MRANZCOG Structured Oral Examination
May 2011 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 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 - Recurrent Miscarriage (Standardised Patient Scenario)

A 36 year old woman presents immediately after a 9 week ultrasound which conclusively shows a blighted ovum. She has had two previous first trimester pregnancy losses, and has no live children. She has had no other significant medical history. The candidate needs to sensitively explain the scan report and its immediate implications; the patient is devastated by the news and desperate for an explanation. Subsequently she returns for a follow up appointment to discuss her wishes to have a family and what may be done to help her.

COMPETENCIES TESTED:
Explaining the distressing news of a third early pregnancy loss.
Demonstrating empathy for the patient and her clinical situation.
Listening to this patient's particular needs and wishes.
Offering an appropriate plan for investigation and ongoing support.

Station 2 - Obesity, raised nuchal and GDM in pregnancy

A 32 year old nulliparous woman with a past history of infertility, PCOS and morbid obesity presents for Obstetric review prior to commencement of a first cycle of ovulation induction treatment in early pregnancy. A BMI of 55 is clearly an issue. Appropriate advice needs to be given and the risks presented must be clearly outlined. Early in a subsequent pregnancy, a thickened nuchal fold is noted on US. The patients request for local Hospital GP care needs to be responded to, and antenatal implications need to be discussed and a plan of care outlined. Severe GDM is diagnosed early and a plan of care outlined. An induction of labour is proposed and a plan of intrapartum care needs to be outlined.

COMPETENCIES TESTED:
Pre-pregnancy counseling and antenatal management of morbid obesity.

Management of early severe GDM
Intrapartum management of morbid obesity and poorly controlled GDM on Insulin

Station 3 - Amenorrhoea, Pelvic Inflammatory Disease (PID), Tubo ovarian Abcess (TOA)

A 15 year old nulliparous female attends the emergency department with lower abdominal pain, vaginal discharge and secondary amenorrhoea (functional hypothalamic amenorrhoea secondary to stress and underweight). She is screened for STIs and hormonal dysfunction as well as having pregnancy excluded. Swabs confirm Chlamydia. An ultrasound indicates a likely tubo-ovarian abscess from PID. A discussion about the management is required. Medical management is unsuccessful and a laparoscopy indicates severe PID, bilateral TOAs with extensive adhesions. Conservative surgical surgery is expected with counseling about follow up and long term implications.

COMPETENCIES TESTED:
Assessment of sexual risk factors and likely PID
Assessment of secondary amenorrhoea and excluding pregnancy
Identification of a child at risk of being in an abusive relationship
Medical and surgical management of tubo ovarian abscesses with long term implications

Station 5 - Menopause on Tamoxifen & Hyperplasia

A 53 year old post-menopausal woman with a past history of breast cancer (of good prognosis) three years previously is taking Tamoxifen. She seeks help for severe oestrogen deficiency symptoms. She subsequently develops some post-menopausal bleeding and requires a hysteroscopy. Histology reports simple endometrial hyperplasia. Candidate is required to assess oestrogen deficiency symptoms, liaise with breast team and offer appropriate non-hormonal treatment options, also balancing the risk of HRT with the benefits. Appropriate investigation of postmenopausal bleeding and the management of simple hyperplasia in this higher than usual risk setting is required.

COMPETENCIES TESTED:
Assessment of oestrogen deficiency symptoms.
Importance of liaison with other health professionals who are also caring for the patient.
Ability to discuss with the patient management options.
Management of simple hyperplasia in this higher than usual risk setting

Station 6 – Gastroschisis (Standardised Patient station)

The candidate is asked to counsel Ms Jane Smith, an 18 yr old G2P0 presenting at 19 wks gestation to receive the result of an ultrasound performed 2 days earlier. The ultrasound result confirms that the baby has gastroschisis. This result needs to be conveyed and a plan of management briefly outlined. After the initial shock of the diagnosis and its implications, Ms Smith is increasingly distressed about the possible link to her drug taking earlier in pregnancy. The candidate needs to demonstrate an ability to accurately and

sympathetically break bad news, and respond appropriately to the patient's legitimate concerns and distress.

COMPETENCIES TESTED:
Ability to break bad news
Knowledge of gastroschisis and its implications
Awareness of management options at 19 weeks gestation
Ability to listen sympathetically to an agitated patient.
Ability to respond to legitimate patient concerns

Station 7 - Ovarian Cyst & Ileus

This is a referral from the general surgeons who have admitted a 78 yrs old woman with acute onset of abdominal pain via the Emergency Department. Recent history of shingles and history of wedge fracture of T10, 11, 12 vertebrae. CT finding of bilateral ovarian cysts. The candidate is expected to investigate the mass and arrange theatres when it is apparent she is not settling. A post-operative ileus occurs requiring further management.

COMPETENCIES TESTED:
Assessment and investigation and diagnosis of a pelvic mass.
Appropriate management plan in acute presentation
Recognition and management of post operative complication

Station 8 - Instrumental, Shoulder Dystocia, 3rd Deg Tear (Practical Station)

A 32 year old para 2 is in labour after a normal pregnancy and after 40 mins of pushing develops a fetal bradycardia. The candidate is expected to assess the patient with a brief history and examination and proceed to an instrumental delivery of their choice. A shoulder dystocia then follows but a third degree tear is sustained. The candidate is expected to explain how this is managed and followed up.

COMPETENCIES TESTED:
Interpretation of abnormal CTG
Assessment, counselling and demonstration of instrumental delivery
Management of shoulder dystocia
Management and follow up of severe perineal trauma

Station 9 - TOP on Warfarin, Perforation

A 28 year old nulliparous woman presents to gynaecology outpatients requesting surgical TOP. She is on warfarin daily following an unprovoked pulmonary embolus four months ago. She requests further information and advice regarding the risks of fetal malformation, and risks of surgical termination. A detailed history and risk assessment is required. After agreeing to proceed, she sustains a uterine perforation which needs to be managed. At follow up, she seeks advice regarding ongoing management of her menorrhagia in light of her risk factors. Also Rhesus Negative.

COMPETENCIES TESTED:
Ability to advise re risks of warfarin to the fetus in the first trimester of an unplanned pregnancy
Managing peri-operative risks to the woman with recent history of pulmonary embolus
Peri-operative planning re anticoagulation
Assessment & management of menorraghia
Management of uterine perforation at time of surgery

Station 11 - Ward handover & Prioritisation

A number of issues requiring attention are described on the handover and the specialist needs to prioritise, outline the essential aspects of management and delegate appropriately. Cases include an induction with a high head, prolonged second stage, VBAC in labour, a gynae patient with RIF pain, oliguria post hysterectomy, and an APH at term. Subsequently, one patient has a postoperative bleeding requiring return to theatre. A discussion about the management of a post vaginal hysterectomy bleed is required.

COMPETENCIES TESTED:
Understanding of the degree(s) of urgency of various situations in obstetric and gynaecology care.
Ability to prioritise
Safe management of postoperative bleeding

Station 12 - Alcohol, Hep C, Herpes in pregnancy

A 23 year old primiparous woman presents as a late booker with a history of alcohol and IV drug use. She has been binge drinking in the pregnancy and needs counseling & support about the risks of fetal alcohol syndrome and her Hep C +ve status.
She later develops a genital ulcer and wishes to explore the differentials (recently in tropical Queensland). This is found to be HSV type II. Prophylaxis needs to be discussed, and she presents in advanced labour with apparent recurrent active lesions. Intrapartum management needs to be discussed and neonatal follow up is required.

COMPETENCIES TESTED:
Management of Alcohol abuse in pregnancy
Management of Hep C+ve patient in pregnancy
Excluding differential diagnoses of genital ulcer in pregnancy
Management of Herpes Simplex at time of labour

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NOTE: Station numbers 4 and 10 were allocated rest stations.