

Australasian College of Dermatologists

Fellowship Examination Report

2006

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DERMATOLOGICAL MEDICINE I

QUESTION 1: Pityriasis alba

A 5 year old Caucasian boy is referred to you by his family doctor because of “white spots” on his face that have been present for 3 years. His mother says they are always more obvious in summer. She says the spots don’t cause any discomfort and that the child is very well. There is no history of eczema, asthma or hay fever. Recently she has applied miconazole and 1% hydrocortisone cream to the affected areas.

On examination the child has several hypopigmented, non-scaly macules each measuring 2-3 cm on the left cheek.

- a. List four likely differential diagnoses, giving the clinical features of each 40%
- b. Discuss the investigations you would perform and the expected findings for each differential diagnosis in this child 20%
- c. Briefly discuss the management options for each of your differential diagnoses 40%

Candidates were expected to recognise that this case scenario was pityriasis alba with a differential diagnosis of pityriasis versicolor, vitiligo, or a hypochromic naevus (naevus depigmentosus).

This question was poorly answered with most candidates failing to relate their answers to the stem of the question. In addition many candidates did not address the questions asked. Candidates listed investigations rather than discussing them and so did not comment on the expected results. In Part c. candidates listed treatments only rather than proposing a management plan including simple measures in addition to prescription medications. The poorest candidates included inappropriate diagnoses, performed extensive and unnecessary investigations, and provided answers lacking in detail.

This common condition should be familiar to all candidates and managed confidently.

DERMATOLOGICAL MEDICINE I

QUESTION 2: Isotretinoin

A 21 year old woman presents to see you in the practice where you are doing a locum. Six months earlier she was commenced on isotretinoin 20 mg/day for acne by the dermatologist you are relieving. She has been taking the drug intermittently since then, in response to flares of her acne. She has not returned to the practice for any follow up visits until her appointment with you. She requests a repeat prescription.

She states she is now pregnant. Examination shows no active acne.

- a. Outline your actions at this consultation and over the ensuing few weeks 50%
- b. Outline how this situation could have been avoided 50%

This question, although a specific scenario, tests knowledge and understanding of isotretinoin therapy and its application in practice.

In general this question was handled well, most candidates passing. Several candidates gave excellent answers.

A few candidates performed poorly in both parts of the question. Several did not confirm or stage the pregnancy, stop the drug, ascertain when the drug was last taken or contact the treating dermatologist. Several candidates did not include a pregnancy test in their pre-isotretinoin investigations in Part b.

Those who failed the question did not appear able to manage this situation and appeared uncertain of the importance of the time relationship between the isotretinoin therapy and the pregnancy.

DERMATOLOGICAL MEDICINE I

QUESTION 3: Diffuse Scalp Alopecia

A 22 year old female primary school teacher of Anglo Saxon descent presents complaining of hair loss over the past 9 months. She reports that her scalp hair is significantly thinner than it was a year ago. She has noticed hair on her pillow in the morning and clogging the shower drain. She counts the hairs lost every day and brings with her a plastic bag containing shed hair. She is tearful while relating her story.

She is otherwise well and has had no serious illnesses in the last year. She takes no medications but is consuming numerous vitamins and zinc on the advice of a trichologist. She has a past history of severe acne and was treated with isotretinoin two years ago. This was partially successful. She is concerned that her hair loss is a late isotretinoin side effect.

On examination you find very mild non cicatricial thinning of the hair on her crown relative to the hair on her occiput and temples. The frontal hairline is preserved. There is slight widening of her part at the crown. The hair pull test is negative. You also note that she has hair on her upper lip and acne on her cheeks and chin.

- a. State your preferred diagnosis and list two differential diagnoses 30%
- b. List the investigations you will perform. 20%
- c. Discuss briefly the advice you would give to the patient and the management you would suggest for your favoured diagnosis. 50%

The history and findings given in this stem are typical of early androgenetic alopecia.

This question tested the candidates' ability to manage sensibly and empathetically this common clinical presentation.

Almost all candidates did well on this question with more than half producing excellent responses. The poorer candidates had most difficulty with management, giving sketchy answers lacking in detail, failing to address any general measures, or omitting any systemic therapy as an option. Several candidates did not mention scalp biopsy or its role in assisting diagnosis. The investigations were otherwise well known.

DERMATOLOGICAL MEDICINE I

QUESTION 4: Vesicular rash in a neonate

You are called to the neonatal nursery to see a 3 day old baby girl who has developed blisters and is having trouble feeding. The mother is a 17 year old sole parent and has no personal or family history of blisters.

On examination the baby has erosions on her right heel, left cheek and dorsal aspects of several fingers. There is a ruptured blister on her hard palate and another on her right forearm. There is an intact blister on her left heel.

- a. List the conditions you would consider in the differential diagnosis and state your favoured diagnosis and the reasons for this. 35%
- b. Discuss the investigations you would perform 25%
- c. Discuss the initial management of this patient 40%

Candidates were expected to recognise that epidermolysis bullosa was the likely diagnosis from the stem but that herpes virus infection was a possibility and needed to be ruled out quickly.

More than half the candidates managed this scenario confidently, several giving excellent answers.

The poorer responses proposed unlikely diagnoses, listed but did not discuss the investigations, lacked content, and failed to give the impression that this situation could be managed safely.

DERMATOLOGICAL MEDICINE I

QUESTION 5: Acute urticaria

A 20 year old university student presents with a rash which she first noticed one week ago. She describes it as 'giant hives'. When the rash first developed she was treated at the local hospital emergency department and was given a cortisone injection and oral antihistamines. Despite this lesions have continued to appear intermittently. She is celebrating her 21st birthday next weekend and wants to be cured. She is otherwise well apart from episodic joint pains over a couple of years.

Examination shows a few scattered erythematous wheals 3-6cm in diameter on her trunk and proximal limbs.

Discuss your management under the following headings

- | | |
|---|-----|
| a. important points in the history and examination that are relevant to managing this patient. | 50% |
| b. investigations and treatment. | 50% |

This is a very common condition and was the subject of a recent article in the Journal of the American Academy of Dermatology. It was disappointing that little more than 50% of candidates clearly passed this question. The better responses recognised that no investigation was an option and that oral corticosteroid therapy would be appropriate given the imminent birthday party.

Many candidates did not address the scenario presented and many over-investigated. The important aspects of the history relating to triggers was very variable, some candidates giving very good answers and others performing poorly.

The poorer candidates ignored the short time frame, did not suggest alternatives if their first treatment failed, omitted detail ("antihistamines" is too general a response for treatment) and did not relate their treatment to the patient presented.

DERMATOLOGICAL MEDICINE I

QUESTION 6: Livedo reticularis with ulceration

A 57 year old woman is referred with painful ulceration on the backs of her calves. She has a history of a breast carcinoma 3 years ago treated with surgery, radiotherapy and chemotherapy. She takes simvastatin for hypercholesterolaemia.

Examination shows livedo reticularis and several areas of ulceration on the lower legs.

- | | |
|--|-----|
| a. List your 3 favoured differential diagnoses | 30% |
| b. List 3 further diagnoses you would consider | 20% |
| c. How would you investigate this patient with a view to reaching a definitive diagnosis? | 50% |

This question tested the candidates' ability to tailor their investigation so as to establish a diagnosis.

Most candidates passed this question with some deficiencies, although there were several excellent answers. Several candidates proposed poorly thought through differential diagnoses but passed because they managed the investigation competently. A number of candidates did not propose a skin biopsy and several gave no detail about the performance or possible results of this.

DERMATOLOGICAL MEDICINE I

QUESTION 7: Erythema multiforme major

You are called to the accident and emergency department to see a 27 year old man who presents some 17 hours after the onset of symptoms with sore, watering eyes and pain on swallowing. He has been on amoxicillin for five days for a chest infection and took a single dose of roxithromycin two hours prior to the onset of symptoms. He has a history of asthma and has had a productive cough for a week.

On examination he has a mild fever but is not unwell. His lips show haemorrhagic crusting and ulceration. His oral mucosa is inflamed and in areas ulcerated. His eyes show bilaterally symmetrical conjunctival oedema and erythema. You notice seven or eight scattered annular erythematous lesions over his limbs up to 1.5 cm in diameter, some showing central blistering and others erosion.

- | | |
|--|-----|
| a. What is the most likely diagnosis? | 10% |
| b. Comment on the possible triggers in this young man | 20% |
| c. Outline your management of this patient | 70% |

This question gave a full description of typical erythema multiforme major in a young man, likely due to mycoplasma or possibly amoxicillin.

All candidates nominated the correct diagnosis and triggers but management was not nearly so well done with several candidates failing as a result.

Very few candidates indicated that they would take a detailed history, and further examination was poorly done. Most nominated mycoplasma as a trigger but very few indicated that they would treat this as part of their management. The other chief problem with management was the prescription of treatment of a magnitude not indicated in the first instance with this clinical scenario e.g. pulse methyl prednisolone with intravenous immunoglobulin. Several candidates did not suggest consultation with an ophthalmologist.

DERMATOLOGICAL MEDICINE I

QUESTION 8: Possible meningococcal septicaemia

You are asked to see a 10 year old boy with fever and a rash who has presented to the Emergency Department. He was well until a week ago when he developed a sore throat. His general practitioner prescribed erythromycin and the sore throat resolved within 3 days. However yesterday he became febrile, complained of abdominal pain and headache and today developed a rash and joint pain.

On examination he appears unwell with a fever of 38°C. He has palpable purpura involving his lower legs and buttocks.

- | | |
|--|-----|
| a. List three likely causes for this vasculitis | 30% |
| b. Outline your immediate management in the Emergency Department | 70% |

Candidates were expected to recognise that an unwell febrile child with a purpuric rash should be managed as meningococcal infection until proven otherwise. Alternate diagnosis included Henoch Schonlein purpura, post streptococcal vasculitis or a drug reaction.

Almost half the candidates did not recognise that meningococcal infection was a possibility and failed this question as a result of their consequent inadequate management. Those candidates who recognised that this presentation is an emergency nominated appropriate testing, admission, intravenous antibiotics and paediatric consultation.

DERMATOLOGICAL MEDICINE I

QUESTION 9: Pemphigoid gestationis

A GP telephones to ask you to see a 30 year old woman who delivered her third child four days ago. She developed intense itching two days prior to her delivery and a rash that began around the umbilicus. She now has widespread blisters which the GP thinks look like chicken pox.

You see her later the same day. On examination there is a 20cm diameter, indurated, erythematous plaque around the umbilicus. Her stretch marks are not involved. There are multiple small erythematous urticated papules, some surmounted by vesicles, on her arms and legs.

- | | |
|---|-----|
| a. List three likely differential diagnoses with a brief comment on the clinical features of each | 50% |
| b. Discuss the investigations you would perform and the findings you would expect in order to make the diagnosis in this case | 30% |
| c. Discuss the management of this patient | 20% |

This question assessed the candidates ability to recognise that pemphigoid gestationis, clearly described in the stem, was the likely diagnosis and that varicella required exclusion.

The question was quite well answered. All candidates included pemphigoid gestationis in their differential diagnosis. Those candidates who failed did so because they did not include the important differential diagnosis of varicella and therefore proposed inadequate investigation and management or had very poor knowledge of the management of pemphigoid gestationis.

DERMATOLOGICAL MEDICINE I

QUESTION 10: Genital pruritus in a young girl

You are asked to see an 8 year old girl in your rooms. Her mother reports that for the last 2 years she has had an “itchy bottom”. She often scratches at school and has been sent home on a few occasions when she became distressed with scratching. Sometimes she also complains of soreness. Her mother applies miconazole cream several times a week when she complains of itch but the problem keeps recurring. The child is otherwise well. She is asthmatic and had typical mild atopic eczema in the first year of life.

Previous treatment includes mebendazole on three occasions and several courses of amoxicillin and metronidazole. Mid stream urine examination and culture and vaginal swab are normal. Mum has taken her daughter to see at least three GPs before finally demanding a referral to a specialist. She is frustrated and angry.

On examination there is mild erythema and lichenification of the labia majora, perineum and perianal skin. The vaginal mucosa appears normal. There is no vaginal discharge or weeping from the skin surface. There is no evidence of lichen sclerosus.

- a. List three differential diagnoses, giving clinical characteristics and outlining the points in the history that support each diagnosis. 30%
- b. Discuss your management under the following headings
 - (i) Discussion with the mother 40%
 - (ii) Specific treatment 30%

This question tested the candidates’ ability to manage appropriately this relatively common presentation in a child with an anxious mother. The majority of responses were poor.

Although most candidates recognised that this was probably eczema or psoriasis and that they needed to help the mother with her anger to achieve good treatment, few were able to proceed to appropriate management strategies. A simple extrapolation of atopic dermatitis treatment was sufficient to pass, but was achieved by few candidates.

Numbers of candidates indicated that they would perform further tests and a biopsy which was not indicated on the basis of the scenario presented and was not asked in the question.

DERMATOLOGICAL MEDICINE I

QUESTION 11: Pemphigus

A 67 year old retired Italian stonemason presents with a two month history of a tender, flexural eruption and mouth ulcers. He has intramuscular gold injections each month for rheumatoid arthritis and takes occasional non-steroidal anti-inflammatory agents before he plays golf. He is a smoker but is otherwise well.

Examination reveals several hyperpigmented patches in his right axilla and three areas of superficial erosion in his left groin. In his mouth there are eroded areas on the hard palate and buccal mucosa. You note a small weeping area in his scalp and a non-specific scaly eruption on his sun damaged upper back.

You suspect he has pemphigus

Discuss your management of this man under the following headings

- | | |
|---|-----|
| a. investigations for diagnosis and treatment | 30% |
| b. therapeutic choices and rationale | 60% |
| c. advice and follow-up arrangements | 10% |

This was a straightforward question which presented a description of typical pemphigus and gave the diagnosis. Candidates were tested on their ability to manage this condition in the patient presented.

The majority of candidates passed this question but there were a significant number of failures due to lack of understanding of the chronic nature of pemphigus, the difficulties of management, and the need for high dose prednisolone and immunosuppression.

Although pemphigus is a rare condition it is a classical dermatological bullous disorder which trainees at the end of their training time should understand in theory. Candidates should have been able to use their knowledge of immunosuppression in other conditions to assist in answering this question. A significant number were unable to do so.

DERMATOLOGICAL MEDICINE I

QUESTION 12: Rosacea

A 44 year old woman presents to your rooms with typical longstanding rosacea. She has erythema, papules, pustules and telangiectasia over her forehead, cheeks and chin. She feels her nose is becoming “lumpy”. She says that the condition has become significantly worse in the last three months.

Outline in point form the advice you would give to this patient about managing her condition. Use headings if you wish.

This straight forward question about the management of rosacea in a middle aged woman was managed competently by most candidates but none gave an outstanding answer. Most had a solid knowledge of how to manage to this practical problem in principle and there was a good pass rate.

Several candidates omitted to take a history from the patient which would assist in identifying possible causes for the recent worsening in this patient’s rosacea, and therefore did not address this important issue in management.

CLINICAL VIVAs – LONG CASES

The examination includes 4 long case Vivas each with 2 patients and each examined by 2 examiners, either 2 members of the Board of Censors or 1 member of the Board of Censors with an occasional examiner.

VIVA 1, CASE 1

Morning Patient – Telangiectasia macularis eruptiva perstans

This man presented typical clinical signs on his trunk with a weakly positive Darier sign and a history of post traumatic stress disorder.

Afternoon Patient – Telangiectasia macularis eruptiva perstans

This man presented very similar clinical signs to the morning patient but a negative Darier sign with no other relevant findings. He had been thoroughly investigated by a haematologist and was said to have bone marrow involvement.

A set of prearranged standard questions was asked in the same order for all 18 candidates. This included a discussion of

- Relevant history and clinical features
- Other conditions that may demonstrate a positive Darier sign.
- Differential diagnosis
- Systemic symptoms and their relevance
- Investigations including blood and skin biopsy
- Likely skin biopsy findings on H & E and special stains
- Biochemical markers
- Management including a discussion of substances to be avoided
- Symptomatic treatment
- Prognosis including the likely course, risk of malignancy and complications

This VIVA was straightforward and relatively easy. Most candidates handled it well and many scored high marks. The candidates who failed this viva were markedly weaker than the other candidates. The main difficulty which these candidates encountered related to taking a very poor history, being unable to reach the correct diagnosis, finding clinical features which were not present, and having a poor understanding of TMEP such that they did not understand the prognosis, treatment, or complications and so could not advise the patient appropriately.

CLINICAL VIVAs – LONG CASES

VIVA 1, CASE 2

Morning Patient – Lupus erythematosus

This young adult male presented with features of discoid lupus erythematosus together with lupus profundus on his face and scalp. He gave a history of active lesions 3 to 4 years ago, improvement with topical corticosteroids, and recurrence about a year ago with subsequent scalp involvement. The lupus profundus lesions are recent. He had commenced hydroxychloroquine with some improvement. The examination findings on the face were consistent with DLE although not marked and there were two clear cut nodules of lupus profundus. The scalp appeared to have a combination of scarring and non scarring alopecia and there was a patch of hair loss in the left beard area overlying a nodule.

Candidates were assessed on the history they had obtained including that relating to precipitating factors or suggestive of SLE or associated disorders. They were assessed also on their examination findings, their technique for taking a skin biopsy of lupus profundus, their synthesis of the diagnosis and proposed management plan including the use of intralesional corticosteroids and provision of a prognosis.

Generally this question was answered quite well with one candidate failing. This candidate really struggled with the diagnosis, appearing to have been told the diagnosis by the patient but being unable to fit in the nodular lesions, making inappropriate suggestions.

Afternoon patient – Erythroderma

This 64 year old man presented with erythroderma of 5 years duration, a list of previous drug reactions, and a history of childhood eczema. The cause of his erythroderma had not been determined. He had taken intermittent prednisolone. Examination revealed widespread erythema with marked lichenification particularly over his arms and chest. He had some cutaneous atrophy and an enlarged right inguinal lymph node.

Candidates were asked for their examination findings, differential diagnosis, investigations and management options. They were also asked to clarify the effects of the erythroderma on this man's quality of life and to discuss the management of long term oral corticosteroid therapy.

Candidates generally did well summing up the situation in this complex patient. Only two candidates found the lymph node. The likely diagnosis was late onset atopic dermatitis and most candidates mentioned appropriate alternative causes of erythroderma. Several candidates did not mention cutaneous T cell lymphoma, and a good number did not mention other malignancies including lymphoma or leukaemia nor the need to screen for them. Few candidates mentioned that a serum IgE might help in diagnosing atopic eczema and few suggested that patch testing might be useful given an extensive range of topical therapy.

The poorest candidates performed poorly with respect to their management plan, with one failing to recognise lichenification.

CLINICAL VIVAs – LONG CASES

VIVA 2, CASE 1

Morning and afternoon patient – Pityriasis lichenoides et varioliformis acuta (PLEVA)

This patient was a teenage male with a 3 month history of papulonodular, vesicular and necrotic lesions running a slowly progressive course, mainly on his trunk but also on his arms and legs. He gave an additional history of tick bites immediately prior to the eruption. There was a family history of SLE in his mother and he was atopic. He was otherwise completely well. He had significant pruritus interfering with his studies. This young man's family were very anxious about his skin condition, particularly given his mother's history of lupus.

Clinically this boy demonstrated PLEVA and told all the candidates his diagnosis.

Candidates were expected to

- Accurately describe the morphology and perform an examination that included a search for lymph nodes and hepatosplenomegaly.
- Discuss the differential diagnosis including lymphomatoid papulosis, CD30 positive large cell lymphoma and possible bite reaction.
- Nominate biopsy as their first step in management and interpret the histopathology report which was presented. This included Pautrier microabscesses and cytological atypia.
- Discuss their further investigation given the histopathology report and recognise that CD30 was an important marker.
- Discuss lymphomatoid papulosis and the difficulty in differentiating this from PLEVA.
- Describe how they would manage this patient and what they would do about the possibility of lymphoma.
- Discuss the prognosis they would offer the patient and his family.
- Describe their management if he were to suddenly develop large nodules.

The majority of candidates handled this case very well despite the rarity of the condition, some scoring very highly. These candidates gave good differential diagnoses, sensible investigations and treatments, and some had very impressive knowledge of what was available. Virtually all were aware that methotrexate is now considered the best treatment for lymphomatoid papulosis. Most gave sensible follow up and acted appropriately in the scenario of deterioration.

Several candidates failed this case demonstrating poor knowledge of PLEVA and lymphomatoid papulosis, failing to appreciate the distress which the pruritus was causing, and appearing unable to adequately manage the patient. The poorest candidates took patchy and incomplete histories, performed inadequate examinations without looking for lymph nodes, and had little knowledge of T cell markers or their importance.

CLINICAL VIVAs – LONG CASES

VIVA 2, CASE 2

Morning patient – Chronic plaque psoriasis

This middle aged man had a long history of chronic plaque psoriasis with joint involvement. He lived in a remote area a long distance from specialist care. His significant history included treatment with acitretin complicated by mucocutaneous side effects and methotrexate complicated by elevated liver function tests. He had commenced efaluzimab, receiving just one dose prior to the examination. He had a history of hypertension and depression for which he was on treatment.

This patient presented a management problem. The diagnosis was quite clear on clinical findings. His past medical history, previous therapies, and distance from specialist care influenced his treatment options.

Candidates were asked to discuss:

- The important features of this patient which would influence his management.
- A logical sequence of treatment options including side effects.
- Biological agents used for psoriasis including indications, contraindications and monitoring requirements.
- The PASI score.

Overall candidates were experienced with the management of psoriasis and its psychological impact. Many candidates lacked a well ordered strategy for management of severe disease. Several candidates failed to enquire of the patient whether he had joint involvement. Although most candidates were well versed in the use of systemic agents for psoriasis some required significant prompting regarding the side effects of systemic agents.

The small number of candidates who failed this viva ran short of time because they were unable to present a logical management plan and had taken incomplete histories and performed incomplete examinations. In addition their knowledge of acitretin and its side effects was patchy, knowledge of the PASI score lacking, and there was poor understanding of the biologic agents.

Afternoon patient – Chronic plaque psoriasis

This middle aged man had a long history of chronic plaque psoriasis with inflammatory episodes including erythroderma. He had no significant joint involvement. He had heavy alcohol consumption, non insulin dependent diabetes, hypertension, and had previously lived in Hong Kong. He had been managed with efaluzimab for the previous 12 months complicated by tiredness and the development of approximately 10 squamous cell carcinomas of his skin while on therapy. He had received PUVA and UVB therapy previously but no oral retinoids or cyclosporin. He was applying 50gms of calcipotriol ointment daily.

This patient presented a management problem. The diagnosis was quite clear on clinical findings.

Candidates were asked to:

- Provide a logical approach to management given the medical history and recent development of SCCs on efalizumab.
- Recognise that this patient's main complaint was of scrotal psoriasis.
- Discuss oral therapy including acitretin.
- Discuss the biologic agents available for psoriasis including their indications and complications.
- Describe the PASI score.

Most candidates handled this case well being aware of the risk of immunosuppression and SCCs on efalizumab as well as the risk of reactivation of tuberculosis given this patient's residence in Hong Kong. Most candidates appropriately considered the introduction of acitretin for his management but many had failed to ask for social factors which would influence use of this drug, including his extensive and ongoing sun exposure.

The small number of candidates who failed this viva obtained adequate histories and recognised the clinical signs, and had some appreciation of the influence of the medical conditions on treatment. Unfortunately they displayed a lack of confidence and knowledge in the use of oral retinoids particularly as regards side effects and a poor appreciation of the monitoring and risks of biologic therapy.

CLINICAL VIVAs – LONG CASES

VIVA 3, CASE 1

Morning and afternoon patient – Systemic lupus erythematosus

This young woman presented a history which enabled a firm diagnosis of SLE to be made on this basis alone. She had discoid lesions of lupus erythematosus on her face and multiple classical secondary anetoderma lesions on her arms and upper back. The patient was a capable and reliable historian. This lady also gave a history of developing retinopathy on chloroquine and was currently taking a moderately high dose of hydroxychloroquine.

The overall performance on this case was excellent. Almost all candidates readily diagnosed anetoderma and most had a good understanding of its relationship to the lupus erythematosus. All candidates understood the importance of ocular monitoring in this patient.

The candidates who failed this case performed poorly, well below the rest of the candidates. These candidates took a poor history and presented incomplete examination findings, demonstrated a poor knowledge of anetoderma and could not synthesise the findings into a confident diagnosis.

Management was not extensively tested on this case. The candidates were examined on their ability to

- Take a meticulous history and recognise the features leading to a diagnosis of SLE.
- Perform a thorough and precise physical examination.
- Discuss anetoderma and recognise its place as part of the presenting illness.
- Discuss the ocular toxicity and monitoring of antimalarial therapy.

CLINICAL VIVAs – LONG CASES

VIVA 3, CASE 2

Morning Patient – Mycosis fungoides

This 52 year old man gave a long history of mycosis fungoides with patch stage cutaneous disease and no systemic involvement. He had been treated with PUVA regularly over 13 years, and was currently receiving narrowband UVB.

Candidates were tested on their ability to

- Obtain an accurate history especially of his previous treatments
- Demonstrate that they had done a careful skin examination and determined the extent of his mycosis fungoides
- Have examined the patient for PUVA side-effects
- Have identified the absence of lymphadenopathy
- Discuss further appropriate investigation
- Explain the condition to the patient
- Plan ongoing follow-up for this patient
- Deal with nausea from oral psoralens
- Discuss the merits of narrowband UVB or other therapy

All candidates passed this case demonstrating an understanding of the disease process and the treatment options available.

Afternoon Patient – Pityriasis rubra pilaris

This man presented with classical adult onset pityriasis rubra pilaris without palmoplantar keratoderma or ectropion. He described quite extreme pruritus and had commenced acitretin therapy only the day before the exam. He demonstrated typical features of pityriasis rubra pilaris on his skin. He was a heavy user of alcohol and lived a long distance from dermatologic care.

Candidates were expected to

- Have examined the patient and identified the features present or absent
- Interpret this patient's biopsy report
- Discuss the prescription of acitretin and the presence of mildly elevated plasma lipids
- Discuss the treatment options and the expected response to acitretin
- Discuss the features of HIV associated PRP

All candidates passed this station. The standard of candidates was quite variable with the better candidates having been involved in managing this condition. The weakest area was the question of expected response to therapy.

CLINICAL VIVAs – LONG CASES

VIVA 4, CASE 1

Morning Patient – Rash in pregnancy

This young woman presented at 30 weeks gestation in her third pregnancy having had a miscarriage in her first pregnancy, onset of a rash in the fourth month of her second pregnancy, and recurrence of a similar rash at four weeks gestation in this pregnancy. She described a severe post partum flare following the second pregnancy requiring prednisolone therapy and she had been treated in this pregnancy with intramuscular corticosteroids. At the examination she presented excoriated papules on her left forearm with post-inflammatory hyperpigmentation on her shins. She brought photographs demonstrating florid erythematous juicy plaques on her left forearm prior to treatment. She had a background history of atopy and some positive patch test reactions. Her skin biopsies had not been diagnostic.

This case tested the candidates' ability to draw appropriate conclusions from the history and propose management for this pregnant lady without a clear diagnosis. Candidates were asked to

- Discuss the history and the differential diagnosis to which this led
- Discuss appropriate investigations
- Discuss pemphigoid gestationis, polymorphic eruption of pregnancy and progesterone autoimmune dermatitis
- Discuss appropriate management for this patient
- Demonstrate an understanding of the risks of corticosteroid therapy during pregnancy and in the post-partum period

All candidates passed this viva although several were borderline passes. All candidates took an adequate history and formulated an appropriate differential diagnosis. A diagnosis of bullous autoimmune oestrogen dermatitis had been proposed but none of the candidates knew of this condition. The problems associated with corticosteroids were understood by all candidates. The weaker candidates presented the history and their differential diagnosis in a disorganised manner, required prompting to extract information and had some gaps in their knowledge.

Afternoon Patient – Severe eczema

This middle aged lady presented with a four year history of severe eczema and with a past history of hay fever and allergy to latex and to some preservatives. She had had poor control despite two years on cyclosporin. Her eczema was predominantly affecting her face, eyelids and the V of her neck. She was wearing nail polish at the examination. There were no significant signs of cyclosporin side-effects on examination.

Candidates were tested on

- Their understanding of late onset atopic eczema.
- The relevance of the allergies and the means of coping with these at work
- Their understanding of air borne contact dermatitis and photosensitive contact dermatitis
- Their ability to formulate an appropriate management plan
- Their understanding of the use of cyclosporin for management of eczema including its interaction with other medications and side-effects.

All candidates passed this case although several were borderline. All candidates obtained a reasonable history and understood the principles of managing eczema with cyclosporin. Most mentioned the impact of the latex allergy particularly with the patient's work. The area of greatest weakness was topical therapy which revealed a lack of experience in managing more severe eczema, and also a failure to consider simpler systemic treatments. No candidate recognised that allergy to nail polish may be contributing to this facial dermatitis. The poorer candidates offered very limited management plans and had gaps in their knowledge relating to cyclosporin therapy.

VIVA 4, CASE 2

Morning Patient – Generalised dermatitis

This middle aged woman presented a weak atopic history with onset of generalised dermatitis three years ago. She had patchy generalised involvement but severe facial involvement with lichenification and peri-ocular oedema.

Candidates were tested on their ability to

- Discuss the progression of the eczema in this patient
- Discuss the exacerbating factors described by the patient
- Outline the investigations and treatments to date
- Present a management plan including improved topical therapy
- Present a management plan to improve oral therapy
- Discuss the use of cyclosporin for severe dermatitis
- Discuss the use of mycophenolate mofetil for atopic dermatitis

As a group the candidates were able to obtain an adequate history from this atopic patient and understood the specifics of cyclosporin and mycophenolate therapy for eczema. The major difficulties were the same as the afternoon candidates on the previous case. Many candidates failed to consider the role of exacerbating factors for this severe facial dermatitis and performed poorly in proposing a management plan to improve the topical therapy.

Few candidates performed poorly being unable to synthesise the history, failing to recognise the role of exacerbating factors, failing to recognise that the facial involvement was the major concern, and having poor understanding of the use of cyclosporin and mycophenolate for severe eczema.

Afternoon Patient – Chronic graft versus host disease (GVHD)

This middle aged man with a history of chronic lymphocytic leukaemia and autologous bone marrow transplantation presented with chronic GVHD after developing acute GVHD. The clinical findings were of sclerodermoid chronic GVHD. He had a large surgical wound from recent excision of a skin cancer.

Candidates were asked to discuss

- The history of progression of this patient's disease
- The symptoms of acute, lichenoid and sclerodermoid GVHD
- The risk factors for GVHD
- The clinical features seen
- The expected histology
- Treatment options directed at the skin
- A long term management and follow-up plan

Overall candidates recognised this condition but did not demonstrate a good knowledge of other manifestations of GVHD nor of the risk factors. Many were unsure of the progression and time frame. There was poor knowledge of skin directed treatment and the majority of candidates did not present a well structured follow-up plan. The candidates who performed at a lower level than the group demonstrated little knowledge of this condition, its treatment, its evolution or the need for long term follow-up.

CLINICAL VIVAs – SHORT CASES

There were 6 short case VIVAs each conducted by a member of the Board of Censors.

VIVA 1

Oral lichen planus

This patient presented with typical lesions of oral lichen planus on the inner aspect of the buccal mucosa, inner aspect of the lips and the cutaneous lip. The patient had no other signs of lichen planus. Candidates were asked for a differential diagnosis and most included appropriate conditions including lupus erythematosus, lichen planus, drug induced lichen planus, amalgam related lichenoid reaction and actinic cheilitis. One candidate reported nail involvement where none was present. Candidates were asked what drugs they would consider to be likely causes of a lichenoid drug eruption of this type and were asked for their treatment of choice for this patient.

In general the candidates performed very well on this patient. Most were able to locate the clinical features appropriately. Most indicated that they would use a potent topical corticosteroid cream as treatment.

Punctate palmoplantar keratoderma

This older gentleman with hereditary punctate palmoplantar keratoderma demonstrated good signs on his hands and feet and coincidental toenail changes consistent with onychomycosis. Most candidates reached the correct diagnosis and identified the onychomycosis. Most were able to name some causes for the clinical appearance and suggest treatment of symptomatic palmoplantar keratoderma firstly with topical lactic acid or salicylic acid preparations and then with oral acitretin at doses from 10 to 25 mg daily.

The poorer candidates had difficulty with the clinical features in the first case and were not able to suggest what the causes of the appearance in the second case might be.

VIVA 2

Retinoid dermatitis from isotretinoin

This 16 year old male student had widespread retinoid dermatitis superimposed on small patches of lichen nitidis on the volar surface of his right arm and adjacent trunk. He had an incidental café au lait macule on his right forearm and adolescent horizontal striae. The majority of candidates recognised the changes but many had difficulty recognising the relationship of the dermatitis with the patient's isotretinoin therapy. This may reflect their hospital based experience.

Hypertrophic lichen planus of the legs

This adult woman presented with partially treated but typical lichen planus of her lower legs and also with typical oral changes. Many candidates had difficulty identifying the diagnosis on the legs but when asked to look in this patient's mouth quickly reached a diagnosis.

CLINICAL VIVAs – SHORT CASES

Urticaria pigmentosa

This adult patient had mastocytosis of urticaria pigmentosa type with classic signs including red brown papules which urticated. He demonstrated typical wheals. Although this was a very obvious spot diagnosis most candidates struggled to identify the condition and appeared not to have encountered it before.

VIVA 3

Pigmented purpuric dermatosis

This middle aged man had two discreet well demarcated patches on his right buttock and posterior leg displaying yellow-brown discolouration with an obvious purpuric element and cayenne pepper spots. The appearances were consistent with a pigmented purpuric dermatosis of Majocchi's type or lichen aureus.

Candidates were asked to describe the lesions and propose a differential diagnosis. They were asked also to categorise this pigmented purpuric dermatosis. One candidate missed the diagnosis but mentioned it subsequently in the differential diagnosis. Surprisingly a number of candidates described these lesions as plaques when they were obviously macular.

Pityriasis lichenoides chronica

This older woman had a classical history of non pruritic lesions coming and going over many years. Candidates were shown her thighs where there were approximately 6 lesions of varying morphology, some post inflammatory hypopigmentation, some lightly pigmented spots, and some small erythematous spots. There were several non specific erythematous papules, 1 with definite annular scale, and a larger flatter scaling lesion. Clinically this was not thought to be an easy diagnosis but the polymorphic nature of the lesions was a clue. Candidates were asked to describe the lesions and to propose a diagnosis and differential diagnosis.

Five candidates confidently nominated pityriasis lichenoides chronica as the principle diagnosis. All other candidates nominated it in their differential diagnosis, although some required considerable prompting.

The poorer candidates nominated a wide range of differential diagnosis for both of these patients naming the correct diagnosis some distance down the list.

CLINICAL VIVAs – SHORT CASES

VIVA 4

Erythema annulare centrifugum

This elderly man presented with recently diagnosed and very typical erythema annulare centrifugum on his back. He had clinically obvious tinea pedis. This man also demonstrated chemotherapy induced alopecia with early regrowth having completed chemotherapy for a carcinoma four weeks previously.

Candidates were asked to propose a diagnosis for the EAC lesions, nominate what other area they wished to examine, examine the feet, and examine the scalp. Most performed competently quickly making a diagnosis of EAC, knowing the associations and correctly assessing the changes on the feet. The better candidates were able to identify the chemotherapy induced alopecia and assess the length of time since cessation of treatment. The poorer candidates nominated very long differential diagnosis lists including an assortment of dermal, subcutaneous and erythematous conditions.

Pretibial myxoedema

This middle aged man presented with very typical pretibial myxoedema complicating Grave's disease. He had mild but visible eye changes. His pretibial skin was severely affected, the dorsum of the foot was spared, and there was involvement of his toes.

Candidates were asked to describe the changes seen on the legs and to propose a diagnosis and differential diagnosis. They were asked also whether they would like to examine any other area of the patient. Most candidates handled this presentation well. The poorer candidates did not recognise on examination that the changes in the legs were primarily dermal and proposed long differential lists without including pretibial myxoedema.

VIVA 5

Unilateral naevoid telangiectasia

This patient had an area of telangiectasia in a linear distribution on the right upper arm extending onto the right anterior shoulder with a small area of atrophy and hypopigmentation from laser treatment. The latter was pointed out to each candidate. Candidates were asked for a description of findings, a diagnosis or differential diagnosis, and suggested treatments.

Most candidates described the findings with some describing more findings than were present. Most gave the diagnosis with 1 or 2 reasonable differential diagnoses and most suggested appropriate vascular lasers for treatment. The poorest performers offered long lists of inappropriate diagnoses.

CLINICAL VIVAs – SHORT CASES

Frontal fibrosing alopecia

This patient presented perifollicular scale, follicular plugging and scarring along the frontal hairlines. She also had diffuse alopecia consistent with female pattern androgenetic alopecia.

All candidates described the findings in the area of frontal fibrosing alopecia and all offered the correct diagnosis. Fewer than half the candidates were confident that this lady had non scarring androgenetic alopecia with most favouring a diagnosis of milder scarring in extension of the lichen planopilaris.

Elastoma

This patient presented faintly yellow dermal papules and nodules forming a ten centimetre diameter plaque above the natal cleft. Candidates were asked to describe the lesion, propose a diagnosis, and comment on any likely associations.

All candidates offered the correct diagnosis and recognised the association with osteopoikilosis in the Buschke-Ollendorff syndrome.

VIVA 6

Cutaneous sarcoidosis

This middle aged lady presented typical annular scaling erythematous plaques over the anterior aspect of her knees with visible Cushingoid features resulting from treatment of pulmonary sarcoidosis. Candidates were asked to provide a differential diagnosis, a favoured diagnosis, and to briefly discuss appropriate investigations.

No candidate suggested sarcoidosis as the principle diagnosis but most included it in their differential diagnosis. All knew the relevant key investigations and overall this case was handled well.

Pilomatrixoma

This patient had a solitary typical pilomatrixoma on the left upper arm. The patient had a history of multiple other cysts including epidermal cysts. Candidates were asked for a spot diagnosis or, alternatively, a differential diagnosis. Most made the diagnosis correctly or included it early in their differential diagnosis list. All candidates were aware of Gardner's syndrome. This case was handled extremely well.

Disseminated superficial actinic porokeratosis

This patient had classical lesions on the legs with associated secondary inflammatory changes and other actinic lesions. Candidates were asked for a diagnosis and then a differential diagnosis for the secondary changes and other actinic lesions.

All candidates correctly spot diagnosed this case and were able to capably discuss the other aspects. This was an easy case well handled.

OSCE

Station 1 – Phototherapy

A photograph was presented of vitiligo involving shins and feet. Candidates were asked to nominate two appropriate methods of phototherapy, identify three features which influence the prognosis in this patient, discuss the adverse outcomes of narrowband UVB therapy, and nominate an appropriate interval between treatments with oral PUVA.

Generally this station was managed well. The candidates who failed this station did so because they recommended treating with PUVA four or more times per week when treatment on consecutive days can lead to potentially serious side-effects.

Station 2 – Non-surgical treatment of SCC in situ

A photograph was presented of Bowen's disease (SCC in situ, intraepidermal carcinoma) on the cheek of an elderly man. Candidates were told that a biopsy had confirmed this diagnosis and were asked to give four appropriate treatments other than excisional surgery. They were then asked to describe how they would instruct the patient to use 5-Fluorouracil topically, and to identify four short term and four long term side-effects of this treatment.

All candidates passed this station. There was no difficulty identifying 5-fluorouracil, imiquimod and photodynamic therapy as appropriate treatment. Very few mentioned ablative laser or superficial x-ray therapy. As a group candidates were able to accurately instruct the patient in the use of 5-fluorouracil and all were able to identify long term and short term side-effects. The commonest error was confusion between the side-effects of 5-fluorouracil and imiquimod.

Station 3 – Surgical repair

This photograph depicted a 1.3cm diameter surgical defect of the upper cutaneous lip of a young woman. Candidates were asked to give three repair options and then to describe in a step by step fashion how they would perform a full lip wedge repair.

Overall this station was poorly done. Very few candidates gave full lip wedge excision as a repair option for this defect and few understood the technique or its performance.

Station 4 – Nail Biopsy

A photograph was presented of longitudinal melanonychia involving the great toenail of a Caucasian man. Candidates were told that the suspected diagnosis was melanoma. This question tested knowledge of biopsy techniques to confirm this diagnosis. Candidates were asked how they were going to anaesthetise the toe, how they would perform the biopsy and how they would proceed if this patient already had a 3mm punch biopsy from the origin of the pigmentation which revealed no abnormality. Candidates were expected to demonstrate knowledge of the appropriate biopsy technique including an appropriate local anaesthetic and its administration via digital nerve block. They were expected also to recognise that a punch biopsy taken and reported elsewhere may not be sufficient to exclude a diagnosis of melanoma and to take steps to speak to the pathologist and arrange a more aggressive biopsy.

OSCE

Overall this station was well handled although few candidates nominated a horizontal/crescentic biopsy as the best option. Most suggested a lateral longitudinal biopsy which is not incorrect but not the best biopsy in the setting. Most candidates suggested a 3mm punch biopsy but most were able to correctly respond to the negative result from this. Several candidates were unable to obtain sufficient marks to pass this station because of their lack of knowledge of the biopsy techniques.

Station 5 – Haemorrhage following injection of local anaesthetic

Two photographs were presented of the forehead of an elderly woman, the first depicting a basal cell carcinoma with planned excision lines and the second extensive haemorrhage into the skin following the injection of local anaesthetic. Candidates were asked to discuss the potential causes for this haemorrhage, immediate management of this patient, and the future management for further surgery assuming that she was taking aspirin and warfarin for significant underlying cardiovascular disease.

This station was poorly answered. Most candidates provided reasonable answers to possible causes of this problem identifying anticoagulant medications, underlying haematologic abnormalities and inadvertent puncture of a supratrochlear vessel as likely problems. Fewer nominated skin fragility due to age or medications e.g. prednisolone. Candidates had most difficulty nominating ways to now minimise further bleeding with use of pressure, ice packs, or additional adrenalin containing anaesthetic. It was hoped that candidates would not electively cease aspirin or warfarin in a patient with significant cardiovascular disease. Most candidates were able to identify the need to check the INR level before further surgery and to speak to the patient's cardiologist before ceasing medications, but the majority remained in favour of ceasing drugs when it was felt by the examiners that this was not necessary.

Station 6 – Periungual verruca

This station presented a photograph of a young woman's hand demonstrating a large untreated periungual verruca present for two years. Candidates were asked to give three appropriate treatment options for this lesion and, to describe the important steps in using diphencyprone immunotherapy, and to nominate three complications of this treatment which they would discuss with the patient.

All candidates passed this station, the majority achieving just the pass mark. Nearly all candidates had a good grasp of diphencyprone technique and its complications but almost all had a poor understanding of the appropriate treatment to select for this extensive verruca. The majority nominated cryotherapy, curettage or imiquimod which were inadequate for the wart depicted. When keratolytics were nominated the strengths were insufficient. The preferred answers were keratolytics at high strength, DCP or DNCB immunotherapy, and bleomycin.

OSCE

Station 7 – Dermoscopy

Photographs were presented of a pigmented basal cell carcinoma and a Spitz naevus. Candidates were asked to describe the features seen in the image and then reach a diagnosis.

The pigmented BCC was easily diagnosed and most candidates identified the features apparent in the image including spoke wheel areas, maple leaf like areas, ovoid blue-grey nests and arborizing telangiectasia. Few commented on the absence of a pigment network.

A significant number of candidates failed this station, all of them diagnosing the Spitz naevus as a melanoma and then naming features to support this diagnosis, although the features were absent from the photograph. Candidates did not have a methodical approach to assessing a dermoscopic image with the poorer candidates making a diagnosis and then trying to find the dermoscopic features expected to support that diagnosis. This tactic is not successful if the global diagnosis is incorrect. The better candidates identified the dermoscopic features and then used these to come to an accurate diagnosis.

Station 8 – Superficial radiotherapy

A photograph of a biopsy proven SCC on the lower lip of an elderly man was presented. Candidates were asked to name two appropriate treatment options and then to explain to the patient the potential benefits of radiotherapy over surgery, the reason that fractionated therapy needs to be used, and the main troublesome side-effect of radiotherapy in this area.

Candidates were able to nominate appropriate treatment options and discuss the benefits of radiotherapy over surgery. The majority of candidates did not appreciate that fractionated radiotherapy results in higher cure rates but did understand the better cosmetic outcome and reduced instance of radiodermatitis. Some of the candidates did not know that mucositis was the main troublesome side-effect. The candidates who performed poorly on this station had a poor understanding of the reasons for fractionated therapy and no appreciation of the resultant mucositis.

Station 9 – Cryotherapy for superficial BCC

A photograph of a 1.2cm diameter superficial BCC on the left forearm was presented. Candidates were asked to nominate two techniques of cryotherapy using liquid nitrogen which would be appropriate and then to discuss the performance of the timed spot freeze technique including making the appropriate markings on the photograph.

Almost all candidates managed this station well.

Station 10 – Flap repair

A photograph was presented of an upper lip defect following Moh's micrographic surgery in an elderly woman. Candidates were asked to name three appropriate closures and then to draw a rotation flap repair on the image. They were asked specifically to locate the position of the key suture in this flap and to name an appropriate deep suture material.

OSCE

Most candidates were unable to name three specific closures. Acceptable options were considered to be a rotation flap, subcutaneous island pedicle flap, side to side closure with partial wedge, and perialar crescentic advancement flap. Burow's full thickness skin graft was an acceptable but less satisfactory option. As a group the candidates struggled with drawing a rotation flap, most demonstrating little understanding of the principles. Most identified appropriate suture materials. The majority of candidates scored borderline marks with a small number of failures on this station.

Station 11 – Dermatopathology – Fixed drug eruption

This slide was an H&E stain of a skin biopsy from the arm of a 54 year old man. Candidates were asked to describe four relevant findings seen on the sections and to give a differential diagnosis of three conditions. The slide demonstrated epidermal cell necrosis with Civatte body formation, a prominent lichenoid tissue reaction with vacuolar degeneration along the basal epidermis, melanin incontinence, red blood cell extravasation, a chronic lymphocytic inflammatory infiltrate but normal blood vessels without evidence of vasculitis. The favoured diagnoses were a fixed drug eruption or erythema multiforme with Stevens Johnson syndrome, TEN, lupus erythematosus, lichenoid drug eruption, polymorphous light eruption, and an allergic contact dermatitis being acceptable alternatives.

More than half the candidates failed this station, but several candidates scored almost perfect marks. The failures were due to a combination of inability to recognise the pathologic features and an inability to put the features seen together into an appropriate diagnosis.

Station 12 - Dermatopathology – Jessner's lymphocytic infiltrate

This station was eliminated from the final marking of this examination.

The slide presented was a H&E section of a biopsy of an erythematous plaque on the neck of a 47 year old woman. Candidates were asked to describe four relevant features seen and to nominate a differential diagnosis of three conditions. The slide demonstrated a prominent dermal localised lymphocytic infiltrate with dense areas of peri-vascular and peri-appendageal small lymphocytes which were monomorphic. The intervening dermis was largely normal and there was no vasculitis. There were, however, some epidermal changes present although these were not the major feature of the biopsy. Nonetheless many candidates focused on the epidermal changes and did not look in any detail at the dermal infiltrate. It was felt by the examiners on reviewing this station that the case should be eliminated.

OSCE

Station 13 – Dermatopathology – Squamous Cell Carcinoma

This slide displayed H&E sections of a biopsy of a lesion on the leg of a 60 year old man. Candidates were asked to describe four relevant findings, give a single favoured diagnosis and nominate an additional special stain which was relevant in this case. The slide demonstrated an infiltrating carcinoma arising from the epidermis with squamous differentiation and keratinisation. Mitoses were visible, there was an area of perineural invasion deep to tumour, and the surrounding dermis contained fibrosis and some mild chronic inflammation.

The poorer candidates failed to recognise the features seen and made incorrect diagnoses including melanoma, Merkel cell carcinoma, Kaposi's sarcoma, necrobiosis lipoidica, and mycobacterium ulcerans infection.

Station 14 – Dermatopathology – Chromoblastomycosis

This slide contained H&E sections from the biopsy of a nodule on the forearm of a 67 year old man. Candidates were asked to describe relevant findings seen, propose a favoured diagnosis, and name two special stains which would assist with the diagnosis. The slide demonstrated prominent suppurative granulomatous inflammation with multinucleated giant cells and characteristic brown "copper penny" bodies.

Most candidates saw the features and made the correct diagnosis. Those who failed this station were unable to recognise the features seen and proposed a variety of tumours as the diagnosis.

Station 15 – Dermatopathology – Cellular blue naevus

This slide contained H&E sections from excision of a lesion from the scalp of a bald headed man. Candidates were asked to describe five relevant features seen, propose a single favoured diagnosis, and nominate one special stain which would be helpful. The sections contained a localised nodular proliferation of spindle cells within the dermis and extending into the subcutis. Melanin pigment was visible. There were no mitoses, no attachment to the epidermis, no inflammation and no necrosis. The favoured diagnosis was a cellular blue naevus or blue naevus but some marks were awarded for congenital melanocytic naevus, intradermal naevus, benign naevus or congenital naevus.

The main problem for candidates was distinguishing this from a melanoma although there were no features in the biopsy to suggest a malignant lesion and there was no attachment to the epidermis. Most of the candidates who failed this station made a diagnosis of malignant melanoma and described features that were not present in the biopsy.

OSCE

Station 16 – Dysplastic naevi

This station involved a simulated patient with whom the candidates were asked to communicate and a photograph of an adult male back demonstrating multiple dysplastic naevi. Candidates were told that the patient had a family history of malignant melanoma and were asked to educate him about his ongoing care and to propose a surveillance protocol. Candidates were expected to discuss sun protection with the patient, the features of skin lesions which would be regarded as suspicious and self examination techniques. In addition, the offer of baseline photography and six to twelve monthly full skin examination by a dermatologist were considered appropriate.

Candidates were then asked to explain to the patient why they did not rely on a computerised recording device for his surveillance and then to respond to his request that ten moles be removed from his back for cosmetic improvement and to reduce his cancer risk. Candidates were expected to recognise that removal of benign naevi does not reduce the melanoma risk, that scars would be significant at this site, and also to discuss with the patient the surgical risk. Some marks were awarded for communication skills and general rapport with this simulated patient.

Most candidates handled this station reasonably well. Better candidates appeared to have dealt with this situation in clinical practice and answered the questions easily.

Station 17 – Vascular laser therapy

A photograph was presented of a port wine stain on the cheek of a young Asian man, not previously treated. Candidates were tested on their knowledge of appropriate treatment modalities and asked to identify negative prognostic indicators in this patient. They were then asked to discuss the advice they would give to the patient regarding the likely post treatment course following pulsed dye laser therapy.

Overall this station was very well handled with no candidate failing. Very few candidates identified mid facial location or Asiatic skin as negative prognostic factors, choosing rather the age of the patient and the presence of thicker areas within the port wine stain. Very few candidates included photoprotection in their post-laser advice, but all offered sufficient information to pass this station.

Station 18 -Chondrodermatitis nodularis helcis

A photograph was presented of chondrodermatitis nodularis helcis involving the left ear of a middle aged man and the candidates were told the diagnosis. Candidates were tested on their knowledge of the most important aggravating factor (pressure), the options for treatment, and then their knowledge of an appropriate technique for surgical intervention. It was expected that candidates would understand the technique of using a long narrow ellipse orientated along the helix with some cartilage trimming.

All candidates performed strongly in this station with no underlying weaknesses noted.

OSCE

Station 19 – Laser therapy

A photograph was presented depicting actinic cheilitis of a middle aged woman and candidates were told that this white plaque was mildly indurated. Further actinic changes were visible on the lip in the photograph. Candidates were tested on their ability to take an adequate biopsy, propose appropriate treatment for actinic cheilitis confirmed on biopsy, and then to advise the patient about the post-operative care following treatment of the lower lip with CO₂ laser.

Almost all candidates took an inadequate biopsy with a small simple punch when an incisional biopsy or deep shave biopsy from the indurated area was expected. Many candidates then did not have an understanding of the post treatment course proposing management on the basis of the first principles of wound healing rather than from any practical experience. The several candidates who failed this station felt that the wound would heal in a few days and did not appreciate the magnitude of care needed. An understanding of the post treatment course is important if this treatment is going to be recommended to patients even if performed by another practitioner.

Station 20 – Photodynamic therapy

This station involved communicating all aspects of photodynamic therapy to a simulated patient. A photograph was presented of a biopsy confirmed superficial BCC on the upper back of a young woman. Candidates were assessed on their understanding of the use of photodynamic therapy for a superficial BCC and on their ability to communicate this information to the patient. Candidates were expected to outline how the treatment works, an appropriate treatment schedule, the expected response to treatment, the possible side effects and complications, and an appropriate follow up schedule.

In general this station was well done. The commonest error was to underestimate the expected reaction to photodynamic therapy. Most candidates gained adequate marks as a result of their knowledge of the side effects and outcome of treatment. Most candidates scored well for the communication skills with many being very relaxed and warm with the patient. The poorer candidates had difficulty addressing the patient at least in part due to their lack of knowledge of PDT.

Station 21 - Side-to-side closure

A photograph was presented of a 3.5 cm diameter surgical defect on the forehead of a middle aged man following Moh's micrographic surgical resection of a BCC. Candidates were asked to propose three reconstruction options and then to demonstrate their knowledge of a high tension vertical side to side closure, including the manoeuvres which would assist in obtaining closure and the potential complications which they would discuss with the patient.

Generally this station was answered well although few candidates nominated a side to side closure as a management option. The flap repairs suggested were appropriate. Most candidates failed to recognise periorbital oedema as a significant complication.

OSCE

Station 22 – Laser epilation

A photograph was presented of the chin of a thirty-four year old woman demonstrating significant hirsutism. Candidates were asked to propose non-systemic treatments other than simple physical epilation and then asked to nominate appropriate therapeutic lasers. They were asked to discuss the side effects of laser epilation in the short, medium and long term.

All candidates did well on this straight forward station, demonstrating sufficient knowledge to discuss this treatment with a patient prior to intervention or referral.

Station 23 – Dermoscopy

Two photographic dermoscopic images were presented and candidates were asked to describe the dermoscopic features and then, from their assessment of the whole lesion, propose a diagnosis. The first image was a benign melanocytic lesion, small and symmetrical with a symmetrical regular discrete pigment network and regular brown globules. Almost all candidates recognised that this was a benign melanocytic lesion.

The second image was a seborrhoeic keratosis with regular diffuse pigmentation, comedo-like openings and fissures and crypts. All candidates made the correct diagnosis.

Station 24 – CO₂ laser

A photograph was presented of multiple eyelid syringomas in a young woman. Candidates were asked to propose appropriate treatments and then to discuss precautions taken to protect the patient, the staff, and others during treatment with Co2 laser.

Overall candidates performed satisfactorily on this station. Most candidates did not state that the patient eye shields should be heat resistant and most did not know the optical density required for eyewear or the nature of an appropriate laser mask. Several candidates failed to include a laser plume extractor as essential equipment and only one candidate mentioned specular reflection by name and identified the need for a Class 4 laser hazard sign. Few candidates knew that doors and windows needed to be covered and several erroneously believed the room should be locked.

Station 25 – Full thickness skin graft

A photograph was presented of a surgical defect on the ear of a middle aged woman following Moh's micrographic surgical resection of a BCC. Candidates were asked to nominate reconstructive options and then to demonstrate their understanding of the performance of a full thickness skin graft at this site including selection of a donor site, the steps in application of the graft, and appropriate dressing.

This station was done well by all candidates.

OSCE

Station 26 – Phototherapy for psoriasis

This station presented a photograph of extensive chronic plaque psoriasis in a 40 year old man with Fitzpatrick type II skin who was receiving narrowband UVB as monotherapy three times weekly with incremental dosage increases. Candidates were asked to discuss their actions if there had been no significant improvement after the 5th treatment and also after the 15th treatment. It was expected that the candidates would recognise that there may well be no significant improvement after the 5th treatment and would continue with increasing doses. After the 15th treatment they were expected to discuss possible reasons for treatment failure and then to propose modified management at this point including a dose increase, the addition of topical therapy, the addition of acitretin or a complete change in therapy.

Generally this station was well done. The poorer candidates took some time to realise that five treatments was too early to start modifying treatment and proposed various interventions before realising this. The poorest candidate did not seem to have an understanding of UVB phototherapy and suggested an increase in treatments to five times weekly which has the potential for serious side-effects.

Station 27 – Anatomy

Two photographs were presented with features numbered and candidates were asked to name the anatomical features on a written answer sheet. The first photograph was of the external ear and tested the naming of surface features. The second photograph was of a face and tested the candidates' ability to name the nerves which supply sensation to the numbered areas. Marks were evenly divided between these two sections.

All candidates demonstrated incomplete knowledge in both sections of this station but most passed this station.

Station 28 – Laboratory Dermatology

Three photomicrographs were presented and candidates were asked to identify the following features

Case A Scabies, mites, eggs and faeces

Case B Pediculus capitis/humanus

Case C Demodex folliculorum

All candidates passed this station with most scoring full marks.

OSCE

Station 29 – Laboratory Dermatology

Three photomicrographs were presented of abnormalities involving hair. Candidates were asked to write their findings and a diagnosis for each on the answer sheet.

- Case A* Trichorrhhexis invaginata in Netherton's syndrome
- Case B* Monilethrix with elliptical nodes, non-medullated internodes
- Case C* Gelatinous nodules surrounding the hair shaft with a possible diagnosis of white piedra or trichomycosis

The majority of candidates were able to name the features seen and recognise the diagnoses.

Station 30 – Laboratory Dermatology

Three photomicrographs were presented.

- Case A* A skin scraping taken from a woman with an erythematous and scaling eruption. This demonstrated budding yeasts and slender pseudohyphae of candidiasis.
- Case B* A skin scraping taken from the inguinal fold of a young woman. This photograph demonstrated septate branching hyphae typical of a dermatophyte.
- Case C* A skin scraping taken from a patient with an itchy rash. Normal polygonal epidermal cells were visible but there was no other abnormality. This was a negative skin scraping.

All candidates recognised the dermatophyte in Case B. Almost half the candidates scored poorly because they could neither describe the features nor make a diagnosis in Case A, and described features not present in Case C.

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Chief Censor
September 2006