Hello, Im Dr RHA and i sat the FRCS part 3 exam in Amman Jordan in april 2019.

Oral (VIVA):

Medicine & neuro:

- scenario of uniocular ptosis and exotropia - diagnosis 3rd nerva palsy - classification of causes into medical and surgical
- scenario of 9 mo old baby presenting with retinal hemorrhages - work up - most important is to exclude shaken baby syndrome - other name shaken impact syndrome - protocol to follow in such situations - get witnesses and senior consultation - report to social services - isolate the child
- picture of unilateral ptosis and miosis - horner syndrome - diagnostic pharmacological test - say apraclonidine test first - most important to exclude are life threatening causes: carotid dissection and pancoast tumour - how to diagnose pancoast: chest CT (dont know if this is right or not)

- Causes of Atrial fibrillation - most common is ischemic heart disease - drugs to control heart rateand arrythmia: amiodarone - digitalis - b blockers - calcium channel blockers like veraamil and diltiazem -
- warfarin intake and preparation for intraocular surgery
- patient waiting in the waiting area - known diabetic - collapses - but not shocked: hypo or hyperglycemic coma - how to diagnose either - management of both

Anterior Segment:

- scenario of 12 mo old baby with lacrimation: DD glaucoma and NLDO - management of NLDO at this age - stepwise: massage if not tried before then probing then intubation - rarely needs dcr - then if this baby where to have high IOP - management of congenital glaucoma- IOP - corneal thickness - examination under sedation or anaesth - surgical management: stepwise: goniotomy if clear - trabeculotomy/trabeculectomy - valve - diode
- picture (very magnified - hazy) of pseudoexfoliation preparation for cataract: check for glaucoma - vision - disc (complete ocular exam) - check for proper dilation in the clinic - what to do if narrow pupil intraoperative (phenylephrine - intracameral preservative free adrenaline - iris hooks malyugin ring - mechanical dilation) - complications associated with surgery - refer to senior - poor dilation - subluxation - corneal decompensation - phimosis
- picture of corneal limbal sutures - magnified and hazy with line in cornea - PKP: types of rejection - management of rejection - risk factor for rejection
- scenario of lady with -2.5 preop astigmatism - how to correct it if shes having catarct surgery: clear corneal incisions - limbal relaxing incisions - lasik - toric iol - glasses
- pic of corneal abscess with melting and thinning- farmer so fungal - management: admission or not - culture and sensitivity - eyedrops (important to say cycloplegics)

- what is meant by surgically induced astigmatism and its importance

Posterior Segment:

- picture of NPDR and DME (fundus photo): management starting from control of DM and cardiovascular risk factors - normal HBA1c - control level of HBA1c - if HTN what medications to give and why (ACEIs and ARBs)
- Picture of retinal horse show tear and RD: surgical options - complications of vitrectomy - PVR grades and how to manage intraoperative
- Picture of solitary flat pigmented lesion: isolated CHRPE - risk factors if multiple - wanted to know names of syndrome associated with atypical CHRPE
- very bad pic of advanced Bull's eye maculopathy and flecked retina - stargardt - DD of bull's eye maculopathy - investigations in this case wanted to hear fundus autofluorescence
- fundus photo of BRVO - risk factors - management - asked if it would make a difference in management if the macular edema is less than 300 or more than 300 microns - if macular edema is present how long before u treat?

Day 2: Clinical:

Posterior Segment:

- slit lamp biomicroscopy: NPDR - management - ques about OCT findings - had ERM: if ERM, would u do focal laser or inject?
- Indirect ophthalmoscope: PDR - management - DME
- slit lamp: anterior granul uveitis - multifocal choroiditis: causes and DD: VKH - SO - TB - sarcoidosis - what is impt vasculitic disease common in middle east: Behcet's

Neuro and Motility:

- 12 yr old girl: first was ortho then decompensated into XT - then during examination had left hypertropia - there was no limitation in movement - was asked as this girl grows taller does this condition improve or worsen ? i didnt know the answer
- mid teens boy on a wheelchair - esotropic with bilateral limitation of abduction in both eyes with narrowing of palpebral fissure on adduction - bilateral Duane type 1 - management

no time to see third case - was nystagmus

Anterior Segment:

- teenage boy: right aphakia and left subluxated cataractous lens: marfan
- 2nd decade female: nystagmus - iris and lens coloboma: why do u think she has nystagmus
- 2nd decade female : pseudophakic - inferior valve : why do u think it is inferior?

- 6th decade male: right pseudophakia and full thickness diffuce corneal haze - other eye had posterior lamellar keratoplasty (DMEK OR DSAEK) - turned out to be advanced Fuch's
- early teens boy: with unilateral full thickness localised corneal opacity and what looked like yellowish golden crystals within opacity - said possible infectious crystalline keratopathy - to be honest dont know the correct answer

Oculoplastics:

- neurofibromatosis type 1: plexiform neurofibroma of upper lid with severe ptosis - said do tests of ptosis on sound eye - measurement and levator function - had sphenoid wing dysplasia causing hollowness of temporal bones bilaterally
- middle aged lady with proptosis and dystopia bilaterally but asymmetrical - lots of talk about thyroid eye disease: features - management - surgical intervention
- 2nd decade female - neurofibromatosis type 1: huge plexiform neurofibroma at medial canthus - enucleated - scleral shell - PEES syndrome - wanted management strategy and algorithm

both days very stressful - you say the answers but you dont know if the answers are correct or not because they remain silent - almost same examiners on both days - clinical exam time is very little - makes u in a hurry to answer and u make mistakes.

good luck to everyone

Rana H. Amin
Assistant Lecturer of Ophthalmology
Kasr Al-Aini Hospital
Cairo University