Examination Report

November 2014 Part 2 FRCOphth Oral Examination

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Contents:

1. Summary

The Part 2 FRCOphth Oral Examination is no longer directly linked to the Written Examination. The OSCE has been modified and consists of five clinical stations at which candidates are required to examine three patients (15 in total). The medicine/neurology station has been replaced with a neuro-ophthalmology station. The communication station remains unchanged. The total number of marks available for the oral examination has increased from 256 to 318 and as a result of these changes with a weighting towards the OSCE is 62% to 38% for the structured viva (SV).

79 candidates sat the examination, which is the smallest cohort since November 2011. The pass mark for the SV was the highest since April 2011, but the OSCE pass mark remains stable in spite of the recent changes to the structure of the OSCE stations.

The reliability of the oral examination remains acceptable at 0.75 (SV) and 0.80 (OSCE).

The pass rate in OST was the highest of any sitting at 70%, which exceeded the pass rate for candidates who were not in OST (48%).

The best marks (median) for the MCQ (for those who sat the oral examination) were achieved by candidates who were not in OST. Candidates in ST5 performed best in the SV. Candidates in ST6 performed best in the OSCE and the oral overall.

There was no statistically significant difference in the success of candidates based upon gender or ethnicity for those in OST.

There was a statistically significant difference based upon first language. Candidates who spoke English as a first language were more likely to pass.

There were differences, which approached statistical significance, based upon country of qualification (UK> not UK), and ethnicity for candidates who qualified in the UK (white > non-white).

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The oral parts of the thirteenth sitting of the Part 2 FRCOphth examination were held in Dundee from Monday 10 November to Thursday 13 November.

2. Candidates

79 candidates presented themselves for the examination.

3. The Structured Vivas

There were five structured vivas, which were held on Monday 10 and Tuesday 11 November 2014 at the West Park Conference Centre, University of Dundee. The communication skills OSCE station was conducted as one of the viva stations, making six stations in all. Each viva lasted 10 minutes. The stations were:

Station 1:	**Patient investigations and data interpretation**
Monday AM	Acute Diplopia
Monday PM	OCT of pigment epithelial detachment
Tuesday AM	Epiphora
Station 2:	**Patient management 1**
Monday AM	ROP screening and treatment
Monday PM	Septo optic dysplasia
Tuesday AM	Vernal keratoconjunctivitis
Station 3:	**Patient management 2**
Monday AM	Coexisting cataract and glaucoma
Monday PM	Myopic cataract patient
Tuesday AM	Cataract Surgery with PXE
Station 4:	**Attitudes, Ethics and Responsibilities.**
Monday AM	Operating day issues
Monday PM	Patient data protection
Tuesday AM	Declarations of interest
Station 5:	**Audit, Research and EBM (5 minutes)**
Monday AM	Herpetic Eye Disease Study
Monday PM	Treatment of POAG
Tuesday AM	Ocular Transplantation
	Health Promotion and Disease Prevention (5 minutes)
Monday AM	CJD and Sterilisation techniques
Monday PM	CJD transmission
Tuesday AM	Screening for DMR
Station 6:	**Communication Skills**
Monday AM	Non Organic Visual Loss
Monday PM	Child Abuse
Tuesday AM	Macular Hole

The vivas and communication skills stations were held in one large hall, with each station housed in an individual booth. There were three teams of examiners (red, blue and green teams). The examination was conducted in five rounds (three on Monday and two on Tuesday).

3a) Results:

Maximum mark (5 stations, 10 examiners, 12 marks per station): 120

Pass mark (using borderline candidate method):	68 (57%)
Mean score:	80.5 (67%)
Median score:	83 (69%)
Range:	39-110 (33%-92%)
Reliability: (Cronbach alpha)	0.74
SEM:	7
Final adjusted pass mark (+ 1 SEM)	75 (63%)
Pass rate before adjustment (pass mark 68/120)	69/79 (87%)
Pass rate after adjustment (pass mark 75/120)	53/79 (67%)

Table 1 Distribution of scores

Score	Distribution	Total
21-30		0
31-40	/	1
41-50		0
51-60	////	4
61-70	///// ///	8
71-80	///// ///// ////// ///// ////	24
81-90	///// ///// ///// ///// ///// ///	28
91-100	///// ///// /	11
101-110	///	3
111-120		0
Total		79

Table 2 Results for each station

Station		Mean score	Median score	Range
1	PI	7.2	7.5	2.0-11.0
2	PM	7.9	8.0	0.5-12.0
3	PM	8.9	9.0	3.5-12.0
4	AER	8.8	9.5	2.5-12.0
5	HPDP/EBM	7.5	8.0	3.0-12.0

Table 3 Correlation between examiner's marks at each station

Team	Station 1	Station 2	Station 3	Station 4	Station 5
	PI	PM	PM	AER	HPDP/EBM
	0.79	0.92	0.70	0.84	0.77

Table 4 Correlation between examiner's global judgements at each station

	Station 1	Station 2	Station 3	Station 4	Station 5
	PI	PM	PM	AER	HPDP/EBM
	0.71	0.89	0.57	0.82	0.79

Table 5 Correlation between viva stations

		Station 1	Station 2	Station 3	Station 4
		PI	PM	PM	AER
Station 2	PM	0.12			
Station 3	PM	0.15	0.22		
Station 4	AER	0.18	0.22	-0.04	
Station 5	HPDP/EBM	0.16	0.23	0.29	0.46

3b) Standard setting for the structured vivas

Table 6

	1		*2*		*3*		*4*		*5*		*Total*
Number of passed candidates	*31*	*33*	*41*	*42*	*56*	*56*	*55*	*56*	*38*	*47*	
Number of borderline candidates	*30*	*28*	*23*	*25*	*19*	*19*	*12*	*13*	*31*	*24*	
Number of failed candidates	*19*	*18*	*15*	*12*	*4*	*4*	*12*	*10*	*10*	*8*	
Median borderline candidate mark	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*6*	*6*	*7*	*68*

The pass mark for the structured viva was increased by 1 SEM from 68/120 (57%) to 75/120 (63%).

4. The OSCE

The OSCE

There were six OSCE stations in all. The five clinical stations were held Tuesday 11 November – Thursday 13 November 2014 at Ninewells Hospital. The communication OSCE was conducted with the vivas. There were three teams of examiners (red team, blue team and green team) and six rounds (one on Tuesday, three on Wednesday and two on Thursday).

The five clinical OSCE stations lasted 20 minutes. The communication OSCE lasted 10 minutes. There were two examiners at each station. In the communication OSCE, one examiner was a trained lay examiner. Details of the patients who made themselves available for the examination are provided in appendix 3.

4a) Results

Candidates examine three patients in stations 1-5. Each patient is worth a maximum of 12 marks (2 examiners x 3 marks x 2 criteria). One patient is examined in station 6 (communication skills). This station is worth 18 marks (2 examiners x 3 marks x 3 criteria)

Maximum mark:	198
Pass mark (using borderline candidate method)	111.5/198 (56%)
Mean score:	133/198 (67%)
Median score:	132/198 (67%)
Range:	87-182 (44%-92%)
Reliability (Cronbach alpha):	0.77
SEM:	10.5
Final adjusted pass mark (+1 SEM)	122/198 (62%)
Pass rate before adjustment (pass mark 112/198)	64/79 (76%)
Pass rate after adjustment (pass mark 122/198)	55/79 (62%)

Table 7 Distribution of scores

Score	Distribution	Total
81-90	/	1
91-100	///	3
101-110	///// ///// /	11
111-120	///// /////	9
121-130	///// ///// //	12
131-140	///// ///// ///// /	16
141-150	///// //	7
151-160	///// ///// /	11
161-170	///	3
171-180	/////	5
181-190	/	1
Total		79

Table 8 Station marks

Station		Maximum possible	Mean	Median	Min	Max
1	Anterior segment	36	26.4	28	9	36
2	Glaucoma & lid	36	27	27	15	36
3	Posterior segment	36	23.8	25	10	36
4	Strabismus & orbit	36	23.6	23	9	36
5	Neuro-ophthalmology	36	19.8	20	6	34
6	Communication	18	12.8	13	0	18

Table 9 Correlation between examiner's marks at each station

	Station 1	Station 2	Station 3	Station 4	Station 5	Station 6
	AS	Glauc/lid	Posterior	Orbit/Strab	Neuro-oph	Comm.
	0.71	0.78	0.78	0.93	0.83	0.83

Table 10 Correlation between examiner's global judgements at each station

	Station 1	Station 2	Station 3	Station 4	Station 5	Station 6
	AS	Glauc/lid	Posterior	Orbit/Strab	Neuro-oph	Comm.
	0.67	0.67	0.81	0.87	0.79	0.77

Table 11 Correlation between station scores (combined marks 2 examiners)

		Station 1	Station 2	Station 3	Station 4	Station 5/6
		AS	Glauc/lid	Posterior	Orbit/Strab	Neuro-ophth
Station 2	Glauc/lid	0.23				
Station 3	Posterior	0.07	0.28			
Station 4	Orbit/Strab	0.10	0.44	0.29		
Station 5	Neuro-oph	0.11	0.32	0.13	0.17	
Station 6	Comm	0.05	0.15	0.20	0.11	0.15

4b) Standard setting for the OSCE

Table 12

Station	*1*		*2*		*3*		*4*		*5*		*6*	
No. of passed candidates	49	46	50	53	42	40	42	45	22	19	54	58
No. of borderline candidates	22	20	24	24	23	19	19	15	28	32	16	16
No. of failed candidates	8	13	5	2	14	20	18	19	29	28	9	5
Median borderline candidate raw score	9.5	12	10	11	10	11	10	9	10	11	4	4

The pass mark for the OSCE was increased by 1 SEM from 112/198 (56%) to 122/198 (62%).

5. Overall results for the oral examination

5a. Results

Pass mark	197/318	(62%)
Mean	214/318	(67%)
Median	210/318	(66%)
Range	150-283	(47%-89%)

To pass the oral examination candidates must achieve 197/318 overall, 68/120 in the viva and 122/198 in the OSCE.

57 candidates achieved 197/318, but only 50 met all three requirements in order to pass the examination overall.

Pass rate for the oral examination	50/79 (63%)
Pass rate overall for candidates in OST	38/54 (70%)
Pass rate overall for non-trainees	12/25 (48%)

Table 13 Distribution of scores

Score	Distribution	Total
141-150	/	1
151-160	//	2
161-170	///	3
171-180	///// //	7
181-190	////	4
191-200	/////// ////	9
201-210	//// ///// /////	15
211-220	/////	5
221-230	///// /////	10
231-240	/////	5
241-250	///// ////	9
251-260	//	2
261-270	////	4
271-280	//	2
281-290	/	1
291-300		0
Total		79

Table 14 Results by OST stage mean (median)

Stage	Number	MCQ	SV	OSCE	Oral	Total	Median attempts
ST5	9	121 (117)	82 (86)	133 (134)	215 (208)	336 (324)	1
ST6	28	125 (123)	85 (84)	144 (140)	229 (227)	354 (343)	1
ST7	11	121 (120)	83 (85)	128 (127)	211 (203)	332 (330)	2
Not in OST	27	126 (129)	76 (74)	123 (123)	199 (198)	325 (321)	1

Stage not known for 4 candidates

Table 15 Results by attempt mean (median)

Attempts	Number	MCQ	SV	OSCE	Oral	Total
1	44	126 (127)	86 (86.5)	142 (139.5)	228 (226.5)	354 (350)
2	20	122 (118.5)	73 (73.5)	122 (123.5)	195 (200)	317 (319.5)
3	8	120 (117)	76 (75)	118 (117)	194 (198)	313 (317.5)
>3	7	122 (120)	75 (76)	131 (126)	205 (209)	327 (329)

Table 16 Correlation between scores in each part of examination

	VIVA	*OSCE*	Oral examination
MCQ	0.37	0.32	0.39
VIVA		0.50	

5b) Breakdown of Oral Examination

Table 17 Breakdown of results by training

	Failed	Passed (%)	Total
In OST	16 (30)	38 (70)	54
Not in OST	13 (52)	12 (48)	25
Total	29 (37)	50 (63)	79

Candidates in OST performed better than those in non-training posts. These differences are statistically significant (p = 0.049)

Table 18 Breakdown of results by gender

	Failed	Passed (%)	Total
Female	9 (31)	20 (69)	29
Male	20 (40)	30 (60)	50
Total	29	50	79

These differences are not statistically significant (p = 0.48)

Table 19 Breakdown of results by deanery

	Failed	Passed	Total
East Midlands	1	3	4
East of England	4	2	6
East Scotland	0	2	2
London	3	12	15
Mersey	0	1	1
North Scotland	1	1	2
North Western	1	2	3
Northern	0	3	3
Northern Ireland	0	0	0
Oxford	0	2	2
Peninsula	1	0	1
South East Scotland	1	1	2
West Scotland	0	1	1
Severn	0	2	2
Wales	0	0	0
Wessex	1	0	1
West Midlands	0	3	3
Yorkshire	3	3	6
	16	38	54

Table 20 Breakdown of results by level of training

	Failed	Passed	Total
ST3	0	0	0
ST4	0	0	0
ST5	2	7	9
ST6	5	23	28
ST7	5	6	11
Total	12	36	48

* Level unknown for 4 candidates in OST

Table 21 Breakdown of results by country of qualification

	Failed	Passed	Total
UK	9	26	
Outside UK	20	24	
Total	29	50	

Candidates who qualified in the UK performed better than those who graduated overseas. These differences are almost statistically significant (p = 0.057)

Table 22 Breakdown of results by first language

	Failed	Passed (%)	Total
English	11 (25)	33 (75)	44
Other	16 (52)	15 (48)	31
Total	27	48	75

*First language unknown for 4 candidates.

Candidates whose first language is English performed better than those with a different first language. These differences are statistically significant (p = 0.017)

Table 23 Breakdown of results by ethnicity

	Failed	Passed	Total
White	6 (29)	15 (71)	21
Non-white	19 (36)	34 (64)	53
Total	25	49	74

* Ethnicity undeclared by 5 candidates

These differences are not statistically significant for white/non-white (p = 0.60)

Table 24 Breakdown of results by ethnicity for UK graduates

	Failed	Passed	Total
White	1 (8)	12 (92)	13
Non-white	7 (34)	14 (67)	21
Total	8 (24)	26 (76)	34

There is a difference in the performance based upon ethnicity for candidates who attended a UK medical school but this does not quite reach statistical significance (p = 0.09)

Table 25 Ethnicity of candidates in OST

Ethnicity	In OST	Not in OST	Total
White	18	3	21
Non-white	34	19	53
	52	22	74

* Ethnicity undeclared by 5 candidates

Table 26 Breakdown for candidates in OST by ethnicity

Ethnicity	Fail	Pass	Total
White	3 (17)	15 (83)	18
Non-white	12 (35)	22 (65)	34
	15 (29)	27 (52)	52

* Ethnicity undeclared by 2 candidates

These differences are not statistically significant for white/non-white in training (P = 0.2*)*

Table 27 Breakdown of results by number of previous attempts

Attempts	Failed	Passed (%)	Total
1 (First)	11	33	44
2	11	9	20
3	5	3	8
4	1	2	3
5	0	0	0
6	0	1	1
7	1	2	3
8	0	0	0
Any resit	18	17	35

5d) Table 28 Comparison to previous examinations

Date	Oct 10	April 11	Nov 11	April 12	Oct 12	April 13	Nov 13	April 13	Nov 14
Candidates	26	46	77	104	95	109	103	104	79
MCQ pass mark	65%	65%	58%	58%	55%	61%	59%	58%	NA*
Reliability	0.8	0.7	0.7	0.7	0.7	0.8	0.8	0.8	NA
EMQ pass mark	64%	65%	59%	58%	59%	NA	NA	NA	NA
Reliability	0.8	0.7	0.7	0.7	0.8	NA	NA	NA	NA
Viva pass mark	56%	63%	60%	62%	58%	60%	58%	57%	63%
Reliability	0.8	0.8	0.8	0.8	0.8	0.8	0.9	0.8	0.8
OSCE pass mark	62%	63%	65%	62%	62%	63%	61%	61%	62%
Reliability	0.9	0.9	0.8	0.8	0.8	0.8	0.8	0.8	0.7
Written pass rate	58%	46%	68%	65%	81%	85%	93%	90%	NA*
Oral pass rate	73%	71%	54%	57%	63%	57%	58%	58%	63%
Overall pass rate	58%	33%	35%	37%	51%	48%	53%	51%	NA
Overall pass rate in OST	NA	43%	46%	43%	63%	56%	64%	65%	70%

* the written examination is now de-coupled from the oral examination

Table 29 Cumulative results by deanery (September 2010 to date)

Deanery	Number of passes	Number of candidates	Pass rate %
East Scotland	5	5	100
Oxford	18	22	82
Severn	14	19	74
Northern Ireland	8	11	73
Northern	16	23	70
London KSS	90	134	67
Mersey	18	27	67
North Scotland	5	8	63
South East Scotland	8	13	62
East Midlands	15	25	60
West Scotland	10	17	59
West Midlands	24	47	51
Peninsula	10	20	50
Wales	14	28	50
Yorkshire	26	57	46
North Western	17	39	44
East of England	8	21	38
Wessex	4	12	33
TOTAL	310	528	33

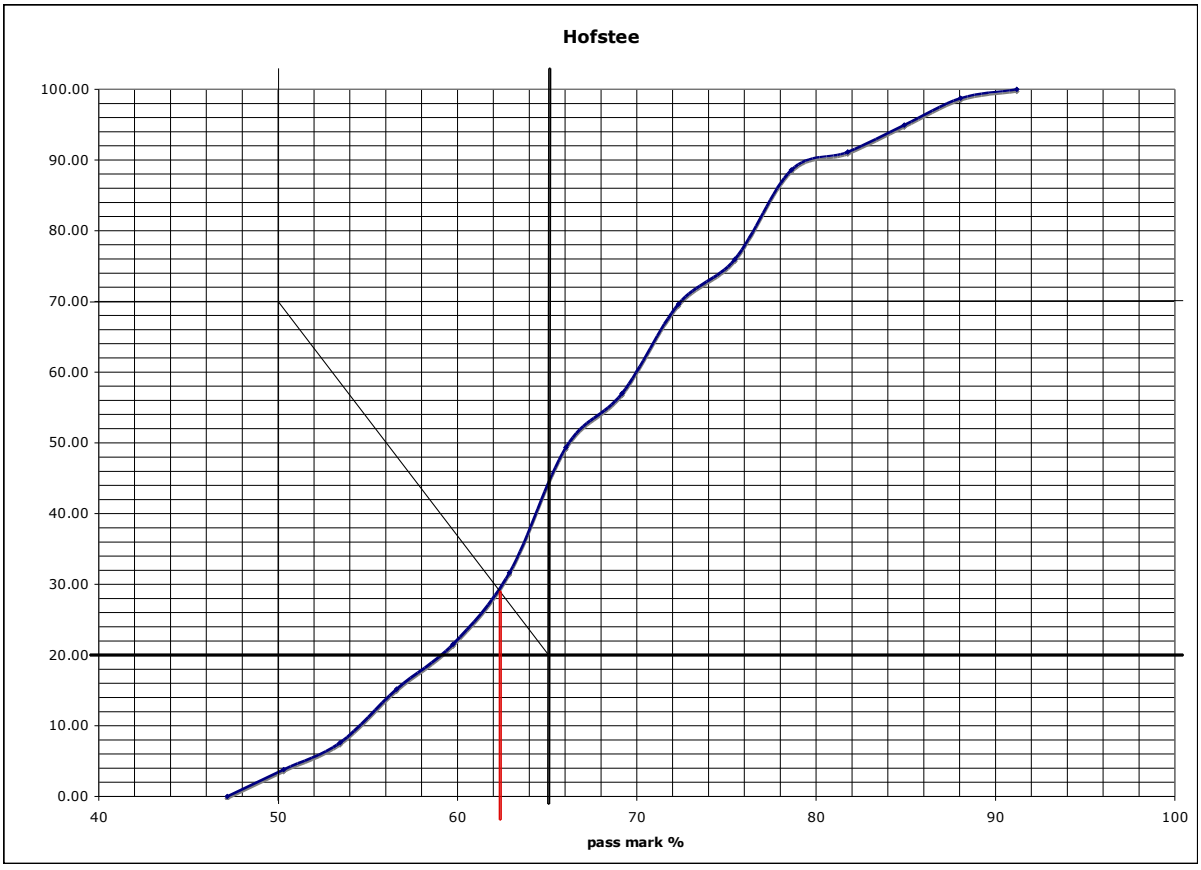
Appendix 1: Hofstee pass mark

The Hofstee method of standard setting is based upon the examiner's opinion on the maximum and minimum credible pass marks and maximum and minimum credible fail rates for the examination. These parameters can then be used to identify a pass mark from a plot of pass mark against fail rate derived from the examination results.
Using the following parameters*:

- Maximum pass mark 65% (207/318)
- Minimum pass mark 50% (159/318)
- Maximum fail rate 20%
- Minimum fail rate 70%

The pass mark for the oral examination using this method would be 197/318 (62%), which is identical to the pass mark derived from the borderline candidate method. (It should be noted that this result is based upon the total marks for the oral examination with complete cross compensation between OSCE and viva results.)

* These parameters do not necessarily represent the values that would be chosen by the part 2 examinations sub-committee.



Appendix 2: Candidate evaluation

Structured Viva

Candidate Feedback – Oral Examination – November 2014

The following feedback is from 13 candidates who took part in the Structured Viva out of 79 (16% response)

Viva Station 1 Patient Investigations & Data Interpretation

Were you treated in a courteous manner by the examiners in this station?
Yes 11 (100%)
No 0 (0%)

No Comments

Were the questions appropriate for the station?
Yes 7 (64%)
No 4 (36%)

Comments

- Dacryoscintigraphy / dacryocystogram are not really investigations requested by a general ophthalmologist and also not found in the standard text books. I haven't come across anybody requesting this in our unit. I appreciate that we should have a basic understanding of this, but to base the whole patient investigation station on this is not helpful in evaluating our knowledge.
- I do not think that most general consultant ophthalmologists know the proportion of PEDs that remain, resolve or become RPE tears, there is little in the literature on this topic. The medical retina consultants at my hospital did not know this! I thought that questions on the pathophysiology of RPE tears were also a bit unreasonable, as this is not known.
- We had lacrimal scintillogram and Dacryocystogram which is not very much preferred investigation modality in most departments for epiphora. I personally think we should be tested on investigations that is routinely used and valid in clinical practice.
- It is almost hard to believe that Scintigram and CT DCG come out as investigation station. Both of these modalities hardly ever used in actual clinical practice unless you work in one of biggest oculoplastic units in the country. Even if you work in one of those units some oculoplastic surgeons will disregard these investigations, questioning the usefulness of these tests. General consultant ophthalmologists definitely not familiar with either of those tests therefore the questions were not appropriate standard for an exit examination.
- We almost never order Hess chart for INO, let alone having it in the exam. Although the problem stem did indicate MS, having Hess chart to interpret threw us off our feet. The main aim of the exam is to evaluate our clinical knowledge and not having trick questions

Were the questions of an appropriate standard for an exit examination?
Yes 9 (75%)
No 3 (25%)
No Comments

Viva station 2 Patient Management 1

Were you treated in a courteous manner by the examiners in this station?
Yes 12 (100%)
No 0 (0%)

Comments
- Friendly and reassuring

Were the questions appropriate for the station?
Yes 12 (100%)
No 0 (0%)

Comments
- Septo-optic dysplasia is extremely rare and although I think it is reasonable to know about midline abnormalities and endocrine disturbances, I think some of the other questions were quite unreasonable and above the level required for a general ophthalmologist.

Were the questions of an appropriate standard for an exit examination?
Yes 11 (92%)
No 1 (8%)

Comments
- Septo-optic dysplasia is a very rare condition and a lot of time was spent trying to get a diagnosis from a single section through an MRI. More time on the management of a blind child would have been more useful in showing competence.

Viva station 3 Patient Management 2

Were you treated in a courteous manner by the examiners in this station?
Yes 12 (100%)
No 0 (0%)

No Comments

Were the questions appropriate for the station?
Yes 12 (100%)
No 0 (0%)

No Comments

Were the questions of an appropriate standard for an exit examination?
Yes 12 (100%)
No 0 (0%)

Comments
- Questions relating to surgical practice were very sup-specialty specific and difficult to answer if one had not come across them.

Viva station 4 Attitude, Ethics and Responsibilities

Were you treated in a courteous manner by the examiners in this station?
Yes 11 (92%)
No 1 (8%)

Comments
- Friendly and relaxed and put me at ease

Were the questions appropriate for the station?
Yes 10 (90%)
No 1 (10%)

Comments
- Yes but the same principle was questioned again and again with different case scenarios
- Difficulty understanding the context
- felt that questions were very repetitive – I was asked essentially the same question three times!

Were the questions of an appropriate standard for an exit examination?
Yes 9 (82%)
No 2 (18%)

Comments
- I felt that the questions forced me in repeating myself – furthermore I understand that this is an exit exam, but still as a trainee we do not get exposed dealing with issues related being on an 'interview panel' or 'drug committee' so it does not reflect on our current clinical practice. Teaching in ethical issues is also very scarce.
- Difficulty understanding the context.

Viva station 5 Audit, research and evidence based medicine

Were you treated in a courteous manner by the examiners in this station?
Yes 12 (100%)
No 0 (0%)

No Comments

Were the questions appropriate for the station?
Yes 10 (83%)
No 2 (17%)

Comments
- Questions were poorly structured
- Question a little unclear. Asked to comment on features of screening programmes with particular reference to the DRSS. Described typical screening program features, then went point by point through them saying how DRSS fit the criteria. Then the examiners stayed silent, so proceeded to outline the way DRSS is conducted. Examiners still silent. Didn't know what else they wanted, but no questions were forthcoming. Released from station

early, yet other people reported getting asked more questions on the topic, including discussion of some aspects which I hadn't covered.
- We very rarely come across CJD in our practice and if we do we refer back to the college website, we are not expected to know them by heart, I think!
- question on decontamination & sterilisation was unexpected for an ophthalmology exam

Were the questions of an appropriate standard for an exit examination?
Yes 9 (82%)
No 2 (18%)

Comments
- When the questions on guidelines are made, i think the questions should be based on prnciples and theories behind guidelines rather than small factual points.
- Questions were poorly structured

OSCE station Communication Skills

Were you treated in a courteous manner by the examiners in this station?
Yes 12 (100%)
No 0 (0%)

No Comments

Was the clinical scenario explained clearly?
Yes 10 (90%)
No 1 (10%)

Comments
- Very large sheet to read in less than 2 minutes
- Ambiguity in the question. Our run had macular hole surgery scenario. 2 sections for the question and not sure which section was addressing to the patient. First section states regarding counselling regarding surgery, posturing etc… then the second section talks about the macular hole characteristics and instructs to discuss management. What is the need for the ambiguity in question please?

Was the clinical scenario appropriate for an exit examination?
Yes 12 (100%)
No 0 (0%)

No Comments

The Structured Viva – Overall Feedback

Was the structured viva examination well organized?
Yes 12 (100%)
No 0 (0%)

Comments
- This was well organized and set out. The structured booths were helpful as they were quiet.

Were you given clear instructions about the structured viva examination?
Yes 12 (100%)
No 0 (0%)

Comments

- Some questions were poorly structured

Did you feel that the structured viva examination was a fair assessment of your knowledge?
Yes 10 (83%)
No 2 (17%)

Comments

- It is almost hard to believe that Scintigram and CT DCG come out as investigation station. Both of these modalities hardly ever used in actual clinical practice unless you work in one of biggest oculoplastic units in the country. Even if you work in one of those units some oculoplastic surgeons will disregard these investigations, questioning the usefulness of these tests. General consultant ophthalmologists definitely not familiar with either of those tests therefore the questions were not appropriate standard for an exit examination. No - Due to the above reason regarding the investigation station.

In your opinion should the structured viva examination be included in the exit examination?
Yes 12 (100%)
No 0 (0%)

Comments

- On a few stations in the Viva I got examined by consultants I work with, but not during my OSCEs. Overall I found it a bit distracting / irritating being examined by somebody I know and in hindsight prefer to be examined by consultants I don't know. I appreciate that logistically it already is difficult to allocate the delegates to the various stations.

Please write any other comments you have about the structured viva examination below.

- The venue was very far to get to, even from the midlands, but it was a nice venue nonetheless.

OSCE

Candidate Feedback - Oral Examination – November 2014

The following feedback is from 14 candidates who took part in the OSCE out of 79 (18% response)

OSCE station 1 Cataract and Anterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 14 (100%)
No 0 (0%)

No Comments

Were the patients you were asked to examine appropriate for the station?
Yes 14 (100%)
No 0 (0%)

No Comments

Were the questions of an appropriate standard for an exit examination?
Yes 14 (100%)
No 0 (0%)

Comments

- I was a bit surprised to be asked to comment on whether a Yag capsulotomy had been performed on an undilated patient, if this is the point of the station the patient should be dilated.

OSCE station 2 Glaucoma and eyelid

Were you treated in a courteous manner by the examiners in this station?
Yes 14 (100%)
No 0 (0%)

No Comments

Were the patients you were asked to examine appropriate for the station?
Yes 14 (100%)
No 0 (0%)

No Comments

Were the questions of an appropriate standard for an exit examination?
Yes 14 (100%)
No 0 (0%)

Comments

- Sometimes questions lacked direction, pushed to give more answers when the list has been exhausted which leads to mistakes

OSCE station 3 Posterior Segment

Were you treated in a courteous manner by the examiners in this station?
Yes 13 (93%)
No 1 (7%)

Comments

- Was less courteous compared with other examiners. Mr.AT especially came across as not being an active listener and was interrupting during examination and not being very clear regarding the questions asked. Candidates should be given the choice of summarizing the findings or talking as you go along. It is very artificial for some candidates including myself to give a running commentary while examining patients. This was very obstructive to the thought process and was not productive. Questions like "what is the treatment for retinal detachment" were slightly confusing as to what is the general treatment for RD or was it in the context of that particular case.

Were the patients you were asked to examine appropriate for the station?
Yes 12 (86%)
No 2 (14%)

Comments

- I was asked to perform indirect ophthalmoscopy on an undilated patient who turned out to have a peripheral retinal tear and cryo scar. The patient must be dilated if the periphery is to be examined, candidates should not be expected to find abnormalities like this otherwise.

Were the questions of an appropriate standard for an exit examination?
Yes 12 (86%)
No 2 (14%)

Comments

- Asked to describe the clinical picture. The word macular oedema was mentioned which was followed by the question "how do you know". The question leads to confusion because it visually evident and after years of ophthalmology training it's an easy sign to pick up. Not sure how the question was going to demonstrate my competence.
- Questions on this station were slightly vague and not very clear
- Not sure. May be more clarity was needed with the phrasing of the questions

OSCE station 4 Strabismus and Orbit

Were you treated in a courteous manner by the examiners in this station?
Yes 14 (100%)
No 0 (0%)

No Comments

Were the patients you were asked to examine appropriate for the station?
Yes 13 (93%)
No 1 (7%)

Comments

- Without a history and the lack of time, it's very hard to hone in on a diagnosis. So when asked "what would you do" the answer will depend on symptoms and weather the strabismus was congenital or acquired. Questions have to be specific and not broad and non-specific

Were the questions of an appropriate standard for an exit examination?
Yes 13 (93%)
No 1 (7%)

Comments

- It's hard to comment fairly because it's hard to answer questions when one hasn't arrived at a diagnosis

OSCE station 5 Neuro-Ophthalmology

Were you treated in a courteous manner by the examiners in this station?
Yes 12 (86%)
No 2 (14%)

Comments

- Treated well enough, but examiners did keep interrupting me as I was trying to formulate systematic answers to questions which broke my chain of though repeatedly.
- The neurologist on this station was very nice. However the ophthalmologist was rude and very unclear in his questions. He seemed determined to be as unhelpful as possible. I would not recommend that he examine again, as he made a stressful situation worse.
- In general everything felt rushed through due to lack of time. With the new system, all the other stations you get more time per patients but with neurology you actually get less. Neurology station used to get 4 patients in 30 min, now you get to see 3 patients in 20 min. This doesn't make sense. Usually in real practice you would get more time per patients in neuro-ophthalmology clinic compared to other general clinics. Also the examiner didn't allow me to do things you would actually do in real life. For instance I would ask during the extra-ocular movement check, when the patient sees double vision. When I did that at the station, the examiner stopped me and told me I am not allowed to do that?! This really put me off. I thought the OSCE is supposed to assess what you would actually do in real life practice. If you are going to make it so artificial, you might as well admit the fact that this form of exam doesn't truly reflect what you are like as a doctor in real life. Overall this station felt badly run and organized. I did not feel this was a fair assessment of my knowledge in medicine and neurology.

Were the patients you were asked to examine appropriate for the station?
Yes 11 (79%)
No 3 (21%)

Comments

- On the whole yes but equipment such as red and white pins were lacking despite a letter stating that all equipment would be provided. Those re-sitting came more prepared. The patient with the peripheral field defect had a very variable filed on examination.
- Mostly appropriate, however I was warned by the examiners that one of the patients was a bit confused and the patient did proceed to be a bit inconsistent with double vision reporting. Also very subtle signs.
- One patient had a 6th nerve palsy, which had clearly almost resolved with compensatory changes in eye movements on the other side, making for very confusing signs. She was also extremely unclear as to whether she had diplopia or not, changing her mind each time. For the short time frame it was extremely stressful to examine her. I was also asked to comment on superior venous pulsation at the optic disc on direct ophthalmoscopy in an undilated pupil, which I did not think was reasonable.
- Some ambiguous clinical signs. But examiners asked to use "pen" as a target for cover test which is not quite the right target for eliciting cover test signs.(as we would be looking at corneal reflexes to work out under/over acting muscles).This was probably because the ocular signs were subtle/ambiguous to be elicited by a torch which is the preferred and recommended target! This need to be brought in to attention.

Were the questions of an appropriate standard for an exit examination?
Yes 11 (79%)
No 3 (21%)

Comments

- Ophthalmologist didnt know the difference between primary optic atrophy vs optic nerve hypoplasia. Which I consider very bad at this level, this took the discussion off the tract but he was humble enough to accept it at the end.
- On the whole yes but once again without a brief history it's hard to hone in on the problem and it makes answering any subsequent broad questions difficult.
- But using pen as a target…was bit surprised with that

The OSCE overall

Was the OSCE well organized?
Yes 12 (93%)
No 1 (7%)

No Comments

Were you given clear instructions about the OSCE?
Yes 13 (100%)
No 0 (0%)

No Comments

Did you feel that the OSCE was a fair assessment of your knowledge?
Yes 10 (83%)
No 2 (17%)

Comments

- I think it can be quite difficult in some stations to convey your knowledge and show your examination skills and therefore run the risk of failing that station.
- It can be quite a stressful environment, with time pressure for both the candidate and examiners' as they have to bring in & take out several patients in a short period of time.

In your opinion should the OSCE be included in the exit examination?
Yes 12 (93%)
No 1 (7%)

No Comments

Please write any other comments you have about the OSCE below.

- As most candidates get different cases, not sure whether it reflects fair assessment. I suppose there might be a case mix element of relatively easy and difficult cases in all the block runs. Not sure whether there is an element of subjectiveness either. Also, when one examiner is leading, the other examiner is writing points and going out to get the next patient ready etc…are they both meant to be listening to the candidate and marking?? This will lead to discrepancy in one examiner saying candidate did pick this finding/ did answer the question etc… when in actual fact were they listening appropriately while getting the next patient in?? I understand the huge amount of hard work that goes in to organizing the exams. But the college should strive to make our system not just good; but excellent.
- The Royal College has informed us that there was no need for us to bring our own instruments, such as torch pens, pins etc. In the Neurology station I was asked to examine patient confrontational visual fields, I asked for the pins and I was told to use my own and that there was no pins provided. This has compromised test and it might have cost the whole station.

Appendix 3: Details of the patients who made themselves available for the examination

TUESDAY 11 NOVEMBER 2014 (PM)

STATION 1 – ANTERIOR SEGMENT

DIAGNOSIS
L pseudophakia. R treated ocular hypertension. L POAG. Fuch's
POAG. Bilateral cataracts
Crystalline corneal dystrophy. Bil uveitis – currently controlled
Bilateral keratoconus
Intermittent uveitis. ? degree of end point nystagmus
DIAGNOSIS
Capsulotomy. Previous high myope. L retinopexy for L operculum
R Fuch's heterochromic iridocyclitis. R pseudophakia
Bilateral Fuch's. Low hypermetropia
Mild keratoconic signs. Vogue straie. C lens wearer
Bil microphthalmos. Bil pseudophakia. Bil trabs. R vitrectomy
DIAGNOSIS
Narrow angle/PAS. Pseudophakia. Open angle/PAS
Anterior segment branch vein across pupil
End stage glaucoma. R with aniridia. Post op review following sulcus suture intraocular lens replacement
Bilateral pseudophakia. Normal tension glaucoma
No iris. Iris sutured IOL

STATION 2 – GLAUCOMA AND LID

DIAGNOSIS
Bil trabs. R early cataract. L pseudo-phakia. Bil advanced glaucoma
Bil open angle glaucoma. L anterior chamber intraocular lens. R pseudophakia
Glaucoma. Very cupped discs
R congenital ptosis. R corneal scar associated with previous bacterial keratitis
Cogin Reese Glaucoma
DIAGNOSIS
Optic nerve asymmetry. Suspect L low tension glaucoma
L pseudoexfoliation with previous trab and cupped disc. R treated OHT
L Glaucoma. L phaco-trab. Bil trichiasis
Bil trabs. Bil advances disc cupping R>L. L optic disc collaterals. R pseudophakia
POAG. L Phacotrabeculectomy
DIAGNOSIS
R glaucoma with significant optic disc cupping. Reg blind.
POAG. L phacotrab
Ocular hypertension. Bil pseudophakia. Bil YAG. Bil PI's
Minimal symptomatic left lower lid intermittent entropion. Marked bilateral lid laxity with intermitted spastic entropion and upper lid ptosis
Pseudoexfoliative glaucoma, previous right vein occlusion, right phacotrabeculectomy, early cataract right eye

STATION 3 – POSTERIOR SEGMENT

DIAGNOSIS
Previous retinal detachment surgery
Cataract. Background diabetic retinopathy. L choroidal naevus
Lattice only. L pseudophakia with silicon oil fill for complicated previous RD
Retinitis pigmentosa. Reg blind. Bil posterior subcapsular cataracts
L diabetic maculopathy
DIAGNOSIS
Bil wet AMD. R treated with Lucentis x 29. L end stage disciform scar
ARMD. R blind eye – disciform scar. Previous L cataract surgery
Wegener's granulomatosis. Previous exudative retinal detachmens with L RPE rip
Bilateral diabetic retinopathy
L phaco IOL. Vitrectomy. Epiretinal membrane peel
DIAGNOSIS
ARMD
L multiple fully operculated retinal tears associated with lattice degeneration. R multiple patches of lattice degeneration
L wet AMD with haemorrhage and subretinal fluid. Bil early cataract
L macula on retinal detachment. Vitrectomy, laser, gas. Post op cataract

STATION 4 – STRABISMUS AND ORBIT

DIAGNOSIS
Ocular myasthenia
Bil TED. Mild lid oedema and reasonably stable restriction of mobility. Mild dry eyes
Age related extraocular muscle weakness with horizontal diplopia controlled by prisms. Bil cataracts
DIAGNOSIS
TED
Bilateral congenital glaucoma. L artificial eye. Previous Baerveldt tube. Recent R cyclodiode
Duane's refraction syndrome
DIAGNOSIS
Consecutive R exotropia
Range secondary to L superior rectus, R superior oblique weakness. 7 degree prism
Stable TED

STATION 5 – NEURO-OPHTHALMOLOGY

DIAGNOSIS
Presumed CPEO – orthoptic pt
L partial 3rd nerve palsy. Ptosis and diplopia. Cataract
L orbital apex meningioma. Early cataracts. Syneretic vitreous right more than left.
R POAG. RAPD
R homonymous hemianopia
R optic atrophy. Dense L amblyopia. R RAPD
DIAGNOSIS
L&H RAPD
Retinitis pigmentosa
L 3rd nerve palsy following communication artery aneurysm. L APD

Advanced POAG. Bil trab. Extensive glaucomatous field loss. Bil early cataract with refractive error
DIAGNOSIS
Bil optic atrophy with twice weekly hyperbaric oxygen treatment
R optic atrophy. RAPD. Previous ON meningioma
L third nerve palsy

WEDNESDAY 12 NOVEMBER 2014 (AM)

STATION 1 – ANTERIOR SEGMENT

DIAGNOSIS
L pseudophakia. R treated ocular hypertension. L POAG. Fuch's
L corneal transplant. Keratoconus recurrence in graft
Bil pseudophakia. L Yag
Vitectomy. IOL-ectomy and anterior chamber verisyse lens implant
R Phaco. Previous R EDTA for band keratopathy with severe post op inflammation. Unstable tear film
Conjunctival scarring disease, probable mucous membrane pemphigoid
DIAGNOSIS
Ocular cicatricial pemphigoid
Bilateral pseudophakia. Endophthalmitis following surgery. Subsequent IOL-ectomy and secondary sulcus IOL
Rubeotic glaucoma. Post CRVO. White cataract. NPL
Bilateral keratoconus
Previous bil upper and lower punctual cautery. History of angle closure glaucoma. Bil peripheral iridotomies
DIAGNOSIS
Plateau Iris
R previous herpetic keratouveitis. R amblyopia. Iris dystrophy and midriasis. Mild ptosis
Mild keratoconic signs. Vogue striae. C lens wearer
Bilateral Fuch's
Aphakia secondary to congenital cataract
L pseudophakia with toric lens. Previous L penetrating keratoplasty for herpes simplex keratitis

STATION 2 – GLAUCOMA AND LID

DIAGNOSIS
Bil open angle glaucoma. L anterior chamber intraocular lens. R pseudophakia
Glaucoma. Bil prophylactic PI's
POAG. L phacotrabeculectomy
?BCC
DIAGNOSIS
Bil glaucoma –L > R. L pseudophakia
POAG, Bil pseudophakia
Pseudoexfoliative glaucoma and previous R trab
Bilateral ptosis with markedly reduced levator function
DIAGNOSIS
R Ptosis
Bil trab blebs. POAG. Early cataract

PDS glaucoma. L RAPD. Bil pseudophakia
Stevens-Johnson syndrome

STATION 3 – POSTERIOR SEGMENT

DIAGNOSIS
High myope. L vitrectomy. L post operative gas cataract
Previous bilateral retinal detachment surgery. L pseudophakia with min lens opacity R eye
L dry AMD. R subretinal fluid - symptomatic
X-linked retinitis pigmentosa. Reg blind
DIAGNOSIS
Long standing wet AMD
Bilateral diabetic retinopathy
Collateralisation and R macular scarring. L retinal pigment epitheliopathy. No vascular pathology.
Diabetic retinopathy
DIAGNOSIS
Previous bil choroidal neovascular membranes . Multiple choroiditis
Macular laser. Bil diab maculopathy but no significant clinical macular oedema
L myopic choroidal neovascular membrane - currently inactive. Previous refractive surgery
Diabetic Retinopathy

STATION 4 – STRABISMUS AND ORBIT

DIAGNOSIS
R Brown's syndrome
R divergent squint with evidence binocularly
Consecutive exotropia. Dense left amblyopia. Presbyopia
Stable TED
DIAGNOSIS
Pseudoexfoliation. L ocular hypertension. L glaucoma. Stable acquired R Brown's syndrome
Presumed neurosarcoidosis. Significant facial Cushingoid changes. Periorbital oedema. Conjunctival chemosis and pain
Venous abnormality. R periocular area extending into R socket
Age related extraocular muscle weakness with horizontal diplopia controlled by prisms. Bil cataracts
DIAGNOSIS
Duane's syndrome
Consecutive R exotropia
L amblyopia. L consecutive exotropi secondary to L amblyopia. Long-standing nystagmus
Stable TED

STATION 5 – NEURO-OPHTHALMOLOGY

DIAGNOSIS
Left recurrent anterior uveitis
Microaneurysm, aniscoria, probable R Adie's pupil
R POAG. RAPD
R homonymous hemianopia
Recovering L VIth nerve palsy. Likely microvascular
DIAGNOSIS

L traumatic IV nerve palsy
Anterior scleritis
Simulated Field Defect
R parietal occipital Grade 4 glioma – resected May 2014. Ocular hypertension secondary to systemic steroids. L homonymous hemianopia
DIAGNOSIS
L partial 3rd nerve palsy. Ptosis and Diplopia. Cataract
L & H RAPD
Intranuclear ophthalmaplegia

WEDNESDAY 12 NOVEMBER 2014 (PM)

STATION 1 – ANTERIOR SEGMENT

DIAGNOSIS
L pseudophakia. R treated ocular hypertension. L POAG. Fuch's
L corneal transplant. Keratoconus recurrence in graft
Vitrectomy. IOL-ectomy and anterior chamber verisyse lens implant
Bilateral keratoconus
Aphakia secondary to congenital cataract
DIAGNOSIS
Chronic uveitis. L pseudophakia. L YAG
Ocular cicatricial pemphigoid
Left classic PXS
Corneal transplant for keratoconus
DIAGNOSIS
Plateau Iris
Bilateral Fuch's
Bilateral nuclear cataract
Previous bil upper and lower punctual cautery. History of angle closure glaucoma. Bil peripheral iridotomies
Conjunctival scarring disease, probable mucous membrane pemphigoid

STATION 2 – GLAUCOMA AND LID

DIAGNOSIS
Bil open angle glaucoma. L anterior chamber intraocular lens. R pseudophakia
Glaucoma. Bil prophylactic PI's
L Marcus-Gunn jaw winking syndrome. (Brow suspension as a child). L amblyopia. Physiological disc cupping
Advanced narrow angle glaucoma R eye. R phacotrab. Mild Fuch's. Occludable angle L eye
DIAGNOSIS
R Ectropion – cicatricial. L operated on
Bil glaucoma –L > R. Left pseudophakia
Reigers. Pseudophakia
Bil trabs. Bil advances disc cupping R>L. L optic disc collaterals. R pseudophakia
Bilateral trabs. Cicatricial change R eye
R upper lid necrotising fasciitis & secondary ischaemic optic neuropathy; RAPD
DIAGNOSIS

R glaucoma with significant optic disc cupping. Reg blind.
Pseudoexfoliative glaucoma. Bil trabs. Bil pseudophakia
Bil glaucoma L worse than R. Bil cataract. L Trab. R macular scar
R Ptosis
L pseudoexfoliation with previous trab and cupped disc. R treated OHT

STATION 3 – POSTERIOR SEGMENT

DIAGNOSIS
Pigment dispersion syndrome. Myopic degeneration
Angioid streaks
L dry AMD. R subretinal fluid - symptomatic
Known hypertensive. Multiple micro-aneurysms at R fundus with breakthrough vitreous haemorrhage
Wegener's granulomatosis. Previous exudative retinal detachments with RPE rip L eye
DIAGNOSIS
Long standing wet AMD
Bil wet AMD. R treated with Lucentis x 29. L end stage disciform scar
Cataract. Background diabetic retinopathy. L choroidal naevus
R cryobuckle retinal detachment repair. Previous L laser retinopexy
DIAGNOSIS
L myopic choroidal neovascularmembrane- currently inactive. Previous refractive surgery
ARMD
Previous bil choroidal neovascular membranes Multiple choroiditis
Diabetic Retinopathy
Bilateral colobomata. Previous L retinal detachment repair
Previous L retinal detachment. Lens lying in inferior vitreous cavity.

STATION 4 – STRABISMUS AND ORBIT

DIAGNOSIS
Bil TED. Mild lid oedema and reasonably stable restriction of mobility. Mild dry eyes
R Brown's syndrome
Recovering L VIth nerve palsy. Likely microvascular
R congenital exotropia
Bilateral Duane's retraction syndrome L > R
DIAGNOSIS
TED
Venous abnormality. R periocular area extending into R socket
Pseudoexfoliation. L ocular hypertension. L glaucoma. Stable acquired R Brown's syndrome
Unrecovered L VI Nerve palsy
Stable TED
DIAGNOSIS
Duane's syndrome
Consecutive R exotropia
R divergent squint with evidence binocularly
Thyroid eye disease
TED, Very mild activity in lids. Small increase in hypotropia

STATION 5 – NEURO-OPHTHALMOLOGY

DIAGNOSIS

Presumed CPEO – orthoptic pt
Parasellar meningioma resection. R optic atrophy with RAPD. Bitemporal hemianopia
Bil optic atrophy with twice weekly hyperbaric oxygen treatment
L RAPD
Ocular myasthenia
DIAGNOSIS
L&H RAPD
Microaneurysm, Aniscoria, Probable R Adie's pupil
Recent left lateral transposition for undercover VIth nerve palsy
R parietal occipital Grade 4 glioma – resected May 2014. Ocular hypertension secondary to systemic steroids. L homonymous hemianopia
DIAGNOSIS
R optic atrophy. RAPD. Previous ON meningioma
L RAPD
Simulated Field Patient

THURSDAY 13 NOVEMBER 2014 (AM)

STATION 1 – ANTERIOR SEGMENT

DIAGNOSIS
L corneal transplant. Keratoconus recurrence in graft
Bil pseudophakia. L Yag
Anterior scleritis
Bilateral Fuch's. Low hypermetropia
Crystalline corneal dystrophy. Bil uveitis – currently controlled
DIAGNOSIS
Bilateral pseudophakia. Endophthalmitis following surgery. Subsequent IOL-ectomy and secondary sulcus IOL
Glaucoma. Blebs. Pseudophakia. Pupils fixed
Bilateral corneal lattice dystrophy
Ocular cicatricial pemphigoid
Bilateral microphthalmos, bil pseudophakia, bil trabs. R vitrectomy
DIAGNOSIS
Plateau Iris
Bil congenital cataract surgery
Bilateral keratoconus ptosis op 2011
Marfan's. Bil pseudophakia. L epiretinal membrane. Protruding L corneal suture. Treated L ocular hypertension
Ocular cicatricial pemphigoid
Left recurrent anterior uveitis

STATION 2 – GLAUCOMA AND LID

DIAGNOSIS
Previous R trab with Mitomycin C Aug 2013
Progressive glaucoma L eye
Bilateral trabeculectomy blebs. POAG. Early cataract

PDS glaucoma. L RAPD. Bil pseudophakia
Bilteral ptosis and markedly reduced levator function
DIAGNOSIS
POAG. Bil pseudophakia
Glaucoma. Bil prophylactic PI's
Pseudoexfoliative glaucoma. Previous R trab
R Ptosis
Pseudoexfoliative glaucoma, previous right vein occlusion, right phacotrabeculectomy, early cataract right eye
DIAGNOSIS
Pseudoexfoliative glaucoma. Bil trabs. Bil pseudophakia
Bil glaucoma L worse than R. Bil cataract. L Trab. R macular scar
Ocular hypertension. Bil pseudophakia. Bil YAG. Bil PI's
Stable glaucoma L eye. L trab
BL glaucoma (L more than R); L pseudophakia
Blepharospasm

STATION 3 – POSTERIOR SEGMENT

DIAGNOSIS
Previous retinal detachment surgery
Capsulotomy. Previous high myope. L retinopexy for left operculum
R retinal surgery for macular hole. Incipient hole with vitreomacular traction. L nuclear sclerotic cataract
Significant right cataract with myopic shift. Burnt out DR
DIAGNOSIS
ARMD. R blind eye – disciform scar. Previous L cataract surgery
L Cryo buckle. R lower retinopexies. L paracentral PED
Bilateral large drusenoid PED. Good VA
DIAGNOSIS
Diabetic Retinopathy
L diabetic maculopathy
Pseudoexfoliative glaucoma. Previous R vein occlusion. R Phacotrab. Early cataract R eye
Stickler's syndrome. History of bilateral retinopathy for lattice degeneration

STATION 4 – STRABISMUS AND ORBIT

DIAGNOSIS
Pseudoexfoliation. L ocular hypertension. L glaucoma. Stable acquired R Brown's syndrome
Distance esotropia with prism
Primary exotropia. Anisometropia. Marfanoid features
TED. Bil medial and inferior recessions
DIAGNOSIS
Duane's retraction syndrome
Stable TED
L microtropic full accommodative esotropia
Asymmetric TED. L Proptosis 2/52 post op IR recession OMS still abnormal
DIAGNOSIS
Duane's syndrome
Consecutive R exotropia
Stable TED

STATION 5 – NEURO-OPHTHALMOLOGY

DIAGNOSIS
L Long standing non-artertic ischaemic optic neuropathy
R POAG. RAPD
Presumed CPEO – orthoptic pt
Recovering L VIth nerve palsy. Likely microvascular
Visual field defect. Altitudinal due to ischaemic optic neuropathy
DIAGNOSIS
Craniopharyngioma. Bitemporal hemianopia. Fields to confrontation
R APD. R pale disc. Traumatic optic neuropathy
Decompensating exophoria
Presumed neurosarcoidosis. Significant facial cushingoid changes. Periorbital oedema. Conjunctival chemosis and pain
DIAGNOSIS
R APD. R acoustic neuroma
R parietal occipital Grade 4 glioma – resected May 2014. Ocular hypertension secondary to systemic steroids. L homonymous hemianopia
L IV traumatic nerve palsy
Intranuclear ophthalmaplegia