

# Examination Report

## November 2015 Part 2 FRCOphth Oral Examination



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Michael Nelson BSc (Hons) FRCOphth MAEd  
**Education Adviser**

## 1. Summary

This is the third time that the Part 2 FRCOphth oral examination has been taken by candidates since it was de-coupled from the written examination. The OSCE consists of 5 clinical stations at which candidates are required to examine 3 patients (15 in total). The medicine/neurology station is 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 there is weighting towards the OSCE of 62% compared with 38% for the structured viva (SV).

72 candidates sat the examination, which is the smallest cohort to date.

The reliability of the oral examination is high at 0.80 (SV) and 0.80 (OSCE), but slightly lower than previous years.

The pass rate in OST was the highest of any sitting at 86%, which exceeded the pass rate for candidates who were not in OST (40%).

There were statistically significant differences in the success of candidates based upon OST, and UK graduates. Candidates who were in OST were more likely to pass, as were UK graduates.

There was no statistically significant difference in success based upon ethnicity, gender, or those who spoke English as a first language.

Trainees in OST stages 5 and 6 were more successful than those in ST4 and ST7.

The oral parts of the 13<sup>th</sup> sitting of the Part 2 FRCOphth examination were held in Manchester from 9 to 13 November 2015.

## 2. Candidates

72 candidates presented themselves for the examination.

## 3. The Structured Vivas

There were five structured vivas, which were held on Monday 9th and Tuesday 10th November 2015. 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:

<b>Station 1:</b>	<b>Patient investigations and data interpretation</b>
Monday PM	Neurological visual fields
Tuesday AM	Glaucoma
Tuesday PM	Pupils
<b>Station 2:</b>	<b>Patient management 1</b>
Monday PM	Paediatric watery eye
Tuesday AM	Vernal disease
Tuesday PM	Uveitis secondary to JCA
<b>Station 3:</b>	<b>Patient management 2</b>
Monday PM	Dislocated lens
Tuesday AM	Endophthalmitis
Tuesday PM	Aqueous misdirection
<b>Station 4:</b>	<b>Attitudes, Ethics and Responsibilities.</b>
Monday PM	DVLA/visual impairment
Tuesday AM	Visual impairment
Tuesday PM	Never events
<b>Station 5:</b>	<b>Audit, Research and EBM (5 minutes)</b>
Monday PM	Diabetic maculopathy
Tuesday AM	Avastin
Tuesday PM	Retinal vein occlusion
	<b>Health Promotion and Disease Prevention (5 minutes)</b>
Monday PM	Overnight contact lens
Tuesday AM	Child screening
Tuesday PM	Screening for diabetic retinopathy
<b>Station 6:</b>	<b>Communication Skills</b>
Monday PM	Wrong site squint surgery
Tuesday AM	Choroidal mass
Tuesday PM	Functional visual loss

### 3a) Results:

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

Pass mark (using borderline candidate method):	66/120	(55%)
Mean score:	82/120	(68%)
Median score:	83/120	(69%)
Range*:	48-110 (40%-92%)	
Reliability: (Cronbach alpha)	0.8	
SEM:	7	
Final adjusted pass mark (+ 1 SEM)	73/120(61%)	
Pass rate before adjustment (pass mark 66/120)	63/72	(88 %)
Pass rate after adjustment (pass mark 73/120)	57/72	(79%)

**Table 1**            **Distribution of scores**

Score	Distribution	Total
21-30		
31-40		
41-50	//	2
51-60	////	4
61-70	////////	7
<b>71-80</b>	<b>/// // // // // // // //</b>	18
81-90	//// // // // // // // // //	22
91-100	//// // // // //	12
101-110	//// /	6
111-120		0
Total		72

The pass mark for the structured viva was increased by 1 SEM from 65.5/120 (55%) to 73/120 (61%).

## 4. The OSCE

### The OSCE

There were six OSCE stations in all. The five clinical stations were held Wednesday 11 November to Thursday 12 November 2015. The communication OSCE was conducted with the vivas.

The five clinical OSCE stations each 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 and. 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)	112/198	(57%)
Mean score:	132/198	(67%)
Median score:	132.5/198	(67%)
Range:	71-178	(36%-90%)
Reliability (Cronbach alpha):	0.8	
SEM:	11	
Final adjusted pass mark (+1 SEM)	123/198	(62%)
Pass rate before adjustment (pass mark 112/198)	59/72	(82%)
Pass rate after adjustment (pass mark 123/198)	52/72	(72%)

**Table 9** Distribution of scores

Score	Distribution	Total
71-80	/	1
81-90	//	2
91-100	////	5
101-110	////	5
111-120	///// /	6
121-130	//// // // //	15
131-140	///// //	7
141-150	///// // // //	17
151-160	////	5
161-170	///// //	6
171-180	///	3
181-190		0
Total		72

The pass mark for the OSCE was increased by 1 SEM from 112/198 (57%) to 123/198 (62%).

## 5. Overall results for the oral examination

### 5a. Results

Pass mark	196/318	(62%)
Mean	214/318	(67%)
Median	218/318	(69%)
Range	136-281	(43%-88%)

To pass the oral examination candidates must achieve 196/318 overall, 66/120 in the viva and 123/198 in the OSCE.

Fifty-six candidates achieved 190/318, but only 50 met all three requirements in order to pass the examination overall.

Pass rate for the oral examination	50/72	(69%)
Pass rate for candidates in OST	37/43	(86%)
Pass rate for non-trainees	10/25	(40%)

Correlation between structured viva and OSCE = 0.44

**Table 17** Distribution of scores

Score	Distribution	Total
131-140	/	1
141-150	/	1
151-160	////	4
161-170	//	2
171-180	////	4
181-190	//	2
191-200	/// //	8
201-210	//// ////	9
211-220	//// //	8
221-230	//// //// /	11
231-240	//// ////	9
241-250	//// //	7
251-260	/	1
261-270	///	3
271-280	/	1
281-290	/	1
291-300		
Total		72

## 5b) Breakdown of Oral Examination

**Table 18 Breakdown of results by training**

	Failed	Passed (%)	Total
In OST	6	37 (86%)	43
Not in OST	15	10 (40%)	25
Total	21	47(69%)	68

Candidates in OST performed better than those in non-training posts. These differences are statistically significant ( $p = 0.0001$ )

**Table 19 Breakdown of results by gender**

	Failed	Passed (%)	Total
Female	8	16	24
Male	14	34	48
Total	22	50	72

Unknown 2

These differences are not statistically significant ( $p = 0.79$ )

**Table 20 Breakdown of results by deanery**

	Failed	Passed	Total
East Midlands	0	0	0
East of England	0	2	2
East Scotland	0	0	0
London	0	13	13
Mersey	1	0	1
North Scotland	0	1	1
North Western	0	1	1
Northern	1	0	1
Northern Ireland	0	1	1
Oxford	0	1	1
Peninsula	0	0	0
South East Scotland	0	0	0
West Scotland	1	1	2
Severn	0	2	2
Wales	0	3	3
Wessex	0	2	2
West Midlands	0	8	8
Yorkshire	3	2	5
	6	37	43

**Table 21 Breakdown of results by level of training**

	Failed	Passed	Total
ST3	0	0	0

ST4	1	1 (50%)	2
ST5	1	13 (93%)	14
ST6	1	17 (94%)	18
ST7	3	6 (67%)	9
Total	6	37 (86%)	43

\* Data not available at time of writing

**Table 22 Breakdown of results by country of qualification**

	Failed	Passed	Total
UK	3	30	33
Outside UK	19	20	39
Total	22	50	72

Unknown 4

Candidates who qualified in the UK performed better than those who graduated overseas. These differences are statistically significant ( $p = 0.0002$ )

**Table 23 Breakdown of results by first language**

	Failed	Passed (%)	Total
English	11	28	39
Other	5	8	13
Total	16	36	52

\*First language unknown for 27 candidates

These differences are not statistically significant (Fisher's exact  $p = 0.36$ )

**Table 24 Breakdown of results by ethnicity**

	Failed	Passed	Total
White	4	16	20
Non-white	16	29	45
Total	20	45	65

\* Ethnicity undeclared by 11 candidates

These differences are statistically not significant ( $p = 0.17$ )

**Table 25 Breakdown of results by ethnicity for UK graduates**

	Failed	Passed	Total
White	1	11	12
Non-white	2	17	19
Total	3	28	31

The difference in the performance based upon ethnicity for candidates is not statistically significant for candidates who attended a UK medical school ( $p = 0.67$ )

**Table 26 Ethnicity of candidates in OST**

Ethnicity	In OST	Not in OST	Total
White	16	3	19
Non-white	25	18	43
	41	21	62



\* Ethnicity undeclared by 14 candidates

**Table 27 Breakdown for candidates in OST by ethnicity**

Ethnicity	Fail	Pass	Total
White	1	15	16
Non-white	5	20	25
	6	35	41

\* Ethnicity undeclared by 4 candidates

These differences are not statistically significant for white/non-white in training  
(P = 0.23)

**Table 28 Breakdown of results by number of previous attempts \***

Attempts	Failed	Passed (%)	Total
1 (First)			
2			
3			
4			
5			
6			
7			
8			
Any resit			

\* Data not available at time of writing

**5d) Table 29 Comparison to previous examinations**

Date	Nov 11	April 12	Oct 12	April 13	Nov 13	April 14	Nov 14	April 15	Nov 15
Candidates	77	104	95	109	103	104	79	77	72
Mcq pass mark	58%	58%	55%	61%	59%	58%	NA*	NA*	NA*
Reliability	0.7	0.7	0.7	0.8	0.8	0.8	NA	NA	NA
EMQ pass mark	59%	58%	59%	NA	NA	NA	NA	NA	NA
Reliability	0.7	0.7	0.8	NA	NA	NA	NA	NA	NA
Viva pass mark	60%	62%	58%	60%	58%	57%	63%	60%	61%
Reliability	0.8	0.8	0.8	0.8	0.9	0.8	0.8	0.9	0.8
OSCE pass mark	65%	62%	62%	63%	61%	61%	62%	60%	62%
Reliability	0.8	0.8	0.8	0.8	0.8	0.8	0.7	0.9	0.8
Written pass rate	68%	65%	81%	85%	93%	90%	NA*	NA*	NA*
Oral pass rate	54%	57%	63%	57%	58%	58%	63%	62%	69%
Overall pass rate	35%	37%	51%	48%	53%	51%	NA	NA	NA

Oral pass rate in OST	46%	43%	63%	56%	64%	65%	70%	80%	86%
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\* The MCQ examination is now de-coupled from the oral examination

**Table 30 Cumulative results by deanery (September 2010 to date)**

Deanery	Number of passes	Number of candidates	Pass rate %
East Scotland	5	5	100
Oxford	22	26	85
Severn	16	21	76
Northern Ireland	9	12	75
London KSS	108	153	71
North Scotland	6	9	67
Northern	16	24	67
Mersey	18	28	64
East Midlands	17	27	63
South East Scotland	8	13	62
West Midlands	35	58	60
Wales	17	32	53
Peninsula	11	21	52
West Scotland	11	21	52
North Western	23	45	51
Yorkshire	32	66	48
Wessex	8	17	47
East of England	13	28	46
<b>TOTAL</b>	<b>375</b>	<b>606</b>	<b>62</b>

## Appendix 1: Hofstee pass mark

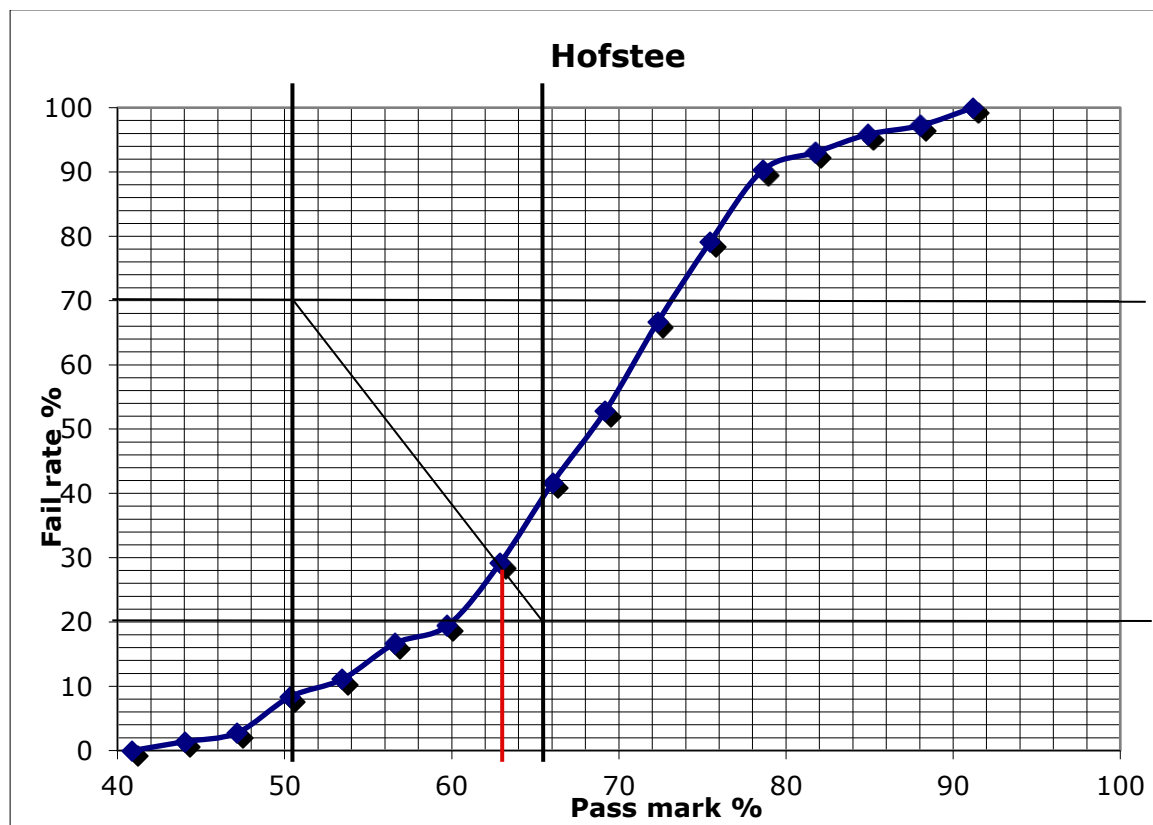
The Hofstee method of standard setting is based upon the examiner's opinion on the maximum and minimum credible pass marks and maximum and minimum credible fail rates for the examination. These parameters can then be used to identify a pass mark from a plot of pass mark against fail rate derived from 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 200/318 (63%), which is similar to the pass mark derived from the borderline candidate method (62%). (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.



## Candidate Feedback – Part 2 FRCOphth Oral Examination

### Structured Viva

The following feedback is from 15 candidates who took part in the structured vivas/comms skills out of 72 (21% response)

#### Viva Station 1 Patient Investigations & Data Interpretation

**Were you treated in a courteous manner by the examiners in this station?**

Yes 100%      No 0%

**Comments:**

- Well managed
- The examiners were very nice

**Were the questions appropriate for the station?**

Yes 100%      No 0%

**Comments:**

- Again very well managed and fair
- There was a small issue in the case history and optic nerve photograph were of one eye and there was single visual field of the same patient was of their contralateral eye which meant there was some confusion as to where the field defect was as I wasn't sure which eye the examiners were asking about – by the examiners responses I felt I probably wasn't the only candidate who had this difficulty.

**Were the questions of an appropriate standard for an exit examination?**

Yes 93%      No 0% Yes & No 7%

**Comments:**

- Interpreting an MRI to detect carotid dissection is likely to be beyond most consultants who would rely on their radiologist.
- As above
- One of the examiners was unaware that the term “benign intracranial hypertension” has been changed for some time now to “idiopathic intracranial hypertension”

#### Viva station 2 Patient Management 1

**Were you treated in a courteous manner by the examiners in this station?**

Yes 100%      No 0%

**Comments:**

- The corneal photo presented on an iPad was atrocious! I would struggle to find a worse and more blurred photo of a cornea if I tried. Made diagnosing the condition virtually impossible. Without being able to diagnose the condition it was futile trying to answer all the follow-up questions (e.g. How would you treat this condition?).

- Examiners were stern but fair

**Were the questions appropriate for the station?**

**Yes 93%      No 7%**

**Comments:**

- The questions were inappropriate because they were all based on the assumption that one could actually see the rubbish photo on the iPad.
- The pictures were a bit misleading – the first showed a swollen bruised eye not consistent with the history and the second was so grainy it was difficult to interpret

**Were the questions of an appropriate standard for an exit examination?**

**Yes 80%      No 20%**

**Comments:**

- The quality of the photographs used for the 7-year-old paediatric patient were abysmal – highly pixillated and impossible to use as the basis for a diagnosis. It is essential that the problem of poor image reproduction (which has arisen so often both in the written paper and the oral) should finally be resolved.
- My run had all PM components on glaucoma surgery (particularly complications of trabeculectomy). That makes it difficult/unfair to compare with other PM stations that other candidates had.
- See above.
- I thought that to know the generic names of Vexol and Lotemax was a bit tough!
- One of the scenarios was of a rare paediatric congenital condition which is unlikely/unrealistic to come across. If we came across this in practice, we would refer to our paediatric colleagues. Thought it was a bit of a waste of a scenario. Would have been better to ask about management of a more common/sight-threatening condition.

**Viva station 3 Patient Management 2**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 100%      No 0%**

**Comments:**

- Efficient and fair

**Were the questions appropriate for the station?    Yes 100%      No 0%**

**Comments:**

- I was asked to describe the two methods of performing a vitreous biopsy. I answered by saying that the same needle could be used for biopsy and intravitreal antibiotics, or alternatively the biopsy needle could be used and a separate needle used for

antibiotics. After leaving the station, I realized that the examiners probably wanted me to describe needle versus vitrector biopsies. In fact, I think both answers would have been reasonable responses to the question as it was asked, and I hope that I (and any others who answered similarly) will not lose marks as a result. If it was important to extract the answer about the use of a vitrector, I think this should have been prompted (e.g., “is there an alternative to the use of a needle?”), which was not the case.

- Overall the questions were appropriate, however I could have given much more detailed and better answers. The complete lack of interaction at times throughout the viva felt awkward and inhibited me from expressing my knowledge fully. It is clear that the examiners are instructed against prompting candidates, however this results in a very stunted and quite strange interaction, which is off-putting. I found it difficult to express my knowledge fully when the examiners have such blank poker-faces during the conversation.

**Were the questions of an appropriate standard for an exit examination?**

**Yes 93%      No 0%      Yes & No 7%**

**Comments:**

- There is a wide variance of opinion between glaucoma consultants on how to manage aqueous misdirection. The direction of questioning suggests that this was not reflected in the mark scheme.
- Most of them were appropriate except for the final question on congenital dacryocoele.

**Viva station 4 Attitude, Ethics and Responsibilities**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 93%      No 7%**

**Were the questions appropriate for the station?**

**Yes 93%      No 7%**

**Comments:**

- I was very glad to be asked how I would escort a severely sight impaired patient to my clinic room, as I have long been struck by the fact that throughout my ophthalmology specialist training, I have never received any teaching in this regard, and it is clear from observation of my colleagues (and indeed my consultants) that few of them have either. I am fortunate that this was taught at my medical school. It is absolutely fair for the questions to feature in FRCOphth Part 2. However, this should also serve as a timely reminder that it absolutely needs to feature in every deanery’s postgraduate OST teaching programme too.
- The mark scheme was out of date. Some candidates reported examiners asking them about the National Patient Safety Agency (disbanded in 2012 and responsibilities taken over by the NHS Commissioning Board). When I talked about reporting to the Commissioner, and the Strategic Executive Information System and the National

Reporting and Learning System the examiners did not act like I had met the mark scheme.

- Unfortunately a large part of the station was focused on a single aspect of how one would physically aid an elderly patient into a clinic room!

**Were the questions of an appropriate standard for an exit examination?**

**Yes 86% No 14%**

### **Viva station 5 Audit, research and evidence based medicine**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 93% No 7%**

**Comments:**

- One of the examiners was extremely rude and intimidating throughout his questioning. His diction was poor and it was difficult to understand him. I felt that he was making an effort to be aggressive to me in his method of questioning, in the tone of his voice and even in his posture. I felt his behavior was inappropriate for any situation, but especially so for such an important exam.
- Efficient and fair
- The examiners were very friendly

**Were the questions appropriate for the station?**

**Yes 79% No 14% Yes & No 7%**

**Comments:**

- The questions I was asked were vague and the examiner described above seemed intent on tripping me up. He interrupted my answers regularly and succeeded in constantly breaking my train of thought. The result was my complete lack of confidence during the station to the point where I was afraid to answer any more of his questions.
- Questions on contact lens wear was not appropriate

**Were the questions of an appropriate standard for an exit examination?**

**Yes 93% No 7%**

**Comments:**

- See above

### **OSCE station Communication Skills**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 100% No 0%**

**Was the clinical scenario explained clearly? Yes 87% No 13%**

**Comments:**

- The scenario did not specify if the squint was alternating or not. This would have affected the subsequent discussion.
- I wasn't sure if I was supposed to be giving a list of differential diagnosis or breaking bad news. I was concerned that if I gave lots of differentials I would confuse the patient, so didn't, but wasn't sure if I was losing marks because of this. Please can you just tell us what you want us to tell the patient to remove this uncertainty?

**Was the clinical scenario appropriate for an exit examination?****Yes 87%      No 13%****Comments:**

- Discussing the clinical details of a patient with her husband in her absence and without evidence of consent is a breach of confidentiality, but one could not very well refuse to participate in the scenario. It was also quite a challenging scenario to complete within time compared to the other ones used.
- The scenario was very unrealistic as it is truly a never event to operate on the incorrect eye
- Having operated on the wrong eye of a patient is bad enough but adding that it was in a child equates a nightmare scenario. Though entirely appropriate for a training simulation perhaps not in an OSCE. I certainly came out of it pretty rung out and had a definite dip in the next few stations and I'm not sure you could have equivocal scenarios in the other sessions

**The Structured Viva – Overall Feedback****Was the structured viva examination well organized?****Yes 100%      No 0%****Comments:**

- See comments above. It is essential that where images are used, e.g. to form a differential diagnosis, the quality of the image must be fit for purpose.
- very well organized; staff did their best to keep us at ease and keep excellent timing
- Well organized, fantastic venue and very helpful college staff
- Extremely well organised

**Were you given clear instructions about the structured viva examination?****Yes 100%      No 0%****Comments:**

- Good use of iPads although some examiners were more technically proficient at tablet use than others!

**Did you feel that the structured viva examination was a fair assessment of your knowledge? Yes 67% No 27%      Yes & No 6%****Comments:**



- Yes and no – there was nothing unfair about the knowledge domains being tested, but occasionally the questions were posed in an unclear manner, which made it hard to work out what was being asked. Mostly, it was a fair assessment, but lack of clarity in the questions meant that sometimes I failed to answer a question, not because of gaps in my knowledge, but because the question was unclear or ambiguous.
- Too much glaucoma, no retina, plastics, cornea or strabismus.
- Overall the questions were appropriate, however I could have given much more detailed and better answers. The complete lack of interaction with the examiners at times throughout the viva felt awkward and inhibited me from expressing my knowledge fully. It is clear that the examiners are instructed against prompting candidates, however this results in a very stunted and quite strange interaction, which is off-putting. I found it difficult to express my knowledge fully when the examiners have such blank poker-faces during the conversation.
- It is very distracting to try to answer questions while one examiner is scribbling comments and the other one is trying to read from an answer sheet. Neither examiner has the time to make eye contact, which in my opinion is an important part of answering questions.

**In your opinion should the structured viva examination be included in the exit examination?**

**Yes 80%      No 20%**

**Comments:**

- I think there is certainly a role for the viva in this examination – without it, it would be hard to examine areas that do not lend themselves to an OSCE, e.g. evidence based medicine, communication skills, paediatric ophthalmology, knowledge of surgical procedures, knowledge of guidelines etc. This is not to say that the format of the examination is beyond improvement, and I think several changes could usefully be made, but it would certainly not be appropriate to eliminate this component from the exit examination.
- This is a test of performance not knowledge. Knowledge is best tested in the written. There is massive variability in the extent to which examiners ask leading questions, help the candidates to answer and the time they allow you to reach the correct answer when you are struggling to think of it.
- However, I feel that a candidate should only retake the OSCE if he/she passes the viva.

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

- Very crowded rooms
- One of the examiners I had in viva Station 5 had an appalling manner and poor diction. He should not be allowed to examine in future.
- For some stations, the pictures on the tablet were not clear and it was difficult to describe and thus further discuss the findings.

- I think that the structured viva would be better served by short answer questions. The examiners seemed to be waiting for me to say certain sentences or phrases, this type of interrogation could be carried out on paper, with time to consider the responses. Also, the other candidates had a different set of scenarios, if we had short answer questions there would be no need for this, which would make the exam fairer. It would also save 2 days of examiners time, and I should imagine be cheaper to conduct. If it is a requirement of the GMC that we undergo a viva we could count the questions at the end of the OSCE as the viva.

**The following feedback is from 16 candidates who took part in the OSCEs out of 72 (22% response)**

**OSCE station 1          Cataract and Anterior Segment**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 100% No 0%**

Comments:

- Courteous and fair

**Were the patients you were asked to examine appropriate for the station?**

**Yes 100% No 0%**

**Were the questions of an appropriate standard for an exit examination?**

**Yes 100% No 0%**

**OSCE station 2          Glaucoma and eyelid**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 88% No 12%**

Comments:

One examiner was courteous, the other adopted a hectoring tone throughout the station, making sarcastic comments about my examination of one patient, and verbally and non-verbally signalling incredulity and exasperation at some of my answers. Comparing notes afterwards with other candidates on the same circuit, I learned that he appears to have treated all candidates in the same manner, and indeed that some were treated more abrasively than I was.

- Courteous and fair
- The male examiner in this station was abrupt and discourteous. From speaking to other candidates in my cycle after the examination, it was apparent that they had had similar experiences.

**Were the patients you were asked to examine appropriate for the station?**

**Yes 88%          No 12%**

#### Comments

- There was one patient with mainly an orbital problem
- Trauma patient with previous surgery

#### **Were the questions of an appropriate standard for an exit examination?**

**Yes 81% No 19%**

#### Comments:

For one of the glaucoma patients, I was asked to examine the patient (no history and no further instructions – eg, one eye or both) and use my findings to piece together his previous history. I am not sure that this is a helpful exercise, especially as his signs were consistent with more than one hypothesised sequence of events.

- Some of the questions were vague.
- However, I felt that the questioning was vague for all 3 cases and there could have been some more guidance as to what aspects of work-up/management etc. that the examiners wanted me to discuss. Over the course of the 5 OSCE stations, there was huge variation in the amount of guidance that examiners gave. It was unfortunate that in this station I felt that if I was not giving the examiners exactly what they were thinking, then there was little guidance to help get me on the right track. I believe that this will be reflected in a poor mark for this station.

#### **OSCE station 3            Posterior Segment**

#### **Were you treated in a courteous manner by the examiners in this station?**

**Yes 94% No 0% Yes & No 6%**

#### Comments:

Yes and no. I was asked to examine one patient's fundus and periphery with an indirect ophthalmoscope. The patient was seated upright. All my colleagues on other circuits also had a patient to be examined with indirect ophthalmoscopy, but their patients were reclined by the examiners, in most cases before the candidate entered the room. I had to make a quick calculation whether to recline my patient for examination, as I always would in a real clinical setting where time was less constrained. I was concerned by the amount of time I would lose if I were to recline him, and (to my later regret) elected to examine him seated. After I completed my examination of the patient, one examiner asked me if "it is your usual practice to perform indirect ophthalmoscopy on a seated patient", to which I had to answer no. It can be argued that my decision not to recline the patient was a failure of judgement. However, notwithstanding the differences in clinical presentations between the circuits, it is important that every possible effort should be made to ensure that the circuits are as closely equivalent as possible. Candidates on all other circuits who did not need to make a decision about reclining the patient, or about the time that they would lose in doing so, were clearly not at the same disadvantage as candidates on my circuit who faced this dilemma, and this does not seem just or objective.

- Courteous and fair

**Were the patients you were asked to examine appropriate for the station?**

**Yes 100% No 0%**

Comments:

One patient had (I think!) birdshot retinochoroidopathy. I believe I picked up the signs and gave an adequate differential diagnosis. But the signs were quite subtle, and although birdshot is an important diagnosis for candidates to know about, I wonder whether this particular patient was a good choice.

- The indirect examination was in a pseudophakic with a small pupil and though that is a necessary skill I'm 6' 1" and had to stand on my tip toes to get the appropriate distance from the patient who was already reclined fully, I raised this at the time with the examiners but I'm not sure how anyone shorter candidate would have coped.

**Were the questions of an appropriate standard for an exit examination?**

**Yes 100% No 0%**

#### **OSCE station 4      Strabismus and Orbit**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 88% No 12%**

Comments:

- Very courteous and reassuring
- Courteous and fair
- One of the examiners was very rude and intimidating. He kept asking me to hurry up, which is most inappropriate in an ocular motility station.
- Since one of the cases was very difficult the examiners were very understanding and helpful
- I felt I wasn't allowed to examine the patients without interruption, I felt the patients were ill at ease as was I. This was in stark contrast to the excellent courtesy and manner of the other examiners in all of the other stations.

**Were the patients you were asked to examine appropriate for the station?**

**Yes 88% No 6% Yes & No 6%**

Comments

Yes and no. Two of them appeared to have more than one diagnosis, which is quite a tall order in a time-limited examination scenario.

- If it is known that a procedure is tender for a particular patient, please do not ask a candidate to perform it. My patient clearly had misgivings about having exophthalmometry done. The examiner said, "It is tender for this patient, but go ahead quickly." One patient had an artificial eye on one side. This should have been clearly mentioned at the start, with some sort of background given to me. It is in very poor taste to ask someone to do a cover test on a patient with one artificial eye.

Valuable time was wasted by me thinking “This cannot be an artificial eye, can it?” In a usual clinic, this background knowledge would already be there, or the patient can be examined at the slit lamp instead of my having to ask the patient during an exam, “Is that an artificial eye?”

- I was not given an opportunity to examine the second patient. The eye was hypotropic and exotropic. I was asked to give a likely palsy: said third. But told with previous history of trauma it was a 4<sup>th</sup>. Unfair
- One of the patients was very complex (multiple cranial nerve palsies and INO) ophthalmologist we have to make diagnosis without the help of orthoptists

**Were the questions of an appropriate standard for an exit examination?**

**Yes 94% No 6%**

### **OSCE station 5 Neuro-Ophthalmology**

**Were you treated in a courteous manner by the examiners in this station?**

**Yes 81% No 19%**

Comments:

#### **Exceptionally courteous and reassuring**

- Although examiners were very stern
- Very understanding and helpful examiners
- The examiners adopted a very aggressive "examination style". This made me feel more nervous and reduced my performance during that station and the following OSCE stations.
- Unfortunately both examiners were really very aggressive in their questioning, interestingly I had the very same complaint against one of the examiners from my previous attempt in Swansea who then was also examining the Neuro Ophthalmology station.
- I found the examiners on this station to be very aggressive. This was my first station and it really put me off for and was a bad start to the whole OSCE. Please could these examiners either be removed or separated for future exams? I definitely don't think they should both be on the same station again.

**Were the patients you were asked to examine appropriate for the station?**

**Yes 100% No 0%**

**Were the questions of an appropriate standard for an exit examination?**

**Yes 75% No 19% Yes & No 6%**

Comments:

- Slightly odd to have detailed questioning on the mechanism of traumatic optic neuropathy – which is poorly understood and controversial.
- All of the examiners in the OSCE stations went out of their way to put me at ease. I did not do very well in some stations, which was not the fault of the examiners. However, in the strabismus and orbit station, I did not perform to my full potential due to a nasty examiner, who kept interrupting and asked me to perform a test that

was clearly painful for the patient. The second examiner in this station kept a low profile and did not speak much at all to support me.

- When asked for differential for cerebropontine angle after the likely acoustic neuroma, I was told you cannot get a meningioma at the cerebro-pontine angle as a cause for 5, 6, 7 palsy.
- Some questions were inappropriate i.e. in a patient with a 6th I was asked which one of the other cranial nerves is the most important to be examined. The answer was supposed to be the 5th cranial nerve but why should a 3rd, 4th, 7th or 8th cranial nerve have a lower priority? I feel that all cranial nerves should be examined in this situation.
- The aggressive manner in which questions were asked was a problem.
- I was quite confused by the examiners questions. The first patient had an orbital apex lesion and I was asked to discuss pathology of the cavernous sinus instead of this. The second patient had a pupil involving 3<sup>rd</sup> nerve palsy, I was asked the causes of a third and the examiners seemed to get very upset that I started from the brainstem and not with compressive as this was pupil involving. They said that they wanted me to discuss “this” patient – which wasn’t what they had wanted with the first patient, where they had essentially invented pathology asking me to “imagine that her vision was normal”. This seems like a small point, but since it was the first station and they were both quite aggressive towards me it was really difficult to perform well and put me off to a very bad start for the rest of the exam. This was a shame as the rest of the examiners were very encouraging.

## **The OSCE overall**

**Was the OSCE well organized?      Yes 100% No 0%**

Comments:

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A mammoth undertaking, and I am full of admiration for the organisers and the patients who made it possible.

- Very well run and wonderful variety of cases; several diagnoses that I had never seen before

**Were you given clear instructions about the OSCE?**

**Yes 93% No 0% Yes & No 7%**

Comments

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We were given clear instructions by the staff from the College, but the clarity of the instructions given by examiners in the stations was variable.

- Well organized with good timing

**Did you feel that the OSCE was a fair assessment of your knowledge?**

**Yes 67% No 27% Yes & No 6%**

Comments:

Yes, in some stations. But not in others. I was particularly concerned by the unnecessary hurdle erected in the posterior segment station, and also by one examiner's conduct in the glaucoma / lid station (see my comments above). It is so important that every effort be made to achieve maximum equivalence across the different circuits since failure to do so inevitably disadvantages some candidates unfairly. Regarding the manner in which examiners perform their duties, it is clear that a bullying or hectoring approach risks flustering candidates and impairing their performance – not just for the station concerned but also for the next several stations – and is therefore completely unacceptable.

- Not given opportunity to examine the orbit/strabismus patients
- Having done this exam before, the patient case-mix is completely random – it appeared to be very skewed towards trauma/orbital cases. Some of the examiners had clearly just examined the patients 5 minutes before we did as candidates and were themselves a bit unsure of what was required.
- Trying to establish the diagnosis based on the findings without a complete history does not represent the daily clinical practice. This is a major flaw of the exam.
- Please see above comments regarding neuro station

**In your opinion should the OSCE be included in the exit examination?**

**Yes 93% No 7%**

Comments:

It's clearly an absolutely essential component of any exit examination, and is a massive undertaking requiring formidable levels of planning and organisation. It's an admirable achievement all round. But there are still some areas where changes are needed if it's to be the objective, standardised and equitable exam it aims to be.

- Very difficult to ensure fairness and consistency with each candidate only seeing 15 patients with necessarily very disparate pathology.
- It is impossible to completely standardize this portion of the exam. Unless each candidate sees exactly the same patients as their fellow candidates, it is not possible to be completely objective.

**Please write any other comments you have about the OSCE below:**

Many thanks to all the very pleasant and encouraging examiners (ie, the vast majority of them), who continued to be supportive even when their examinee was not excelling. This made it possible to turn a new page when moving on to the next patient / next station, without feeling battered, bruised and flustered. They set a superb example in how to examine candidates. And many thanks equally to all the College staff assisting at the exam, who were kind and helpful to us, highly professional, and incredibly well organised.

- Excellent venue. No facility for cleaning the slit lamps between patients – if I was a patient I would want that.
- Examining styles varied vastly between different examiners. Some sat back and said nothing – expecting you to talk non-stop from the start. Others were keen to prompt you in the right direction from the get-go, but then it's not clear whether we would be penalized for requiring prompting. The viva is much more objective – each candidate gets the same scenario and same questions. It is hard to understand, having successfully gained the MRCOphth, why at this late stage in the training programme, why an OSCE is necessary. The old style exam was viva only.
- In my Strabismus and Orbit station, I felt like the examiner was imposing his technique on me as opposed to letting me detect findings with my own technique.
- The assessment of surgical skills should also be part of the exit exam in a surgical specialty.



### Appendix 3

#### Wednesday AM

##### Station 1– Anterior Segment

Station	Diagnosis	Carousel
Anterior Segment	congenital glaucoma	B
Anterior Segment	corneal graft	B
Anterior Segment	aphakia, right prosthetic eye	B
Anterior Segment	left hzvc keratouveitis	B
Anterior Segment	duanes right aphakia	C
Anterior Segment	keratoconus, BE PK, Glaucoma	C
Anterior Segment	FED	C
Anterior Segment	right PK for HSV keratitis, keratoconus, RP	C
Anterior Segment	bilateral herpetic uveitis	C
Anterior Segment	right neovascular glaucoma, PRP BE	C
Anterior Segment	aphakia glaucoma	D
Anterior Segment	Right ICE, Right tube, Right PK	D
Anterior Segment	FED	D
Anterior Segment	previous penetrating injury, left iris defect, retinal tear, LASIK	D

##### Station 2 – Glaucoma and Lid

Station	Diagnosis	Carousel
Glaucoma and Lid	punctal stenosis	B
Glaucoma and Lid	NAG	B
Glaucoma and Lid	L Bells	B
Glaucoma and Lid	uveitic glaucoma	B
Glaucoma and Lid	congenital glaucoma, right trab, right PK	B
Glaucoma and Lid	glaucoma, right ptosis, left ectropion	B
Glaucoma and Lid	Tarsorrhaphy, loss of blink, etc	C
Glaucoma and Lid	bilateral ptosis and dermatochalosis, melonoma right eye	C
Glaucoma and Lid	poag	C
Glaucoma and Lid	right ptosis/aniridia/ aphakia/ stem cell dysfunction	C

Glaucoma and Lid	PXF, bilateral pseudophakia, bilateral trabs	C
Glaucoma and Lid	POAG	D
Glaucoma and Lid	bilateral brow ptosis, left dermatochalosis	D
Glaucoma and Lid	PDS, PI, cataracts	D
Glaucoma and Lid	left facial palsy secondary to cerebellopotine low grade glioma	D

### **Station 3 – Posterior Segment**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Posterior Segment	bilateral wet AMD, POAG, PSC	B
Posterior Segment	PDR	B
Posterior segment	wet AMD	B
Posterior Segment	right nasal RD, left prev RD/ peel	B
Posterior Segment	pseudoanthoma elasticum	B
Posterior segment	adult vitelliform dystrophy	B
Posterior segment	FEVR	B
Posterior segment	DMO	C
Posterior segment	vasoproliferative tumour, chronic uveitis	C
Posterior Segment	wet amd, right AE	C
Posterior segment	right wAMD	C
Posterior Segment	right aphakia, right iridectomy following penetrating injury	C
Posterior Segment	pseudoanthoma elasticum	D
Posterior segment	left erm	D
Posterior Segment	glaucoma, AMD	D
Posterior segment	left PRE PDR, right mac laser	D
Posterior segment	RP, pseudophakia	D
Posterior Segment	Vitelliform	D

### **Station 4 – Strabismus and Orbit**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Strabismus and Orbit	Presumed TED	B
Strabismus and Orbit	left 4th	B
Strabismus and Orbit	left AE	B
Strabismus and Orbit	age related restriction of abduction	B

Strabismus and Orbit	left spheno-orbital meningioma	C
Strabismus and Orbit	Right AE	C
Strabismus and Orbit	TED	C
Strabismus and Orbit	bilateral 4th	C
Strabismus and Orbit	right superior oblique palsy	D
Strabismus and Orbit	TED, right orbital decompression	D
Strabismus and Orbit	RTA/ head injury	D
Strabismus and Orbit	left AE	D

### **Station 5 – Neuro ophthalmology**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Neuro	left adies pupil	B
Neuro	Left sup VF defect & RAPD	B
Neuro	Bilateral optic atrophy	B
Neuro	suspected pituitary lesion	B
Neuro	left hemianopia	C
Neuro	right carotid artery aneurysm	C
Neuro	Cavernous sinus meningioma	C
Neuro	right VI from brain stem meningioma removal	C
Neuro	right crao, left artificial eye	C
Neuro	bilateral optic atrophy with unknown cause	D
Neuro	left pseudoptosis, ?marcus Gunn, right congenital SO palsy	D
Neuro	bilateral plateau iris and glaucoma	D
Neuro	Cerebellar strokes	D
Neuro	Left CRVO. BE Glaucoma	D

**Wednesday PM**

**Station 1 – Anterior Segment**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Anterior Segment	right ciliary epithelial cyst	B
Anterior Segment	Right DSAEK, left PK	B
Anterior Segment	right traumatic iridodialysis	B
Anterior Segment	aphakia, right prosthetic eye	B
Anterior Segment	left herpetic keratouveitis	B
Anterior Segment	NF1	B
Anterior Segment	MMP, ischaemic CRVO, left YAG PI, right AMD	B
Anterior Segment	congenital glaucoma	C
Anterior Segment	macular corneal dystrophy	C
Anterior Segment	FED	C
Anterior Segment	artisan lens right eye	C
Anterior Segment	NF1	C
Anterior Segment	bilateral chronic uveitis	C
Anterior Segment	linear IgA disease	D
Anterior Segment	FED	D
Anterior Segment		D
Anterior Segment	corneal macular dystrophy	D
Anterior Segment	previous penetrating injury, left iris defect	D

**Station 2 Glaucoma and lids**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Glaucoma and Lid	punctal stenosis	B
Glaucoma and Lid	NAG	B
Glaucoma and Lid	bcc	B
Glaucoma and Lid	bilateral brow ptosis, left dermatochalosis	B
Glaucoma and Lid	POAG	B
Glaucoma and Lid	congenital glaucoma, right trab, right PK	B
Glaucoma and Lid	glaucoma	B
Glaucoma and Lid	Right maxillary sarcoma	C
Glaucoma and Lid	keratoconus, BE PK, Glaucoma	C
Glaucoma and Lid	bilateral ptosis and dermatochalosis, right melanoma	C
Glaucoma and Lid	poag	C
Glaucoma and Lid	POAG, left RD surgery	C
Glaucoma and Lid	right neovascular glaucoma, PRP BE	C
Glaucoma and Lid	glaucoma	D
Glaucoma and Lid	NAG	D
Glaucoma and Lid	left facial palsy secondary to cerebellopotine low grade glioma	D
Glaucoma and Lid	POAG	D
Glaucoma and Lid	POAG	D
Glaucoma and Lid	POAG, high myope	D

### **Station 3 – Posterior Segment**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Posterior Segment	birdshot chorioretinopathy, right glaucoma, pseudophakia,	B
Posterior segment	wet AMD	B
Posterior segment	vasoproliferative tumour, chronic uveitis	B
Posterior Segment	right nasal RD,	B
Posterior Segment	pseudoanthoma elasticum	B
Posterior segment	adult vitelliform dystrophy	B
Posterior segment	FEVR	B
Posterior segment	DMO	C
Posterior segment	retinal vasculitis	C
Posterior segment	Right choroidal naevus	C
Posterior Segment	PDR	C
Posterior Segment	L wet amd, R AE	C
Posterior segment	right wAMD	C
Posterior segment	PIC/ MFC/ Myopic	C
Posterior Segment	pseudoanthoma elasticum	D
Posterior segment	birdshot retinopathy	D
Posterior segment	bilateral AMD	D
Posterior Segment	bilateral RD	D
Posterior segment	bilateral wet AMD	D
Posterior Segment	Right cryobuckle for RD	D
Posterior Segment	Vitelliform	D
Posterior segment	right wet amd	D

### **Station 4 – Strabismus and Orbit**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Strabismus and orbit	Presumed TED	B
Strabismus and orbit	left 4th	B
Strabismus and orbit	double blowout fracture	B
Strabismus and orbit	left AE	B
Strabismus and orbit	age related restriction of abduction	B
Strabismus and orbit	left sphenoidal meningioma	C

Strabismus and orbit	amblyopia, ET, KCN, dry eyes	C
Strabismus and orbit	Right AE	C
Strabismus and orbit	TED	C
Strabismus and orbit	bilateral 4th	C
Strabismus and orbit	right superior oblique palsy	D
Strabismus and orbit	TED, right orbital decompression,	D
Strabismus and orbit	Right XT	D
Strabismus and orbit	RTA/ head injury	D
Strabismus and orbit	left AE	D

### **Station 5 Neuro-ophthalmology**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Neuro	optic disc pit, hypoplastic disc	B
Neuro	left adies pupil	B
Neuro	Left sup VF defect & RAPD	B
Neuro	Bilateral optic atrophy	B
Neuro	suspected pituitary lesion	B
Neuro	Right Horners	B
Neuro	left hemianopia	C
Neuro	right carotid artery aneurysm	C
Neuro	Cavernous sinus meningioma	C
Neuro	meningioma	C
Neuro	right crao, left artificial eye	C
Neuro	bilateral optic atrophy with unknown cause	D
Neuro	left pseudoptosis, ?marcus Gunn, right congenital SO palsy	D
Neuro	bilateral plateau iris and glaucoma	D
Neuro	Left AION left altitudinal defect	D

Neuro	CRAO	D
Neuro	Cerebellar strokes	D
Neuro	Intracranial bleed	D
Neuro	Left CRVO. BE Glaucoma	D

### **Thursday AM**

#### **Station 1 - Anterior Segment**

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
Anterior Segment	cicatricial conjunctivitis	<b>B</b>
Anterior Segment	aphakia, right prosthetic eye	<b>B</b>
Anterior Segment	FED	<b>B</b>
Anterior Segment	chronic glaucoma	<b>B</b>
Anterior Segment	left herpetic keratouveitis	<b>B</b>
Anterior Segment	right DSAEK	<b>C</b>
Anterior Segment	left herpetic keratitis	<b>C</b>
Anterior Segment	uveitis, glaucoma	<b>C</b>
Anterior Segment	FEDS, right DSAEK, Left PK	<b>C</b>
Anterior segment	right aphakia, right iridectomy following penetrating injury	<b>C</b>
Anterior Segment	Fuch heterochromic uveitis	<b>D</b>
Anterior Segment	bilateral chronic uveitis, right secondary glaucoma, left cataract	<b>D</b>
Anterior Segment	right PK, Left DSAEK, right optic atrophy	<b>D</b>
Anterior Segment	OCP	<b>D</b>



### Station 2 – Glaucoma and lids

Station	Diagnosis	Carousel
glaucoma/ lids	POAG	B
glaucoma/ lids	NAG	B
glaucoma/ lids	left facial palsy secondary to cerebellopotine low grade glioma	B
glaucoma/ lids	POAG	B
glaucoma/ lids	congenital glaucoma, right trab, right PK	B
glaucoma/ lids	PXF	C
glaucoma/ lids	POAG	C
glaucoma/ lids	NAG	C
glaucoma/ lids	CPEO + ptosis	C
glaucoma/ lids	LEFT Fuch heterochromic cyclitis,	C
glaucoma/ lids	anterior segment dysgenesis, glaucoma, failed right trab	C
glaucoma/ lids	poag	D
glaucoma/ lids	bilateral brow ptosis, left dermatochalosis	D
glaucoma/ lids	PDS, PI, cataracts	D
glaucoma/ lids	POAG	D

### Station 3 – Posterior Segment

Station	Diagnosis	Carousel
Posterior Segment	bilateral wet AMD, POAG, PSC	B
Posterior segment	wet AMD	B
Posterior segment	vasoproliferative tumour, chronic uveitis	B
Posterior Segment	right nasal RD,	B
Posterior Segment	juvenile XL retinoschisis	B
Posterior Segment	pseudoanthoma elasticum	B

Posterior segment	FEVR	B
Posterior segment	DMO	C
Posterior segment	myopic degeneration	C
Posterior segment	Right choroidal naevus	C
Posterior segment	RP, PSCLO	C
Posterior segment	right wAMD	C
Posterior segment	left erm	D
Posterior segment	presumed sarcoidosis	D
Posterior segment	pseudoanthoma elasticum	D
Posterior segment	RP, pseudophakia	D
Posterior segment	Vitelliform	D

#### Station 4 – Strabismus and orbit

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
strab/ orbit	Presumed TED	B
strab/ orbit	left 4th	B
strab/ orbit	age related restriction of abduction	B
strab/ orbit	longstanding IR/ SO underaction	B
strab/ orbit	left AE	B
strab/ orbit	left spheno-orbital meningioma	C
strab/ orbit	amblyopia, ET, KCN, dry eyes	C
strab/ orbit	right fibrous dysplasia	C
strab/ orbit	TED	C
strab/ orbit	bilateral 4th	C
strab/ orbit	right superior oblique palsy	D
strab/ orbit	Right ocular trauma, left 6th	D

strab/ orbit	TED	D
strab/ orbit	RTA/ head injury	D
strab/ orbit	TED	D

Station 5 – Neuro ophthalmology

Station	Diagnosis	Carousel
neuro	GCA	B
neuro	CPEO	B
neuro	suspected pituitary lesion	B
neuro	bilateral asymmetrical 3rd nerve palsy, retinal dystrophy	B
neuro	ocular albinism	B
neuro	Cavernous sinus meningioma	C
neuro	CPEO	C
neuro	Aphakic, nystagmus, XT, correctopia	C
neuro	right carotid artery aneurysm	C
neuro	bilateral optic atrophy with unknown cause	D
neuro	Kearns sayers, glaucoma	D
neuro	Cerebellar strokes	D
neuro	Left CRVO. BE Glaucoma	D

Thursday PM

Station 1 – Anterior Segment

Station	Diagnosis	Carousel
Anterior Segment	aphakia, right prosthetic eye	B

Anterior Segment	corneal macular dystrophy	B
Anterior Segment	corneal macular dystrophy	D
Anterior Segment	FED	B
Anterior Segment	FED	B
Anterior Segment	FEDS, left DSEK,	D
Anterior Segment	iris cyst	D
Anterior Segment	left herpetic keratitis	C
Anterior Segment	left herpetic keratouveitis	B
Anterior Segment	Left PK for HSV, right Artificial eye	B
Anterior Segment	macular corneal dystrophy	C
Anterior Segment	NF1	C
Anterior Segment	OCP	D
Anterior Segment	Osteogenesis imperfecta	B
Anterior Segment	right iris naevus	B
Anterior Segment	Right lipid keratopathy, SJS, cicatrizing conjunctivitis, PK	C
Anterior Segment	right PK, Left DSAEK, right optic atrophy	D
Anterior Segment	right PXF, right failed DSAEK, right baerveldt tube	C
Anterior Segment	uveitis, glaucoma	D

Station 2 – Glaucoma and lid

glaucoma/ lids	bilateral brow ptosis, left dermatochalosis	C
glaucoma/ lids	bilateral narrow angles	C
glaucoma/ lids	Congenital glaucoma	B
glaucoma/ lids	congenital glaucoma, right trab, right PK	B
glaucoma/ lids	glaucoma	B
glaucoma/ lids	left facial palsy secondary to cerebellopotine low grade glioma	D
glaucoma/ lids	NTG	D
glaucoma/ lids	POAG	B
glaucoma/ lids	POAG	B
glaucoma/ lids	POAG	C
glaucoma/ lids	POAG	D
glaucoma/ lids	POAG, high myope	D
glaucoma/ lids	POAG, ptosis	B
glaucoma/ lids	R Neovascular glaucoma	C
glaucoma/ lids	Right ice, right tube, right pk	D
glaucoma/ lids	right trab, right pxf, right cataract	C

Station 3 – Posterior Segment

Posterior Segment	Adult Best	C
Posterior segment	bilateral AMD	D
Posterior Segment	birdshot chorioretinopathy, right glaucoma, pseudophakia,	B

Posterior segment	choroidaemia	C
Posterior segment	FEVR	B
Posterior segment	myopic degeneration	C
Posterior Segment	PDR	D
Posterior Segment	presumed sarcoid	D
Posterior Segment	pseudoanthoma elasticum	B
Posterior Segment	pseudoanthoma elasticum	D
Posterior segment	Right choroidal naevus	C
Posterior Segment	Right cryobuckle for RD	B
Posterior Segment	right nasal RD,	B
Posterior segment	right RRD, bilateral dry AMD, Left choroidal naevus	D
Posterior segment	Right toxoplasma retinitis	C
Posterior segment	right wAMD	C
Posterior segment	vasoproliferative tumour, chronic uveitis	B
Posterior Segment	Vitelliform	D
Posterior segment	wet AMD	B

#### Station 4 – Strabismus and orbit

Strab/ orbit	age related restriction of abduction	B
Strab/ orbit	bilateral 4th	C
Strab/ orbit	bilateral VI, left VII, left III, botox right MR	D
Strab/ orbit	double blowout fracture	B
Strab/ orbit	Grave's orbitopathy	B
Strab/ orbit	left 4th	B
Strab/ orbit	left AE	B

Strab/ orbit	left amblyopia	D
Strab/ orbit	left phisical eye/ chronic uveitis	C
Strab/ orbit	left spheno-orbital meningioma	C
Strab/ orbit	longstanding IR/ SO underaction	B
Strab/ orbit	Presumed TED	B
Strab/ orbit	right fibrous dysplasia	C
Strab/ orbit	TED	C
Strab/ orbit	TED	D
Strab/ orbit	TED	D

Station 5 – Neuro ophthalmology

<b>Station</b>	<b>Diagnosis</b>	<b>Carousel</b>
neuro	Aphakic, nystagmus, XT, correctopia	C
neuro	bilateral optic atrophy with unknown cause	D
neuro	cavernous sinus meningioma	C
neuro	Cerebellar strokes / Nystagmus	D
neuro	CPEO	B
neuro	CPEO	C
neuro	GCA	B
neuro	Intracranial bleed	D
neuro	Left AION left altitudinal defect	D
neuro	Left CRVO. BE Glaucoma	D
neuro	Left Horner's: Ptosis	B
neuro	ocular albinism	B

neuro	R CRVO	C
neuro	right carotid artery aneurysm	C
neuro	suspected pituitary lesion	B