

Intercollegiate Specialty Examination in Oral & Maxillofacial Surgery

Section A

Theme: Never Events

Scenario: Never Events

Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)

What do you understand by the term 'Never Events'?

Key Points for Discussion:

Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)

What do you think would constitute a 'Never Event'?

How may such events be avoided (Never Report 2011)?

Key Points for Discussion:

Wrong site surgery (excludes wrong site anaesthetic block)

Wrong implant prostheses inserted (excludes cases where implant does not fit and substituted or if based on clinical judgement at time of op – must be recorded in notes)

Retained foreign object after surgical intervention (eg swab/throat packs)

Accurate note keeping

Surgeon does consent

Checking consent

Marking patient

Make sure right patient

Minimising theatre changes/staff

Comply with 'WHO Surgical Safety Checklist 2009' and theatre protocols (Swab, instrument and needle counts: Managing the risks, 2005; Reducing the risk of retained throat packs after surgery 2009).

Question 3: (complications of management)

You are called to theatre and your SPR calls you to report that he has taken two canine teeth out which should have been exposed. The patient is 16 and still asleep. How would you proceed?

Key Points for Discussion:

Consider replantation

Accurate records

Critical incident report

Inform commissioners / CQC

Inform patient / parents

No exhibits

End of Item D32674

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Section B

Theme: Tracheostomy

Scenario: We are going to talk about surgical airway management



Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)

You are asked to perform a surgical tracheostomy in an intubated patient.

What steps need to be taken prior to the procedure?

Key Points for Discussion:

Check consent, position, WHO brief, check equipment and tube.

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)

What are your surgical options of creating a stoma?

Key Points for Discussion:

Permanent - stoma for self care. Allows tracheo-oesoph puncture for valve and voice restoration.

Temporary - window (not 1st ring or get stenosis, less than 1/3 of circumference, stay sutures),

Bjork flap (may create a path for replacement of displaced tube but risk of flap falling back leading to stenosis), vertical split (least stenosis risk but not in adults as rings calcified).

Question 3: (complications of management)

The day following the tracheostomy, you are called to see the patient as it has become difficult to ventilate the patient.

How would you assess the cause?

Key Points for Discussion:

Trachy causes e.g. displacement, obstruction, flap.

Other causes, pneumothorax.

Assess if displaced, safe change of trachy with scope or catheter, consider re-intubation.

No exhibits

End of Item D32332

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Section C

Theme: Cleft septo-rhinoplasty

Scenario: An 18-year-old male with a history of repaired unilateral cleft lip and palate is concerned regarding his blocked nose and difficulty breathing.

Introductory Question: (e.g. integration of information presented/application of basic principles to the situation described in the scenario/differential diagnosis)

What are the causes of nasal obstruction in general population?

Why do cleft lip and palate patients often complain of a reduced nasal airway?

Key Points for Discussion:

Mucosal congestion (common cold, allergic rhinitis, smokers), post-traumatic (acute/chronic), adenoidal hypertrophy, turbinate enlargement, foreign body, congenital (cleft, choanal atresia), iatrogenic (maxillary impaction), neoplastic.

Structural obstruction, mucosal congestion secondary to oro-nasal fistula

Question 2: (e.g. management, relevant applied pathophysiology, anatomy)

How would you assess this patient for a possible cause for his nasal obstruction and how could this help you to diagnose the cause?

Key Points for Discussion:

History

- unilateral or bilateral, constant or variability, duration, previous surgery or injury

Examination

- external nose (asymmetry, deviation), adequacy of nasal passages, Cottle's manoeuvre
- internal, direct inspection, rhinoscopy, nasendoscopy, nasal valve area, septum, upper and lower lateral cartilages, turbinates, nasal bones

CT/MRI

Question 3: (complications of management)

Where is the internal nasal valve area and how may this be opened to improve the nasal airway?

How could a small increase in size of the nasal valve result in significant improvement of the airway?

What warnings would you give?

Key Points for Discussion:

Between cartilaginous nasal septum and upper lateral nasal cartilage.

Place spreader graft, usually autologous cartilage – open approach septo-rhinoplasty.

For each incremental increase in capacity of the valve, the airway resistance is reduced by a power of four times.

Sub-optimal outcome, broader mid-dorsum of nose, septal perforation, bleeding, infection and graft loss.

No exhibits

End of Item D30164
