FINAL FRCR PART B EXAMINATION FOR THE FELLOWSHIP IN CLINICAL RADIOLOGY

AUTUMN 2017

The Examining Board has prepared the following report on the Autumn 2017 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.

EXAMINERS'S REPORT – AUTUMN 2017

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 a half-mark or no mark for the candidate's response. Examples provided in the report for Spring 2016 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.

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

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, even if more than one is shown for the same patient (i.e. a chest plain image followed by a CT scan of the chest for the same patient represents 2 mark scoring opportunities).

Candidates are reminded to extract as much information as possible from the modality first presented (often a plain image) before requesting another modality, and to use the information obtained from the first modality when making observations and interpreting any subsequent modality. US is frequently overlooked in favour of CT or MRI as the next modality for further investigation, even when it may be more appropriate.

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 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).

Candidates should be aware that barely pausing for breath and talking incessantly does not easily give an examiner the opportunity to guide the candidate to summarise, discuss patient management or assess the depth of the candidate's knowledge by additional questions as appropriate.

Candidates are requested to speak clearly as mumbling and muttering makes it difficult for the examiners to hear what they are saying and know whether or not what they are saying is correct.

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.

The identified areas of weakness in oral examination performance remain unchanged from recent previous sittings: knowledge of anatomy, observation and interpretation of plain images (particularly chest and abdomen), and clinical aspects relevant to the images being shown (e.g. clinical presentation, further management).