

**My experience in FRCS ophthalmology Glasgow June 2017**

First I would like to thank Allah for his kindness and forgiveness

Also special thanks to my family, friends and colleagues, many thanks to ophthalmology group of Ophthalmology-E-learners-Academy for their valuable interactive online simulating courses.

* **First day (viva)**
1. **neurology and emergency medicine:-**
* patient in the waiting area with acute chest pain, how you will manage (in order Call for help, ABC, vital signs monitoring and the important investigation mainly ECG) he said ok what else (I said I will take a history from the relative specially cardiac disorder and the support team of my hospital usually arrive within 2 minutes), he said do you think that there is something important to give (I stressed that I’m an ophthalmologist and not qualified for managing cardiac patients, but if the relatives are sure if ischemic heart disease and he carry nitrates in his pocket I will give him sublingual nitrates with Oxygen, he smiled), then he asked what is ECG finding in myocardial infarction (elevated ST segment, pathologic Q) what important lab study (cardiac enzymes) and DD (acute coronary syndrome, tension pneumothorax, pulmonary embolism, aortic dissection and ruptured oesophagus).
* Patient collapsed during FFA what will you do (Call for help, ABC, vital signs monitoring and the important investigation) what is your DD (anaphylactic shock and vasovagal shock) how to differentiate ( tachycardia in anaphylactic shock, bradycardia in vasovagal) the how to treat anaphylactic shock in details and doses and discharge after 48 hours due to biphasic anaphylaxis (he specifically asked about that), then if we need to repeat the FFA what is the precautions (I said better to use OCT which is non invasive) he said no I need to repeat FFA (I said will be done with resuscitation team and availability of bed in the ICO with injection of hydrocortisone before FFA and special notes on patient file in the hospital and written consent after patient counselling)
* Female 30 ys patient with intermittent ptosis increase by the end of the day what is you dd (mythenia and other causes of ptosis in adult) then discussion about mythenia systemic, ophthalmic signs and how to investigate in details including edrophonium test without strange questions and how to treat (refer to neurologist).
* Middle age male patient with continuously increase in his foot size what will you think about (I told him if only one leg may be DVT) he said no his both legs (I said may be Acromegally due to pituitary lesion) he said yes what will you do (history S&S of chiasmal lesion and increase intracranial tension with stress on fundoscopy, visual field finding and MRI).
* Photo of disc swelling he said what is your DD (I said is it unilateral or bilateral) he said tell me both and I told him then he ask me about ION and arteritic type but not in details.
* Young patient newly diagnosed as diabetic and lost his consciousness, what is your dd (hypoglycaemic coma, diabetic ketoacedosis and hyperglycaemic coma) how to differentiate between DKA and hypoglycaemic coma (HGT level and keton bodies).

***I don’t know how come I answered these many questions in 20 minutes (all my colleges were asked a maximum of 4 qs) my replay was rapid, short and to the point, I think they like that and this help not to be asked in useless details.***

1. **Anterior segment and Oculoplasty:-**
* Photo of anterior segment with PEX, first describe finding (mouth eaten papillary defect and dandruff material at the anterior lens capsule) then ask about other finding in details (elevated IOP, krukenberg spindles, sampolisy line, others), he asked me about difficulties of cataract surgery in that patient (intraoperative high IOP, poor papillary dilatation, lens sublaxation and how to manage each, then post operative capsular phimosis)
* Posterior capsular tear during cataract surgery, how to manage (stop phaco, don’t remove the phaco tip, inject healon then assess the size of the tear, vitreous loss, hardness and size of the residual nucleus and most important is your skills and experience and try to be safe as much as possible, if soft nucleus small quadrant and small tear, continue phaco with low bottle. If not, open and convert, or ask for help).
* A hazy photo of hypopyon ulcer to describe the I noticed a large corneal defect close to the limbus which is rely not clear, then how to manage (history, investigation and ttt, dot forget tectonic graft) and the session directed to traumatic corneal perforation and endophthalmitis and how to manage (ttt of hypopion ulcer and endophthalmitis in details) the he asked me if the vision in this eye already NPL how will you manage from the start (evaseration).
* The examined gave me a refraction +5.0/-.50\*180, told me this is a refraction of post operative cataract patient after two weeks, What you suspect (a detailed causes of post operative refractive surprise) but he still insisting that I missed a cause that can be intraoperative (I told him sulcus IOL will not cause that) but he told me that the IOL is wrongly implanted on the opposite face but I told him this will not give this high refractive error, then he ask me about IOL formulas and uses of each one in different axial lengths (I remembered only holyday, but I told him I have a table I’m using as a reference and don’t remember it now).
* A photo of anterior segment with corneal foreign body rust, how to manage (history, examination, exclude intraocular FB, US,) simple question only.
* Oculoplasty case of lower lid swelling, describe ( size ½ lid margin, pearly border, surface telengectasia, loss of lid architecture, old age patient, classic BCC) how to manage (history, LDs assessment, incisional biopsy, histopathological examination) he told me histopathology revealed BCC what will you do (referral to oculoplastic surgeon, excising with safety margin mohs micrographic surgery, Huoghes technique)
1. **Posterior segment:-**
* A photo of diabetic retinopathy for describtion, how to manage (history and risk factors, examination other eye, FFA, OCT, referral to diabetic medicine clinic) simple questions
* A photo of retinal detachment, describe (RD, macula off, PVR), how to manage (history of trauma and other ocular and systemic and surgical risk factors, surgery) what type of surgery (PPV + encircling buckle) (at first I forgot to tell history he was annoyed and asked me if I want to ask about history)
* Visual field of arcuat sotoma right eye, describe (he was insisting to give a detailed explanation of the visual filed starting from the stimulus, target, strategy, the programme which really I don’t remember) the he ask me about my DD (Glaucoma and NAION)

(It was my last viva session and I really lost my energy, but I think good performance in the other two sessions was helpful especially neuro session which is the key point of viva exam).

* **Second day (Clinical exam)**
1. **Posterior segment**
* Middle age female in dark room, gave me indirect and ask directly to examine the fundus (extremely narrow pupil, whitish reflex, iris coloboma, very difficult fundoscopy, told me to look only inferiorly, peripapillary excavation and inferior coloboma not involving the papillomacular bundle), then ask me simply about complication and expected prognosis.
* About 50 years female, indirect fundoscopy, examine (tortuosity of veins congested disc, NVEs, vit Hge, whitish scare of recent PRP, macular edema, macular scar) the DD (CRVO, PDR) how to assess (history, FFA, OCT) how to manage both of them (don’t forget systemic work up)
1. **Neurology and strabismus:-**
* Old age lady in dark room, examine the pupil (inspection 🡪 left sever ptosis and dilated pupil with exotropia, light reflex and swinging 🡪 left sluggish, I forgot accommodative miosis), then he started asking about causes of RAPD and I was confused why he is asking about that in a patient with anisocoria, So I decided to be conclusive and I told him frankly (**THIS IS A PUPILLARY INVOLVING THIERD NERVE AND THIS IS AN EMERGENCY CONDITION AND NEED URGENT MANAGMENT)** this was only to clear my side in extremely important point as I felt that there is misunderstanding from my side to his question and I think this was useful then the discussion went to simple questions I don’t remember.
* Well chaired young man, started examine the motility (I told him I will start with cover/uncover what about visual acuity, he told me good, cover uncover revealed alternating exotropia, but strangely when I repeated the test nothing was there and the patient was not exotropic ! and I was confused, then with motility bilateral limited adduction with ataxic nystugmus on abduction, classic INO, then defective convergence and abnormal saccades, when I told him bilateral INO he told me describe only and don’t give me a diagnosis, while describing ataxic nystagmus he told me what is the meaning of ataxic and I told him sorry it is nystagmus only. Then he ask me about final diagnosis I told him this is a case of bilateral intermittent exotropia with bilateral limited abduction with defective convergence and saccades (he seems to be happy and satisfied but I was stressed).
1. **Oculoplastiy session:-**
* Old age female on the slit lamp, examine right eye anterior segment (diffuse lid swelling and telangiectasia, tube in the medial canthal area I never saw lester Jhons tube before but it was) ask me about its indication (obstruction less than 8 mm from the canalicular opening) then examine the other eye (lid telangiectasia, lower lid medial ectropion) he told me this patient complaint of epiphroa how to manage? (forgot to ask history, I told him regurge test, probing and irrigation test and other tests for epiphora) he told me so what will you do specially in this patient, (will treat first medial lower lid involutional ecropion with medial canthal tendon pliacation, forgot to test lid distraction test and snap back test, also you have to exclude other causes of ectropion as paralytic)
* Old age patient bilateral sever ptosis, examine ptosis (Observation, full ophthalmic examination in details and he was fully observing my steeps and ask me in details about the result) then he ask my about DD (I told him everything and forget only myotonic dystrophy and unfortunately he was!) he ask me few simple questions about mythenia and CPEO and its association (retinitis pigmentosa, etc…).
1. **Anterior segment.**
* Old age female on slit lamb examine left cornea only (very deep multiple central opacities close to the endothelium separated with clear cornea, with superficial whitish lines) what is you diagnosis (endothelia dystrophy mostly fuchs!, unfortunately it was granular!, and the superficial lines was prominent corneal nerves!) ask me about other stromal dystrophies, names only. Then examine the right cornea only (decentred quite PKP, iris is totally attached to the corneal periphery outside the graft in 360 degree, the corneal periphery was extremely opaque but there is something strange, thanks good it is iris new vascularisation (which is extremely difficult to detect due to dens peripheral corneal opacity) he was satisfied and told me IOP in this patient is low, what the cause ( told him, there is no wound leaks and it seems to be old graft as all sutures are removed, may be medication, atrophic eye, trabe or shunt, forgot to tell previous cyclodistructive surgery).
* Young man with examine right cornea only (typical lattice degeneration), examine the other eye (lamellar keratoplasty with two old scars related to already removed all sutures), why lamellar (rusts in the interface) what is the cause of opacity (sutures related infection or previous rejection episodes or vascularisation).
* 30 years man examine right cornea only (typical KPs of fuchs heterochromic uveitis, I described in detailes) what is the cause (FHU) then I stopped him and asked him to examine the AC for cells and was positive and I asked him about IOP and was elevated, Also told him I want to examine left eye for iris heterochromia also positive. The patient was pseudophakic in right eye, what is the cause? (topical steroid, uveitis), causes of visual loss (glaucomatous optic atrophy secondary to topical steroid) this patient may develope a problem during cataract surgery? (anterior chamber haemorrhage), what is the cause (abnormal blood vessels in the angel, Amsler sign).

**Important tips:-**

* Past candidate experience is highly valuable.
* In all sessions of exams try to express to the examiner that you are a member of teamwork and your are safe to the patient and in case of you don’t know you will consult and will not proceed blindly.
* It is not the matter how much knowledge you know but how much knowledge you will use.
* One of the vital clues to pass the exam is to express that you are confident, will organised and safe doctor.
* When you find and important or emergency sign you have to tell the examiner directly and don’t wait him to ask as this will give you a strong position and the time may end without discussing this point and this is against you.
* Most of the examiner are very cooperative and don’t relay on their facial expression as this is extremely misleading, it is just personal expression not related to the final marks.

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