Item D18834

Intercollegiate Specialty Examination in Plastic Surgery

Theme: Burn injury

Scenario: 55 yr old man sustained 34% burns to arms, legs and chest after his clothes caught fire from a gas fire in his house.

Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)
The patient has just entered ED, how would you manage him?

Key Points for Discussion:
ABCDE, Hx, expose, BSA, burn depth, resus, monitoring.

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)
How would you determine if this patient has an inhalation injury, how would you determine if this is a 'significant' injury? How would you manage an inhalation injury?

Key Points for Discussion:
Soot/burns in airway, CarboxyHb, increased ventilation pressure, direct pulmonary injury, other organ injury by COHB and other toxins like cyanide.
Oxygen dissociation curve shift to left, effect on PML's by oxygen free radicals. Management – ITU, steroids, NO, ECMO.

Question 3: (complications of management)
How would you manage this patient's wounds? What technology has changed this aspect of burn care in the last 20 years? What is the evidence and which advances would you use and why?

Key Points for Discussion:
Exn/tangential exn, grafting, skin substitutes (biobrane, integra, matriderm others), use of TNPT, Mx of antibiosis.

No exhibits

End of Item D18834

Item D35209

Intercollegiate Specialty Examination in Plastic Surgery

Theme: Aesthetic

Scenario: 38 year old lady with a BMI of 31 in your clinic has lost a lot of weight and is unhappy with her appearance

Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)
1. She's particularly unhappy with her breasts, how would you manage this?
2. She doesn't like the appearance of her abdomen, what can you offer her?

Key Points for Discussion:
Is she happy with the size? Would she prefer to be smaller? Assuming she wishes to be smaller what type of reduction would you do?
Does the candidate recognise that there's little breast volume and she is at risk of over-reduction. Discuss Free Nipple Graft versus pedicled technique in this scenario.

Type of abdominoplasty, standard pattern/Fleur de Lys/Belt Lipectomy/Body lift.

Relevant risks and complications including scars, asymmetry, nipple necrosis, techniques, haematoma, fat necrosis, infection, thromboembolic events, revision surgery.
Approved info sheet (BAPRAS, BAAPS) and arrange second appt. for further discussion at least 2 weeks later for a cooling off period.

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)
The patient is 3 weeks post- breast reduction and presents with a hard mass in the right breast? You did not notice it pre-op. She tells you there is a family history of breast cancer. What do you do?
Did you send the tissue off for histology? What are your reasons? What does the literature say?

Key Points for Discussion:
Fat necrosis versus breast pathology. Referral to the breast clinic for investigation which may include ultrasound, spot compression and biopsy if necessary. Check breast pathology from resection.
Should routinely send off tissue. What does the literature say? Some papers say no, some say all, some say over age 34, below is not worth it.

Question 3: (complications of management)
Histology report shows a 15 mm lobular carcinoma in the right breast reduction specimen of 600g. How would you deal with this scenario? What will you tell the patient and further management?

Key Points for Discussion:
Breaking bad news, how, where, with breast care nurse. Referral to breast mdt and need for follow-up. ? further imaging / breast surgery, nodal surgery. Is mammography
How would you do a SLNB in this patient, would you? Why? What does the literature have to say about this situation?

No exhibits

End of Item D35209

Item D36688

Intercollegiate Specialty Examination in Plastic Surgery

Theme: VPI

Scenario: A four year old child is referred to the cleft clinic by his GP because he has developed nasal speech and nasal regurgitation of food following adenoidectomy and tonsillectomy 6 months ago. The cleft speech therapist has assessed him and feels that he has cleft type speech due to inadequate velopharyngeal closure.

Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)
How would you manage this child?

Key Points for Discussion:
Oral examination for cleft/submucous cleft/scarring tethering of palate etc.
Good candidate will look for evidence of 22q11 microdeletion syndrome (characteristic facial features, history of cardiac surgery, immune deficiency, hypoparathyroidism).

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)
The palate shows a bifid ulvula and zona pelucida. What would you do next?
What palate repair would you do? How would you do it?

Key Points for Discussion:
Reasonable to proceed to palate repair without further investigation.
Some may do videofluoroscopy and/or nasendoscopy but probably doesn't change management.
Should warn parents that further surgery may be needed.
Radical muscle repair, intravelar veloplasty, Furlow – any recognised palate repair is acceptable.

Question 3: (complications of management)
6 weeks post op the child is back in clinic and parents report that he still has nasal speech and regurgitates food into his nose. What would you do?
After 6 months the lateral videofluoroscopy shows a mobile palate with good elevation and a "knee" in the posterior half of the velum, but it is too short to reach the posterior pharyngeal wall. What would you do?

Key Points for Discussion:
Examine repair to ensure that it is intact. Don't re-operate! Wait for 6 months for tissue equilibrium. Then consider formal reassessment of speech, videofluoroscopy and/or nasendoscopy.

This patient needs an operation, speech therapy will not cure a short palate.
Pharyngoplasty, pharyngeal flap, fat grafting of the posterior pharyngeal wall are all acceptable.
Should be able to discuss potential complications (nasal obstruction, sleep apnoea, fat embolism etc.).

No exhibits

End of Item D36688