

OCTOBER 2005

# MRANZCOG Oral Examination

**T**he second MRANZCOG Oral Examination for 2005 was held on Sunday 16 October. Congratulations to all the successful candidates and thanks to all the hard working examiners and College staff involved on exam day and with the preceding two-day examiners workshop. The examiners were generally impressed by the standard of candidates. Once again however, some candidates did not do their performance justice by failing to carefully read the introductory details or provided results. Future candidates are encouraged to read and listen carefully, to think on their feet, and to expect scenarios to run differently to how they may have practiced cases with their colleagues. The exam was run over eight standardised stations. The passing standard was set using the concept of a Minimum Acceptable Passing Standard (MAPS). A brief summary of the stations and the key issues or competencies assessed within each, is presented here for the interest of both Trainees and Fellows.

## Station 1

(Actor or standardised patient station.) At this station, candidates clinical competence and communication skills were assessed. The candidate was asked to conduct an appropriate consultation with the standardised patient, directing all communication to the patient while using appropriate language.

The station introduced a 35 year-old mother of two children with a past history of depression. She presents upset by the identification of a soft marker for T21 at a 19 week screening ultrasound, following a low-risk given at a 12 week nuchal scan. In addition her eldest child reports a flu-like illness and a school diagnosis of 'slapped cheek'. The T21 issue is discussed and appropriate reassurance given. Parvovirus seroconversion is confirmed at a second visit two weeks later. The young mother is very anxious and distressed, and appropriate explanation and a plan of management is called for.

### Key Issues

- Understanding the implications of soft T21 markers, and the management of parvovirus exposure and seroconversion and possible foetal anaemia.
- Offer appropriate reassurance and explanation for this anxious mother.
- Acknowledge the history of depression and antidepressant use, offer support.
- Listen to the patients questions and concerns.



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## Station 2

A young woman is referred with a blood stained vaginal discharge and a cervical Pap smear suggesting a high-grade glandular abnormality. Colposcopy is unremarkable; however a repeat smear again shows a suspected high grade abnormality.

A cone biopsy is indicated and cervical adenocarcinoma *in-situ* is diagnosed. A secondary haemorrhage requires management and a plan of follow up is called for. Issues relating to safe sex practices and contraception are also raised.

### Key issues

- Management of a high grade abnormality on Pap smear with a normal colposcopy.
- Management of a positive chlamydial swab.
- Management and follow up of cervical adenocarcinoma *in situ*.
- Management of a secondary hemorrhage post cone biopsy.
- Recognition of the need for adequate contraception, and safe sex education.

## Station 3

A 34 year-old woman presents keen to conceive having ceased the combined pill 18 months ago. She is overweight with very infrequent periods. PCOS is diagnosed and explained. A plan of management is suggested. Ovulation induction with Clomid is not successful, IVF results in a pregnancy and an emergency presentation with low abdominal pain.

### Key Issues

- Address pre-pregnancy issues, respond to a family history of cystic fibrosis.
- Management of infertility.
- Management of PCOS and obesity.
- Management of patient frustration and impatience.
- Appropriate use of ovulation induction agents.
- Management of abdominal pain early in IVF pregnancy.

## Station 4

A 32 year-old primigravida at 35 weeks gestation is involved in a motorcar accident. She and her husband have been injured. The husband has been admitted to a major general hospital with multiple trauma. The woman is admitted to an obstetric hospital, reporting generalised bruising and soreness. The candidate is phoned by the junior obstetric registrar for their advice on initial management. As the candidate arrives at the bedside, the patient suffers a cardiac arrest and CPR is commenced. Immediate delivery is called for. A large haemoperitoneum is found and a ruptured uterus is diagnosed and repaired. The baby survives and the patient recovers, and is reviewed by the candidate seven days later.

### Key Issues

- Management of major trauma in late pregnancy.
- Management of resuscitation in a gravid patient.
- Management of ruptured uterus.
- Appropriate follow up counselling.

\*Trainees are reminded that adult resuscitation is a required competence of the obstetrician / gynaecologist.

## Station 5

A 41 year-old woman presents with night sweats, hot flushes and amenorrhoea. She has a family history of breast and bowel cancers. Examination reveals a small distinct lump in her left breast. She subsequently presents with vaginal itch due to a chronic vulval dystrophy. A photograph of lichen sclerosus is shown to the candidate. Explanation and a management plan is called for.

### Key Issues

- Follow up of a recognised breast lump. Counselling regarding breast cancer risks.
- Diagnosis and management of premature menopause.
- Explanation of the pros and cons of HRT for this patient.
- Explanation and management of chronic vulval dystrophy.

## Station 6

A 34 year-old primigravida with a past history of hypertension, and hypercholesterolaemia presents midway through her first pregnancy. A 22 week ultrasound shows the fetus to be already small for dates and suggests early severe uteroplacental insufficiency. A plan of management is called for. Fetal growth remains poor, and issues surrounding fetal surveillance and the timing of delivery arise. Severe preeclampsia at 27 weeks eventually prompts delivery.

## Key Issues

- Management of essential hypertension in pregnancy.
- Investigation and surveillance of early severe growth restriction, including consideration of fetal anomaly.
- Explanation and approach to a possible extremely preterm delivery.
- Recognition and management of severe pre-eclampsia.

## Station 7

An overweight menopausal 64 year-old woman, presents with worsening urinary incontinence. Examination reveals a large fibroid uterus. Investigations confirm genuine stress incontinence. Symptoms improve with conservative measures, however at review six months later the fibroid has grown. The possibility of uterine sarcoma should be raised. Appropriate investigations are called for. The management of a possible sarcoma is discussed. After TAH BSO a urinary fistula needs to be considered and managed.

### Key Issues

- Initial investigation and management of urinary incontinence.
- Management of a post menopausal pelvic mass.
- Management of an expanding post menopausal fibroid, consideration of a possible uterine sarcoma.
- Surgical approach to a possible uterine sarcoma in an obese patient.
- Recognition and initial management of a likely post operative vesico-vaginal fistula.

## Station 8

A 28 year-old primigravida lives in a remote rural setting. At her first antenatal visit, she gives a history of ongoing drug usage. Social support and urgent referral to a methadone service are called for. A past history of vulval herpes is also noted. A preterm PROM without contractions occurs at 23 weeks, requiring level III transfer. A management plan is called for. At 31 weeks the patient goes into labour, not long after a vaginal swab identifies GpB strep growth. Upon arrival in the delivery unit, the resident rings reporting a suspected face presentation approaching full dilatation.

### Key issues

- Management of drug use in pregnancy in rural setting.
- Management of recurrent HSV in pregnancy.
- Management of very preterm and then prolonged PROM, including of the particular perinatal hazards presented.
- Management of GBS and prolonged preterm PROM.
- Management of a face presentation in labour.