SURGERY OSPE VIVA BATCH 40
COMPILED BY: HASSAN AHMAD (BATCH 41 RMU)

--DR. IDREES WARD OSPE ANSWERS----

Station 1: Rectal carcinoma
Radical excision of rectum with mesorectum and associated lymph nodes. Assessment of spread by CT and PET scan to identify mets
Station 2: Diabetic ulcer management:
Management of local and systemic factors i.e. precise diabetic control is vital for wound resolution and minimizes recurrence. Management of contributing systemic factors like hypertension hyperlipidemia atherosclerosis obesity
Change in diet
Wound debridement: non-viable infected tissue is removed from ulcer
Wound coverage:
Apply sodium chloride dressing. Optimal wound coverage requires wet to damp dressing which supports autolytic debridement
Station 3:
All tumors of superficial parotid gland are managed by superficial parotidectomy whether benign or malignant
Radical parotidectomy in patients with clear histological evidence of malignant tumor
Facial nerve palsy indicates a malignant lesion with infiltration of nerve
Station 4: ERCP indications:
Diagnostic: Determines cause and level of obstruction of common bile duct
Bile can be sent for microbiology and cytological examination
Assessment of bile duct strictures by taking brushings from strictures for cytological studies
Therapeutic: stone removal or stent placement to relieve obstruction
Complication:
Pancreatitis
Intraluminal or intraductal bleeding
Perforation
Cholangitis
Cholecystitis

Station 5: ETT indications: When complete obstruction of airway is imminent i.e. respiratory burns, anaphylaxis
In unconscious patient to protect airway
To give positive pressure ventilation in patient with respiratory arrest
In general anesthesia
Complications: wrong size or misplaced can lead to hypoxia and death
Accidental intubation of esophagus
Oropharyngeal trauma
ETT inserted too far i.e. endobronchial intubation

Station 6: Intestinal clamp uses: Used for resection anastomosis in case of strangulated hernia

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Occlude Intestinal lumen to prevent slippage of contents
Controls bleeding

Station 7: Normal JVP is 3-4 cm from sternal notch
Complications of cvp: air embolism, hemothorax pneumothorax, AV fistula, arterial puncture with hematoma
Placed in subclavian vein internal jugular vein or femoral vein

Station 8:
Diagnostic Investigation: plain film radiographs, CT scan for staging, biopsy only after staging process is completed
Osteosarcoma treated with neoadjuvant chemotherapy and surgery i.e. amputation, excision alone, excision and replacement with graft or prosthesis

Station 9: Complications of hydatid cyst: rupture of cyst in peritoneal cavity causing peritonitis
Rupture through diaphragm producing empyema
Rupture into biliary tract causing obstructive jaundice or rupture into stomach
Management: medical: albendazole or mebendazole course
Surgical: liver resection or local excision of cyst or deroofing with evacuation on contents

Station 12: Ureteric stone management: NSAIDS for pain. Removal of stone by endoscopy or ureteroscopic stone removal or lithotripsy. Ureterolithotomy.
Metabolic abnormalities: hyperparathyroidism, hyperoxaluria, hypercalcemia, hyperuricosuria, cystinuria, chronic metabolic acidosis

Station 10: Diagnosis: Sialadenitis, sialothiasis or tumors Management: Submandibular gland excision for sialadenitis and salivary tumors.
Complications of surgery: hematoma, wound infection, marginal mandibular nerve injury, lingual nerve injury, hypoglossal nerve injury

Station 13: Pancreatitis
Conservative: keep NPO analgesics and anti-emetics if mild case.
Severe attack: admit in icu, analgesia, aggressive fluid resuscitation, measurement of vital signs, urine output and cvp. Supplemental oxygen and serial ABG analysis. Nutritional support if necessary. Prophylactic antibiotics to prevent local sepsis. CT scan if clinical deterioration. Treat underlying cause: ERCP to remove stone within 72 hours of onset of symptoms. Sphincterotomy or biliary stent placement in case if cholangitis.

Station 14: carpel tunnel syndrome
Median nerve involved

Station 15: cystic hygroma maybe

SU2 HFH OSPES----SU 2 HFH OSPE

1.Xray gas under diaphragm, diagnosis, management
2.laproscopic scissors identify uses
3.laproscopic camera identify uses
4.spleenic trauma
5.chlocystectomy identify complications
6.ct scan pancreatic ca identify complications management
7.ulcer over breast, identify, conditions leading, treatment
8.ureteric stone
9.exophthalmos, cause, treatment
10.babcock forceps, which structures to hold, which not
11.vericose veins points in history, treatment
12.cystic hygroma identify, treatment, complications
13.ulcer at back of neck in diabetic, identify. Immediate treatment, take home precautions
14.rectal prolapse identify, symptoms, causes, treatment in neonates
15.intestinal clamp. Structures to hold, not to hold

---SOME MORE SU1 BBH OSPES----

SU 1 BBH OSPE

1.calculate fluid requirement in patient with 30% burn and dose, complications of burn
2.enterocutaneous fistula
3.calculate ranson score. Treatment. Complications
4.ETt uses complications
5.RTA 90/50 b.p... which fluid to give? Approach? Death triad?
6.gas under diaphragm
7.ercp identify indications
8.intestinal obstruction identify x-ray...treatment.
9.post op thyroid hematoma. Identify... How to treat... Other complications of thyroidectomy

BBH SURGERY

Short cases

1) Breast lump,
2) para umbilical hernia,
3) bilateral hernia (direct and indirect) and
4) varicose (short sap. system was affected) in short cases.
5) MNG was present in the starting groups.

BBH SU1 SHORT CASES:

1) Thyroid
2) Incisional Hernia (command was to examine the abdomen)
3) Indirect Inguinal Hernia
4) Varicose Veins

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In short cases **Dr. Naeem Zia** was asking about investigations and management of varicose veins and DVT. And treatment options of indirect inguinal hernia

Long Case: Intestinal Obstruction (in a known case of rectal carcinoma who underwent APR with Permanent End Colostomy a month ago)

Dr. Tariq Nawaz asked:
Causes of intestinal obstruction
Investigations of intestinal obstruction
Management of Intestinal Obstruction
Treatment options for rectal carcinoma and why we didn't do Anterior Resection in this patient? (Chance of recurrence)
What is restaging?
How to detect recurrence of rectal carcinoma?
Complications of stoma?
How would you treat parastomal hernia?

Relocation of the stoma, with prophylactic mesh in a sublay position at the new site and sublay mesh repairing the incisional hernia at the primary site, is the standard method for treating parastomal hernia #PubMed

Restaging: A process used to find out the amount or spread of cancer in the body if it comes back or gets worse after treatment. Restaging may also be done to find out how the cancer responded to treatment

BBH SU2

Short cases:

1) Paraumbilical hernia
2) Inguinal hernia
3) Thyroid
4) Varicose veins

Short cases k liay bhot kam time day rahay thay . Even abhi aap inspection hi krty ho or sir puch lety hain beta what is your diagnosis. Koi b aap ki examinations skills or steps nahi dekh raha sahi say. short pay b theory-based viva ho raha hai almost. Is liay hernia thyroid breast or varicose veins ki theory sahi say kr k jao sub! Mayo repair??

Inspection or palpation thora jaldi jaldi krain but don't miss any steps and keep the diagnosis in mind. Jo k most probably aap ko pehlay say hi pata hon gain k ander kon kon say short cases paray hain. Presentation of findings jo k hum detail bolnay ki practice kr k gaey thay us ka koi scene nahi tha. They just wanna hear the exact word. Whether it is goiter, inguinal hernia, varicose veins etc.

On thyroid examination don't ask the patient to swallow. ask him to drink water. To check the tremors of hands you are supposed to place a paper on the out stretched hands. Yeh external nay sub ko kaha

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hai. They won't even allow you to expose the patient. Like varicose k liay sir nay Kaha bas neechay is patient ki shalwar KNEE tak kr lain. saphena varix b nahi dekh sakty aap! : Trendelenburg test bhi bas kapron k upar say hi kia phr main nay . So, it's all about theory-based viva. Lakin achi baat yeh hai k sub ko pass kr rahay.

In **SU1 OF BBH**, there was so much time to examine. Almost whole examination can be performed in that time. then they start like what are your findings,

perform ring occlusion test, what findings are in favour of your diagnosis, what are investigations treatment etc.
You got enough time to think about your viva questions even and while performing your examination, they are not looking at you

You have to properly expose the patient in front of them, then ap chahain to unko btayen k sir m foot end py gai, i asked him to cough, ask the patient in front of examiner, and show him bulge of swelling, and then explain why it is so.

Hmary 6 short cases thy and ap ko randomly khty k is bed py khray ho jao, phr baki sary apna perform krty rhty hn aur 2 logon ka viva chlta h, ek ka internal k pas ek ka external k pas, even ek do PGs jo sth ghom rhy hoty hn wo apko bta b jty hn diagnosis

LONG CASE (CA BREAST)
DR. TARIQ NAWAZ
- Diagnosis
- How is Breast CA investigated?
- What was the stage?
- How was she treated?
- MRM
- What is Level 2 of lymph node?
- Radical Mastectomy?
- What to do if the lesion recurs? Ans: Restage. Better to use CT or MRI this time.
- FNAC vs Trucut Biopsy

LONG CASE STOMA DUE TO PREVIOUS HISTORY OF ANAL ABSCESS
DR TARIQ
Summarize your case
What is necrotizing facitis
Classification of perianal abscess
Difference of ischiorectal and perianal abscess
How we identify
Treatment of perianal abscess. why we call patient after one month for follow up (There are chances of developing anal fistula there)

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OSPE:

1) Melanoma
2) Chest Drain
3) Hepatic metastasis CT Scan
   Observed:
4) How to put on Surgical gloves,
5) History of abdominal pain and weight loss for 2 months, Topics written in logbook.
6) Modified Radical Mastectomy
7) T tube cholangiogram
8) Fracture shaft of humerus X Ray.
9) Cystic Hygroma/Cervical lymphadenopathy

SHORT CASE:

1) Varicose vein (both short and long saphenous affected)
2) Lipoma/Sebaceous cyst in parotid region
3) Undescended testes.
4) Thyroid nodule.

OSPE:

MRCP, pancreatic pseudocyst, lipoma, fracture of femur treatment, gastric outlet obstruction, basal cell carcinoma, fogarty catheter, Testicular torsion pic,
Observed: Stiches lgana, history of a patient with H/O pallor and weight loss, Log book and viva of operations observed in wards.

SHORT CASES: Thyroid, indirect inguinal hernia, incisional hernia, varicose vein, ulcer- 2 krne the, on one station external on second external.

>In Stitches do see how to hold the needle holder and forceps. Take 1 cm margin from incision.
>Hernia questions.
Latest approach is Laparoscopy.
In bilateral hernia TEP is preferred.
Pre-operative investigation is USG pelvis to measure post void volume.

SURGERY

SU 1 BBH

ERCP pic, air fluid levels, achalasia bird beak appearance, breast lump differentials, tru cut biopsy needle, wrist drop, pneumothorax scenario

SU 2 HFH

Basal cell CA pic, Allies forceps, Proctoscope, CVP set, Marjolijn's ulcer, X ray air under diaphragm, varicose veins and thyroid examinations, parotid swelling scenario and pic, facial nerve palsy scenario

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QUESTIONS ASKED BY DR IDREES

Dr Idrees on short cases thyroid (diagnosis +management jo lafz bolo gy uci c next sawal. Y total y subtotal thyroidectomy. Malignancy k risk ktna hta MNG m.) incisional hernia (diff b/w recurrent n incisional. Factors causing jcy h kaho g faulty technique to sutures p ajain gy n how to avoid incisional hernia)

He wd ask v basics rather than procedures of choledeudonostomy
Dr Idrees CBD stricture k causes
Malignancy ko rule out krne k lia markers aur stricture benign ha ya malignant if ha to kse pta lgyga yani tumor marker
Ca 199 kis ka marker ha
ERCP k use
Agar lower CBD ka cancer ha then kia kro gy

Dr Idress....diagram of hepatobiliary system .... complication of gallstones and management...

my case "**cholelithiasis**"
Sir Idrees viva: P/C n provisional. Diagnosis. what is biliary colic? How to manage acute cholecystitis. What is gall stone ileus and where does the stone get impacted in this case (ileocecal junction). What is acalculous cholecystitis and in which patients does it occur.
External viva: P/C n diagnosis. Treatment of acute cholecystitis, why is the patient kept NPO, which antibiotics given, which analgesics given, when to perform cholecystectomy. N what is the point in favor of interval cholecystectomy. (Bowel rest. N diclofenac or in severe cases tramadol)

DR JSK most benign tumor of parotid
aur malignant kse pta lgy ga main history me
Parotid duct ki location
aur treatment of injury of facials nerve
Sign of frey syndrome
Dr. JSK most imp cause of hernia in males (BPH) ...Shouldice repair, management of hernia

There was picture from laparoscopic view and cystic artery was being ligated
Q: Konsa structure ligate KAR Rae HN
Slip sign in short case pooch Rae the
Carbuncle

DR IDREES

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8.ureteric stone
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DR JSK
Liver trauma
Carpel tunnel syndrome...Test for median nerve.
Rheumatoid arthritis
Laparoscopic scissors
Choledocholithiasis
Limb ischemia
Foot ulcer tha koi

DR HANIF simple viva lety hain ...
Jo common batin book main likhi ha asan b aur ziyada lamba b ni ... history b kehty hain summary btao.
Like murphy's sign
ERCP indication complication of lap coli ...