MRANZCOG Structured Oral Examination
May 2012 Summary

The structured oral examination (SOE) consists of 10 stations covering the range of clinical practice in obstetrics and gynaecology. Each question is scored out of 20, including 5 marks awarded for overall performance (global competency). The scoring scheme for the remaining 15 points is developed during a 2 day exam workshop conducted prior to the examination, and the pass mark for each station determined at the end of the workshop using a modification of the Angoff standard setting process. The pass mark for the examination is calculated as the sum of the pass marks for all 10 stations. There are no 'critical' stations or encounters so that it is possible to 'fail' one or more individual stations and still pass the examination by a strong performance in other stations. The marking scheme is structured so that a minimal acceptable passing standard candidate should be able to score at or above the pass mark for each station.

Station 1 – Vaginal Prolapse (Communication Station)

A post-menopausal woman who had a vaginal prolapse operation and has found that her vagina is too tight to have intercourse.

The standardised patient is Mrs Mary Parrish. Mary is 58 years old, and she is the manager of a newsagency. She has had four vaginal births, the heaviest baby weighing 10 pounds. She had a symptomatic vaginal prolapse, and was managed with a vaginal hysterectomy and repairs performed three months ago. The operation was performed by trainee under the supervision of the specialist and appeared straightforward

This was quite inconvenient, as the newsagency is a busy place to run and the work is very physical. She had to employ extra staff for six weeks during the perioperative period and during her recovery.

The post-operative check revealed good healing, and normal bladder and bowel function. However, her vagina was noted to be tight and she was advised to use oestrogen cream and commence intercourse gently.

Consent for the operation had been obtained by a Registrar. The notes from the Gynaecology clinic indicate that she was counselled about possible infection, bleeding and damage to bowel or bladder and thrombosis but don't mention vaginal narrowing.

Mary has returned today, annoyed. Despite the post-operative advice, she and her husband have been apareunic. They have not been able to have penis-vagina intercourse. She and her husband had expected to have an improvement in their sex life once the prolapse had been fixed. She is NOT INTERESTED in having to take any more time off work for further surgery.

The candidate is expected to listen to the standardised patient's complaints, apologise and explain that this sometimes happens, but that the use of graded vaginal dilators will usually solve the problem.

COMPETENCIES TESTED

- Ability to communicate with angry patient
- Ability to listen sympathetically to an agitated patient
- Ability to commence a response to legitimate patient concerns
- Open disclosure

Station 2 - Birth Suite Prioritisation

Six women are described on the delivery suite board and the specialist needs to prioritise their care. Subsequently, one of these women has preterm birth related to abruption. She is delivered by caesarean section. Delivery is complicated by uterine atony and DIC.

COMPETENCIES TESTED

- Understanding of the degree(s) of urgency of various situations in obstetric care.
- Safe management preterm birth, placental abruption and PPH.

Station 3 - Endometriosis

A 20 year old woman presents with severe dysmenorrhea and dyspareunia. An initial approach to management is called for. A pelvic ultrasound is essentially normal. A trial of the combined pill is followed by consideration of laparoscopy. This needs to be explained and consent obtained with a view to managing possible endometriosis. At operation lateral pelvic wall endometriosis is identified and needs to be safely managed. Following surgery, ongoing pain needs to be managed.

COMPETENCIES TESTED

- Management of a young woman with painful periods.
- Contemporary management of endometriosis.
- Understanding the role of laparoscopy and consent for surgery in the management of endometriosis.

Station 5 - Epilepsy

A young woman is referred by her GP for pre-pregnancy advice. She has a long history of epilepsy; seizure control has been poor of late. Alcohol intake is excessive. Appropriate pre-pregnancy advice, particularly with reference to epilepsy is called for. The patient subsequently presents in early pregnancy following a 12 week ultrasound scan, for early pregnancy review. At 32 weeks gestation the patient is admitted semiconscious, following a fall and presumed grand mal seizure at home. A thorough emergency assessment and consideration of closed head injury is called for. Following a vaginal delivery a plan of post natal care is required.

COMPETENCIES TESTED

- Management of Epilepsy in pregnancy
- Pre-pregnancy
- Early pregnancy
- Late pregnancy and postnatal
- Management of a suspected head injury in pregnancy

Station 6 - Menorrhagia

A 44 year old woman in a new relationship presents with a history of increasingly heavy periods that are painless. Trial of NSAID and tranexamic acid unsuccessful. She has an increased BMI. She is initially keen to 'maintain fertility.' Imaging reveals a uterus with polyps. Hysteroscopy and polypectomy does not control things. She discovers that her fertility is very low and wishes to discuss further options. After endometrial ablation she returns after 2 months with some cyclical bleeding.

COMPETENCIES TESTED

- Investigation and management of menorrhagia
- Explanation of low chance of fertility
- Explanation of indication / procedure / consent issues for hysteroscopy
- Risks and benefits of mirena, endometrial ablation, hysterectomy
- Awareness of bleeding issues after endometrial ablation

Station 7 - Previous fetal growth restriction in two pregnancies.

A woman presents for pre-pregnancy advice, but is found to be pregnant at the first visit. Development of a management plan is required. Develops IUGR again this time along 5th centile then static growth at 30 weeks, requiring steroid cover, $MgSO_4$ neuroprotection, and urgent delivery.

COMPETENCIES TESTED

- Investigation and management of growth restricted fetus
- Recurrent problem not previously investigated
- Discussion re mode of delivery

Station 9 – Increased risk of Down Syndrome (Communication Station)

The patient is a socially-disadvantaged woman from an isolated rural area who has undergone nuchal translucency screening and been found to have a risk of one in 100 for Down syndrome. She has been referred for discussion and counseling about amniocentesis.

The candidate is expected to explain the issues and potential risks and benefits in a very simple, easily-understood manner to the patient.

COMPETENCIES TESTED

- Explanation of the difference between a screening test and a diagnostic test
- Explanation of amniocentesis
- Handling discussions in a sensitive and understanding manner

Station 10 - Macrosomic baby with gestational diabetes.

Overweight 39 year old woman with PCOS has first pregnancy following IVF treatment. Diagnosed with gestational diabetes following GC test at 28 weeks. Sugar control is acceptable with no need for insulin, but sequential ultrasound reveals a fetus with measurements above the 90th centile. Reaches 38 weeks with discussion regarding timing and mode of delivery. Opts for induction of labour at 39 weeks, but slow progress in labour and shoulder dystocia.

COMPETENCIES TESTED

- Diagnosis and management of gestational diabetes
- Management of fetal macrosomia
- Recognition of anti-Lewis antibodies as not significant
- Management of shoulder dystocia

Station 11 - Cancer Risk

A 38 year old woman presents with a request from her geneticist to discuss 'risk reduction.' Her sister has recently been treated for an aggressive form of breast cancer at age 42, their mother had ovarian cancer at age 54 and succumbed to this, and two maternal relatives (aunt and great aunt) both had early-onset bowel cancer. There is a suspicion that the family carries a mismatch repair gene mutation, but this might take a while to test for. The woman wants to reduce her risk of malignancy (the geneticist suggests five-yearly colonoscopy and yearly breast MRI). Asks for information about screening vs risk reducing surgery. Had peritonitis from a car accident as a teenager, with large midline laparotomy so removing tubes/ovaries won't be easy. Eventually has general surgeon help with laparoscopic bilateral salpingo-oophorectomy and is found to have occult carcinoma in a tube.

COMPETENCIES TESTED

- Knowledge of screening and risk reduction for women at increased genetic risk of ovarian, breast, and bowel cancers.
- Preparation for surgery in patients with previous abdominal surgery
- Management of stage one ovarian cancer

Station 12 - Recurrent Miscarriage

A 30 year old woman presents with a history of three consecutive early pregnancy losses. She is not immune to rubella. She has a BMI of 32 and some PCO appearances. Investigation reveals that she has a uterine septum but other investigations are normal. This is resected but the uterus sustains a large perforation, and she returns for management of the next pregnancy.

COMPETENCIES TESTED

- Investigation and management of recurrent miscarriage
- Management of large uterine septum
- Plan for pregnancy after large uterine perforation

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NOTE: Station numbers 4 and 8 were allocated rest stations.