Regulations and Syllabus relating to Fellowship Examination In Otorhinolaryngology FCSorl(ECSA)

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Fellowship examination in Otorhinolaryngology leading to the qualification of FCSORL(ECSA)

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1 Introduction

The College of Surgeons of East Central and Southern Africa awards Membership (MCS) and Fellowship (FCS) examinations. Approved trainee surgeons shall be trained in the hospitals of the region with guidance and support provided by the College.

The Fellowship examination in Otorhinolaryngology leads to the qualification of Fellow of the College of Surgeons of East Central and Southern Africa, FCSORL (ECSA). This fellowship is recognition that the candidate has reached the level of knowledge, understanding and practice of Otorhinolaryngology sufficient to practice independently at a consultant or specialist level. It should be recognised however that surgery is not a static art and fellows should continue to increase knowledge and skills by means of research, conferences meetings and reading.

2 Registration as a trainee

All candidates for the FCSORL(ECSA) examination are required to register as trainees with the College. Applications to register as a trainee must be made on COSECSA application forms, which are available from the COSECSA Country Representative (CCR). These should be completed and returned to the CCR accompanied by certified copies of certificates showing MCS or equivalent examination.

A registration fee of US$50 should be given to the CCR or his representative. On receipt of the registration fee, the CCR will give the candidate:

i) A copy of the examination regulations and syllabus
ii) A logbook
iii) A list of recognised hospitals and approved courses
iv) Assessment forms to be filled in at the end of every training post by the trainee and the supervising consultant.
v) A recommended reading list for the relevant examination
vi) An application form to sit the examination
vii) A registration number, which remains unique to the candidate. This is only done if candidate does not already have a registration number.

3 Training requirements

Academic

Candidates for the fellowship examination in Otorhinolaryngology should normally have passed the membership examination of this college and possess the diploma MCS (ECSA). Exemption to this requirement may be given to those who have passed an equivalent examination such as MMed (Surgery) of one of the constituent countries of the ECSA community, or Fellowship of the Royal Colleges of Surgeons of England, Scotland, Ireland, Australia, or South Africa. The basic surgical training examinations of other colleges and institutions may also be acceptable but each one will have to be reviewed by the Examination and Training Committee of the College before exemption can be given.

Training Posts

Candidates will have to have spent 3 years in recognised supervised training posts after completing the requirements for MCS. Of these three years two must involve elective and emergency Otorhinolaryngology, one year may be spent in an elective unit not dealing with emergencies. One of the three years may be spent outside the region in a post that has been prospectively agreed with the Examination and Training Committee. This post may be in an elective unit. Trainee and trainer should fill in assessment forms for each training post.

Forms to fill in for each training post are provided for each candidate.

4 Logbook

During the training period candidates must keep a logbook prospectively recording all their training experience. The book should be available for inspection at any time by the CCR. Consolidation sheets should be filled in at the end of every post or annually for posts longer than one year, and a final consolidating sheet for the whole training period. The logbook should also contain details of all courses attended and the trainee and post assessment forms for the whole training period.

More detail on completing logbooks is provided in the logbook itself.

Before submission to the examination the CCR should check the logbook for completion, fill in and sign a checklist, which remains at the front of the logbook.

At the time of clinical and oral examination the logbook should be handed to the examination administration secretary. Candidates will not be allowed to sit for the examination if this is not done.
5 Application to sit Examinations

Candidates who are registered as trainees (see §2 above) may sit the examination at the end of their third year of FCS training provided that they have completed 36 months of training by that time. Application for the examination must be made by March 1st of the year of the examination. Candidates should submit a completed examination application form to the CCR with the examination fee of US$450. On receipt of the form and the fee, candidates will be informed by the CCR of the precise times dates and places for the exams.

By applying to the examination a candidate agrees to be bound by the rules and regulations of the College.

If a candidate withdraws from an exam more than 12 weeks before the exam is due, then the fee can be transferred to the next exam date. Fees will not normally be returned if the candidate withdraws permanently, unless due to special circumstances as determined by the college.

Candidates must pass the examination within four years of their first attempt. After this they will not be allowed to resit. A total of four attempts only will be allowed.

6 Examination Format and Conduct

The standards of the examination will be set by the examination committee, drawn from members of the council of the college, which will recommend those standards required by both examiners and candidates. A panel of examiners will chosen by the examination committee from amongst Fellows of the College for each examination. The chairman of the examination committee will keep a register of examiners. An examination board will be constituted for each diet of examinations, comprising the chairman of the examination committee, two members from each examination panel and at least one external examiner. The role of the external examiner(s) is to:

a) Moderate the written question papers
b) Assist with the examination of candidates
c) Assist with any pass/fail vivas
d) Provide external independent assessment of the examination
e) Report on the conduct of the examination to the examination committee

The exam comprises written, clinical and oral parts

The written FCSORL (ECSA) exam will comprise two 2-hour papers. The first paper will consist of fifty 5 part short answer or MCQ questions. There will be +2 marks for a correct answer and -1 mark for a wrong answer. It will be marked out of 500. The second paper will comprise 10 compulsory short essays each marked out of 50. A minimum score of 500 out of 1000 (50%) will be required to pass.

Written examinations may be held in any of the countries of the region. In exceptional circumstances the examination committee may approve an examination
site outside the region. The written examinations are held simultaneously on the first Wednesday of September, at a recognised examination centre with impartial invigilation.

The examination papers will be set by members of the examination committee and independently moderated by an external examiner. They will be sent to COSECSA administration office in Arusha by 1st March and will be stored confidentially there. One copy per candidate will then be sent by courier or secure delivery to a named country representative at all sites that are holding examinations 2-3 days before they are held.

After the examination the CCR will make photocopies of the candidates’ completed exam scripts for safekeeping, and send the originals by courier or secure delivery to the relevant panel chairman. The panel chairman will coordinate marking of the examination paper.

The clinical and oral part of the examination will comprise the following:

An oral examination (viva) that will take place approximately 3 months after the multiple-choice exam, in a country and at a site designated by the college. There will be two 30 minute orals covering critical care, principles of surgery including operative surgery and applied anatomy, clinical surgery and pathology, based on the experience demonstrated in the candidate’s logbook.

A clinical examination, which will take place at the same time and at the same site as the oral. This will comprise six 20-minute cases.

A closed marking scheme will apply for clinical and orals

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>unredeemable</td>
</tr>
<tr>
<td>40</td>
<td>just redeemable fail</td>
</tr>
<tr>
<td>45</td>
<td>bare fail</td>
</tr>
<tr>
<td>50</td>
<td>bare pass</td>
</tr>
<tr>
<td>55</td>
<td>clear pass</td>
</tr>
<tr>
<td>60</td>
<td>good pass</td>
</tr>
<tr>
<td>65</td>
<td>very good pass</td>
</tr>
<tr>
<td>70</td>
<td>excellent pass</td>
</tr>
</tbody>
</table>

Examiners will choose one of these marks. Candidates have to pass the written, clinical and oral sections of the examination in order to pass overall. If a candidate scores a mean of 49% in one section and has over 50% in the other two sections then he or she will be given a pass/fail viva. The chairman of the examination panel will select two examiners, excluding those who had failed the candidate, together with an external examiner, to conduct this viva.

The chairman of the examination panel will endeavour to minimise the chance of a candidate being examined by an examiner from his or her own country.
The panel of examiners will give the results to the examination board who will meet on the day of examination. The board will then approve the results on behalf of Council and publish them.

For each candidate who fails the exam, the panel will allocate a Fellow of the College (usually a member of the panel) who will communicate with the candidate and offer advice as may be indicated. Details of marks will not be given.

Appeals against results must be made in writing to the Council within 60 days of the completion of the examination. The President of the College will then appoint an impartial committee to investigate the appeal, and require a written report to be filed by the Chairmen of the examinations panel and board. The Appeals committee will then take all considerations and its own findings into account and recommend a decision that will remain final and binding.

7 Syllabus

Surgical Anatomy of the Head and Neck

Detailed anatomy of the head and neck. Sound knowledge of the embryology, Osteology, morbid anatomy and congenital abnormalities will be expected from Candidates

Applied physiology of the head and neck

- Physics of sound
- Physiology of middle, Eustachian tube and sound conduction.
- Physiology of the inner ear and sound conduction
- Physiology of the nose and para nasal sinuses and smell sensation
- Physiology of deglutition and phonation and taste
- Vestibular system
- Auditory system
- Olfaction
- Salivary gland physiology

Basic principles in audiology and vestibular testing

- Pure tone audiology, speech discrimination, recruitment and tone decay
- Impedence audiology
- Oto-acoustic emissions
- Elective evoked response audiometry
- Vestibular testing: caloric stimulation, electro-nystagmography, videonystagmography and vestibular evoked myogenic potentials
- Basics of BAHA (Bone Anchored Hearing Aids)
- Basics Of Cochlear Implantation
Clinical Examination Principles

- Basic otorhinolaryngological examination with particular reference to endoscopic techniques both flexible and rigid
- Systematic neck examination with reference to nodal levels
- Microscopic Ear examination and Otoscopic examination

Diseases of the ear

- Congenital Malformations of the Auricle
- Benign and Malignant lesions of the pinna
- Haematoma Auris
- Otitis Externa
- Outer ear insect infestation
- Malignant Otitis Externa
- Benign and Malignant Tumours of the External auditory Meatus
- Meatal Stenosis
- Acute and Chronic Suppurative Otitis Media
- Eustachian Tube dysfunction
- Middle Ear Effusions in African Population
- Cholesteatoma
- Chronic Ear disease in The African Population
- Surgical Restoration of Hearing Loss
- Complications and Their Management of Acute and Chronic Suppurative Otitis Media
- Tymanosclerosis
- Otosclerosis
- Benign and Malignant Tumours of the Middle Ear
- Trauma to Middle Ear and Ossicles
- Facial Nerve paralysis
- Diseases of the Labyrinth
- Temporal Bone Trauma and Fracture
- Management of Vertigo
- Meniere's Disease
- Wagner’s Granulomatosis and other rare Otolological Conditions
- Sensorineuronal Hearing Loss – Congenital, Acquired and Sudden
- Hearing Aids/Bone Anchored/Cochlear implantation
- Ototoxicity
Surgery of the ear

- Management of benign and malignant lesions of the pinna
- Management of benign and malignant lesions of concha and external auditory meatus
- Surgical Management of Ear keloid formation
- Reconstruction of ear after surgery for malignant disease
- Otoplasty Techniques
- Removal of foreign bodies from the external auditory canal
- Surgical management of exostosis
- Surgery for Middle ear effusions- Myringotomy/Tympanostomy Tubes
- Myringoplasty
- Tympanoplasty types 1,11, and 111
- Cortical Mastoidectomy
- Modified and Radical Mastoidectomy
- Surgical Management of complicated suppurative otitis media
- Ossicular Reconstruction
- Stapes Surgery
- Meatoplasty techniques
- Mastoid Obliteration Techniques
- Subtotal Temporal Bone resection and Lateral skull base surgery
- Middle Cranial Fossa approaches
- Posterior Cranial Fossa Approaches
- BAHA techniques
- Cochlear Implantation techniques
- Role of Adenotonsillectomy to middle ear health and Eustachian tube dysfunction
- Surgery For Vertigo
Diseases of the nose and para nasal sinuses

- Congenital defects of nose
- Benign and Malignant lesions of nasal skin
- Choanal Atresia
- Cleft Lip and Palate
- Rhinitis
- Sinusitis
- Fungal Rhinosinusitis in African Populations
- Epistaxis,
- Nasal and facial fractures
- Allergic rhinitis and sinusitis
- Chronic Hypertrophic Allergic Rhinosinusitis
- Nasal polyposis
- Mucoceles
- Benign and Malignant tumours of the nose and para nasal sinuses
- Benign and Malignant Tumours of the Nasopharynx
- Angiofibromas
- Ossifying fibromas of facial bones, nose and sinuses
- Facial Pain and Headache
- Smell and Taste Disorders

Surgery of the Nose and Sinuses

- Surgical Management of Benign and Malignant Nasal skin lesions
- Facial flaps for nasal reconstruction
- Glabellar flaps for total nasal reconstruction
- Surgical Management of vestibular stenosis
- Removal of foreign bodies from the nose and sinuses
- Nasal cautery techniques
- Nasal Granulomas
- Surgical reduction of Inferior turbinates
- Septoplasty techniques
- Septal Perforation Repair
- Intranasal Septorhinoplasty and Bony /Cartilagenous nasal reconstruction
- External Septorhinoplasty
- Surgery for epistaxis
- Sphenopalatine art. Ligation
- Trans Maxillary Sinus Approach to Pterygopalatine fossa approach to maxillary artery ligation
- External Carotid artery Ligation for epistaxis
- Surgical Management of ossifying fibromas
- Lateral Rhinotomy
- Ext Maxillectomy
- Caldwell Luc Approach to Maxillary Sinus
• Surgical Management of Oroantral Fistula
  • External Frontethmoidectomy
  • Lynch Haworth incision and approach
  • Frontal Sinus Trephine
  • Frontal Sinus Obliteration Technique
  • Maxillary Sinus washout
  • Endoscopic sinus surgery for rhinosinusitis
  • Endoscopic Sinus surgery for epistaxis
  • Endoscopic Orbital decompression
  • Endoscopic Frontoethmoidectomy
  • Endoscopic Medial Maxillectomy
  • Facial degloving approach to angiofibromas and posterior nasal tumours
  • Dacrocystorhinostomy
  • Surgical Management of Complications in Endoscopic Sinus Surgery
  • Surgery of the Nasopahrynx

Diseases of the Throat, Salivary Glands, Pharynx, Larynx and Neck and Thyroid Gland

• Oral Cavity Infections
  • Adenotonsillitis and Quinsy
  • Sialadenitis
  • Oral Cavity Salivary Gland Calculi
  • Benign and Malignant Tumours of the Oral Cavity
  • Benign and Malignant Tumours of the Oral Vestibule
  • Oropharyngeal Tumours
  • Snoring
  • Stridor /Stertor
  • Hypopharyngeal tumours
  • Laryngeal Tumours
  • Paediatric airway problems
  • Paediatric Neck Masses
  • Benign and Malignant Neck Disease
  • Deep Space Neck infections
  • Benign and Malignant Disease of Salivary Glands
  • Benign and Malignant Disease of the Thyroid Gland
  • Benign and Malignant Disease of the Parathyroid Glands
  • Benign and Malignant Disease of the Cervical Oesophagus
  • Vocal Cord Paralysis and Videostroscopy
  • Laryngeal Trauma
Surgery of Pharynx, Larynx, Salivary Glands, Thyroid and Neck

- Adenotonsillectomy
- Direct Laryngoscopy
- Microlaryngoscopy
- Oesophagoscopy and Dilatation
- Bronchoscopy
- Foreign Body Removal from Upper Aero digestive Tract
- Emergency and Elective Tracheostomy
- Surgery for Pharyngeal Pouch
- Hemiglossectomy
- Composite Resection of Oral cavity/Oropharyngeal Tumours
- Surgery of Salivary Glands
- Thyroid Surgery
- Parathyroid Surgery
- Sistruncks Procedure
- Branchial Cyst Surgery
- Cystic Hygroma Surgery
- Selective, Modified and Radical Neck Dissections
- Partial, Supraglottic and Vertical Hemi and Total Laryngectomy
- Tracheoeosophageal Fistula formation for Voice Restoration
- Delto pectoral flap design
- Latissimus dorsi design
- Pectoralis major flap design
- Free Radial forearm composite flap design
- Free Fibular composite Flap design

Surgery ENT Surgeons Should be Familiar With

- Mediastinoscopy
- Pneuminecetomy
- Facial Plastic Surgery
- Gastric Pull up procedure

Ancillary ENT speciality knowledge

- Radiology in ENT
- Radiotherapy
- Chemotherapy
- Speech and Language and ENT surgery
- Microbiology of Head and Neck Infections and manifestations of HIV
- Statistics and ENT Literature Evaluation
- Pharmacology of ENT drugs
7.4 OTHER SURGICAL DISCIPLINES

Candidates for all FCS(ECSA) fellowship diplomas will be expected to have detailed specialist knowledge in their own field, but will also be able to have reasonable competence in dealing with emergencies in other disciplines. In particular they will be expected to be able to deal with:

- Head injuries
- Chest injuries
- Spine injuries
- Limb injuries
- Acute abdominal emergencies
- Caesarian section

Candidates will be expected to be able to perform endotracheal intubation and perform simple general anaesthesia using intravenous or inhalational agent. They will also be expected to be able to use local anaesthesia safely and perform regional and spinal blocks.