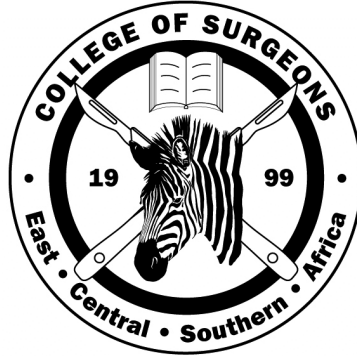


College of Surgeons of East, Central & Southern Africa



Regulations and Syllabus relating to
Fellowship Examination
In General Surgery

FCSgen(ECSA)

2016 edition

COSECSA, PO Box 1009, Arusha, Tanzania
Tel (+ 255) 27 2549362; email: info@cosecsa.org
Website: www.cosecsa.org

COLLEGE OF SURGEONS OF EAST, CENTRAL AND SOUTHERN AFRICA

Regulations and Syllabus for Fellowship Examination in General Surgery leading to the qualification of FCSgen(ECSA)

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1. Introduction

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

The Fellowship examination in General Surgery leads to the qualification of Fellow of the College of Surgeons of East, Central and Southern Africa, FCSgen(ECSA). This fellowship is recognition that the candidate has reached the level of knowledge, understanding and practice of surgery 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.

The information given in this document is intended as a guide to persons sitting the College examinations and shall not be deemed to constitute a contract or the terms thereof between the College and a candidate or any third party, or representations concerning same.

The College is not responsible and shall not be bound by errors in, or omissions from these regulations; the College reserves the right to revise, amend alter or delete academic regulations at any time by giving such notice as may be determined by COSECSA Council in relation to such changes.

2. Registration as a Trainee

Applications to register as a trainee must be made online on the COSECSA website. In order to register you will need an electronic copy of your primary medical qualification, your medical council (or equivalent) registration, a passport-style photo, and, if applicable, copies of any other surgical qualifications you may have. Applications will only be accepted online. Applications will be assessed by COSECSA, and if found suitable, applicants will be accepted to the training programme provisional upon payment of the programme entry fee.

The programme entry fee can be paid online, by bank transfer to the COSECSA Secretariat bank account in Arusha, Tanzania or to the COSECSA Country Representative. Please see the COSECSA website for details of all fees.

On receipt of the registration fee, the Secretariat will send the candidate:

- Personal login details, which will allow access to the COSECSA Electronic Logbook and e-learning platform (School for Surgeons)
- Assessment forms to be filled in at the end of every training post by the trainee and the supervising consultant.
- A registration number, which remains unique to the candidate.

3. Training Requirements

All requirements below will need to be fulfilled without exception.

- 3.1. Before being eligible to sit for the fellowship examination in general surgery, candidates will be required to be registered with the College (see Section 2 above).
- 3.2. Candidates must be registered in the FCS General Surgery training programme for at least three years before appearing in the FCSgen Examination. Registration by the end of February in a given year allows that year to count as a full year of training and will enable the candidate to sit the Clinical/Oral examination at the end of the following year.

- 3.3. Candidates for the fellowship examination in general surgery should normally have passed the membership examination of this College and possess the qualification MCS(ECSA).
- 3.4. Candidates are required to have spent three years in supervised COSECSA accredited training posts. Of these three years, one and a half years must be spent in a general surgical unit dealing mainly with adult abdominal surgery. The remainder of the time can be spent in units specialising in other branches of surgery, for example: thoracic, urology, trauma, paediatric surgery and plastic surgery, provided that these units deal with emergencies on a regular basis.
- 3.5. Of the three years, up to six months may be spent outside the region in a post that has been prospectively agreed with the COSECSA Examinations and Credentials Committee. This post may be in an elective unit.
- 3.6. Candidates are reminded that it is in their interest to experience a wide spectrum of surgical disciplines.
- 3.7. Exemption to the requirement of possessing the MCS(ECSA) qualification may be given to those who have passed an equivalent examination. In order to obtain an exemption, applicants must either:
- Have completed an MMed(Surgery) qualification in one of the constituent COSECSA countries or in a COSECSA accredited training centre outside the COSECSA region, and provide evidence of three years of specialty training in general surgery as described in section 3.4. For applicants completing a four year MMed(Surgery) programme the minimum further requirement is one year in a COSECSA accredited training programme. For candidates completing a four year MMed(Surgery) programme the minimum further requirement is two years in a COSECSA accredited training programme.
 - Have completed FRCS, FCS(SA) or another similar specialist qualification and be working as a specialist in a COSECSA country. 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.
 - Candidates who are granted exemptions will be required to register with COSECSA by the end of February in the year in which they intend to sit the examination.
- 3.8. Candidates will be required to complete at least 6 (out of a total of 10) FCS General Surgery cases on www.schoolforsurgeons.net in each year of their training.

4. Logbook

COSECSA is transitioning from the use of a paper-based logbook to an electronic logbook. FCSgen candidates for the examination in 2017 and in all subsequent years are required to use the COSECSA electronic logbook. Candidates for the 2016 examination may use the paper based logbook as used in previous years.

Paper based Logbook (for candidates for the 2016 FCSgen examination)

During the training period candidates must keep a logbook recording all of their training experience. The book should be available for inspection at any time by the Country Representatives. Consolidation sheets should be filled in every 6 months and a final consolidating sheet filled in to cover 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 Country Representatives should check the logbook for completion, fill in and sign a checklist which remains at the front of the logbook.

At the August council meeting of each year, the Country Representatives will hand over to the Examinations and Credentials Committee Panel head, a copy of the checklist together with copies of the Training post assessment form, Trainee assessment form and the final consolidation sheet (up to August) of all the candidates taking the examination that year.

Before the start of the clinical and oral examinations, the logbook should be handed to the examination administration secretary. Proof of attendance at an approved Basic Surgical Skills course, Basic Surgical Science course and Critical Care or Trauma Course should be brought to the oral examination. Candidates will not be allowed to sit for the examination if this is not done.

Electronic Logbook (for candidates for the 2017 FCSgen examination, and all subsequent examinations)

Candidates are required to log all operations for the duration of their training period in the electronic logbook. In advance of the examinations, details from each candidate's electronic logbook will be made available to their Country Representatives and the COSECSA Examinations and Credentials Committee. At the examinations details from each logbook will be provided to the relevant oral examiners. Only operative experience logged in the electronic logbook will be taken into account and candidates will not be allowed to sit for the examination if operative experience is not adequately recorded.

At the August council meeting of each year, the Country Representatives will hand over to the Examinations and Credentials Committee Panel head, a copy of the Training post assessment form and Trainee assessment form.

Before the start of the clinical and oral examinations, a print out of the electronic logbook operations list (signed by the trainee's supervisor) and consolidation sheet should be handed to the examination administration secretary. Proof of attendance at an approved Basic Surgical Skills course, Basic Surgical Science course and Critical Care or Trauma Course should be brought to the oral examination.

5. Application to Sit Examinations

- 5.1. Candidates should submit the examination fee by the end of July in the year of their exam. Please see the COSECSA website for details of all fees. Examination fees can be paid online, by bank transfer to the COSECSA Secretariat bank account in Arusha, Tanzania or to the COSECSA Country Representative.
- 5.2. On receipt of the examination fee, candidates will be informed of the precise times, dates and places for the exams.
- 5.3. By applying to the examination a candidate agrees to be bound by the rules and regulations of the College.
- 5.4. If a candidate withdraws from an exam not less 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 Council.
- 5.5. Candidates must pass the examination within four years of their first attempt. After this they will not be allowed to re-sit. A total of four attempts only will be allowed.
- 5.6. Candidates who pass the written examination but fail the oral and clinical examinations, may attempt the oral and clinical examinations for a maximum of two more years without having to rewrite the written examination, all within a period of four years in total.

6. Examination Format and Conduct

- 6.1. The standards of the examination will be set by the Examinations and Credentials Committee of the College, which will recommend to Council those standards required by both examiners and candidates. A panel of

examiners will be chosen by the Examinations and Credentials Committee from amongst Fellows of the College for each examination. A register of examiners will be kept by the chairman of the Examinations and Credentials Committee. 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 who will be appointed by Council on recommendation of ECC. The role of the external examiner(s) is to:

- Moderate the written question papers
- Assist with the examination of candidates
- Provide external independent assessment of the examination
- Report on the conduct of the examination to the College Council.

6.2. The written FCSgen (ECSA) examination will be comprised of 2 papers. The first paper will consist of single best answer multiple-choice questions. The second paper will consist of extended matching and/or short answer questions and/or single best answer multiple-choice questions.

6.3. Candidates who pass the written examination will be invited by the Chair of the Examinations and Credentials Committee to the clinical and oral examination. Candidates who do not pass the MCQ section will not be invited to the clinical and oral examination.

6.4. Candidates who pass the written examination will be invited by the Chair of the Examinations and Credentials Committee to the clinical and oral examination. Candidates who do not pass the MCQ section will not be invited to the clinical and oral examination.

6.5. There will be two 30 minute orals. A clinical examination takes place at the same time and at the same site as the oral. This will be comprised of six 20 minute cases.

6.6. Candidates have to pass the written examination and the clinical and oral examination in order to pass overall. The written examination 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 COSECSA Country Representative shall be the Chief Examiner.

6.7. The examination papers will be set by members of the examination committee and independently moderated by an external examiner.

6.8. No details of marks will be issued to Country Representatives or candidates. Candidates should bring proof of identity. As discussed in Section 4, candidates using paper logbooks should bring these, and candidate using the COSECSA electronic logbook should bring signed printouts of these.

- 6.9. If a candidate fails their clinical examination then they may attempt the clinical examination for a maximum of 2 more years without having to rewrite the written examination.
- 6.10. The chairman of the examination panel will endeavour to minimise the chance of a candidate being examined by an examiner from their own training institution.
- 6.11. 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.
- 6.12. For each candidate who fails the exam, the Board will allocate a Fellow of the College (usually a member of the panel of examiners) who will communicate with the candidate and offer advice as may be indicated. Details of marks will not be given.
- 6.13. 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 Appeals Committee to investigate the appeal, and require a written report to be filed by the Chairmen of the panel of examiners and the Examination Board. The Appeals Committee will then take all considerations and its own findings into account and recommend a decision which will remain final and binding.

7. Syllabus

The fellowship examination in general surgery of the College is an examination aimed at assessing competence in general surgery at a consultant or specialist level. The syllabus below is an outline of what the candidate will be expected to know. It is not exhaustive, but provides a guideline to the topics candidates should understand and operative procedures with which they should be familiar. It should be noted that section 7.15 includes topics that are not always included in the term “general surgery.” This section is included because in this region of Africa many surgeons practice in areas where they might be the only surgeon available or might be covering at night for colleagues in other surgical disciplines. The level of competence expected in the topics of section 7.15 will not be at a specialist level, but the candidate should have a sufficient understanding and skills necessary to provide adequate emergency care.

Topics and practical procedures in italics are not practised widely in this region so the candidates will not be expected to know about them in detail, or to have practical experience

TOPICS	PRACTICAL PROCEDURES
<p>7.1 Non Trauma Emergency Surgery</p> <p>Assessment of the acute abdomen Biliary tract emergencies Acute pancreatitis Swallowed foreign bodies Gastrointestinal bleeding Appendicitis and right iliac fossa pain Abdominal pain in children Peritonitis Acute intestinal obstruction Intestinal pseudo-obstruction Strangulated hernia Intestinal ischaemia Toxic megacolon Acute ano-rectal sepsis Ruptured aortic aneurysm Acutely ischaemic limb Acute presentations of urological disease Acute presentations of gynaecological disease Scrotal emergencies in all age groups <i>Diagnostic laparoscopy</i></p>	<p>Closure of perforated peptic ulcer, open and laparoscopic Endoscopy for upper GI bleeding Operations for GI bleeding including partial gastrectomy Emergency cholecystectomy Emergency hernia repair Laparotomy for small bowel obstruction Small bowel resection Ileostomy Laparotomy for large bowel obstruction Laparotomy for perforated colon Hartmann's operation Colostomy Appendicectomy Drainage of ano-rectal sepsis Laparotomy for post operative complications Urethral catheterisation Suprapubic cystostomy Exploration of scrotum Reduction of paraphimosis Embolectomy Fasciotomy <i>Organ retrieval for transplantation</i></p>
<p>7.2 Trauma Surgery</p> <p>Assessment of the multiple injured patient including children Closed abdominal injuries, especially splenic, hepatic and pancreatic injuries Closed chest injuries Stab and gunshot wounds Arterial injuries</p>	<p>Injuries of the urinary tract Initial management of head injuries and interpretation of CT scans Initial management of severe burns Tracheostomy Emergency thoracotomy Splenectomy for trauma Laparotomy for abdominal injury</p>
<p>7.3 Surgical sepsis</p> <p>Superficial sepsis and abscesses Pyomyositis Abdominal sepsis Empyema and thoracic sepsis Intracranial sepsis</p>	<p>Tuberculous disease of the chest and abdomen Drainage of superficial abscesses Laparotomy for sepsis Chest drainage for sepsis Thoracotomy for sepsis Burr holes and craniotomy for intracranial abscess</p>
<p>7.4 Critical care</p> <p>Hypotension Haemorrhage Haemorrhagic and thrombotic disorders Blood transfusion and blood component therapy Septicaemia and the sepsis syndrome Antibiotic therapy and the management of opportunist infection Gastro-intestinal fluid losses and fluid balance, including in children Nutritional failure and nutritional support Respiratory failure Renal failure and principles of dialysis Fluid overload and cardiac failure Myocardial ischaemia Cardiac arrhythmias Multiple organ failure</p>	<p>Pain control Cardiac arrest, respiratory arrest and brain death <i>Organ donation</i> Hypo and hyperthermia Diagnosis of brain death <i>Legal & ethical aspect of transplantation</i> Tracheal Intubation Tracheostomy Surgical airway Cardio-pulmonary resuscitation Chest drain insertion Central venous line insertion Insertion of peritoneal dialysis catheter Primary vascular access for haemodialysis</p> <p>A detailed knowledge of the methods and results of invasive monitoring will <i>not</i> be required</p>

<p>7.5 Gastrointestinal surgery Neoplasms of the upper GI tract Gallstone disease Jaundice Gastro-oesophageal reflux and its complications Hiatus hernia Peptic ulceration and its complications Radiation enteritis <i>Neoplasms of large bowel</i> Diverticular disease Irritable bowel syndrome Haemorrhoids Anal fissure <i>Rectal prolapse</i> Fistula in ano Diverticular disease/fistula Colostomy complications <i>Ileostomy complications</i> Inflammatory bowel disease (inc medical management)</p>	<p>Diagnostic upper GI endoscopy <i>Laparoscopic cholecystectomy</i> <i>Conversion to open cholecystectomy</i> Exploration of common bile duct Biliary bypass Gastrectomy Splenectomy Proctoscopy/rigid sigmoidoscopy Flexible sigmoidoscopy & colonoscopy, diagnostic and therapeutic Outpatient haemorrhoid treatment Haemorrhoidectomy Procedures for fistula in ano Right hemicolectomy Left hemicolectomy Sub-total colectomy Resections for rectal cancer, restorative and excisional Ileorectal anastomosis Panproctocolectomy Closure of Hartmann's procedure Rectal injuries</p>
<p>7.6 Surgery of the skin & integument Pathology, diagnosis and management of skin lesions, benign and malignant Basal and squamous cell carcinoma Malignant melanoma Other skin cancers</p>	<p>Excision of skin lesions Excision of skin tumours Split and full thickness skin grafting Node biopsy Block dissection of axilla and groin Surgery for soft tissue tumours including sarcomas</p>
<p>7.7 Endocrine surgery / neck surgery Diagnosis & management of neck lumps</p> <p>Physiology & pathology of: <i>Thyroid</i> Parathyroid Adrenal cortex Adrenal medulla</p> <p>Management of: Thyrotoxicosis Adrenal insufficiency Hyper and hypo thyroidism Carcinoid syndrome Anaesthetic and pharmacological problems Imaging techniques for endocrine organs</p>	<p>Thyroid lobectomy Retrosternal goitre Thyroglossal cystectomy Submandibular salivary gland excision Parotidectomy Approach and exploration of adrenal glands</p>
<p>7.8 Breast surgery Carcinoma of the breast Benign breast disease Hormone therapy for benign and malignant breast disease Histo-/cytopathology Mammography Ultrasound Adjuvant chemotherapy: Chemotherapy for advanced disease Radiotherapy Counselling Hospice care</p>	<p>Treatment of breast abscess Fine needle aspiration cytology Trucut biopsy Excision of breast lump Mastectomy Wide excision of breast tumours Axillary dissection with other breast operations</p>
<p>7.9 Hernias External and internal abdominal herniae. Anatomy, presentation, complications Hernia in childhood</p>	<p>Surgery for all abdominal herniae, using open <i>and laparoscopic</i> techniques Repair of childrens' herniae</p>
<p>7.10 Urology Undescended testicle Development and natural history of the prepuce Pathology of the scrotum and its contents Male sterilization, including counselling and informed consent</p>	<p>Operations for hydrocoele, epididymal cyst and varicocele Adult circumcision Vasectomy</p>
<p>7.11 Paediatric surgery Infantile pyloric stenosis Childrens tumours eg Wilms Congenital abnormalities of bladder and abdominal wall</p>	<p>Ramstedt's procedure Orchidopexy Circumcision in children</p>

<p>Anorectal anomalies Tracheoesophageal abnormalities</p>	
<p>7.12 Vascular surgery Atherosclerosis Ischaemic limb Aneurysmal disease Venous thrombosis & embolism Hyper-hypo coagulable state Chronic venous insufficiency Arteriography Vascular CT scanning <i>Magnetic Resonance Angiography</i> <i>Vascular ultrasound</i> Varicose veins Mesenteric ischaemia</p>	<p>Vascular suture/anastomosis Approach to/control of infra-renal aortic, iliac and femoral arteries Control of venous bleeding <i>Balloon thrombo-embolectomy</i> Amputations of the lower limb Fasciotomy Primary operation for varicose veins <i>Abdominal aortic aneurysm repair, elective and ruptured</i> <i>Femoro-popliteal bypass</i> <i>Femoro-femoral bypass</i></p>
<p>7.13 Research and ethics Critical appraisal of the surgical literature Scientific method & statistics as applied to surgery Informed consent Ethical aspects of surgical practice Genetic aspects of surgical disease</p>	
<p>7.14 Minimal Access surgery <i>Physiology of pneumo-peritoneum</i> <i>Informed consent for laparoscopic procedures</i> <i>Pre and post operative management of laparoscopic cases</i> <i>Port complications</i> <i>Technology of video imaging, cameras, insufflator etc</i> <i>Laparoscopic instruments, clips, staplers and port types</i> <i>Management of equipment failure</i> <i>Recognition and management of laparoscopic complications</i> <i>Use and dangers of diathermy</i> <i>Anaesthetic problems in laparoscopic surgery</i></p>	<p><i>Diagnostic laparoscopy</i> <i>Closed and open techniques of port insertion</i> <i>Laparoscopic biopsy</i> <i>Laparoscopic appendicectomy</i> <i>Laparoscopic adhesiolysis</i> <i>Thoracoscopy</i> <i>Laparoscopic suturing and knotting</i> <i>Control of laparoscopic bleeding</i></p>
<p>7.15 Other surgical specialties limb trauma Open and closed Fractures Dislocation of joints Nerve injuries Flexor and extensor tendon repairs Acute septic arthritis Spinal injury Head injury Open and closed Chest injuries Obstetric and gynaecological emergencies Anaesthesia</p>	<p>Open and closed reduction of dislocations Manipulation and POP splintage of fractures Skin and skeletal traction Open fracture debridement and external fixation Nerve repair Flexor and extensor tendon repair Surgical approaches to the joints and arthroscopy Emergency management of spinal injury Emergency management of closed and open head injury Burr holes and craniotomy Insertion and mangement of chest drains Thoracotomy and post operative management Approaches to the female pelvis Episiotomy Caesarian section Surgery for ruptured ectopic pregnancy Use of local anaesthesia Digital block Axillary block Spinal anaesthesia Use of ketamine Simple general anaesthesia</p>