FINAL FRCR PART B EXAMINATION FOR THE FELLOWSHIP IN CLINICAL RADIOLOGY

SPRING 2021

The Examining Board has prepared the following report on the Spring 2021 sitting of the Final Examination for the Fellowship in Clinical Radiology. It is the intention of the Fellowship Examination Board that the information contained in this report should benefit candidates at future sittings of the examinations and help those who train them. This information should be made available as widely as possible.

General comments

Unfortunately, the planned exam for January 2021 had to be cancelled owing to the second/third wave of the COVID19 pandemic, so this was the second exam sitting with candidates remote from the College for the oral components, this time during full "lockdown" restrictions. Once again, my sincere thanks to the RCR Examinations, IT and Facilities teams, the Board of Examiners and all Exam Board Chairs for ensuring successful delivery of the Final FRCR 2B examination.

Delivery of the written components of the exam on the Practique platform occurred without major incident.

There seemed to be rather more minor technological clitches during the oral components this time, mostly owing to upgrades to MS Teams and the Mac OS introduced only days before the exam week with resultant incompatibilities/loss of functionality that there was not enough time to resolve before the oral exams commenced.

Regardless, all candidates that were able to attend for the exam completed the oral components during their allotted session, with additional time allowed, when appropriate, to compensate for any technological delays. Feedback from all participants has been requested again and will be considered, to continue improvement in the delivery of the exam.

I would like to reassure candidates that all the equipment at all the exam venues meets the minimum specifications stipulated by the RCR so no candidate will be disadvantaged by substandard monitors, poor internet bandwidth and speed.

Comments in previous reports for each component of the exam are still relevant, but given the interim disruptions and time elapsed since fully included in a previous report (Autumn 2018), they are updated and repeated in this report.

I would like to emphasise that minor changes of degenerative arthritis in Rapid Reporting images should be regarded as normal for the purpose of classifying the image as normal or abnormal.

Written Components

Candidates are reminded to view the pre-exam video and visit the Practique demonstration site to familiarise themselves with the exam delivery platform for the written components.

To provide the best chance of giving a correct response, it is essential that plain images, particularly in the Rapid Reporting component but also the Reporting component, are enlarged to full screen and sometimes further enlarged (zoomed) to achieve maximum spatial resolution. This is achieved by double-clicking on the image window in the middle of the question/answer screen. All image manipulation parameters in the drop-down box (top left of screen) remain functional. Double-clicking on the full screen image will return to the

question/answer screen.

Rapid reporting session

Candidates are reminded that there is considerable variation in the number of normal versus abnormal cases between exam sittings.

Abnormalities should be described accurately and fully to avoid the award of half-marks or no marks for the candidate’s response. Examples provided previously are reiterated below:

- Identifying a fracture but failing to identify that this is a **pathological** fracture. If an underlying lesion is visible this should be stated, and if possible, characterised e.g. ”fracture through simple bone cyst”

- Identifying a fracture but failing to accurately describe its anatomic position e.g. if there is a fracture through the base of the fifth metatarsal on a radiograph of the foot, the following responses would not score any marks, as the Examiners cannot be certain that the candidate has identified the correct area of abnormality:
    - Fracture
    - Lucent line through metatarsal
    - Fracture through metatarsal

  The following responses would gain a half-mark:
    - Fracture fifth metatarsal
    - Fracture metatarsal base

  The following response would gain a full mark:
    - Transverse fracture base of fifth metatarsal
    - Fracture base fifth metatarsal

- Identifying a single fracture in a well-recognised fracture complex, where a second fracture would be expected, e.g.:
    - Noting only one fracture in paired bones which normally fracture together (radius and ulna, tibia and fibula)
    - Noting only one fracture in a ring structure (mandible, pelvis)

- Identifying an abnormality but failing to accurately localise it, e.g. identifying a posterior mediastinal mass, but calling it anterior, or identifying a renal tract calculus but mistakenly stating this lies in the kidney instead of the ureter or vice-versa.

- Accurate description of cervical spine injuries should distinguish between unilateral and bilateral facet dislocation, fracture-dislocations and isolated fractures.

- Normal variants that can cause symptoms will not be included, e.g. accessory navicular, supracondylar spur. Normal variants that do not cause symptoms may be included and the correct response for such images would be “normal”.

Candidates are reminded to keep comments short and precise regarding the site and nature of the abnormality identified on an image considered abnormal in order to maximize the opportunity to score full marks (see Spring 2019 report for more detail).

Minor changes of degenerative arthritis should be regarded as normal for the purpose of classifying the image as normal or abnormal.

Reporting session

Candidates are reminded that an adequate answer should be provided for all six cases as two or three detailed responses are rarely sufficient to compensate for poor or brief answers to the other cases and allow a passing score to be achieved. Appropriate allocation of their time between cases is essential to achieve this – a bit less for the straightforward cases and a bit more for the more complex cases.

The experience and clinical knowledge of the candidate should be used to guide their search for additional features, help their interpretation of the findings (e.g. the patient's age, acute/chronic presentation) and prompt the inclusion of relevant negative observations (e.g. absence of metastatic disease in sites common for a particular malignancy). Features that may affect the patient's subsequent management should be considered where appropriate.

The management of the patient should go beyond referral to an appropriate MDT, and the candidate should provide the advice they would give to that MDT whenever possible.

Short sentences and/or bullet points are preferable to long sentences or eloquent prose, particularly for recording the candidate's observations.

Oral components

Candidates are reminded that:

All modalities of imaging shown provide the same opportunity for scoring marks (plain images, US scans, CT scans, MRI scans, radionuclide imaging, contrast studies). Each modality shown is a separate opportunity for scoring marks when a different set of candidate skills can be assessed, even if more than one modality is shown for the same patient, e.g. a chest plain image followed by a CT scan of the chest for the same patient usually represents two mark scoring opportunities.

Plain images are the starting point for several patients shown in the oral components of the exam, so as much information as possible should be extracted from these before requesting another modality. The information obtained from the plain image or any other initial imaging modality should inform the observations and interpretation of any subsequent modality. Ultrasound is frequently overlooked in favour of CT or MRI as the next modality for further investigation, even when it may be more appropriate (e.g. children).

Candidates should try to determine themselves when they have extracted as much as they can from the images presented to them in order to summarise, discuss diagnoses and further imaging/management as appropriate, end the scoring opportunity and move forward to another (either another modality for the same patient or a different patient and pathology).

Anatomy, assessment of plain images and clinical aspects relevant to the images shown are important components of the oral assessment. Discussion of patient management should go beyond referral to an appropriate MDT, and the candidate should provide the advice they would give to that MDT.

Barely pausing for breath and talking incessantly does not easily give an examiner the opportunity to guide candidates to summarise, discuss patient management or assess the depth of their knowledge by additional questions as appropriate. Mumbling and muttering makes it difficult for the examiners to hear what the candidate is saying and to know whether or not what they are saying is correct. Candidates are encouraged to speak clearly and at a steady pace with short pauses as appropriate.