Introduction

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FRCR Examination Part 2B

The final examination of the Fellowship of the Royal College of Radiologists (part 2B) comprises several components:

- A rapid reporting session
- ***A reporting session*** (or known amongst trainees as the 'Long Cases')
- An oral examination

This guide-book will only concentrate on the reporting session. You may find the structure useful as a basis for future reporting in your practice if you so wish.

What does the *reporting session* consist of?

Currently it consists of:

- Six cases, on 'hard copy' film. In April 2010 for those sitting the examination in the UK, the Royal College of Radiologists will conduct this part of the examination and the rapid reporting section using a digital format. The viva section of the examination is likely to be in digital format in 2012. Please keep updated by visiting the Royal College website at http://www.rcr.ac.uk
- A total of 45 minutes is provided to complete writing all your answers in the booklet provided

The cases may include plain radiographs, ultrasound, radionuclide imaging, CT and MR imaging. The cases may include a mixture of cases from all the six modules with varying degrees of complexity and difficulty. Any type of the stated radiological imaging can occur and often the case can involve more than one imaging modality, e.g. a case can comprise a plain radiograph and further investigations, for example CT and radionuclide imaging. Currently the Royal College of Radiologists has not yet stated that PET or PET-CT will be included. However, this is most likely to be included in the foreseeable future. Any changes will be published on-line and can be found at http://www.rcr.ac.uk

If using 'hard copy' films, you will be provided with:

- A small table and chair
- A double viewing box
- A bright light

- A magnifying glass
- A rule
- An answer booklet to write all your cases

If using the digital format, you will be provided with:

- A small table and chair
- A computer monitor
- An answer booklet to write all your cases

Marking scheme

The marking scheme is relatively straightforward and transparent (see Table 1). However the specific criteria used to obtain the marks cannot be provided.

Each case is eligible for a maximum mark of 8 in a closed marking system. The total marks are then added up to provide a final total mark. In order to pass the reporting session comfortably, you must obtain an average of 6 out of 8 per case. You can afford to fail badly on *a single case* if you average 7 out of 8 per case. This is not advisable though.

If a candidate is on the pass/fail border for the oral component of the FRCR Clinical examinations, the marks from both the rapid reporting and reporting sessions are taken into account.

Table 1 *The marking scheme for the reporting session*

Mark	Scheme
4	Bad fail
5	Fail
6	Pass
7	Good pass
8	Excellent

Guidance and top tips to tackling the long cases

The purpose of this book is to provide some guidance and a strategy to tackle the exam. This book is not intended to be a comprehensive textbook by any means, but to be used for practising and ironing out any issues. We emphasize how important it is to be vigilant with TIMING and to be very strict about it. This is an area which the majority of individuals may not have prepared for or thought about.

All the components of the exams have to be passed and you will want to go to your viva (if you haven't done so already) in a less stressed mental frame of mind rather than worrying about what you may or may not have written for the 'long cases'.

Whatever you think about your performance in each section of the examination, it is vitally important that you stay focussed on the part of the examination that you are currently undertaking. There is no point in reminiscing about what you could have done better in the viva when you have 45 minutes to concentrate on the 'long cases'.

The following guidance notes may seem simple and obvious. However, there is good reason to reinforce these principles not only in this book but also in the guidance notes that are available from the Royal College of Radiologists' website

(http://www.rcr.ac.uk). In spite of this, the guidance is not necessarily being adhered to by candidates.

The approach I have taken in this section of the exam was to place myself in the shoes of the examiner. Put yourself in this scenario: you have spent 3–5 days away from home, invigilating, examining and performing various other duties. You will be exhausted to say the least. Thereafter, you will be given a large stack of long cases to mark!

Also the report represents your ability to analyze and effectively communicate a clinically relevant opinion to all members of the clinical team. If you think in those terms then there should be minimal difficulty.

So what would the examiner marking these booklets want?

The examiner will want to finish his or her work quickly and with minimal effort. How can you achieve this for the examiner?

- Legibility

It is very difficult to give a candidate marks if you cannot read their handwriting. How many frustrated minutes have you wasted trying to decipher a clinician's handwriting and given up?

- Neat

The booklet, if presented well, will be a pleasure for the examiner to mark.

- Structured and logical
- Concise and succinct

I have placed these two points together, as it is hard to separate them. The examiner, on behalf of the Royal College of Radiologists, will want to establish that you have a structured and logical approach to your method of dealing with each case. This will also help you structure your thoughts in the exam, when the adrenalin rush is playing havoc with your normal self.

The second point is to be concise and succinct. For this purpose, I would like to counsel you to place yourself as a clinician reading this report. Clinicians are busy and most likely will not want to read an essay, no matter how accurate and eloquent it is. On the flip side, do not be imprecise or too short. A moderate balance must be reached.

- Safe approach

Demonstrate a safe approach to the case. This must be borne in mind when you are formulating the *management* aspect to the case. Remember, the cases displayed are taken from real-life events. You must not forget about patient care and our duty as CLINICAL RADIOLOGISTS.

- Not necessary to get the absolute single correct answer in all cases

Do not waste time or get too focussed on getting the absolute right answer for an individual case at the expense of the remainder of cases. Timing for the reporting session is very important. Some of the cases may be more complex cases, which may require differential diagnosis rather than a single answer. Remember back when you may have performed a maths test, it was more important to demonstrate your abilities by displaying the analysis and deduction in solving the equation. Similarly it is crucial to display your observational skills, interpretation and deduction.

- TIMING

I cannot stress how important this aspect is. This must be practised rigorously. Each case is set out as a single exam. Inaccurate timing resulting in missing out a single case is disastrous as you will lose out on 8 marks. Once lost, this is extremely

difficult to recover from. Whatever method you use, you must do all six cases in the 45 minutes. This equates to 7½ minutes per case. However, if you practise doing a case in 6 minutes, that will provide you with 9 minutes to go over the cases again or go back to any cases which you were unsure about. Clearly more complex cases will take longer and straightforward cases less time.

I would advise that if you are stuck on a case, then do not waste time on it, carry on and return to it. You will still be able to obtain marks by writing as much as possible; i.e. the examination, observations and interpretation. **NEVER LEAVE A CASE BLANK**.

- Finally, remember that the report you write would mirror what you would be expected to do in a clinically relevant report in your department every working day.

An ideal report

There is no such thing as an ideal report. However, a useful approach when tackling an examination is the following questions that you may want to ask yourself.

There are four essential elements to be answered. If you remember these questions then it provides a grounded approach, especially when the imaging may be unfamiliar to you.

1. What can be seen?
   This assesses your observational skills. This can include both normal features that are relevant to the case and abnormalities.
2. Why does it look like that?
   Once you have recognized an abnormality, you must be able to describe it so that when someone reads just the report they will be able to imagine it. This technique is also useful in the viva – describe features on the film as if the examiner were at the end of a phone and unable to see the film.
3. What has caused it?
   This question is asking about the diagnosis or possible diagnoses. It is assessing your analytical skills and whether you are able to understand what you have seen is significant or not.
4. What needs to be done next?
   Finally, this question is about what you do with your findings or management.

The clinical radiologist is pivotal in steering the clinician in providing appropriate management. This is clearly vital when an urgency arises and there is a need for urgent clinical input. This is the safe approach. Often it is the radiologist who clinches the diagnosis and provides the information necessary to allow further management to proceed.

Example of a well-presented case

Further examples of a specimen report can be found on the RCR website (http://www.rcr.ac.uk).

Question

History: haemoptysis, CTPA showed mass lesion. For staging please.

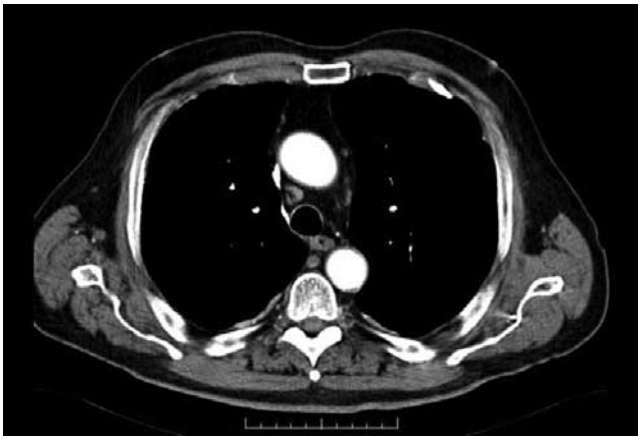


Figure I.1

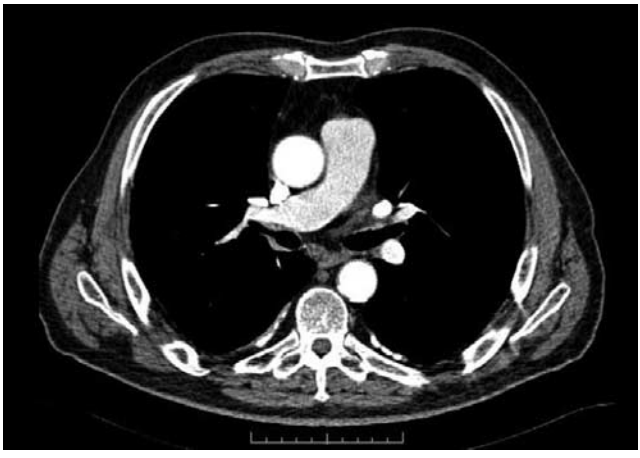


Figure I.2

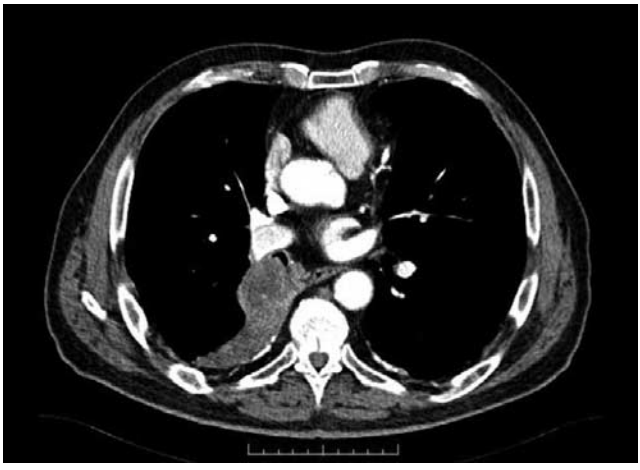


Figure I.3

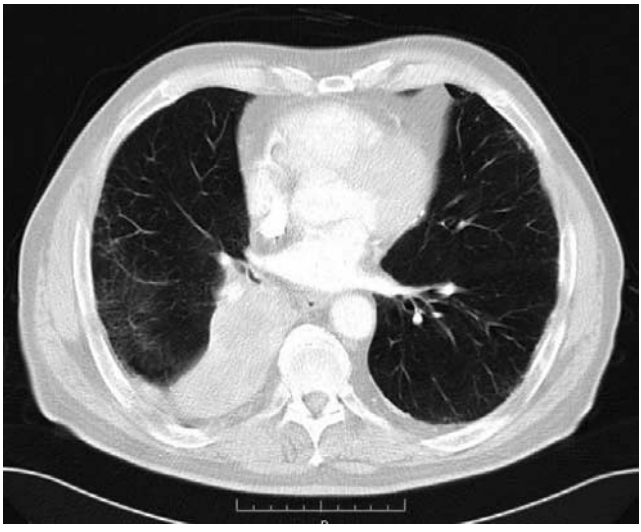


Figure I.4

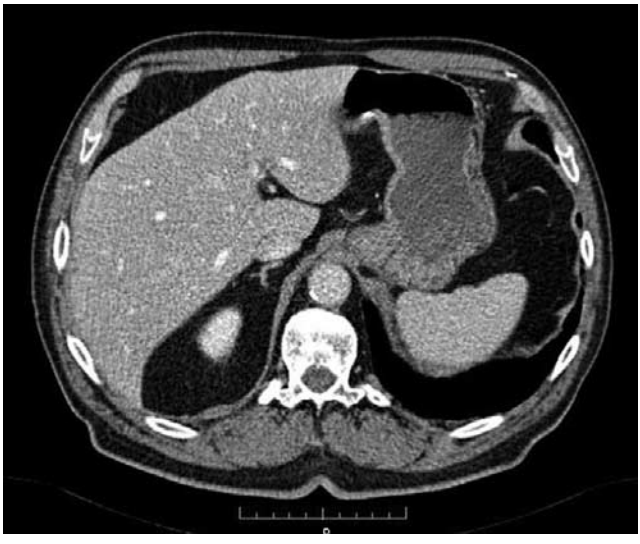


Figure I.5

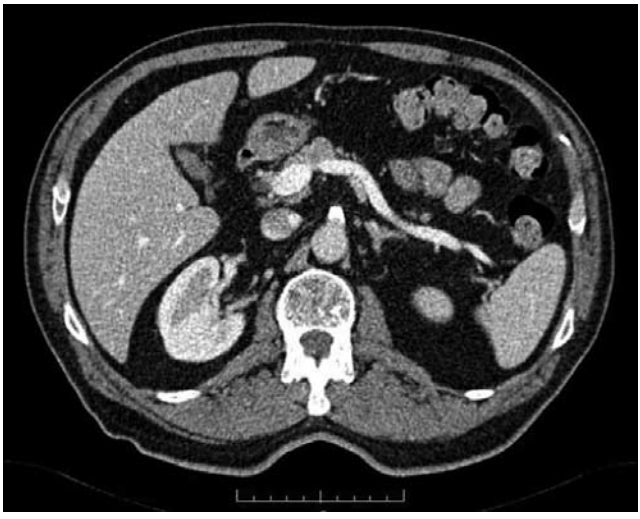


Figure I.6

Examination

- Axial CT chest and liver examination with IV contrast.

Answer

Observations and interpretations

CT chest and upper abdomen with IV contrast.

- There is luminal narrowing of the bronchus intermedius due to external compression by a soft tissue density mass.
- There is near complete obstruction of the right lower lobe bronchus also with complete collapse of the right lower lobe.
- It is difficult to delineate the soft tissue mass from the post-obstructive consolidation and associated collapse of the right lower lobe. However it is approximately greater than 3 cm in the transverse diameter.
- There is a right-sided precarinal ovoid lymph node with a fatty hilum. This is most likely a benign node.
- There is a 1 cm subcarinal lymph node, which may be significant by size criteria in this clinical context.
- Calcified pleural plaques suggestive of previous asbestos exposure.
- No supraclavicular, axillary or left hilar lymphadenopathy.
- The liver appears normal with no focal lesion.
- Both adrenal glands appear normal.
- Background generalized bilateral moderate emphysematous change with bullous formation in both lower lobes.
- Degenerative change in the axial skeleton.

Diagnosis

- Right-sided primary bronchogenic carcinoma causing complete collapse of the right lower lobe and near complete occlusion of the middle lobe bronchus with a highly suspicious subcarinal lymph node.

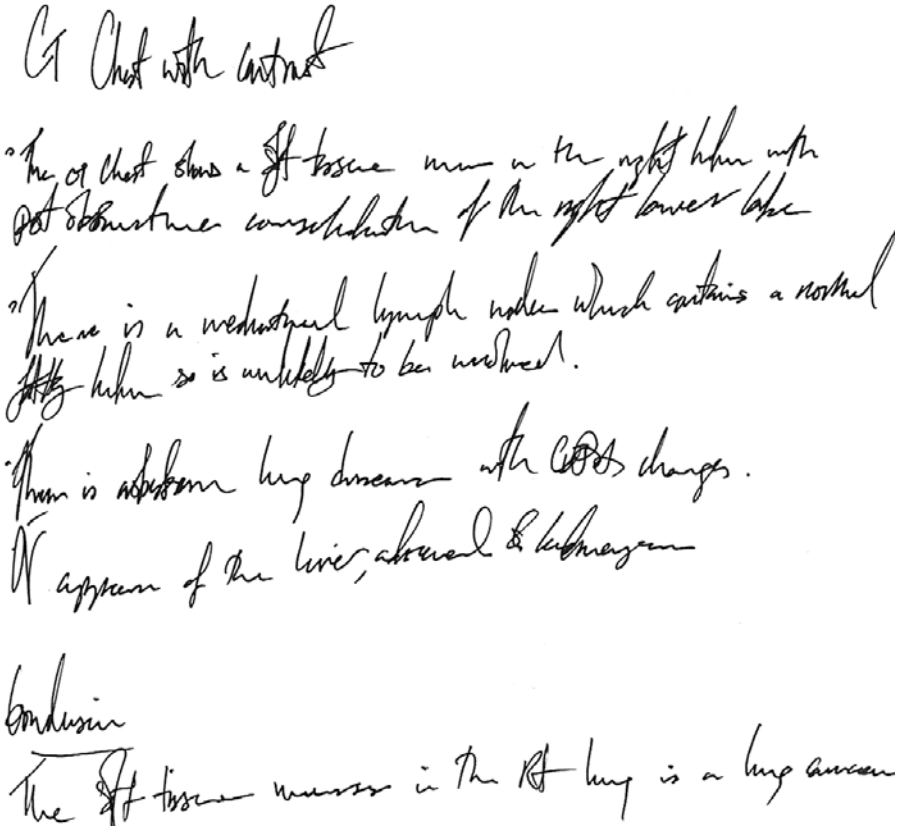
- This is on a background of previous asbestos exposure and generalized emphysematous change.
- There are no distant metastases.

Management

- The report needs to be **highlighted to the referring clinical team urgently** either via phone or faxing the report.
- The patient is to be discussed in the next multidisciplinary lung cancer meeting for further histological diagnosis.
- Soft tissue may be obtained via a bronchoscopy or CT guided lung biopsy depending upon the lung function and any bleeding diastheses, which will need to be reversed, e.g. warfarin therapy.

Example of an unsuitable case

Using the same case as above, the following report is issued by the candidate.



Packet 1 Case 1 Question

ALICE POCKLINGTON

Clinical history

A 51-year-old woman called for first screening in the NHS Breast Screening Programme.

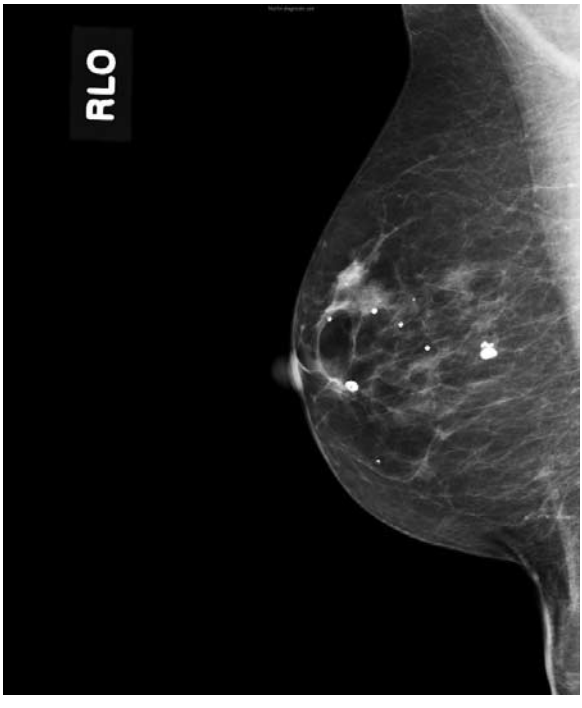


Figure 1.1.1

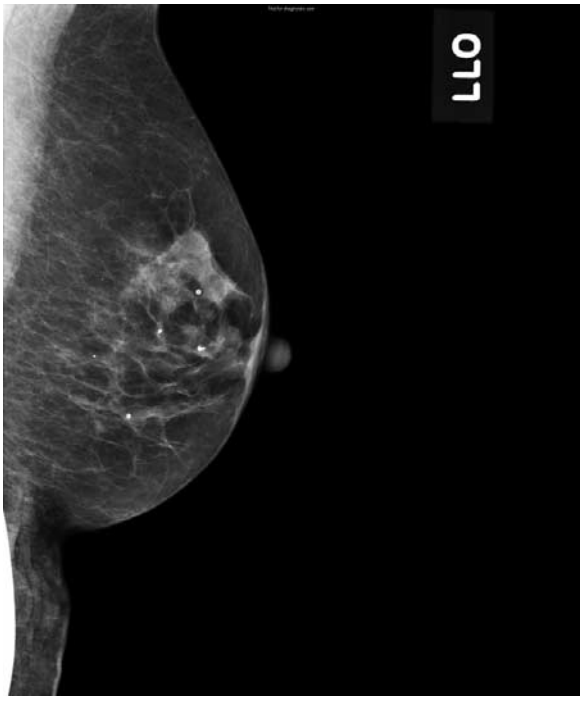


Figure 1.1.2

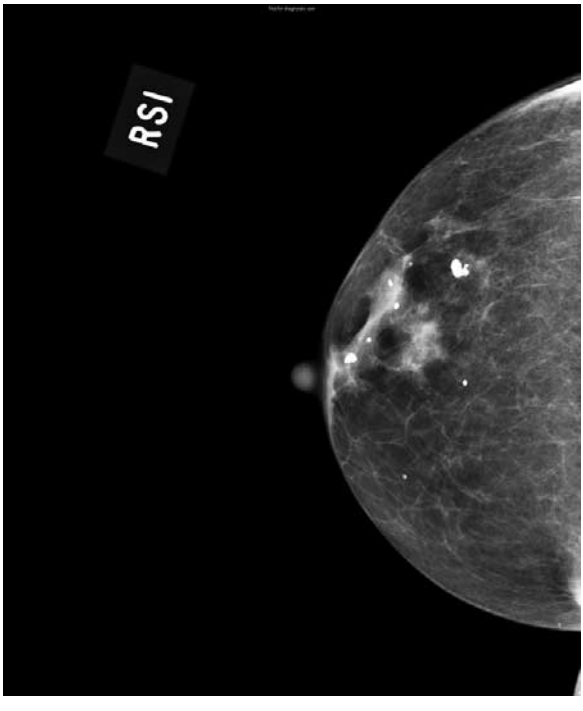


Figure 1.1.3