ECVO Residents only Meeting 2023 - Minutes

Ben Blacklock opened the meeting explaining that during that session Residents had time to ask questions to the ERC. He added that Simon Pot was attending as chair of the Examination Committee.

Q1: In the previous Information Brochure during the HED exam you had to fill in the form and keep it, but from what I understood from the previous session, you can also use a laminated one, is that correct?

Yes. The key is practicing the forms. You can take a photograph to have a copy of it, but we won't ask to see that.

Q2: On the online forms, where you log in the cases in the HED section, there is a different list of abnormalities than in Holland. And when I have a dog with multiple abnormalities, it will look like I have seen more HED cases than I have actually seen. E.g. because I have a PPM and a retinopathy it will look like I have seen two cases instead that single one.

Answer 2: (BB) Yes, that is a good point, please keep logging it. We will feed that back to the committee.

Q3: Last year we were promised to get on the surgical log that little button in the upper part of the page so that we don't need to scroll all the way down through 250 procedures. This hasn't been done, has it?

Answer 3: (BB) This has not been realized, that is true. Apologies – we will feed that back to the Committee.

Q4: I will have to submit my credentials in July, but my residency will end in October. I will be missing some equine cases at the time of submitting the credentials. Georgina Fricker just stated that all must be completed when submitting the credentials. Should I reschedule it and do it earlier?

Answer 4 (BB): Yes - we cannot issue the ERC completion certificate if you have not fulfilled the requirements. Please try to reschedule and do it earlier.

Q5: ExamSoft is amazing, but the exam fee is very high, and the fee of other colleges is not that expensive. The fee has never been as high as it is now, it has almost tripled, why?

Answer 5 (SP): Maybe for inflationary reasons, the costs have gone up. I am not aware the costs have gone up because of the online examination. I do know that we may actually pay more than other colleges, but we have extra support from Rob Malinowski. And I think it's invaluable. He does an extremely good job. He is always available during the entire sessions for the online examinations, although it's in the middle of the night for him because he is US based. And he does all the work, or a lot of the work afterward as well, other than the actual grading of the questions. But all the organization is done by him and I would be very hesitant to take that over from him because I think it reduces the risk of error basically along the way. So that might be the reason why we are more expensive with the online examinations than some of the other colleges. But again, I am not aware that the costs have been increased recently. If we are talking about 10 or 15 years ago, then yes, that might be, but I think that is more for inflationary reasons. I can ask the treasurer as this is more a question for the executive committee.

Q6: I have a question regarding the website and the surgical log: after the update of the Information Brochure, I noticed that Evisceration and Prosthesis is still a column on the surgical log. And my understanding from the new Brochure is that it's no longer required.

Answer 6 (BB): It is no longer required, as per the Information Brochure. There are going to be other updates to the procedures that will change shortly, and we will give notice of that, as some surgeries are getting outdated.

Q7 Who will these changes be applied to?

A7 (BB): Usually you will follow the Information Brochure that you started with. But often, where guidelines have been relaxed in an updated IB (e.g. removing a required procedure, or adjusting number of a species requiring to be examined), we will advise you to follow the updated requirements (only where the changes are beneficial to the Residents).

Q8: Are there any specific instruments required? Are any instruments not allowed?

A8 (SP): If these are appropriate instruments for that purpose then, yes, you can use them.

Q9 About species number: A person has seen 30 Bovines in her Residency, so about 10 per year, should they see more?

A9: (BB): These numbers are the recommended splits over the years. Technically you can see them all at once, but it may be better to spread them out over the residency. The total number is what is interesting in the end.

Q10: There was a comment made regarding a meeting at the faculty with all Residents from other colleges and they suggested to organise themselves and liaise with other Residents. There is a Dropbox account where things can be shared. They recommend sharing questions, discuss things etc. Is there a better platform for this purpose?

A10 (Resident) Negar sets up a group – if you want to be part of it sent an email. And please do not delete anything in the group.

Q11: Previously I have received feedback with my online submissions that Cadaver work done without the asterisk should be logged in "other" with the asterisk. So, with the updates of this year, do I need to go back and delete all of those?

A11: (BB) No do not delete anything. We had a debate about how to best log the cadavers recently. There were people who did lots and lots of cadaver surgeries and logged all of them and clinical cases got lost amongst all the cadaver surgery. It is recommended to keep the cadaver surgeries on an excel sheet. If some procedures are not sufficient in numbers, you can show that you did a high number of these procedures on cadavers at least. That could be useful.

Q12: When we log cases as first case or re-exam, there is not a huge amount of clarity in the information brochure about how you clarify that. And I 've found that even between our residents within our institution people log them differently. I basically log it based on how it's booked on the diary for simplicity. If it is a re-exam consult, I'd log it as a re-exam, other people log everything as a first case unless it's hospitalized and you are looking at it the next day and then it is a re-exam. I am just wondering if there is a bit of clarity as how we should be logging first case versus pre-exam.

Answer 11 (BB) Yes, good question. I always assumed it was as you are doing it, so you know, first case is the first time you see a case and a re-exam, the next time you see it. So actually, if a co-

resident has admitted something to the hospital for Phacoemulsification, then I would suggest that you could log that as a first case when you look at it first time in hospital and as a re-exam when you check it the day after surgery for example.

Q13: If a patient comes in as a re-exam in the system, but it is the first time you have seen that patient, can you log this as a first appointment? And if it is a case you have seen about a year ago and you have not seen it for a year, is this counted as a re-exam? But what if it is coming for a different problem?

A11: (BB) Please just use your discretion and be sensible. If you have examined the left eye a year ago and you are now examining the right eye, then it would be appropriate to log that as a new case. But if you see it three months later for the same condition, then it is a re-exam. We have no way of policing that, we require to trust you on that.

Q14: That is a good point: If a co-resident has seen a case under control and I saw it, it is no fun that she has her diagnosis. So, she thought of doing every control of mine as a re-exam rather than a first exam because she already knows what it is.

A14 (BB): Sure, if you think that this is more appropriate, so you have already discussed the case and you already know somebody else has already examined it and made the diagnosis and you want to log that as a re-exam, I think that is okay. In some ways it doesn't really matter in terms of the total numbers because we are interested in the total numbers at the end. When I investigate the forms, I do not look too closely at the new case versus re-exam. If there is a massive discrepancy , if someone e.g. saw 700 new cases and no re-exams than this would be weird and the same vice versa. Then we might start to worry. But most people seem to have a sensible ratio of new cases to re-examinations. Please do not worry too much about it, please do what feels right for the case, then that is okay. Please remember that the indicated is a minimum number and you should see a lot more. If there are some cases that you have "shared" with your colleagues, there is no problem with this, because you have all the other cases.

Q15: Do we bring our instruments and consumables ourselves? A crescent knife or trephine e.g.?

A15 (SP): Yes, all apart from liquids to flush (saline) and ordinary gloves. But anything else, like visco and blades, trephines, etc. please bring with you. Please note that different clinics will have different sets of instruments – so please bring all your consumables with you. If you need specific types of gloves (latex free), please bring them with you.

Q16:Do we need to bring drapes do we need to drape in the eye lid surgery for example?

A16 (SP): If you are comfortable with a specific type of draping, then yes, please bring it.

Q15: How to log patients that are in for longer and examined multiple times
A15 (BB): It is not intended that you log the same case over and over again during one hospital visit/during the management of the same disease. Unfortunately, the committee cannot provide clear guidelines dealing with all cases, as the circumstances will vary hugely. Please be sensible, discuss with your supervisor and you may exercise your discretion. Most residents examine far in excess of the minimum numbers. If you want to boost your numbers of patients, you can still do a short internship at another clinic for example.

Q16: Coming back to the question about draping, are you getting a deduction if you do not drape your cadaveric head?

A16: (SP): No, there will not be. But if you feel more comfortable by doing it, you won't get a deduction for doing it either.

Q17: Lately we discussed extraocular surgery between residents. We were wondering whether it is appropriate to tie suture material with fingers. Is that appropriate during extraocular surgery or not for the exam?

A17: (SP): I think that would depend on the situation and it would certainly depend on the size of the suture. Everything thinner than 6.0, you do not want to tie with your hands. But I am a little hesitant to give any common guideline or response to that. But if you use suture that is sizable enough then that would be okay.

Please note, the most important thing during all of these surgeries is your performance. If you are asked to perform a specific procedure or if you select a specific procedure, perform it correctly and be very careful and aware of tissue handling. Those are the two major things. And with tissue handling comes proper handling of instruments and proper handling of sutures. Those are the things the examiners are going to be looking for.

Please put away some concerns about fails and passes. The examination is all about doing the live animal examination in a structured, organized way. Look at the eye in periocular structures, do a structured and complete examination, tell us what you are doing. So, for example by going through the different structure, just say " I am checking this", "now I am checking that" – so we can check this off our list. You will also receive a form with an eye schematic – which you can use to draw in the lesions that you saw.

There is going to be a minimum of two examiners in the room with you. There can be three – this doesn't mean anything. They will have clipboards and will mark down things that you say, what you have seen, or during surgeries they mark down if you do certain things or do not do certain things. Do not be concerned about that – people writing down a lot doesn't mean that you are making a lot of mistakes. They will sometimes approach when you are examining the animal or during surgery, but again, that does not necessarily mean anything.

For the live animal examination, we are going to mark what you state (orally) and the things that you write down. If you saw a lesion, but you did not state that you saw it, nor write it down, we cannot know that you saw it and therefore we will assume that you did not. I think that is fair enough. If you either state it or write it down, then it is fine. I implore all of you to practice this with your mentors, both the clinical examinations and the surgeries. Just practice being in an examination session and go through these surgeries. Have your mentors critique you and make sure that you get your money's worth regarding your mentor supervising some of these cadaver surgeries. I think this is really important. That is maybe the most critical thing regarding exam preparation and then of course just doing it a lot.

Also, absolutely practice on cadaver tissues. Cadaver tissues handle differently from life tissue. For example, doing lid surgery in a cadaver head is not the same as doing lid surgery on a live animal. We will have tissues there that are amenable to surgical interventions, but it is different from live animals.

And the last thing about that is while practicing - and that is probably mostly about corneal surgery and regarding intraocular surgery – get yourself in trouble. Do practice a capsulorrhexis, make it go astray, make it divert and practice, explore up until what point you can confidently get it back under

control and how to do that. Because this is going to prepare you for the worst case – it is always good to have been in that situation before. The same with CCTs – why not prepare your lamellar graft and perforate the eye while doing it, then continue and complete the surgery? Because if that happens during the examination, that is not an imminent failure – but you will have to deal with it, you must get yourself out of that situation. And as this can happen in our job every day, it can also happen in the exam.

If you get a radial tear on your capsulorrhexis - we have seen people doing that during the examination – the proper thing at this point is probably to get your instruments out of the eye, take a deep breath, think about what has happened and tell the examiner. Do not think that they did not see it or anything. If you make a mistake, if you hit the endothelium, tell the examiner, and try not to do it again. Come up with a plan to finish the procedure or convert the procedure. Just think of what you would do in a patient at that point, because you would not just pack up and leave. So, this is how you need to get yourself out of that situation. I have seen these things happen and I have seen candidates pass that station with relatively high marks still. Because if you handle the situation well, it is okay.

And then one other thing: be tidy, it does not mean that we are going to take a ruler and measure how far your instruments are apart on the table, but if it is a pile of junk on your table, it is going to take some points off. It is not a big number of points, but it is going to take some points off. And if you are sloppy while handling tissues, e.g. you are grabbing, re grabbing, re grabbing – that is a couple of points off. Or for example, your sutures are all over the place, they are deep, they are shallow, they are long, they are short – that is a couple of points off. These things do not lead to direct fails, but they can add up and at some point, you fall under the 65 points mark. So be mindful of these things.

Q18: In the surgery room will there be 2 examiners?

A18: (SP) Yes, absolutely.

Q19: Regarding the eye lid surgery and the selection of techniques for eye lid surgery, you know there are 5000 of types what you can do with eyelids. What kind of eye lid surgery can it be in the exam?

A19: (SP) It can be anything, but what is typically going to happen is that you are either going to be presented with a problem, like a pug with lagophthalmus, it has got nasal pigmentation, we have got rolling in of lower eyelid, etc. – this is a problem, and we are going to ask you to solve that. But the problem you must focus on is the problem that is stated by the examiners. This is the problem that you are going to be asked to deal with and then you select an appropriate procedure. That can be one situation.

Another situation can be that you are asked to do a specific procedure, like a Kuhnt Szymanowski on a dog that has a lower lid ectropion , and you are asked to solve that problem with that particular technique. You are presented a problem, which is stated, or you are asked to do a specific procedure.

Q20: Is there a list of procedures of which we can be asked to do?

A20: (SP): Unfortunately, there is no list of procedures now, but it is not going to be an extremely exotic type of procedure. It is going to be one of the more common procedures. Do not worry about that too much! But practice techniques, especially if it is techniques that you do not necessarily do in your practice.

Q21: A related question: In term of the surgical aspect, just to make it clear, I can start a corneo-conjunctival transposition (CCT) for example and end up with the rotational pedicle flap and it will be still acceptable?

A21 (SP) If you are asked to do a CCT then no. It really depends on the actual situation. If you cannot get the requested procedure done, try to find a solution try to find an alternative.

BB asked if there was any other question? He explained that the entire Education and Residency Committee was happy to receive questions by email at any time. All of them know the situation and are very happy to help.

He thanks Simon Pot for attending remotely. SP added that there are members of the exam committee onsite at the conference and they are also very happy to answer questions. He invited the Residents to approach them in person or contact the committee by email.

The meeting was closed at: 12.55.