

## **GUIDANCE FOR CANDIDATES FOR THE FINAL FRCR EXAMINATION**

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*This document is intended to offer advice from trainees who have already sat the examination. It has been drafted without input from the FRCR examiners and does not necessarily represent their views.*

This document is aimed at Clinical Oncology trainees who are preparing to sit the Final FRCR Examination. Hopefully it will help these trainees to focus their studying and improve their chances of passing. This is the last major examination hurdle to be cleared before one can apply for a consultant post. The words "FINAL FRCR" can still put even the most senior oncologists into a cold sweat. On the positive side, it is the last exam you ever need to sit!

It may be reassuring to know that the Final FRCR is an intermediate examination, *not* an exit exam. In other words, at the time of examination, the examiners are trying to decide whether a trainee has learned a sufficient amount of knowledge and experience to proceed to the 5<sup>th</sup> and final year of training.

There are a number of sample SBA questions and the exam's scoring system available elsewhere on the RCR website.

This document will go through the structure of the exam as well as giving some tips on how best to prepare for each of the 3 components.

### **GENERAL**

#### When to start studying

Preparing for this exam is a gradual process. Experience gained during training of MDTs, radiotherapy sessions and clinics is invaluable. The final "push" should complement this. Exactly when to start studying very much depends on how you normally study for exams. Some people start several months in advance whereas others tend to cram for exams. This sort of exam is not best suited to "cramming" and, in general, is easier to study for in small groups. It is useful to speak to post FRCR colleagues at your centre to obtain a consensus on when to get started. Most people would say anything from 3 to 9 months before the exam.

#### Studying methods

As mentioned above, it is much easier to study for this exam with others. Trying to arrange at least weekly meetings with other candidates is strongly advised, particularly when it comes to the clinical and oral components. Review the Final FRCR syllabus together before you start studying and draw up a methodology and time frame for your revision programme. It is usually best if each person in the group can have some cases for discussion such as tricky patients who were discussed at a recent MDT and recent new patients seen in clinic.

#### Courses

There are 4 Final FRCR courses, held in Sheffield, Cardiff, Canterbury and Edinburgh respectively. The Sheffield course is held in July, the Cardiff course in September, the Canterbury course in February and the Edinburgh course every two years in April. In addition there is a one day skin course held in Norfolk and Norwich every August which is highly rated. These courses are helpful, partly in that they give you a sense of how you are faring compared with other candidates. Perhaps the most useful aspect of the courses is the mock clinical/oral exams. These put you under the spotlight and allow you to be examined by consultants who don't know you which is excellent preparation for the exam. It is important to book early as these courses usually fill up quickly.

There is also the Cambridge Fundamentals of Radiotherapy Planning course which is advertised elsewhere on the RCR website. It is not designed specifically for the Final FRCR but candidates may find this a useful course to attend. For further details of this course please see the events page at the RCR website.

### Studies

I have yet to meet the candidate who has been asked about any clinical trial during the exam. Therefore, spending hours learning trial protocols is not recommended. However, the introductory sections in trial protocols can give very useful background information. Furthermore, knowing which radiotherapy doses and schedules to quote in the exam can be quite stressful since many centres use different schedules. If you quote the doses and schedules that are used in the standard arm of current trials then you cannot be criticised and it is certainly a safe answer to give.

### The Pass Mark

The Part A pass marks are released following the exam – with results – as is general practice for a standard-set written paper. The Part B pass mark is advertised in the marking scheme as 71 out of a maximum of 104. The scores are made up of 26 different independent judgements made by the examiners (16 assessments in the eight oral questions and 10 in the five clinical stations.) Examiners have repeatedly stressed that they are trying to pass all competent candidates if at all possible. While those who have been unsuccessful in the exam might not agree with this, it is a consistent point that is made.

### **PART A SINGLE BEST ANSWER EXAM**

This is trying to test core knowledge of Oncology. As a general rule, you are likely to be asked relatively straightforward questions about uncommon cancers and more in depth questions about the common cancers. Therefore, spending hours and hours learning all about in depth management of obscure cancers is not recommended. As interesting as this might be, you will not be asked about it and there is plenty else to fill your time! In general, they are testing principles and common sense.

Most of the core knowledge can be found in “Practical Clinical Oncology” which accompanies the Cardiff Final FRCR Course. The vast majority of candidates would regard this book as the most useful for the Part 2.

### **Time management:**

Some would also recommend finding a textbook with SBA questions. As much as anything, it gets you in the way of answering many questions in a short space of time. This leads on to the endurance test that is the actual exam. There are 120 questions to cover in each paper in the space of three hours, with an hour and 15 minutes between papers. This leaves 1.5 minutes per question. Many candidates find this quite tight for time. Keeping a fairly regular eye on the clock to check that you are roughly on time (e.g. have completed about 40 questions in the first hour) is recommended. Since there is no negative marking, it is imperative that every question is answered since, even if it is a complete guess, it might be correct! Running out of time and leaving answers blank is simply not an option.

### **PART B CLINICAL**

This consists of five stations each lasting eight minutes with one minute between cases to stop shaking/mop your brow/wipe away your tears/compose yourself/consider other career options. It is difficult to know how long to spend examining the patient and how long to save for the discussion. Don't be surprised if the examiners rush you through parts of the examination e.g. you may start with the hands in a GI exam but they may then direct you to simply examine the abdomen. Do not be put off by this – they are trying to help you!! Examiners consistently report on poor quality of examination skills. Read the examiners' reports which are available on the RCR website for further details on this. Similar clinical standards to those required for MRCP are expected in the FRCR.

In the lead up to the exam, it is well worth timing yourself to see how long you take to perform different examinations and try to get them to around the four to five minute mark. Although it is tempting to spend longer examining the patient, the examiners do have set questions to ask you and if you spend the whole time examining, you will not be able to get credit for answering the questions, some of which are pretty straightforward (even if they don't seem so at the time!).

You can be pretty much guaranteed that three of your cases will be skin, head and neck and breast. Therefore, it is essential that you are confident in these areas. Remember that many oncology patients will have had surgery at some stage so have a very good look for scars. Do remember to take a couple of seconds to view the patient as a whole before embarking on the requisite subsite examination. It gives you a moment to compose yourself and allows you to make a mental note of more general things such as cachexia, alopecia, Hickman/PICC lines, walking aids, inhalers, permanent marks/tattoos for radiotherapy localisation.

### **Likely cases:**

Remember that recruitment of patients to present as stations in the exam starts happening several weeks before the exam and therefore, in general, the organisers must select patients who have stable findings or who will not yet have commenced treatment. This means that cases for the clinicals tend to be consistent and more predictable.

- **Skin: BCC, SCC, superficial melanoma** *For skin, expect a discussion on the pros and cons of using electrons versus superficial X-rays and the depth that each modality will treat to, whether you need bolus, likely side effects etc.*
- **H&N:** Although mirrors or flexible nasendoscopy skills are expected at the time of examination, it is unlikely that you will be asked to demonstrate these proficiencies, as no patient would be able to tolerate multiple examinations and/or lignocaine throat spray. Therefore, it is very likely you will be asked to perform an oral examination and of course, an examination of the neck. *For head and neck, if you have a friend who specializes in ENT, ask them to show you how to examine someone's oral cavity properly. Alternatively, try to attend head and neck clinics for advice. If this is performed well, it will look very slick and score points with the examiners.* Make sure you obtain lots of experience in both oral and neck examination, as it is easy to miss something that may in fact be quite obvious and even visible from the end of the bed (which is where the examiners will be standing!).
- **Breast:** *For breast, important things to assess are the size of breast lumps and their fixity to either skin or underlying muscle. Also, don't forget to examine for axillary lymph nodes!* Be aware of normal breast examinations due to neo-adjuvant chemotherapy. Make a mental note if the patient appears to be under the age of 45, as it may become relevant in the discussion in terms of fertility considerations.
- **Abdomen:** More variable. Splenomegaly is fairly common since it tends to be quite stable and tests basic radiotherapy principles. If you have a case with splenomegaly, don't list all the non-cancerous causes first! Say something like: "there are numerous causes of splenomegaly, in the context of this exam, the commonest causes in this patient (eg age, other signs like Hickman lines or anaemia) would be..." Hepatomegaly, groin nodes (don't forget Virchow's node if you can't find anything elsewhere!) and caecal masses may crop up. Noticing radiotherapy tattoo marks usually impresses the examiners. Think about how to examine for portal hypertension.
- **Neuro:** can be daunting so practise well and especially practise components, eg right upper limb only, CrN 7-12 only and so on. Look for Horner's, asymmetry in body posture, asymmetrical muscle wasting, walking aids, glasses. Cases could include Horner's due to any cause, brachial plexopathies (check axilla of masses), cranial nerve palsies, cerebellar signs (mass in cerebellopontine angle), spinal cord compression.
- **Chest:** chest wall masses tend to be unusual in the exam but axillary, SCF or neck masses might be more common. Don't forget to look for a Horner's! A case of treated/stable SVCO might present so remember to look for more subtle signs such as prominent upper chest wall vasculature which might be difficult to spot in a cubicle.

## **PART B ORAL**

This consists of eight cases each lasting five minutes. You will be with two examiners for 20 minutes then swap to two other examiners for the last 20 minutes. There is a computer screen in front of you and the examiners sit on either side of you which is a pretty odd feeling but they do try to help put you at ease. One examiner will go through two cases with you while the other takes notes and then they will swap over.

### **Likely cases:**

- Imaging interpretation – MRI is a common pitfall; make sure you practise viewing pelvic MRIs for prostate, rectal and cervical cancers and ask a radiologist for help if necessary
- Simulator style planning of treatment fields – especially palliative cases (see below) CT planning for rectal or prostate cancer
- Evaluation of radiotherapy plans

Expect to interpret scans, draw on treatment fields and evaluate radiotherapy plans in this part of the exam. Spending some time learning basic radiology anatomy is helpful. As for treatment field drawing, I would strongly recommend printing out several pelvic/skull X-rays and any other X-ray you can get your hands on and drawing on various fields such as a typical pelvic brick for a cervix patient and a field for a base of skull/palliative whole brain etc. It will make you much more confident when faced with this in the exam.

It is important to have a logical approach to radiotherapy plan evaluation and speaking to helpful Physics staff at your local centre is advised. Learn a routine for evaluating a plan and run through it every time you review a plan, until it becomes second nature. Make sure you are comfortable with critical OAR tolerances, how to look at both cumulative and differential DVHs, and take a look at ICRU 50, 62 and 83 (all of which will be in your radiotherapy department) which report the international guidance for radiotherapy planning.

The best way to prepare for this part of the exam is to use patients that are discussed at MDTs and that are seen in new patient clinics. Essentially the examiners want to know that, if you were at an MDT by yourself, would you be able to make a safe, sensible decision. Try not to say anything too outrageous and make your treatment intentions clear, e.g. “This is clearly a palliative situation and so I would offer this patient...”

- Don't forget fertility issues. If the case involves a young patient needing chemo or XRT to the pelvis, it is imperative to discuss this.
- **Cancer in elderly patients** – if chemotherapy is a potential treatment option, remember to comment that hepatic and/or renal metabolism may be less efficient in elderly patients and that this must be taken into consideration in addition to performance status and evaluation of social support.
- **Palliative cases:** spinal cord compression, SVCO, bone metastases, brain metastases, skull base metastases, orbital metastases, bleeding bladder, splenomegaly, large lung mass causing pain

**Carcinoma of unknown primary** - Candidates may find this reference useful for unknown primaries. A Clinical Review of the Investigation and Management of Carcinoma of Unknown Primary in a Single Cancer Network P.H.S. Shaw, R. Adams, C. Jordan, T.D.L. Crosby Clinical Oncology (2007) 19: 87e95

## **FINALLY**

Know your oncology emergencies. It is highly likely that, at some point, you will be asked about a typical emergency situation, be it spinal cord compression, SVCO, extravasation etc. Be familiar with all of these and other similar emergencies as at least one will come up at some point.

Most of the clinical/oral examination questions are straightforward with small complexity. All you need to do is be sensible and think what you would do if you have this case in real life. Medicine is not always black/white and the examiners will sympathise with you if you can justify your approach within reason.

Be confident. Phrases like “in my practice” and “I often do that in these sort of situations” are what the examiners are looking for. Particularly if you have come across similar situations in the past, try to show that you have “hands on” knowledge of how to manage tricky cases. Phrases such as “I will discuss this at the MDT” and “at my centre” seem to irritate the examiners and are best avoided.

**BEST OF LUCK!!**

### **USEFUL RESOURCES**

Hanna L, Crosby T. Practical Radiotherapy Planning. Cambridge University Press; 2008

Barrett A, Dobbs J. Practical Radiotherapy Planning 4<sup>th</sup> Ed. Hodder Arnold (UK); 2009

Hoskin P, Goh, V. Radiotherapy in Practice – Imaging. Oxford University Press; 2010.

<http://www.e-lfh.org.uk/projects/radiology/index.html>

[http://www.rcr.ac.uk/docs/oncology/pdf/Dose-Fractionation\\_Final.pdf](http://www.rcr.ac.uk/docs/oncology/pdf/Dose-Fractionation_Final.pdf)

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