poor so I did that with torch. It was really difficult to perform that and what I got was nystagmus on extreme gazes. Patient also has left esotropia which I later found out on Cover Uncover. Questions were what is nystagmus? Describe nystagmus in this patient? What are the Causes? And when I said sensory deprivation, he asked do you think that this patient have sensory nystagmus? (As I have done EOM with torch I had noticed IOL in his left eye) so I said yes he may have. He asked me to have a look on anterior segment with torch. Patient had Right miosed pupil (posterior synechiae) and left IOL with peaked up pupil and IOL capture. He asked me which eye is P.P. I said left. He said okay.

Good Luck future Candidates

DR.KANWAL LATIF
FCPS (Ophth), FRCS (Glasgow)
Assistant Professor
Sir Syed College Of Medical Sciences, Karachi, Pakistan
E-mail: kanwallatif@hotmail.com