Clinical Radiology
The Royal College of Radiologists

FINAL FRCR PART B EXAMINATION FOR THE FELLOWSHIP IN CLINICAL RADIOLOGY

SPRING 2017

The Examining Board has prepared the following report on the Spring 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 – SPRING 2017

Rapid Reporting Session

Candidates are reminded that there is considerable variation in the number of normal/abnormal cases between papers.

Marks continue to be lost when an abnormality is incompletely or inaccurately identified or described, resulting in the award of a half-mark or no mark for their response. The report for Spring 2016 gives examples of these responses.

Reporting Session

Candidates are reminded to allocate their time appropriately between cases – a bit less for the straightforward cases and a bit more for the more complex cases – but to ensure an adequate answer is provided for all six cases. It is difficult to compensate sufficiently for poor/brief answers with two or three detailed responses and achieve a passing score.

The candidates' clinical knowledge and experience should be used to help interpretation of their findings (e.g. age of patient, acute/chronic presentation), guide their search for additional features, and prompt inclusion of relevant negative observations (e.g. absence of metastatic disease in sites common for a particular malignancy).

Bullet points or short sentences are preferable to long sentences or eloquent prose, particularly for the observations made. Features that may affect the patient's subsequent management should be considered where appropriate and the further management of a patient should go beyond referral to an appropriate MDT. Ideally, the candidate should provide the advice that would be given to that MDT.

Oral Component

Candidates are reminded that the opportunity for scoring marks is the same for all modalities shown; plain images, US scans, CT scans, MRI scans, radionuclide imaging, contrast studies. Each modality shown, even if more than one for the same patient, is a separate opportunity for scoring marks (e.g. a chest plain image followed by a CT scan of the chest for the same patient represents 2 mark scoring opportunities).

Candidates are advised to extract as much information as possible from the modality first presented (often a plain image) before requesting another modality, and to build on the information obtained from the first modality when making observations and interpreting any subsequent modality. Even when most appropriate, US is frequently overlooked in favour of CT or MRI as the next modality for further investigation.

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

The further management of a patient should go beyond referral to an appropriate MDT, and the candidate should provide the advice that would be given to that MDT.

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.

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).