EXAMINATION HELD ON 4th then 26th NOVEMBER 2016

at regional centres (4 Nov 2014) then at AMC National Test Centre, Melbourne, Victoria.

1. EXAMINATION

OVERALL PASS RATE 67%

This year, 24 candidates presented for the examination and 16 were successful.
2. WRITTEN SECTION

See Appendix A for the educational resources regarding each question.

General information:
Always, candidates need to:

1. Answer the question.
2. Plan the answer in a logical fashion and demonstrate an organised approach.
3. Give succinct answers and avoid repetition.
4. Use headings and dot points if asked to list or discuss briefly.
5. Give definitions of specialist terms (e.g. neuropathic pain, placebo response or breakthrough analgesia). Examiners are unable to assume understanding or meaning of a particular term without clear definition. Similarly for abbreviations.
6. Start answer with “I would do…” if asked to “outline your approach to…”

Candidates were required to answer ten compulsory questions of equal mark value. Where there were more than one section to the question, all sections were to be answered.

General comments: Candidates should endeavour to introduce their responses with accurate definitions of the pivotal terminology in the question. Consideration of the broad sociopsychobiomedical aspects of the question must be provided. As always legibility of responses continues to challenge the markers. Needless to say, there is no substitute for a sound knowledge of the subject matter.

As has occurred with all recent sittings, many answers lacked the sophistication expected of specialist pain medicine physicians. Once again, there was concern about the lack of knowledge in some key and basic areas given the candidates are supposed to be specialists in the area and know more than the referrer. It remains apparent that the trainees are not digesting the content of recent journals, nor is adequate priority being accorded to on-line resources provided by the Faculty, including the curriculum and training handbook.

Candidates are reminded to read the questions carefully, and to attempt to write legibly.

Many candidates continue to use generic templates to answer questions, and whilst these are not specific to task, they are then poorly adapted to it.

Abbreviations always, and specific medical terms generally, require definition when used for the first time.

*   *   *

__________________________________________________________________
Question 1 (92%) successful
1. Define ‘Opiate Tolerance’.
2. How does it develop?
3. When admitted for total knee replacement patient, what preoperative strategy do you give a 57 year old opiate tolerant man with failed back surgery syndrome?

Question 2 (79%) successful
Describe how you distinguish clinically between active visceral nociception, visceral hyperalgesia, and referred pain.

Question 3 (79%) successful
What information would you include in a submission aiming to inform about over-the-counter (OTC) availability of codeine-containing analgesics?

Question 4 (46%) successful
Discuss the diagnosis and management of a patient with Post Traumatic Stress Disorder (PTSD) and persistent pain.

Question 5 (58%) successful
Write brief notes on the main concepts involved in culturally responsive care in pain management for patients from diverse backgrounds.

Question 6 (67%) successful
In a patient with renal or hepatic impairment, the changes may affect the pharmacokinetics of analgesics prescribed.
Summarise the key changes and indicate how they might influence your choice and/or the dose of medications used for pain management in these patients. Include both opioid and non-opioid drugs in your answer.

Question 7 (63%) successful
Your tertiary pain management centre needs to improve community access and reduce waiting times to your pain services.
   a) What are the issues to consider?
   b) What strategies can be used to address these problems?

Question 8 (79%) successful
Write short notes on the use of Lidocaine in the management of pain.

Question 9 (58%) successful
A 22 year old sales clerk is referred to you by a neurologist with “medically unexplained” pain, weakness and numbness of the entire left “hemi-body” after a minor motor vehicle accident two years ago. She is wheelchair bound and holds her left hand in a claw-like posture.
Describe your approach to assessment and management of this patient.

Question 10 (4%) successful
The number needed to treat (NNT) has become widely utilised to compare the efficacy of chronic pain treatments.
   1. Define NNT
   2. Outline the potential problems associated with its calculation and interpretation
   3. A systematic review of clinical trials of morphine establishes the NNT is 2.5 (95% confidence interval 1.82 - 4.0). Explains what this confidence interval means and why is it important.
In accordance with the Faculty of Pain Medicine Training Handbook, in the course of the examination day each candidate was required to undertake 8 viva voce stations of 15 minutes each, undertaken in two rounds of four vivas each. Each viva attracted equal marks. The following qualities were assessed:

- clinical judgement
- the application of principles of acceptable and safe pain medicine practice
- prioritisation
- interpretation of complex clinical situations
- an ability to make decisions based on changing clinical situations
- anticipation of clinical actions and their sequelae
- effective communication.

Actors were utilised in some stations. Examiners in-training observed in some stations.

3.1 OBSERVED STRUCTURED CLINICAL EXAMINATION (OSCE) PASS RATE (88 %)

This section consisted of four highly structured viva voces which were carefully scripted to assess specific educational objectives.

OSCE1:
You are called to see a 44 year old patient in the surgical ward who had a L4-5/S1 spinal fusion the day before. The patient started to complain of increasing pain around 0300 hrs that did not seem to be covered well enough with the Patient Controlled Analgesia (PCA).

The overnight anaesthetic registrar was called and increased the PCA bolus dose at 0600 hrs. Since then, the patient’s pain has seemed to increase even more rapidly and is now reported as 8/10 at rest.

The patient had a previous surgery: an L4/5 laminectomy 2 years ago and says he/ she was taking only paracetamol, amitriptyline and gabapentin prior to admission.

*Please outline the brief pain history you would obtain from the patient?*

OSCE 2:
You have been referred a 56-year-old woman who has had widespread pain for 20 years. She saw a rheumatologist 1 year ago who diagnosed Rheumatoid Arthritis. She was rheumatoid factor positive with a titre of more than 100 in addition to being anti-CCP positive. She is now on Abatacept injections after not responding to three months of methotrexate. Her inflammatory markers are all now completely normal

Past history of Hypertension and Obesity with borderline Blood Sugar Levels. She admits with time weight gain.

On examination she has widespread tenderness in all four quadrants. Her MCP joints are tender but not swollen and no more tender than other joints of her hands.

This case study will focus on her management.

*How do you interpret her presentation?*

OSCE 3:
As a Specialist Pain Medicine Physician, you are asked by a local GP to consult on a 38-year-old woman
called Jodie, who has presented with a history of increasingly severe and disabling bifrontal headache for the past three weeks.

She is a smoker but otherwise in good general health. She has had intermittent lumbar pain in the last six months, which has been put down to her work as a clothes retailer.

Please consider your clinical approach to the assessment of this patient.

**OSCE 4:**
Mr Smith is a 45 year old man from interstate seeking the continuation of medication for the management of his chronic abdominal pain. He has moved to your city to live with his girlfriend.

He claims to be on OxyContin 80mg TDS prescribed by his previous GP. He brought a letter from the GP to you stating his GP could not be contacted as he was on holiday.

Mr Smith was 20 minutes late to his initial appointment scheduled for 0900. He apologised to you for being late stating the bus was delayed. Your impression was that this man’s breath smelt of alcohol.

What is your differential diagnosis for this man’s abdominal pain?

3.2 STRUCTURED ORAL VIVAS

**VIVA 1**
A 43 year old woman presents to you as an outpatient for pain management. 12 months ago she presented for a micro-discectomy at C5/6 because of a herniated intervertebral disc causing a left C6 radiculopathy. Following this operation the patient awoke quadriplegic and has remained so. She complains of ongoing chronic pain and spasticity in the neck, trunk and all 4 limbs.

What is the prevalence of chronic pain following spinal cord injury?

**VIVA 2**
Your patient reports to you that your trainee is being bullied by your co-worker.

How is workplace bullying defined?

**VIVA 3**
A patient who warrants but refuses palliative care for pancreatic carcinoma and assertively requests that they want pain control via coeliac plexus block.

Re Ashley Brown  DOB 24/4/1969  Leawarra Way Clifton Beach VIC 3245
Dear Dr,
Many thanks for seeing Ashley who has had a recent diagnosis of carcinoma of the pancreas. He was not a suitable candidates for a Whipple’s procedure and we are currently undertaking some palliative chemotherapy (Gemcitabine, 5-fluorouracil (5-FU) Oxaliplatin ). His pain is being managed by his GP with OxyContin, pregabalin and some endone. He is unwilling to consider palliative care at the moment however would like to discuss the possibility of a coeliac plexus block with you. He has developed some uncomfortable peripheral neuropathy also. Ashley is a teacher married with two children aged nine and 13. Obviously this recent devastating diagnosis has been a shock to him and his family.
VIVA 4
35-year-old man admitted to hospital 1 week ago following an aircraft crash. He sustained 3rd degree fuel burns to 40% of his body (torso and legs). Four days ago, he had surgical debridement of this injury. He requires daily dressings on the burns ward for the next 2 weeks.

What are your first priorities in this situation?

4. OVERALL EXAMINATION COMMENTS:

The Faculty has continued working towards optimised assessment processes, which enquire into the competence with which the candidates have mastered the 2015 Curriculum.

Written short answer questions were chosen from across the curriculum, and the viva voce questions were carefully designed to ensure, as much as was possible, the full breadth of the subject material was examined.

The FPM Examinations Committee remains concerned that some areas of the curriculum are not well understood. Practice of an organised approach to tasks is essential both for success in the examination but more importantly for clinical practice. So as to improve overall performance in the vivas, candidates are encouraged to practice synthesising impromptu responses and presenting these in an organised fashion, such as to display one's ability to discuss intelligently and maturely a wide range of relevant topics.

The Court of Examiners acknowledges the External Observer for 2016, Dr Michael Jones, ANZCA Councillor and Chair Examinations (ANZCA) who provided valuable reflections on the examination processes.

I am most grateful for the support and assistance provided by the Faculty staff, both in Melbourne and the regions, as well as the team at the AMC Assessment Centre. In particular I gratefully acknowledge the tremendous generosity of self which has been provided by the members of the Examination Committee and the Court of Examiners.

5. THE BARBARA WALKER PRIZE / CERTIFICATES OF MERIT

The Barbara Walker prize was not awarded for the 2016 examination. Certificates of Merit were awarded to Dr Anthony Carrie (NZ), Dr Megan Eddy (VIC), Dr Irina Hollington (SA) and Dr Alan Nazha (NSW).

NEWMAN L. HARRIS
Chairman

GRETA M. PALMER
Deputy Chair

February 2017