



*Sir William Osler (1849-1919)*

# *The Osler Institute*

*Excellence in Continuing Medical  
Education*

## *Plastic Surgery Review Course*

Disc 1

Disc 2

Disc 3

Disc 4



*Sir William Osler (1849-1919)*

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## *Plastic Surgery Disc 1*

How to Pass the Written and Oral Exam

*Herve Gentile*

Rhinoplasty

*Herve Gentile*

Cleft lip and Palate

*Herve Gentile*

Head and Neck Tumors

*Herve Gentile*

Ear Reconstruction

*Herve Gentile*

Otoplasty

*Russell Reid*

Maxillofacial Trauma

*Russell Reid*

Craniofacial Syndromes

*Russell Reid*

Principles of Microsurgery

*Robert Lohman*

Nerve and Tendon Injuries

*Robert Lohman*

Hand and Wrist Fractures

*Robert Lohman*

Dupuytren's Disease

*Robert Lohman*

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# How to prepare for the written examination

# Test Format

# Current status

- Given in October at designated computer centers ( Prometric )
- Multiple choice and true and false questions ( each individually weighted )
- Theoretically, all examinees can pass (if they can demonstrate the required knowledge in each content area )

- In 2002 the ABPS administered its first Written Examination developed from a content-based standard setting exercise. The experts in the different subspecialties of plastic surgery determined, in each content area, the performance standards that would be expected of a certified plastic surgeon. Grading on the exam was established as content-based, rather than the traditional norm-referenced (“curve”) method.

- The 2002 Examination serves as a base examination to which the 2003 was equated, as well as subsequent examinations, until the next content-based exercise is held
- Failure rates:
  - in 2002-----23.1%
  - in 2003-----23.0%

# Written Exam Failure Rates

|        |            |              |
|--------|------------|--------------|
| ■ 2000 | -----23.1% | 242 (takers) |
| ■ 2001 | -----21.2% | 241          |
| ■ 2002 | -----23.1% | 242          |
| ■ 2003 | -----23.0% | 230          |
| ■ 2004 | -----16.7% | 214          |
| ■ 2005 | -----19.4% | 237          |

- 2006----- 19.8%      242 (takers)
- 2007----- 19.6%      235
- 2008----- 17.5%      251

# Why is a multiple choice format a gift ?

- Any standard test is readily beatable
- All answers are on the page, not necessarily in your head
- Multiple choice tests preclude any in dept testing on any one topic

# What is a valid test question?

- It must have a discrimination value of 60-80% ( it can't be too hard or too easy )
- It has to be field tested before it can be included on the boards

# Who writes the questions?

- 1) Dogma vs. Heresy
- 2) there is an inner circle of test questions writers ( " the experts" ) and if you are taking their test read and learn what they have written ( Dogma )
- 3) core knowledge vs. peripheral ( ex. Dermatology )

# Test Taking Tips

- Remember that on a multiple choice test the answers are directly in front of you.

If you can't decide on the proper answer try to ignore the question and see which answer standing by itself makes the most sense.

- Pathology and X-ray slides – try to answer the question without looking at the slides. The correct answer should be determined before examining the evidence ( why do you think pathologists and radiologists always ask for the history on the request form? ).

- Beware of the “regional excluder” (what goes on in NY does not go in LA ).
- Beware of the double negative  
never don't = do it,  
no in question = no in answer

The National Board of Medical Examiners (NBME) recommended eliminating “negative” items to improve the quality of the exam and eliminate bias, especially for candidates with disabilities. The ABPS stated in 2005 that those questions were revised and used the following question as an example: “Negative-worded” items would be those that read “all of the following are true, except...”

Question writers are selected from those who have been nominated to become Directors of the Board by one of the 20 sponsoring organizations. These individuals are then educated in the process of item writing through a program developed by the NBME. These questions and the question writers are then vigorously reviewed by the Advisory Councils to the Board and members of the Written Examination Committee (the experts in the field). A final review is conducted with the medical editors of the NBME to accept, delete or rewrite them to allow a more accurate and discriminative exam. In conclusion the process is as fair as it can get.

## a few tips:

- In CM remember that cuspid = canine;
- In Hand the kite flap = neurovascular flap;
- In CM Hemangioma is treated conservatively (Mulliken ) but laser may be a correct choice in an exclusion type question;
- In Rhinoplasty the internal valve angle is  $>15$  while the Nasolabial angle in women is 90-115;
- Revision Rhinoplasty for the boards is performed after 12 months;
- Different definitions: Klippel-Trenaunay is similar to Parkes-Weber syndrome but instead (1) it involves the lower extremities or (2) has no A-V fistulas or (3) they are identical (K-T=P-W )

In a sagittal split osteotomy of the mandible the neurovascular bundle should remain in which of the following segments of the mandible?

- a) proximal segment
- b) distal segment
- c) lateral segment
- d) superior segment
- e) inferior segment

A 42 yw female has a pigmented matrix lesion in the index finger. Bx of the lesion shows a subungual melanoma. Which of the following is the most appropriate management?

- a) Ablation of the nailbed and matrix resurfacing with skin grafting
- b) Amputation of the distal interphalangeal joint
- c) Amputation of the proximal interphalangeal joint
- d) Ray amputation

A 75 yw male has a discolored 4 mm lesion of the nondominant thumb after removal of the nail plate for chronic paronychia. A bx shows a subungual melanoma with thickness of 3 mm. Lymphoscintigraphy shows 2 positive nodes in the axilla. Which of the following is the most appropriate level of amputation?

- a) Carpometacarpal joint
- b) Metacarpal diaphysis
- c) Metacarpalphalangeal joint
- d) Proximal phalanx diaphysis
- e) Interphalangeal joint

**WHY PASS?**

**Respect, financial, avoid the  
agony of preparing again.**

**GOOD LUCK**

# How to prepare for the oral examination

# The Board Triad

The entire exam is purposefully designated to evaluate three specific areas:

- 1) safety
- 2) ethics
- 3) competency

## Oral Examination Failure Rate Statistics:

|                     |       |              |
|---------------------|-------|--------------|
| 1998-----           | 16.3% | 245 (takers) |
| 1999 March-----     | 12.6% | 215          |
| 1999 September----- | 16.3% | 203          |
| 2000-----           | 18.6% | 279          |
| 2001-----           | 22.9% | 236          |
| 2002-----           | 13.5% | 222          |
| 2003-----           | 16.0% | 206          |
| 2004-----           | 19.1% | 209          |



|      |            |     |          |
|------|------------|-----|----------|
| 2005 | -----20.2% | 203 | (takers) |
| 2006 | -----17.8% | 241 |          |
| 2007 | -----21.4% | 229 |          |
| 2008 | -----17.8% | 230 |          |

To pass the most important thing you need to do is to communicate to the examiners that you are:

1. competent and you do have the knowledge and the confidence to deal with any plastic problem = you solidly have acquired the principles of Plastic Surgery;
2. caring and compassionate;
3. safe surgeon;
4. not a rambler, but your thinking is clear;
5. ethical and honest.

# ANSWERING PROBLEM CASES

- KEY: YOUR FIRST STATEMENT
- MY GOLDEN TIP: AFTER YOU LOOKED AT THE PICTURES IMAGINE A REAL PATIENT WITH THE SAME PROBLEM IN THE ER, HOSPITAL OR YOUR OFFICE AND PLACE THAT VISUAL IMAGE BETWEEN YOU AND THE EXAMINERS
- MAKE SURE YOU EYE THE ADJACENT AREAS ON THE PHOTO'S

- Do not hide any problem! Be Honest!!!  
Remember that everybody has had complications or problems that they wish they would just go away ( and so did your examiners ).
- Acknowledge any errors whether related to documentation, coding, omission, etc. accept responsibility and the lesson learned and then move on.
- Do not be defensive.

- Be concise, clear, do not ramble; remember you have a real patient in front of you and imagine that you are discussing him with your referring physician.

- C/O, HX of the Lesion or the Problem
- Past Medical and Surgical Hx
- Allergies and Meds
- Family and Social Hx
- PE – lesion or problem itself, adjacent areas and general medical exam

- Tests ( lab, ct scan, bx )
- Differential Diagnosis
- Diagnosis
- Plan of Treatment
- Informed Consent
- Risks and Complications

One should now be able to offer a differential diagnosis

1. K- Congenital
2. I - Infection and Iatrogenic
3. T - Trauma
4. T - Tumor
5. E - Endocrine
6. N - Neurologic
7. S - Systemic

# 1. Congenital

- inherited or non-inherited
- diagnosis and differential diagnosis
- discuss your plan of approach
- other specifics of the problem ( ex in CP: speech, swallowing and hearing )
- consent and complications
- describe operative procedure

## 2. Inflammatory

- Bacterial, viral and fungal
- Establish diagnosis and extent, tests, PE
- Consultation if appropriate
- Local and systemic therapy

# 3.Tumor

- Benign vs Malignant
- Establish diagnosis, extent and diff diagnosis
- Consultation if appropriate
- Formulate treatment plan ( address primary and metastasis )
- Radiation, Surgery, Chemotherapy
- Prognosis

# 4. Trauma

- Mechanical, thermal, electrical, chemical
- Extent of injury and associated injuries
- ABCs, remember that you are in the ER
- Immediate vs delayed treatment plan
- Complications and sequelae

# Facial Trauma Patient with Fx

- ABC's in the resuscitation of the trauma pt ( you are in the ER )
  - 1.airway obstruction, 2. aspiration,3. hemorrhage, 4. C-spine (10% of associated injuries), 5. severe head trauma
- Obtain C-spine and CT scan, Do a complete PE with neurological exam
- Stabilize pt prior to instituting specific therapy
- Think anatomically. What is fractured in each anatomic location? What is the pt's normal occlusion ( Angle classification )? Eye eval?
- Know the goals of Facial Fx management:
  1. Emergent phase ( resuscitate and stabilize pt )
  2. Definitive facial fx/soft tissue repair phase ( restoration of pretrauma occlusion and facial balance )

## 5. Endocrine and Systemic

- Diabetes, Gout, Collagen Diseases (RA, Scleroderma), Dupuytren's, etc.)
- Establish diagnosis
- Full hand exam
- X-rays
- Define pt's needs
- Match treatment plan to pt's needs
- Complications

## 6. Iatrogenic

- Obtain old record
- Discuss case with experienced PS
- Be modest
- Assume professional obligations
- Be honest
- Be prepared on how to handle the unhappy pt ( yours, referred or other)

# Summarizing:

- Establish an etiology or diagnosis ( Diff. Diag)
- Complete H &P
- Lab tests and X-ray ( to confirm or eval extent)
- Consultation?
- Discussion with pt emphasizing risks, needs, alternatives, etc.
- Potential complications ( how will I stay out of trouble, infection, necrosis, nerve damage
- Remember the Informed Consent

## Operative approach:

1. Severity of problem ( wide CL )
2. Specifics of patient ( psychological, cosmetic, hand rec.)
3. Associated problems (ex. lower extremity trauma, heart disease, smoking and DM )
4. Specifics of the case ( “Although in general I prefer \_\_\_\_\_”, due to the specific location of the tumor, I would----”).)
5. Potential complications ( exposed structures, infections,)
6. Logical sequence from simplest to most complex, from least risk to most from cure to palliation

# TIPS:

- Dress conservatively
- Know your cases cold, know the literature, the alternatives and the complications. Remember that all the material you submitted is fair game.
- Know plan B, plan C, etc.
- Be prepared to defend your option but do not be aggressive or argumentative

- Keep talking, this way you can continue elaborating what you know; if you stop they will ask you a question which you may or may not be as comfortable with.
- If you are asked a repeat question, wake up! The examiner may have a reservation about you; think about your answer and explain why you choose it.
- If there is a controversy, acknowledge it immediately so that you are considered safe and explain your belief in your choice as well as the difference in opinions ( ex. RND in melanoma ).

# Other thoughts:

- Plan to arrive at the site of the exam at least a day early.
- If you are flying carry your case-books, books, etc with you.
- Your exam will start with your case-books; review them carefully just before the exam as this may reduce your stress .

# Changes for 2010:

- **The case collection period will increase from 7 months to 9 months beginning with case collection on July 1, 2009.**
- **Candidates must submit all cases performed during the 9 month case collection period. However, surgical practice submissions of less than 9 months are acceptable if they meet the criteria of sufficient quality, complexity and variety of cases to allow for an equitable case report examination.**
- **There will be a new requirement of a minimum of 50 operative cases performed during the case collection period.**
- **For admissibility to the 2010 Oral Examination, the case list must also meet minimum criteria for categories of practice and anatomical regions. The details of the categories and anatomy criteria will be published next year.**

## Scoring:

1. Unsatisfactory (Incapable): demonstrates minimal understanding, undeveloped or inappropriate application process or analytic skills and limited ability to evaluate information.
2. Marginal (Some capability): demonstrates basic understanding, some deficiencies in application of process or analytic skills, some ability to evaluate information.
3. Satisfactory (Proficient): demonstrates broad understanding, demonstrates effective application of process and analytic skills, evaluates information appropriately.
4. Excellent (Distinguished): demonstrates extensive understanding, consistent, effective application of process or analytic skills to solve problems and extensive ability to evaluate information.

## In the Case Report Sessions, this scoring item will be augmented by separate grades in:

- Safety: practices within acceptable standards; avoids excessive risks.
- Ethics: honest, ethical and professional in the practice and business of plastic surgery.
- Case Report Preparation: clarity, completion, detail, and honesty/integrity.

**The following criteria are provided to the examiners as guidelines. The candidate is rated on:**

1. **Diagnosis/Planning:** identifies general problem, notes key problems and evaluates patient.
2. **Management/Treatment:** surgical indications, operative procedures, and anesthesia.
3. **Complications/Outcome:** unexpected problems, alternative plans and approaches.
4. **Clinical Judgment/Limitations:** reasoning ability, problem solving, risks and benefits.

**In conclusion to pass the boards you must have satisfactorily demonstrated to the examiners that you are a safe, ethical and competent surgeon.**

# WHY PASS?

- Respect
- Financial
- Avoid the agony of preparing again
- Good luck and welcome to the most exclusive Club

GOOD LUCK