MRCOG part 3-November 2018 Recalls by modules

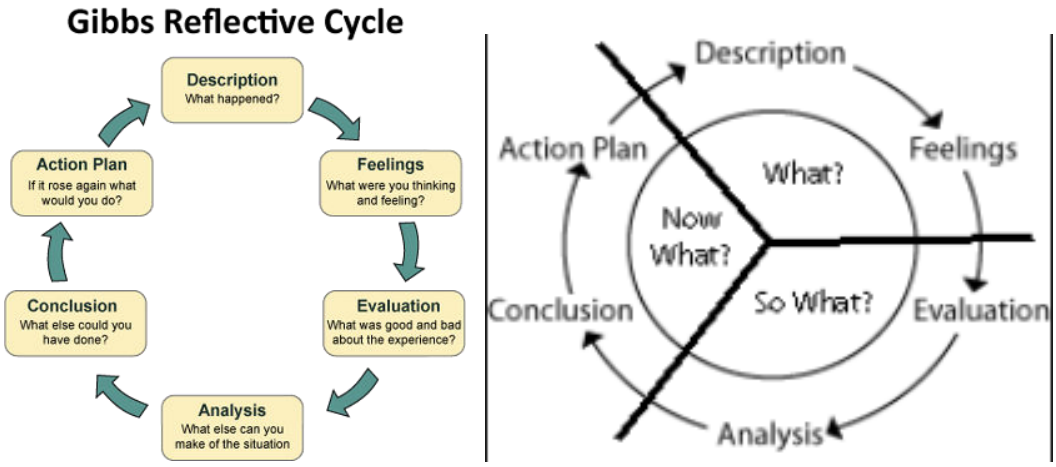
Thanks to all who shared

Teaching:

1. **Day 1:**
   - ✓ **SCT: Teaching CTG to FY2.**
   - ✓ 10 or 20 minutes CTG base line 120 bpm, good variability, there was one acceleration, but early decal with 4 of the contractions.
   - ✓ Typical teaching template. Take him thru DR.C BRAVADO & apply it on the provided CTG..

2. **Day 2:**
   - ✓ **SCT: Teaching to FY1 severe pre eclampsia.**
   - ✓ Primi 36weeks 3+alb and HELLP syndrome.
   - ✓ From what shared, it looks as a CBD for me. Any how you need to follow the teaching template and explain plan of mng according to NICE. HELLP means liver affection and microangiopathic anemia and a criteria for severity which will likely need termination. Mention other specialities.
   - ✓ At some point he mentioned she wants to go home. Say we need to discuss the condition and tell her it may not be safe to do so and we recommend ……

3. **Day 3**: [also early preg]
    - ✓ **SCT: giving feedback for a ST3 who missed the diagnosis of ectopic.**
    - ✓ Pillars of junior feedback: Non blaming, non-disciplinary atmosphere. Explain the importance of seeking advice from senior when in doubt of something. Always say "isn't it better to do…., dont you thank it will be more clear if ……." Rather than "you must……you should……..why didn't you…….". Appraise good points. Don't let any wrong info or figure without correcting it.
    - ✓ Don't forget to check his background knowledge about the case, discharge notes & about mng of ectopic.
    - ✓ Undermining was an issue here. Probe [are you ok, do you want to tell me any thing,…], reassure [what said here will stay her], show empathy [I am really sorry for that], offer help [do want to talk further, may be I can help], get more details [since when, any other behavior that he think unacceptable, is affecting his performance, has he tried to talk with someone] & offer solutions [talk with him in private, if you cant or no response, talk to someone in your hospital "clinical director, educational supervisor, college's tutor" or to the work place behavior champion in your area. All can offer help. Don't be afraid to raise your voice as others may be affected too. The issue may be raised up to GMC and your confidentiality will always be maintained].
    - ✓ Update: it looks that it wasn't a feedback station, but rather a "reflective practice session". Remember the cycle: [simplest model is Rolfe's framework: **What? so what? and now what**?]
        - **What** ...is the problem? ...was my role? ...happened? ...were the consequences?
        - **So what** ...was going through my mind? ...should I have done? ...do I know about what happened now?
        - **Now what** ...do I need to do? ...broader issues have been raised? ...might happen now?
    - ✓ Another frame is Gibb's cycle:
        - **Description** of what happened→
        - **Feelings** [What did you think and feel about it?]→
        - **Evaluation** [what was good and bad about that experience] →
        - **Analysis** , including his rationale about his "other" diagnosis or "not" doing specific thing/exam/test →
        - **Conclusion** [what else could have been done to avoid what happened] →
        - **Action plan** [what to do now-eg revising the GTG, talking with edu supervisor-and in future-write it down in your R2 form prior to ARCP- and what to do if similar pt came again].



- ✓ In one of the courses, they provided their own template for reflective practice. It was on a missed Ca Cx case. See Here.

4. **Day 4:** [can be uro-gyne]
   - ✓ **SCT: Teaching pessary insertion.**
   - ✓ Both ring and shelf were provided.
   - ✓ Indications, C/I, how to insert, how to choose [diff between ring and shelf], how to follow,….

Early pregnancy:

5. **Day 1:**
   - ✓ **SPT: Counselling a woman who came to discuss her baby's post-mortem results.**
   - ✓ Same as station 9 in Nov 17 recall.
   - ✓ Some added +ve Ig G for Parvo.

6. **Day 2:**
   - ✓ **SD: Recurrent miscarriage. [3 consecutive early 2nd TM].**
   - ✓ A bunch of paper results given. US showed subserosal 3cm fibroid and bicornuate uterus. Asked to discuss mng.
   - ✓ Last miscarriage history showing element of cervical incompetence.
   - ✓ Mng: history, exam, invest [here thrombophilia screen must be added]. Ongoing mng will depend on findings. Surgery for bicornuate unlikely to provide benefit [not sure].

7. **Day 3**: [can be core surgical]
   - ✓ **A junior who attend suction evac of molar has wrote the operation sheet. Wants you to sign it.**
   - ✓ Similar to feedback. Check her background knowledge about writing op notes and about mng of molar disease. Tell the importance of the operation notes and how agood one must look like, apply this to what the junior wrote in non-blaming atmosphere.
   - ✓ This what I remember from may 2017 exam:
     - She wrote: patient name [only name, no DOB,…], consultant name [CJK, like this], surgeon name [not written], type of anesthesia [GA],

type of surgery [ERPC], Findings [normal cx, 12/52 uterus], procedure [uterus was evacuated, no other details], EBL [800ml]. Post op plan [routine observation, nothing else mentioned], follow-up plan [no follow-up. GP for contraception]. I think there was no comment about instrument/swab count.

- ✓ She clearly lack the knowledge about a good op-notes and mng of molar disease. Need to take her thru both [need to be written by one of the team involved who is familiar with the procedure and op-notes, avoid abbreviations, suction evac rather than ERPC, post-op monitoring as lost 800 ml, what was BG,..]. Appraise good points [she recorded BPE exam findings & EBL,..].
- ✓ Conclude by "I'll be happy to sign the notes after you make the changes we came out with from our discussion".

8. **Day 4:**
    - ✓ **SPT: Counselling a woman who was admitted with HG. Given her US.**
    - ✓ Scan clearly shows complete mole [she is un aware].
    - ✓ Same as the station came in May 2017.

Maternal Medicine:

9. **Day 1:**
   - ✓ **SD: you are doing your ward round with the consultant at 6:00 pm in a tertiary center. The consultant [the examiner], before leaving the hospital, wants to discuss one of the cases with you.**
   - ✓ She is a PG, MCDA twins, now 27^{+4} wks. Referred as her scan showed 1^{st} twin with DVP of 17 cm, EFW at 95^{th} c, normal Doppler. 2^{nd} twin showed DVP 2cm, EFW<5^{th} c, REDF.
   - ✓ **Questions:** diagnosis?, your mng till delivery.
   - ✓ Go quickly thru quentero staging & mng options of TTTS from GTG.

10. **Day 2:**
   - ✓ **SD: Perinatal Mental Health.**
   - ✓ 16 wks pregnant, diagnosed as [? Or FH of] BPD with history of ?puerperal psychosis and admission to MBU. Given her current assessment [PHQ & GAD scoring].
   - ✓ She was using "quetiapine" which she discontinued when she discovered herself to be pregnant.
   - ✓ On PHQ 9 THERE WERE ALL ZEROS ENCIRCLED. ON GAD 7 1 encircled in 2 questions.
   - ✓ **Q1**: how are you going to mng her?
     - MDT [name them].
   - ✓ **Q2**: According to the mbrace uk what are the red flag signs?
     - Not sure now but I think history [personal and FH] of mental illness, history or current severe depression, recent change in mental state, new thoughts of self harm, feeling estranged from baby.
   - ✓ **Q3:** What Are the indications to admit this patient in MBU?
     - Last trimester or first 9 months post delivery for women suffering from an acute episode of serious mental illness [e.g PPP, BPD, severe

depression]. There are exclusiions criteria, for example if mum has showed serious violence that may pose to her own or other's babies.

- ✓ **Q4:** What do you understand about MBU structure and what is the idea behind it, and who will supervise this woman there and prevent mother from harming the baby.
  - MDT involving…….. Idea is to provide treatment of Serious Mental Illness while maintaining mother-infant relationship. Supervision is by group of experts trained in…..Prevent mum from hurting the baby by ? close observation, talking with her, involve partner & family, improve bonding,… [I don't know]
- ✓ Some said the examiner asked about quitapin???? Atypical antipsychotic used to treat "severe" mental illnesses, can act as dopamine, serotonin, and adrenergic antagonist, and a potent antihistamine with some anticholinergic properties. Can interact with many drugs/Ab and cause serious S/E. may interact with alcohol.

11. Day 3:

- ✓ **SD about pregnancy with Ulcerative colitis. Infliximab BNF papers attached.**
- ✓ I think same as station 4 in Nov 2017 recall, but the examiner asked questions.
- ✓ When to stop infliximab, what precautions? → Just read from BNF but stop before 6m. if stopped for >16 wks may cause hypersensitivity Rxn.
- ✓ Who in this lady's MDT? → OBS, gastroenterologist, dietician, pharmacist, specialist MW & nurse.
- ✓ What do you do when you encounter on an unsual drug? → look on BNF, ask consultant, pharmacist, local drug service,..
- ✓ Effect on preg? → Miscarriage, anemia, malnutrition, SGA,…what else?
- ✓ Effect of preg? → Need to modify drugs, relapse [flare/deterioration], need for admission,…

- ✓ Post delivery? → BF ok, vaccination with life vaccine may be C/I if this drug continued.
- ✓ In Nov 2017 the lady came for booking at 16 wks. A bit late. Need to address this as possible social factor. Also may consider continue infliximab as passed embryogenesis. Down screening will be by quadruple test. She will need LMWH from 28 wks onward [after risk assessment]. 4 wkly growth scans. Aim for VD at term. Normal BF.

12. Day 4:

- ✓ **SD about pregnant sickler who presented to A&E with "?chest" pain & fever.**
- ✓ Her notes tell that she is 34wks now, she is an Indian.
- ✓ You will be asked about her mng & whom to communicate with → H, E & invest.
- ✓ She can speak good English [you may need to specifically ask about this]. Her Hb was 7.
- ✓ Guide your self based on the D/D: acute chest syndrome, PE, infection [Pneumonia, UTI,..].

ANC:

13. **Day 1:**
    - ✓ **SPT with lay examiner: 26 yrs old Wheel chaired woman who herself was a case of spina bifida [had surgery as a child]. Now pregnant. Came for counselling [? booking]. Attached are US scan & your hospital VTE risk assessment protocol.**
    - ✓ Unplanned pregnancy but happy to continue. First pregnancy. Pregnancy discovered late [? 20 wks???]. Some difficulty controlling urine [manageable incontinence]. Walks only with aids. Supportive husband. No FH of clots. Taking folic [? Prescribed?]
    - ✓ US is normal.
    - ✓ think of it as MM module. So explain what are the expected complications, how to reduce them, take her thru ANC, delivery & PP.
    - ✓ she asked? Are you sure may baby has no SB? [It is kind of abnormality that is unlikely to be missed & the scan was done by competent practitioners & it showed no SB]. If challenged again, tell that you will be happy to arrange another one if this satisfies her.
    - ✓ She asked about mode of delivery. [Hmmmm. If you don't know, Tell that time and mode will be determined by the course of pregnancy, the options will be discussed, consultant will be involved and decision will be shared].

14. **Day 2**: [also maternal medicine]
    - ✓ **SD: SD about a kidney transplant woman, now 36 wks GA. Her management till delivery. Her recent scan, drugs and checks given.**
    - ✓ Scan: EFW <10th c but normal Doppler & liquor volume.
    - ✓ Creatinine progressively declining from initial 125 , last reading was 105. All other labs normal. And hemoglobin was probably 9.9 g
    - ✓ Taking cyclosporine, tacrolimus, aspirin, Nefidepine. LMWH just stopped. BP now normal.
    - ✓ Planned for section? Some said they were asked about their opinion about mode of delivery.
    - ✓ **Q1**: when and how to deliver? [or may be do you agree for the dicision taken for her to deliver by CS?]
        - Mode: CS for obstetric indications.
        - Time: Now or later? Plan to be agreed by MDT opinion [FMS to guide timing of delivery of the FGR baby].
        - Delivery should take place in a specialised centre with access to renal physicians [fluid balance,..]. No steroids here so no stress dose cover.
    - ✓ **Q2:** in CS, what skin incision? Any "special" measures during CS?
        - Routine I think. Expect adhesions. Senior involved. Routine CS and avoid unnecessary "poking" with swabs.
    - ✓ **Q3:** what about 3 stage?
        - Oxytocin is safe but with adequate fluid balance. PG is safe.
        - If asked about post partum period: adequate fluid balance, cycosporin & tacrolimus level check, LMWH for 6 wks.
        - If asked about baby: need peads check for signs of thymic hypoplasia, adrenal insuff [if was on steroid?] signs of infection [neutropenia]. Local drug inf service for safety of drugs with BF.
        - If asked about contraception: can use POM, CHC with low dose pill but not 3rd g progesterone [higher risk of VTE], IUD.

15. Day 3:

- ✓ **SPT: counselling a woman with IUFD at 32 wks for postmortem.**
- ✓ Post mortem consent, SAND leaflets & others were attached.
- ✓ No obvious cause by now. Written that you are not required to sign the consent now [i.e just explain].
- ✓ Remember to show sympathy and avoid (nice to see you) and offer condolences, support, counsellor,...
- ✓ Remember to explain that it can prove very valuable to find a cause, which can affect her mng of future pregnancies.
- ✓ Also remember that it can be full postmortem or, if she shows reluctantly, partial, with only some pieces of tissues taken. Tell that this may give less info but still worthy to think about.
- ✓ Also offer imaging and placenta exam.
- ✓ Reasonable to ask about her views- wants to wait or deliver soon? Need to exclude HTN as cabergolin may need to be given.
- ✓ She asked about funeral → agree and support.

16. **Day 4:**

- ✓ **SPT: a nurse has called you to counsel a woman as her "home readings"- which were ok-doesn't go with her HbA1c [very high].**
- ✓ Looks similar to that showed in RCOG course in October 2016:
  - 18 yrs type 1 DM 32 wks with macrosomia [given growth-chart, was on 90th c]. Home readings are ok, but high hba1c:70 [confirmed twice].
  - ? type 1 DM with good readings/results but US findings suggestive for poor control.
  - My suggested points: Approach without blaming: History mainly to check understanding, compliance & storage of insulin, device check/maintainance, frequency of her visits, diet & excrcise, any previous admissions. Then explain & give possible causes without blame ..eg lab/device error,… Offer admission under MDT care to adjust dose, check her device calibration, stress on the importance of follow up & compliance to avoid complications…
- ✓ Some said she showed total lack of understanding of the importance of control, she gave excuses like busy life. She also showed some lack of concern about baby [said her parents will take care of]
- ✓ Some even suggested she acted abnormal and they thought of some "mental illness".

Management of labour:

17. **Day 1:**
    - ✓ **SPT: counselling a woman about her options for delivery. Age? . P2, both VD, 1st was induced for post date, 2nd was home delivery. No complications. Now 38 wks into her 3rd pregnancy-Breech. Recent US report given.**
    - ✓ She is asking for VD, so essentially the template of counselling a woman that her mode of birth may not be the safest. The scan is favorable [no hyperextension, average Wt,..]. some added extended breech.
    - ✓ Start by making it clear that "this is just an open discussion to give you the info you need to help you make your mind/choice. Whatever option you choose, we will support you".
    - ✓ After quick history, take her thru the options as given in PIL. Try to give pros and cons for each option.
        - 1st is trying to turn your baby in the womb into the head-first position, called external cephalic version (ECV). it is usually offered at or after 36 wks of pregnancy and generally works in 1in 2 women. It is still an option in your case but with your labour already started, the chances of success may be lower.
        - The 2nd option is to have a CS. Research has shown that planned caesarean section is safer for your baby than a vaginal breech birth. Caesarean section carries slightly more risk for you than a vaginal birth and can increase your chances of problems in future pregnancies. [Mention some if time allows: longer recovery, bleeding, infection, bowel/bladder trauma and-for future CS-more difficult surgery, placental problems]
        - The 3rd option is vaginal breech birth. A successful vaginal birth carries the least risks for you, will mean earlier recovery, more likely to deliver vaginally in furure, but it carries a small increased risk of your baby dying around the time of delivery and may also cause serious short-term complications for your baby. [if time allows: this is because sometimes difficulties may arise at the time of delivering the head. Short term complications likes injuries/fractures,..]. 4 in 10 women choosing vaginal breech birth will need emergency section.
    - ✓ Some said ECV was offered and failed. So you can offer a repeat procedure with "adding some medicines that can make your womb more relaxed and so increase the chance of success.
    - ✓ She asked "if I had CS this time, what about my next baby?". Tell that with uncomplicated CS, her chance to deliver vaginally is 9 in 10.
    - ✓ She asked for water birth: "With water birth we may anticipate some difficulties. This is due to the lack of gravity-which is a helping factor- and difficulty anticipated if interventions required. Also monitoring your baby's

heart will be more difficult". Don't say we can't offer or it is unsuitable. Let her decide.

18. **Day 2**:
    - ✓ **SD: Maternal collapse. You encountered on a term woman who suddenly collapsed on the floor.**
    - ✓ Some candidates asked if i have any other history about this patient or any observation he said no.
    - ✓ What are the reversible causes of maternal collapse? [the Ts]
    - ✓ What are you going to do [Resuscitation till you reach peri-mortem CS].
    - ✓ When you come to CPR, he asks how.

19. Day 3:

- ✓ **SPT: A 41 yrs old PG, now 38 wks. She had 4 cm ?fundal fibroid. Wants home birth and physiological 3rd stage.**
- ✓ Remember the theme of "counselling a woman that her preferred place/mode/plan of birth may not be the safest/recommended one". Always start by something like "this is a friendly discussion to give you all the info you need and to answer your concerns in order for you to make your choice, which will be respected."
- ✓ In history, ask for details of this pregnancy, ask permission to see notes, her view [why asking for home birth] then skim thru remaining history, specially medical and surgical.
- ✓ Then try to tackle each option [home, obstetric unit, active & physiologic 3rd stage] in pros & cons format. Then justify what you recommendations. Offer a compromise [alongside MW unit, physiologic mng with close observation,..]
- ✓ An issue here was her age. So explain that you advice delivery before her due date as after that the risk of still birth is double that in younger mothers. If time allows explain methods of IOL and if showed reluctancy, offer sweep. If IOL denied at all, show understanding but encourage frequent checks.
- ✓ Finally offer PIL & another meeting with consultant, with partner involved.

20. **Day 3:** [can be ANC]
    - ✓ **SPT: ?PG, MCDA twins, now 32 wks. Asking for home delivery. Have a check-list attached.**
    - ✓ Given some of her notes and recent scan. Essentially everything is normal.
    - ✓ Again, same theme as above. Justify your recommendation about place of birth.
    - ✓ Need to come to her check list. Start by saying "your wishes will be respected", then try to tackle them & justify your recommendations:
        - Wants spont. VD: PTL is common but if reached 36 wks, need to consider IOL as after this, the risk of stillbirth may increase. If still willing, advice frequent checks.
        - Doesn't want epidural: probe her views [why not?], Agree for that and explain that other options of pain relief will be discussed.
        - Needs a quiet place: Agree for that. Tell will can try or best in hospital to do so.
        - Need to move around during labor. Explain that likely to need "baby's monitor" attached but will check the availability of telemetry-a kinda of wireless monitoring.
        - No medicines in labor. Agree but explain may need things to mng with pain, nausea, fluids to avoid hydration-can avoid if she nourished her self well-and may need a drip to help with delivery of second twin and placenta.
        - Some said this "wish list" came only after questioning specifically about it.
    - ✓ Conclude as above.

21. Day 4:
    - ✓ **SD about labour ward prioritization.**
    - ✓ ? same as station 2 Nov 2017 recall.

Management of delivery:

22. Day 1:

- ✓ **SPT: Counselling a woman in labour about her options. She has been pushing for ? 1h [fully dilated for 3h ?]. fully dialated, head +2 DOA, +1 caput & moulding, head not visible with contractions. CTG given.**
- ✓ She is PG [correct timings for 2nd stage]. On epidural but now can feel pain [may offer top-up by the anesthetist]. CTG showed ? variable decal.
- ✓ Seems almost the same for that of stratog [counselling for instrumental delivery]. So just click here.

23. **Day 2:**
    - ✓ **SD: given an Audit done for shoulder dystocia [4 papers]. what is your opinion and how to re-audit [critical appraisal of audit].**
    - ✓ This is a suggested answer by a friend:
    - ✓ I read every page and then commented as an appraisal. That was about outcomes of management of shoulder dystocia in that unit, was done over 1 year retrospective study 20 cases of shoulder dystocia noted in that time and just 8 case notes were explored. So i said less than half cases are included which is very less. And cannot give us full picture. In results of audit they mentioned ethnicity of patients and diabetic and non diabetic and demographics. So i said it shows about epidemiology and not the outcome. Also results wre showing documentation 67 percent and rcog proforma filled in 80 percent. No brachial plexus injury. Recommendations were staff training, improve documentation, filling of proforma, reaudit. When i talked about steps of audit she said keep in mind this particular case. I told about the fetal outcomes documentation and incident reporting and rcog proforma. Then she prompted me about what maternal outcomes? Then i mentioned those as well. She asked me in detail about questionnire .

24. Day 3:

- ✓ **SD about mng of a case of PTL where there is NICU shortage.**
- ✓ Probably same as that of Nov 2016.
- ✓ This is all i got about the station, again quoting from a friend:
  - lot of papers like ctg partogram,….
  - phone call to inform consultant about ptl 29w cx 2cm only one place in nicu. What to tell? Sbar i told ...then i told need his opinion to arrange intrauterine transfer to another hospital
  - Told me what you will give her ? I told corticosteroids and mg sulfate
  - Told me what to need if mg sulate give? RFT, UOP, PR, RR , Continue ctg
  - She asked me how you will do ? I told i will call neonatal consultant of nearest hospital to arrange trasport
  - Asked me if you can't transfer now what to do and what neonatologist need ? Told arrange delivery informing prepare intubation for baby ? Neonatal resuscitate medications
- ✓ What I can add: Toco is reasonable in this scenario as there is a clear indication for referral [NICU and pead shortage].
- ✓ One said the examiner asked: what if no pediatrician available? →this will again be considered as indication for referral for a tertiary center where a neonatologist is available..
- ✓ Another Q: what to do just before refer? → check progress of labour and make sure a trained MW and a doctor accompany her.
- ✓ And what if you find here fully dial before discharge? → will deliver her here, see if a neonatologist/pead can be summoned [on call or from nearby hospital] or consider Ex-utero transfer.

25. Day 4:

- ✓ **SPT: counselling a woman in labour.**
- ✓ She has a previous scar [cord prolapse]. Willing for VD.
- ✓ Now footling breech, passing meconium. CTG written normal.
- ✓ She was a bit worried “why my waters are greeny?”. She also asked about ECV as an option [not suitable as footling].
- ✓ Remember that Prolapse may again occur in this delivery.

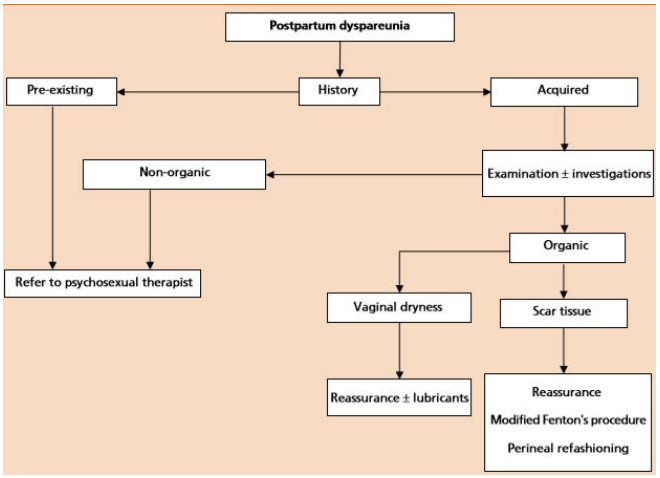
Post-partum problems:

26. Day 1:

- ✓ **SD: A woman who has VD 3 wks [?m] ago, came with superficial dyspareunia.**
- ✓ Will need history about delivery, ascertain there was an episiotomy, ask about recovery/healing, is she lactating, tried anything, need to examine her [thick, tender scar, or someone said a picture of small red area near fourchette, and there was a history of anl fissure/constipation]…. Then put D/D [defected scar, estrogen diff if lactating or early pregnancy,….] & possible mng options[PFMT, lubricants, triners, E cream, psychosexual counselling & finally refashioning].
- ✓ Other useful points:
    - Explain that excision of the scar and re-suturing will create a new scar
    - Dissolvable sutures will be used but healing will take 2 weeks or so
    - Do not attempt intercourse until new scar has healed
    - Cannot guarantee that new scar will be better than existing scar.
    - Check her plans for contraception when intercourse resumes.

27. Day 2:

- ✓ **SPT with lay examiner: Postpartum dyspareunia**
- ✓ letter from GP; was unable to take her scheduled smear [vaganismus] 3 months after ventouse VD.
- ✓ History: ask about her and baby, then type of dyspareunia [sore in the outside or with deep penetration. Here it was superficial], duration, urinary /bowel symptoms, effect on sexual life, tried anything , screening Q for mental health,..
- ✓ Exam: Normal scar, ?dry vagina.
- ✓ She asked about options & when can the smear be re-scheduled.
- ✓ Remember: causes are physical or psychological. Physical can be due to scar tissue formation, poor anatomical reconstruction following perineal trauma or vaginal dryness [BF, some pills]. Psychological may follow traumatic birth experience & fear of another pregnancy.



28. Day 4:

- ✓ **SD about a case of post VD vulval hematoma. [7x8 cm].**
- ✓ The lady was PG, induced for post dates at 41 wks, had prolonged 1st & 2nd stage, delivered vaginally, 4.5 kg baby. Episiotomy was sutured by MW.
- ✓ The MW called you as pt has significant pain at episiotomy site despite paracetamol & brufen. What else do you want to know? [may be above details are shred only if you ask]. You need to know more about labour [1st & 2nd stage, was there an epidural?], type of delivery, any difficulties in suturing episiotomy, blood loss, has she passed urine? [very important].
- ✓ You came and examined her→ vulval hematoma with stable vitals.
- ✓ Given her observations over a period of time [PR changed from 90 to 110, BP changed from 130/70 to 140/80].
- ✓ Other Questions:
    - What are the possible causes/RF in this case?
    - You want to tell the consultant by phone. What are you going to tell him?.
    - How are you going to mng? [conservative, surgery if no response/deterioration]. He asked about details [pre, intra and post op].
    - How to mng if urine retention occur later?

Gyne problems:

29. Day 1:

- ✓ **SPT: a pt C/O vulval itch. Later on given a picture [LS]**
- ✓ GP tried some anti-fungal creams to no work. Swabs & STI screen normal. Her age was 36.
- ✓ Remember these general points in such a station:
    - History: duration, relieving & aggravating, a/w discharge, impact on social & sexual, medicines tried, urinary symp, other allergies or auto imm diseases, cx smears
    - Exam: general (scalp, oral mucosal) & local (inspection, speculum) with chaperon. When you explain that you need to examine her, she will likely handle you the photo.
    - Tests: swabs, skin patch test, ferretin, ?test for auto imm disease if indicated
    - Mng: accordingly. Once showed the LS picture then steroids, how to use, follow up, involve derma, hygiene advice, when to come back
- ✓ So:
    - Info gathering: relevant history.
    - Com with Pt: explanation in lay, listen to concerns,...
    - Applied knowledge: how to msg LS
    - Pt safety: involve derma, consultant,..efforts to exclude sinister (smear history, speculum, when to come back, biopsy if suspicion)
- ✓ She asked about the chance of “sinister”. Tell that chances are low [?4 in 100], that she will be followed up so that if there is no response or other changes, a tiny piese of skin can be taken after numbing the area and send it to the lab.

30. **Day 2:**
    - ✓ **SPT: A woman referred by her GP with HMB. Counselling about her mng options.**
    - ✓ A bit worried. Hysterectomy was mentioned as an option by her GP.
    - ✓ She has not tried anything before and she wants to know about all options.

31. **Day 2:**
    - ✓ **SPT: An elderly lady with Alzheimer has PMB. You have scan & MDT results & about to see & debreif her daughter and answer her concerns.**
    - ✓ Scan was abdominal as she didn't tolerate TVS. Showed thickened endo with increased vascularity. MDT suggested EUA, hysteroscopy & biopsy.
    - ✓ Looks that daughter was in a hurry as she repeatedly asking will sign consent form am busy I can't come every now n then. [showed least concern]
    - ✓ Quick history about red flags [wt loss, FH of cancer,…], her mum mental state [can she decide for her self?], and if not, any advance directive? Who is the named guardian?. Offer to assess her mental capacity.
    - ✓ Need to explain possibilities [EH, sinister] and tell the experts' opinion it to examine her mum under anesthetic so that it will be comfortable/less painful, & then doing hysteroscopy, that is to pass a telescope into the womb to have a closer look on the lining of the inner side, and to take a piece of tissue and send it to the lab to rule out sinister.
    - ✓ Her mum will also need anesthetic assessment as she is an elderly. Future mng will again be guided by experts but may involve surgery.
    - ✓ If time allows, can give more details about hysteroscopy, like complications,..

32. Day 3:

- ✓ **SPT: A 26 yrs old pt referred by GP with history suggestive for PMS.**
- ✓ In history remember to to establish timing with periods and to tackle other [physical & psychological/emotional] symptoms. Probe severity of psych symptoms if any. Ask how is it affecting her life.
- ✓ Offer symptom diary if not done already.
- ✓ Explain that is likely PMS: PMS is the name given to a collection of physical and emotional symptoms that can occur in the two weeks before you have your period. These symptoms usually get better once your period starts and often disappear by the end of your period. The exact cause of PMS is not known. One or more factors may be involved including changes in hormonal level, being over-wt & doing little excecise, and also stress. It is common, occurring in one and two in 20 women.
- ✓ Then discuss mng options: life style, psychological support, drug Rtt & finally surgery.
- ✓ if she is willing for a pregnancy "soon", then tell that COCs are contraceptive & may interfere with her plans. I think this is better than telling it is not suitable.
- ✓ If asked for herbal, tell that some may do good & some may not and evidence may not be clear. It is advised to buy remedies from a reputable source. look for a product licence or traditional herbal registration (THR) number on the label to ensure that what you are buying has been checked for safety and quality.
- ✓ Will pregnancy help with symptoms? Probably yes as hormones may drop. Hormonal changes are one of theories behind PMS.

33. Day 4:

- ✓ **SPT: Counselling a woman who was referred with a chief complain of irregular periods & reduced libido.**
- ✓ Same as station 12 in Nov 2017 recalls, but here reduced libido was a serious concern for her. [psychosexual counselor, Tibilon if suitable].

Sexual & Reproductive health:

34. day 1:

- ✓ **SPT with lay examiner: A lady came to you on the on-call with very painful blisters on the vulva. A picture was given**
- ✓ 23 yrs. Recently knew she is pregnant [5 wks]. Never had such a thing before. She is currently with her "1st ever partner". Urinary symptoms?. No lesions elsewhere.
- ✓ Tell about likely cause →HSV [& explain it], still need tests to confirm , tests for other STI [offer GUM clinic referal]. Then tell about mng options: analgesia [oral tablets-paracetamol, and a cream- lidocaine gel] , acyclovir [may reduce severity & duration of symptoms. Unliscenced but unlikely to cause harm]. No risk for cong anomalies or miscaeeiage. May recur [so may be offered acyclovir from 36 wks] & can aim for VD. See GP if voiding difficulty or Re-blisters in the future.
- ✓ No additional monitoring for the remainder of pregnancy.

35. Day 2:

- ✓ **SPT: 15 yrs old requesting EC.**
- ✓ LMP was 2-3 wks ago [she wasn't sure]. Didn't want her parents to know. Boy of similar age. If you asked for PT it will be –ve. UPSI 4 d ago and yesterday.
- ✓ Typical EC template. Can't think of twists right now. If period regular and every 28d, then I think Ellaone and coil valid even if LMP 3 wks ago. Levonelle less suitable as >3d. Clearly mention that coil has higher chances and pill may not work of ovaries released an egg, so again ask about LMP. When she tell she cant remember, tell this may affect her suitable option. Remember safety issues [safe sex, when to come back-PT if period delyed,…]

36. Day 3:

- ✓ **SPT: a 25 yrs old referred by GP for persistent VD. Microscopy showed "clue cells". Counsel and answer concerns.**
- ✓ Same as Nov 2017. Take relevant history [can you tell me more, than ask duration, any itch, for how long with current partner, allergies]. She will give typical description of BV, even mentioning fishy odor.
- ✓ She will ask from where did I get it. Important to explain that this isn't an STI. [An imbalance between bacteria normally present in your vagina].
- ✓ She asked about Rtt. General advice [avoid douches, shower gels, bath shampoo,….] and Metronidazole. Advice to avoid alcohol during and 2 days after it as it can cause unpleasant symptoms.
- ✓ Asked if it can affect pregnancy. UK national guide line quotes "In pregnancy BV is associated with late miscarriage, preterm birth, preterm premature rupture of membranes, and postpartum endometritis". FPA fact sheet adds LBW and quotes "If you have symptoms of bacterial vaginosis during pregnancy, it's important to go for a check-up so treatment can be given if needed- Rtt is safe during preg".
- ✓ If denied Rtt, explain this may increase her risk of acquiring HIV if she had UPSI with someone who is HIV +ve. [don't say you may pass it to others. It is not STI].
- ✓ She asked how to prevent this from happening again? → Give General advice as above as those may impair the natural imbalance. The FPA factsheet quotes "Using the combined oral contraceptive pill and using condoms during vaginal sex may help reduce the risk of bacterial vaginosis occurring.".
- ✓ What if it kept coming back?→ Some people may be given a course of antibiotic gel to use over a number of months. Others may be given antibiotic tablets to use at the start and end of their period. Some people may find it helpful to use a lactic acid gel (available from a pharmacy) to restore the pH balance in the vagina.
- ✓ Doesn't like tablets? Offer metronidazole vaginal gel.
- ✓ Allergic to metro? Offer clindamycin cream. Condom may break with gels/creams.
- ✓ Asked about yoghurt? → There are researches about local "probiotic" therapy to reduce recurrence, but I need to update myself on that and will come back to you.
- ✓ Does it cause cancer? → big No.
- ✓ Partner notification not indicated. TOC not required unless persistent symp.
- ✓ See more in station 8 of Nov 2017 recalls.

37. Day 4:

- ✓ **SPT: counselling a woman who was referred with a chief complain of ? vaginismus.**
- ✓ GP letter tells 2 yrs infertility, when they tried to do TVS, she cried as it was very painful. In history, she never attend for her smears [fear of pain].

Subfertility:

38. Day 1:

- ✓ **SD: Mr & Mrs. Smith. Trying for 2 yrs. All workup given.**
- ✓ Semen analysis: normal parameters. ? some WBCs?
- ✓ Mrs. Smith: cycle comes every 3-4m, some hirsutism. BMI 25 FSH/LH/E/PRL/TSH/Testosteron normal. Progesteron on day?=2. HSG: Septate ?arcuate uterus [report saying filling defect likely septum] but patent tubes. US typical PCO [tell why].
- ✓ **Questions:** discuss pictures, what is your diagnosis based on this workup, how can you mng these couples [options]. When you suggest clomifen, will ask how given, possible complications. What do you think about hysteroscopy? Are you going to offer surgery for septum?
- ✓ Likely PCOS [justify]. Options are healthy life style plus clomit, clomit + metformin, HMG & laparoscopy. Hysteroscopy to get more details about cavity & may consider surgery [debatable but my improve outcome Vs no surgery]. S/E effects of clomit are general like GIT symptoms, ?flush?, and specific like multiple pregnancy and-in this case-OHSS.

39. Day 2:

- ✓ **SPT: counselling a woman about her options**
- ✓ Trying for 3 yrs. SA normal. HSG showing right tube was filled with dye but there was no spill and Ieft tube no dye seen, with comment on report that there was pain and procedure was stopped after injecting only 10 ml dye.
- ✓ Address what happened and show sympathy. Offer to repeat it with better form of analgesia, or lap and dye. Explain risks of laparoscopy.
- ✓ May need IVF if block confirmed. She didn't like the sound of IVF. You can mention adoption and surrogacy as alternatives.

40. Day 3:

- ✓ **SPT: A woman in IVF cycle, came back unwell 3 days after ovum retrieval. Investigations attached.**
- ✓ I think same as may 2017:
  - thirty something, undergone first IVF cycle 3 days ago, 15 [or more] eggs were retrieved. Came today with abd pain & nausea. FBC: TWBC 12.700, HCT 41, US enlarged ovaries [sizes given-?9cm- with multiple follicles-number?]. She is in pain during discussion, wants to go home for elderly mum or something. Counsel her about possible cause, answer concerns, formulate paln.
  - Explain that is likely Moderate OHSS [a complication of fertility treatment where there is an excessive response to fertility drugs].
  - Myself I think it is reasonable to advice admission [to observe, mng with pain, may need blood thinners] But also to exclude other complications.
  - Show understanding of not willing for admission abut advice to wait for consultant while start mng her symptoms.
  - Asked about “her eggs”. Explain that this IVF cycle may need to be cancelled to avoid complications, her eggs will be preserved [frozen] for future use and this is unlikely to affect the success rate.

41. **Day 4:**
    - ✓ **SPT: counselling a woman who is requesting reversal of sterilization.**
    - ✓ Very angry pt. 40 yrs old, 3PS. Claimed that during last CS, doctor told her it will be risky for her to have another CS, so he sterilized her.
    - ✓ Now she came to know that people can have 5 or 6 CS without any complications. She thinks this was done unnecessarily.
    - ✓ She thinks that NHS should fund her re-sterilisation.

    Main issues here are to : show understanding, ask permission to access notes to know more about the incident [when, why done, what method], involve your consultant

Core surgical skills:

42. day 1:

- ✓ **SD: gyne list prioritization. You are required to discuss risks in each case, what measures to minimize complications, then show your order of the list.**
  - I. Age?(young), infertility and CPP, planed for diagnostic laparoscopy ± Rtt of endometriosis. BMI 18. The examiner asked: how to create pneumo-peritoneum, what are you going to do if you find stage 1 endometriosis. She allergic to latex.
  - II. 48 y, HMB, 15 cm fibroid, planned for TAH± BSO. BMI 38. Type of incision? Are you going to remove the ovaries?
  - III. Evacuation of complete molar preg, uterus size 12, Rh neg. What to do if heavy bleeding After evac.
  - IV. 30 yrs, planned for laparoscopic lt cystectomy (6cm, ca125 12). She is para 1 (CS). How to enter abdomen?
- ✓ Same as station 1 in Nov 17 recalls. There I forgot to add latex allergy to case 1. I think you guys had dissected this latex allergy issue ☺. But generally, check other allergies, use latex free gluves, catheters and other instruments, alert staff, cleary write on notes/tag, put 1st on list to avoid "? Air-brought" latex particles from other surgeries.

43. Day 3:

- ✓ **Consent a woman for diagnostic laparoscopy for ? long standing dysmenorrhea.**
- ✓ The consent template:
  - I understand that you have been offered a key-hole surgery? ? Well, I'm here to give you the information you need to make your choice. So, I need to ask you few Q-& of course answer yours-. By the end of the discussion you may sign the consent if you agree to it.
  - Focused history to check symptoms, her LMP and CC use, alternatives [COC], FH of endometriosis, medical, surgical, allergies.
  - Then hold the consent and start writing. May I confirm your name again and DOB [and write down]. The procedure you are offered is called…….or you can ask-can you tell me what surgery you came along to have it done? [and write down diagnostic laparoscopy under name of proposed procedure]. The aim is to try a find a cause for your symptoms and if possible, to treat endometriosis if found [and write this down under intended benefit]. Then take her thru the procedure, offer anesthetic review [and check on general/regional box], then come to risks. Tell this is a very common procedure but complications do occur. At least Mention shoulder tip pain & wond infection as frequent, damage to internal organs, hernia & not finding anything or inability to enter abdomen as serious and write them down. Say we have meaures to reduce risks like involving seniors. Then say in case of complications we may need to do open surgery, and if there is excessive bleeding we may need to give you blood [and write these down under extra procedures]. Ask about position from blood transfusion.
  - Finally say before I sign here, do you gave any Q?
  - If you mng to, sign and move the paper to her.
- ✓ Need to mention that if endometriotic nodulues found, may burn them [she may deny] but sometimes this may be difficult.

44. Day 4:

- ✓ **SD about a theater list.**
- ✓ Same as day 1.

Post-op complications:

45. day 1:

- ✓ **SPT with lay examiner: Day 1 post laparoscopic TAH.**
- ✓ She feels unwell. Given her observations [high RR, high T, high PR, low BP→sepsis??]. on history, no problems passing urine but she has loin pain and feels that her abd is ?distended.
- ✓ She will need further checks & imaging as possibility of injury to ureters [explain], involve consultant & colleagues in urology, , may need surgery.

46. Day 2:

- ✓ **? SPT: counseling a woman with complications after emergency surgery.**
- ✓ She had emergency laparotomy and dermoid cyst removal 2days back
- ✓ Now developed severe pain. And Spo2 92% RR 20.
- ✓ ON asking she said chest pain breathing difficulty and leg swelling. She was not drinking much and was out ob bed just once since surgery and was using OCP till surgery.
- ✓ So all management of suspected pulmonary embolism till discharge and follow up [strongly recommend that she need to stay if she asked to go home].
- ✓ Some said she asked about "? Long term effects" of PE?? [SOB, sleep problems, PTSD, recurrence,???]

47. Day 3:

- ✓ **SD: post-op PE.**
- ✓ ***Same as that of May 2017. I was there so I will quote from memory [recalls☺]:***
- ✓ SD: Risk mng discussion about a lady who developed PE day 3 post TAH. Age 44, BMI 34. Not smocker. Other parts of history I can't remember. In the board there were the unit's VTE risk assess [at admission & pre-op], her operation sheet [nothing significant], MEWS [if you've time you will pick high RR, low Po2,…any how already told she developed PE] & inpatient drug sheet were all there!!!!!
- ✓ 1st question he asked: Give me a summery about the case.
- ✓ He handles you a preop checklist. He asks if there is any thing "eye catching". It was huge paper, I only noticed that BMI was not ticked in the VTE risk checklist but I donno if there is something else.
- ✓ Then he handles the inpatient prescription or drug sheet, again asked if there is any thing eye catching, & I again only noticed that LMWH was started on day 2-late but correct dose, & again not sure if there is something else. There was also a MEWS which picked up SOB early on day 2 [good thing I think].
- ✓ He quotes: The lady is now stable but upset as she was told-preop-that she will be discharged after 2 days & now already day 4. Show me how would you explain what happened. [honest, duty of candour things]
- ✓ He also asked: Why LMWH? Is there an evidence that LMWH can prevent VTE???????. I'am not sure if this question was asked in 2018.
- ✓ What else are you going to do? [incident reporting which will likely recommends RCA which will….., feed back session,…].

48. Day 4:

- ✓ **SPT: debriefing a husband about his wife who has lost her womb as a complication of UAE.**
- ✓ Same as the station 6 in Nov 2017 recall.

Uro-gynecology:

49. day 1:

- ✓ **SPT: a lady was referred with a "lump in her vagina".**
- ✓ History of recurrent UTI. Tried all types of antibiotics possible. Lump sometimes painful. Needs further details like age, job [heavy lifting things], any problems in her water works-difficulty passing urine, need to digitate, any bowel symp, how is it affecting her life/sexual life, has she tried anything, family complete?,….
- ✓ She refused to be examined [? in her GP surgery?]. Reassure that examination will keep her dignity, will be with a chaperon, can give valuable info.
- ✓ Some candidates added dysuria, drippling & dyspareunia as +ve points in history. These "3Ds" may point to urethral diverticulum.
- ✓ Some also added more details: there was irritative symptoms [urgency], and a decription was given [3cm diameter mass in ANT vaginal wall].
- ✓ Some said she "leaks" whe she press on it
- ✓ D/D: POP [all compartments possible], urethral diverticulum, vaginal cyst, mass [tumor, polyp,..]. I even thought of an infected Bartholin. So local exam essential.
- ✓ Mng will depend on findings.

50. Day 2:

- ✓ **SPT: a 37 yrs old pt referred by GP with symptoms suggestive of BPS. Want to discuss options.**
- ✓ P2. Some dyspareunia. Tried NSAID but no relief.
- ✓ Kept asking for immediate relief.

51. Day 3:

- ✓ **SD: a woman who have OAB symptoms, given her cystometry.**
- ✓ likely the same as in September 18 exam.
- ✓ Questions were what further info you want to know from history, what further invest and what is your mng.
- ✓ Medical H is important [diabetes, neuro,..].
- ✓ Here diary was done [typical for OAB], urodynamic was normal apart from reduced 1st sensation [120ml] & capacity [? 320], so can be sensory urgency. Still may need MSU for culture
- ✓ The difference from DI is that you **CAN'T** offer any surgical options [botox, PTSNS, augmentation,,,,, but otherwise every thing the same [life style, bladder training, antimuscarinics].
- ✓ May be better to put in on the MDT if asked about Botox or nerve stimulation, or at say something like "it may not work, but this will be discussed by a group of specialists".
- ✓ NB: persistent pain for >6wks can put BPS as a differential.

52. Day 4:

- ✓ **SPT: counselling a pt with clear symptoms of OAB about her mng options.**
- ✓ The pt asked about what life style measures she can try, and what are the S/E of medicines.

Gyne-oncology

53. Day 1:

- ✓ **SPT. 45 yrs old, referred by her GP since she had some lower abd pain. Attached GP letter shows CA-125 of 900 & A scan report showing Rt ovarian cyst with complex features [? Size??].**
- ✓ She still has periods [premeno]. History for red flags & risk factors [No loss of wt or change in bowels. No FH oc concern. Smoking?], protective factors [e.g do you have children, are you currently on any CC, family complete? Ever used the pill?
- ✓ In my opinion this is not a "typical" BBN template. Explain results. Clearly tell that she needs further workup to role out sinister [imaging, MDT discussion]. Will likely need surgery that may include taking out……

54. Day 2:

- ✓ **SPT: Counselling a woman with H/O breast cancer-currently on Tamoxifen-now C/O PMB. Scan showed 7mm endo thickness with possibility of endometrial polyp.**
- ✓ She is 47, 3 yrs into menopause.

55. **Day 3:**
    - ✓ **SPT: 36y did hysteroscopy for ? HMB. Biopsy showed atypical EH. Explain.**
    - ✓ Targeted history [fertility wishes].
    - ✓ Thickening of the lining of your womb. Not a cancer but if left without Rtt and follow up, can progress to cancer.
    - ✓ Wants to be pregnant. So mirena till at least one normal biopsy [her safety, higher pregnancy rate], then refer for fertility specialist to discuss assisted reproduction [to expedite pregnancy. live birth rate is higher and it may prevent relapse compared with women who attempt natural conception], follow up & then hysterectomy when family complete.
    - ✓ If risk unacceptable, egg freeze and surrogacy can also offer having a biological baby.
    - ✓
    - ✓ Her BMI was high, so advice about life style.
    - ✓ Remember if EH was on biopsy from pipelle, then she will need hysteroscopy.

56. **Day 4:** [can be teaching]
    - ✓ **SCT: Teaching oncology MDT referral letter.**
    - ✓ Same as for that came in May 2017. It was a feedback about a poorly written MDT form. The junior asked “who should be the leader of this MDT?”.

MHD