

VOLUME 1: STATIONS 1 AND 3

# An Aid to the MRCP PACES

FOURTH EDITION

R.E.J. Ryder, Afzal Mir and Anne Freeman



 WILEY-BLACKWELL



**An Aid to the MRCP PACES**

**VOLUME 1**

**STATIONS 1 AND 3**

*'MRCP; Member of the Royal College of Physicians . . .  
They only give that to crowned heads of Europe'.  
From The Citadel by A.J. Cronin*

Dear Reader of *An Aid to the MRCP PACES*

Please help us with the next edition of these books by filling in the survey on our website for every sitting of PACES that you attend. It does not matter if you pass or fail or pass well or fail badly. We need information from all these situations. These books are only as they are because of candidates in the past who filled in the surveys. Please do your bit for the candidates of the future.

The website where you can fill in the survey is **[www.ryder-mrcp.org.uk](http://www.ryder-mrcp.org.uk)**

Good luck on the day.

Best wishes,

*Bob Ryder*

*Afzal Mir*

*Anne Freeman*

# An Aid to the MRCP PACES

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## FOURTH EDITION VOLUME 1 STATIONS 1 AND 3

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A John Wiley & Sons, Ltd., Publication

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This edition first published 2012, © 1986, 1999, 2003 by Blackwell Publishing Ltd, 2012 by John Wiley & Sons Ltd.

Wiley-Blackwell is an imprint of John Wiley & Sons, formed by the merger of Wiley's global Scientific, Technical and Medical business with Blackwell Publishing.

*Registered office:* John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

*Editorial offices:* 9600 Garsington Road, Oxford, OX4 2DQ, UK  
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*Library of Congress Cataloging-in-Publication Data*

An aid to the MRCP PACES. – 4th ed. p. ; cm. Aid to the Membership of the Royal College of Physicians Practical Assessment of Clinical Examination Skills includes bibliographical references and index. Summary: "The first volume in this revised suite of the best-selling MRCP PACES revision guides is now fully updated. It reflects both feedback from PACES candidates as to which cases frequently appear in each station. Also taken into account is the new marking system introduced in which the former four-point marking scale has been changed to a three-point scale and candidates are now marked explicitly on between four and seven separate clinical skills"—Provided by publisher. ISBN 978-0-470-65509-2 (v. 1 : pbk. : alk. paper) – ISBN 978-0-470-65518-4 (v. 2 : pbk. : alk. paper) – ISBN 978-1-118-34805-5 (v. 3 : pbk. : alk. paper) I. Wiley-Blackwell (Firm) II. Title: Aid to the Membership of the Royal College of Physicians Practical Assessment of Clinical Examination Skills. [DNLM: 1. Physical Examination—Great Britain—Examination Questions. 2. Ethics, Clinical—Great Britain—Examination Questions. WB 18.2]610.76—dc232012020848

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: © Wiley-Blackwell  
Cover design by Sarah Dickinson

Set in 8.75 on 11.5 pt Minion by Toppan Best-set Premedia Limited

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# Preface

*'MRCP; Member of the Royal College of Physicians...They only give that to crowned heads of Europe.'*\*

## **A short history of *An Aid to the MRCP PACES***

*'Remember when you were young, you shone like the sun . . . .'*†

At the beginning of the 1980s, Bob Ryder, an SHO working in South Wales, failed the MRCP short cases three times.‡ On each occasion I passed the long case and the viva which constituted the other parts of the MRCP clinical exam in those days but each time failed the short cases. Colleagues from the year below who had been house physicians, with me the SHO, came through and passed§ while I was left humiliated and without this essential qualification for progression in hospital medicine. The battle to overcome this obstacle became a two or more year epic that took over my life. I transformed from green and inexperienced¶ to complete expert in everything to do with the MRCP short cases as viewed from the point of view of the candidate. I experienced every manifestation of disaster (and eventually triumph) recorded by others in Volume 2, Section F. By the time of the third attempt I was so knowledgeable that I was out of tune with the examiner on a neurology case simply because I was thinking so widely on the case concerned. || I believed at the time that I came close to passing at that attempt, although one never really knows and it was, after all, the occasion where I failed to feel for a collapsing pulse! \*\* This was an important moment in the story because it was from this failure, along with the experience in the neurology case in my second attempt¶ that the examination *routines* and *checklists*, which are so central to this book, emerged. I finally passed on the fourth attempt whilst working as a registrar. †† During the journey, various consultants, senior registrars and colleague registrars tried to help in their various ways and amongst these one of the consultants in my hospital, Afzal Mir, offered the advice that I should make a list of all the likely short cases and make notes on each and learn them off by heart. His exact advice was to 'put them on your shaving mirror'. An important

point should be made at this juncture. In order to be able to achieve this, one needed to attain the insight that it was indeed possible to do this. In those days there was no textbook for the exam, like the one you are reading, and there was no syllabus. Things had perhaps improved a little since the quote at the top of this Preface from A.J. Cronin,\* but nevertheless MRCP did carry with it an awe, a high failure rate and an aura that the exam was indeed one consisting of cases you had not seen before and questions you did not know the answer to. Indeed, many of us sitting it at the time would have found this a reasonable definition of the MRCP short cases. A crucial part of my two or more years, four-attempt, journey that formed the seed that eventually grew into the first edition of this book, was the realization that, in fact, behind the mystique the reality was that the same old cases were indeed appearing in the exam over and over again, that there was a finite list and, indeed, from that list some cases occurred very frequently indeed. ‡‡ The realization of this led me to do exactly what Afzal Mir had advised (without the shaving mirror bit!). At the time there was a free, monthly journal that we all received called *Hospital Update* and it had a regular feature dedicated to helping candidates with MRCP. In one issue the writer listed 70 cases which he reckoned were the likely short cases to appear in the exam and an eye-balling of this suggested it was fairly comprehensive.

And so I studied each of these 70 cases in the textbooks and made notes which were distilled into their classical features and other things that seemed important to remember and I wrote out an index card for each of the 70. Thus, the original drafts of the main short case *records* were penned whilst I was still sitting MRCP.

Another major contributor to my final success with the exam was junior doctor colleague, Anne Freeman. She had been on the Whipps Cross MRCP course with me prior to our first sittings of the exam and she passed where I had failed. Until that point, I think we would have considered ourselves equals in knowledge, ability

and likelihood of passing.‡ I would describe Anne as being like Hermione Granger.§§ In her highly organized manner she had written down the likely instructions that might be given in the short cases exam and under each had recorded exactly what she would do and in what order should she get that instruction. She then practised over and over again on her spouse until she could do it perfectly without thought or mistake or missing something out, even in the stress of the exam.\*\* I, on the other hand, was not like Hermione Granger. I could examine a whole patient perfectly in ordinary clinical life but had not actually thought through exactly what I would do, and in what order, when confronted with an instruction such as ‘examine this patient’s legs’ until it actually occurred in the exam.¶ And so eventually I did what Anne Freeman had done and the first versions of the *checklists* (for which I am especially grateful to my wife, Anne Ryder, who wrote them out tidily and then ticked off each point as I practised the examining, pointing out whenever I missed something out!) and primitive versions of the examination *routines* were born, again whilst I was still sitting MRCP.

Having finally passed the exam, it seemed a shame to waste all the insights into the exam and the experience I had gained, and all the work creating the 70 short case index cards and the examination *routine checklists* I had created and practised and honed so laboriously – and so I conceived the idea of putting them in a book for others to have the benefit without having to do so much of the work or, perhaps, to go through the ordeal of failing through poor preparation as I had done. I shortlisted what seemed to be the four major publishers of the moment and on a day in 1982 was sitting in the library of the University Hospital of Wales penning a draft letter to them. At a certain moment I got stuck over something – I have long since forgotten what – and on an impulse went down to Afzal Mir’s office to ask him something to do with whatever it was I was stuck over. It was a defining moment in the history of these volumes. When I exited Afzal Mir’s office the project had changed irrevocably. I was a registrar, he was a consultant. He was extremely interested in the subject himself and my consultation with him ended up with the project being one with both of us involved and me with a list of instructions (consultant to registrar!) as to what to do next!

And so an extremely forceful and creative relationship began, which led to *An Aid to the MRCP Short Cases*. It was not that we worked as a peaceful collaborative team – rather the thing came into existence through

creativity on a battleground occupied by two equally creative and forceful (in very different ways) people with very different talents and approaches. There are famous examples of this type of creative force, e.g. Lennon and McCartney or Waters and Gilmour.¶¶ Looking back, there is no doubt that without the involvement of myself and Afzal working together, an entirely different and inferior book would have emerged (probably the short 100-page pocket book desired by Churchill Livingstone – see below) but at the time I did not realize this and only thought that I was losing control of my project through the consultant-registrar hierarchy! My response was to bring in Anne Freeman, who I am sure would be very happy to be thought of as the Harrison/Starr or the Wright/Mason of the band!¶¶

Anne and I, in fact, also became a highly creative force through the development of the idea of surveying successful MRCP candidates to find out exactly what happened in the exam. It started off with me interviewing colleagues and this led to the development of a questionnaire to find out what instruction they had been given, what their findings were, what they thought the diagnosis was and their confidence in this, what supplementary questions they were asked, and their comments on the experience of that sitting. I distributed it to everyone I could find in mine and neighbouring hospitals, whilst Anne took on, with tremendous response, the immense task of tracking down every successful candidate at one MRCP sitting and getting a questionnaire to them! We asked all to report on both their pass and previous fail experiences.

Our overture to the publishers resulted in offers to publish from Churchill Livingstone (now owned by Elsevier Ltd) and Blackwell Scientific Publications (now owned by John Wiley & Sons) with the former coming in first and so we signed up with them. They were thinking of a 100-page small pocket book (70 brief short cases – a few examination routines, hardly any illustrations) sold at a price that would mean the purchaser would buy without thinking. The actual book however created itself once we got down to it and its size could not be controlled by our initial thoughts or the publisher’s aspirations. We based the book on the, by now, extensive surveys of candidates who had sat the exam and told us exactly what happened in it – the length and the breadth. This information turned the list of 70 cases into 150 and from the surveys also emerged the 20 examination *routines* required to cover most of the short cases which occurred. As to what should be included with each short case, that was determined by

ensuring that we gave everything that the candidate might need to know according to what they told us in the surveys. We were determined to cover everything that the surveys dictated might occur or be asked. It was also clear that pictures would help. We battled obsessively over every word and checked and polished it until it was as near perfect as possible. By the time it was finished three years later, the 100-page pocket book had turned into a monster manuscript full of pictures.

I took it to Churchill Livingstone who demanded that it be shrunk down to the size in the original agreement or at least some sort of compromise size. We were absolutely certain that what we had created was what the MRCP short case-sitting candidates wanted and we refused to be persuaded. And so we were rejected by Churchill Livingstone. This was a very depressing eventuality! I resurrected the original three-year-old offer letter from Blackwell Scientific Publications and made an appointment to see the Editorial director – Peter Saugman. I turned up at his office carrying the massive manuscript and told him the tale. Wearing his very experienced publisher hat he instantly and completely understood the Churchill Livingstone reaction but also understood something from my passion and certainty about the market for the book. He explained that he was breaking every publishing rule but that he was senior enough to do that and that he would go ahead and publish it in full on a hunch. In 1986, he was rewarded by the appearance of a 400-page textbook-sized book, which rapidly became one bought and studied by almost every MRCP candidate. Indeed, that original red and blue edition can be found on the bookshelves either at home or in their offices of nearly every medical specialty consultant in the UK.

After this, our first and best, we all pursued solo careers with Afzal making clinical videos of patients depicting how to examine them, and writing other books such as *An Atlas of Clinical Diagnosis* (Saunders Ltd, 2nd edition, 2003), Anne developing services for the elderly and people with stroke in Gwent, and me pursuing diabetes clinical research in various areas. Meanwhile, Anne in particular continued to accumulate survey data and in the second half of the 1990s we came together again to make the second, blue and yellow, edition of the book (1999). The surveys (which by this stage were very extensive indeed) had uncovered a further 50 short cases that needed to be included and the original material all needed updating.

Then, in 2001, the Royal Colleges changed the clinical exam to PACES. Until then the short cases exam had been a room full of patients of all different kinds with the can-

didate being led round them at random – according to the examiners whim – for exactly 30 minutes. Anything from 4 to 11 patients might be seen. This was now transformed into Stations 1, 3 and 5 of the PACES exam, each 20 minutes long, thus doubling the time spent with short cases and ensuring that patients from all the main medical specialty areas were seen by every candidate. Hence, *An Aid to the MRCP Short Cases* was transformed into *An Aid to the MRCP PACES Volume 1* with the short cases divided into sections according to the Stations. Specialists helped us more than ever with the updating and by now surveys had revealed that there were 20 respiratory cases that might occur, 19 abdominal cases, 27 cardiovascular cases, 52 central nervous system cases, 51 skin cases, 19 locomotor cases, 18 endocrine cases, 21 eye cases and 8 ‘other’ cases. The long case and viva sections of the old clinical exam were replaced by Stations 2 (History taking) and 4 (Communications and ethics). To help us with these we recruited new blood – a bright and enthusiastic young physician who had recently passed MRCP – Dev Banerjee, and he led on the Volume 2 project and finally in 2003 the third edition was published in silver and gold.

After many years intending to do this, we also created a medical student version of the short cases book on the grounds that medical student short cases exams are essentially the same as MRCP in that it is the same pool of patients and the examiners are all MRCP trained so that is how they think. However, whilst most MRCP candidates continue to use our books, most medical students have not discovered their version – it has the wrong title – medical students no longer have short cases exams – they have OSCEs! Those who have discovered it report that they have found it useful for their OSCEs.

And now the Royal Colleges have changed the exam again. And so *An Aid to the MRCP PACES* has become a trilogy. Stations 1 and 3 remain roughly the same and hence Volume 1 covers Stations 1 and 3 and Volume 3 has been created to deal with the new style of Station 5. Each short case has been checked and updated by one or more specialist(s) and these are now acknowledged at the start of the station concerned against the short case they have taken responsibility for. The same applies to the short cases in Station 5. Nevertheless, I have personally checked every suggestion and update and took final editorial responsibility, changing and amending as I thought fit. The order of short cases was again changed according to new surveys (now done online) and yet again a few more new short cases were found from surveys – only four for Volume 1 – kyphoscoliosis and collapsed lung for Respiratory, PEG tube for Abdominal and Ebstein’s anomaly for Cardiovascular. New young

blood has again been recruited – a further two bright, young and enthusiastic physicians. The updating of Volume 2 covering Stations 2 (History taking) and 4 (Communications and ethics) has been led by Nithya Sukumar. Volume 3, covering the new Station 5, has had major input from Ed Fogden.

We are grateful to the specialists, now listed in the appropriate sections, who have checked and updated the cases in their specialties, and especially grateful for the enthusiasm with which they have done this despite the considerable workload involved. We are grateful to Mrs Jane Price, patient representative and advocate at the

Royal Gwent Hospital, for her input into Volume 2, Station 4. Our surveys have always dictated the content of the books and so we are especially grateful to all the PACES candidates who have taken the trouble to fill in the on-line MRCP PACES survey at [www.ryder-mrcp.org.uk](http://www.ryder-mrcp.org.uk). Finally, we are particularly grateful to our colleagues for their support in the ongoing project, which is a considerable undertaking, and we reiterate the deep thanks to our families expressed in the previous prefaces.

*Bob Ryder*  
2012

\*From *The Citadel* by A.J. Cronin.

†From the song *Shine on You Crazy Diamond* by Pink Floyd from the album *Wish You Were Here*.

‡‘The result comes as a particular shock when you have been sitting exams for many years *without* failing them.’ Vol. 2, Section F, Quotation 374.

§See Vol. 2, Section F, Experience 108.

¶See Vol. 2, Section F, Experience 109.

|| See Vol. 2, Section F, Experience 145.

\*\*See Vol. 2, Section F, Experience 144.

††See Vol. 2, Section F, Experience 175. I measured my pulse just before going into start this, my final attempt at MRCP clinical, and the rate I remember is 140 beats/minute, but in retrospect I feel it must have magnified in my mind through the years –

nevertheless whatever it was it was very high. It is clear though that stress remains a major component of the exam – see Vol. 2, Section F, Experience 15.

‡‡See Vol. 2, Section F, Useful tip 328 and Quotations 349 and 411–415.

§§A prominent character in the Harry Potter books by J.K. Rowling. Highly organised; expert at preparing for and passing exams.

¶¶Lennon and McCartney were the writing partnership of the Beatles with Harrison and Starr as the other members of the band. Similarly Waters and Gilmore for Pink Floyd with Wright and Mason as the other band members. In both cases it is believed that there was a special creativity through the coming together of the different talents of the individuals concerned, though the relationship was sometimes adversarial.

## Preface to the third edition

The second edition of *An Aid to the MRCP Short Cases* comprehensively dealt with the old MRCP short cases exam. Stations 1, 3 and 5 of the MRCP PACES exam (Practical Assessment of Clinical Examination) have replaced this exam. Though the new exam is more structured and potentially more fair in several important ways, it is, in its essence, fundamentally the same exam, testing the same things. The skills and experience required to pass it remain the same, as do the many ways of failing it. Thus, the third edition of *An Aid to the MRCP Short Cases* has become *An Aid to the MRCP PACES*, Vol. 1 and we have been able to focus all that was helpful in the first two editions on the new format of the exam. This book deals with Stations 1, 3 and 5 of the MRCP PACES exam.

At the time of writing the exam remains relatively new, but we have already been able to undertake an initial survey. As with our previous editions this forms the basis of the book. Though smaller than previous surveys, candidates were again aware of our book and poured out information to us. On reflection, it is not surprising that we have found that the same old short cases continue to occur with frequencies that are not dissimilar. This is inevitable because the same patient pools are being tapped and the same patients lend themselves to testing the clinical skills that the College wishes to assess. In terms of frequency of occurrence, there are some notable exceptions. For example, the wider and earlier use of cardiac surgery has led to 'prosthetic valves' becoming the most common cardiac case, with 'mitral stenosis', which was the most common at the time of our first survey in the 1980s, now relegated to sixth most common as patients with this condition get fewer and are operated on earlier.

The new format of the exam has also had its effect. For example, the fact that there 'must be' a 'skin' case in Station 5 has meant that the majority of the small number of new short cases we have had to create for the new edition are 'skin' cases. Nevertheless, we have yet again found from the feedback from candidates in our survey that overall the cases seen, mistakes made or avoided, accounts of triumphs, tragedies and downward spirals remain remarkably constant as each sitting comes and goes.

We have during the first year of PACES been able to amass enough questionnaires from candidates to update the 'frequency of occurrence' figures and apply them to each of the subsections of Stations 1, 3 and 5. Because the new survey is as yet not great enough to cover all the less common short cases, we have adapted the figures from earlier surveys where there were inadequate data from the new surveys. In acknowledgement of the creation of Station 5, Locomotor, in PACES, we have created for this new edition two new examination *routines*: 'Examine this patient's knee' and 'Examine this patient's hip'.

In the guide notes for host examination centres, the College states: 'The patients attending the clinical stations should exhibit mainstream medical conditions. Patients with esoteric conditions are not suitable'. There is a problem, however, as to what constitutes an 'esoteric' condition. One physician's esoteric condition is another's extremely interesting and important one. Our survey suggests that the spectrum of patients being selected remains unchanged. Presumably the more there is a tendency to a consensus that a condition tends towards the esoteric end of things, the less likely such a patient is to be selected. On the other hand, less likely does not necessarily mean never, and this is reflected in the frequency of occurrence rates, which are sometimes very low indeed. Our own view remains that it would be a shame if clinical awareness of uncommon conditions was extinguished from the physicians of the future just because these conditions are rare or considered by some to be esoteric. What about the patient with an 'esoteric' condition? Would he/she not be horrified to learn that there was a policy that his/her condition no longer had to be studied and recognized in the way it had been by physicians in the past? We maintain our belief that failure to recognize a rare condition would never be an important pass/fail factor. On all types of cases, both 'easy' and 'hard', observation shows that some candidates perform well and others badly and all types of case can act as discriminators in one way or another. There is potential, with rarities, to show a breadth of clinical diagnostic skills which may distinguish a candidate from his/her peers.

Before coming to terms with rarities, however, you should ensure you can perform well with the more

commonly occurring short cases. As our overriding principle remains to translate the standards set by the Colleges, we have covered them all in this book – the common and rare with rates of frequency of appearance in the clinical exam given so that you can ensure that you establish your priorities appropriately.

Stations 2 and 4 are dealt with in a new book *An Aid to the MRCP PACES*, Vol. 2. The PACES survey has enabled us to further expand our collection of experiences and anecdotes that are now presented in Vol. 2. We have been able to present a number of hardly edited complete PACES accounts written in the first person. At the same time the similarity of Stations 1, 3 and 5 to the old short cases exam has meant that most of our older collection of experiences and anecdotes from our previous editions are as valuable now as ever and they have been retained.

## Medical Short Cases for Medical Students

In previous editions we encouraged medical students to use this book and many did. We have therefore written a medical student version, *Medical Short Cases for Medical Students*. We invite all of you who find this book useful to draw the attention of your medical students to the medical student version, to help with their clinical exams, whether OSCE or the traditional short case format.

## Acknowledgements

We are extremely grateful to the following for reviewing some or all of the second edition short cases and/or

examination routines related to their speciality. Many of these devoted a considerable amount of their valuable time to this task for no reward other than the accolade of ‘Speciality advisor to *An Aid to the MRCP PACES*, Volume 1’. We should stress that we did not necessarily always take the advice given but we hope the errors of fact are minimal. They are acknowledged in order according to the number of short cases they dealt with: S. Sturman (neurology), C. Tan (dermatology), T. Millane (cardiology), D. Banerjee (respiratory), S. Jones (endocrinology), D. Carruthers (rheumatology), P. Wilson (gastroenterology), P. Dodson (medical ophthalmology), J. Wright (haematology) and T. Pankhurst (renal). We are grateful to D. Banerjee who wrote the first drafts of two of the new short cases – stridor and lung transplant – and to D. Carruthers who wrote the first drafts of the new examination routines, ‘Examine this patient’s knee’ and ‘Examine this patient’s hip’.

We are grateful to so many candidates for their encouragement and enthusiasm and especially the many who have filled in questionnaires and to colleagues for their tolerance and support. Finally, we once again reinforce the gratitude, expressed at the end of previous prefaces, to our long-suffering families without whose forbearance and help the whole venture would never have happened.

*Bob Ryder*

*Afzal Mir*

*Anne Freeman*

2003

## Preface to the second edition

Following publication of the first edition, my co-authors continued making surveys of candidates and accumulated an overwhelming number of questionnaires finding that many candidates, now aware of our book, poured out information to us. These greatly reinforced the information found in our original surveys and presented in the first edition. We found another 50 short cases which we present in this new edition, yet overall the cases seen, mistakes made or avoided, accounts of triumphs, tragedies and downward spirals remain remarkably constant as each sitting comes and goes. Our much more limited time, now that I have also become a consultant, meant that we were not able to analyse the new surveys to anything like the same extent as in the original edition. Therefore we have not altered the 'frequency of occurrence' figures used in the first edition for the 150 short cases of that edition as we do not believe that a more superficial analysis of the new surveys would be as accurate. It is possible that, for instance, 'old tuberculosis' is occurring in the exam less often than it did as fewer patients who had a thoracoplasty all those years ago are still available (patients with similar signs due to partial or complete pneumonectomy may appear instead, however, and indeed this is one of the new short cases); similarly Fallot's tetralogy with a Blalock shunt. Nevertheless, the vast majority of cases seem to maintain a remarkably constant rate of occurrence.

We were able to assign an approximate occurrence rate for each of the additional 50 short cases so that they could be merged in with the original 150. One of the new short cases has come into existence since the first edition because of new College guidelines ('Resuscitation Annie') and one because of the spread of a new condition ('AIDS related'). Some of the new cases are relative rarities which appear in the exam just occasionally. We do not believe that such cases should be excluded from the exam. It would be a shame if clinical awareness of uncommon conditions were extinguished from the physicians of the future just because these conditions are rare. At the same time we do not believe that failure to recognize a rare con-

dition would ever be an important pass/fail factor in the MRCP short cases. A candidate seeing such a case is also likely to see a number of other more usual cases on which the main pass/fail decisions would be made.

Nevertheless, there is potential, with rarities, to show a breadth of clinical diagnostic skills which may distinguish a candidate from his/her peers. Before coming to terms with rarities, however, you should ensure you can perform well with the more commonly occurring short cases. In this book we cover them all – the common and rare with rates of frequency of appearance in the clinical exam so that you can ensure that you establish your priorities appropriately. The new surveys have enabled us to considerably expand the experiences and anecdotes in Section 4 and because candidates often 'knew what they were writing for', we have been able to present a number of hardly edited accounts written in the first person.

### Acknowledgements

We are grateful to the following for reviewing some or all of the first edition short cases and/or examination routines related to their speciality. We should stress that we did not necessarily always take the advice given but we hope the errors of fact are minimal. G.S. Venables (neurology), S. Sturman (also neurology), K.S. Channer (cardiology), E.E. Kritzingner (medical ophthalmology), P. Stewart (endocrinology), C. Tan (dermatology), D. Honeybourne (respiratory medicine), T. Iqbal (gastroenterology), M. El Nahas (renal medicine), D. Situnayke (rheumatology), D. Bareford (haematology), P. Harper (medical genetics), K.G. Taylor (lipids) and E. McLoskey (Paget's disease). There was also a contribution from A. Jackowski (neurosurgeon). We thank C. Tan for Figs 3.114b and c, and C. Ellis for Fig. 3.156b.

I am particularly grateful to my co-authors for their tolerance with regard to my contribution to the tardiness of the new edition; to colleagues, in particular Ken Taylor and Sharon Jones for their support; to Anne's family, Pete, Lizzie and Jonathan Williams for

what they have had to put up with; similarly to Lynda, Farooq, Deborah and Joanne Mir (especially for their wonderful hospitality during some crucial sessions over several days at Afzal's house); similarly and more so to my children Bobby and Anna for what they have had to put up with, but most of all sincere thanks

to my wife Anne, without whose support and tolerance, well beyond the call of duty, none of it could ever have happened.

*Bob Ryder*  
1999

# Preface to the first edition

The short cases part of the examination for the Membership of the Royal College of Physicians (MRCP) is, by tradition, considered to be the most critical test of bedside behaviour and diagnostic competence. It forms an important milestone in the development of practising physicians. There is, however, no formal syllabus or tutoring and, despite the high failure rate, there is a notable lack of books specifically written to help candidates with this test.

The spectrum of clinical conditions used in the short cases examination is determined by a variety of interchanging factors such as the availability of patients with demonstrable physical signs, the prejudice of the doctors choosing the cases, that of the examiners taking part in the examination and, occasionally, the speciality bias of the examination centre. The cases chosen by the examiners from those assembled on the day in turn determine the problems presented to the candidates and the clinical skills required of them. For this reason we decided to build this book around an extensive survey conducted amongst successful candidates. Our questionnaires yielded information about the cases presented, the questions asked, answers given and the reactions of the examiners. We have thus been able to identify the chief difficulties of candidates in dealing with this practical examination and have attempted to help with these. The advice in Section 1 on how to prepare for the short cases is based on, and illustrated by, the comments received from the candidates. Section 2 is written around the clinical instructions given by the examiners to the candidates, the likely diagnoses under each instruction as revealed in the survey, and details of the examination steps suitable for each command. Section 3 forms the bulk of the book and presents the clinical features of 150 short cases in order of the frequency of their occurrence in the examination as derived from our survey. Thus, priorities are sorted out for the candidates preparing for the examination. In the final section we pass on the experiences and advice of some of the candidates in our survey which we felt would be of interest.

In fulfilling our main task of helping candidates to improve their performance in clinical examinations, we have used three learning techniques which are rather

novel to this field. Firstly, the iterative approach which exploits the retentive potential of reinforcement by repeating the main clinical features of a number of conditions whenever any reference to these is made. It is hoped that this method will not only reinforce, but will also alert the candidates to other diagnostic possibilities when looking at a related condition. Secondly, in the examination methods suggested by us we have individualized the inspection to the examination of each subsystem, and have provided a *visual survey* to note the features most likely to be present. This enriches the usual advice to look for everything which often accomplishes nothing unless a specific sign is being looked for. Thirdly, we have reduced our suggested clinical methods to simple steps (*checklists*) which, if practised, may become spontaneous clinical habits, easy to recall and execute.

In the age of superspecialization, the task of summarizing and streamlining a subject as vast and diverse as general medicine to the needs of the short cases examinee has been formidable. We are in no doubt that our attempt will have its inadequacies and would be pleased if you would write to us (c/o Blackwell Scientific Publications) about any errors of fact, or with any suggestions which might be helpful for a future edition, or indeed with any other comments. We would also be interested to hear of any short cases which have occurred in the examination and which are not included on our lists (please give us an idea of your confidence that the case was indeed the condition concerned and why – clinical details, invigilator's confirmation, etc.) or of any Membership experiences which might be of interest.

## Medical student note

Although this book has concentrated exclusively on the needs of MRCP candidates, it is noteworthy that the cases included in undergraduate medical short cases examinations are drawn from the same pool as those used in the MRCP examination. Furthermore, physicians are all MRCP trained and tend to use the MRCP style in these examinations. Though clearly the required standard of performance is lower, we feel that medical students preparing for their short cases examinations would also benefit from using this book. It would be a

supplement to information gained from more comprehensive textbooks (we assume much basic knowledge) and an aid to practice on the wards.

### Acknowledgements

We are indebted to the late Dr Ralph Marshall and his team (especially Paul Crompton, Keith Bellamy, Steve Young and Adrian Shaw) in the Department of Medical Illustration at the University Hospital of Wales, and Nigel Pearce and Steve Cashmore at the Department of Medical Illustration at the Royal Gwent Hospital. A large proportion of the photographs in the book are from the archives of these departments.

We are grateful to all the patients who gave their consent to the publication of the photographs depicting their medical conditions. Our thanks are due to many colleagues who have allowed us to use photographs from their own collections and photographs of their patients including: T.M. Hayes, the late C.E.C. Wells, M.S.J. Pathy, R. Marks, the late R. Hall, J.G. Graham, B.H. Davies, P.J.A. Holt, J. Jessop, M.H. Pritchard, N.W.D. Walshaw, I.S. Petheram, J.M. Swithenbank, M.D. Mishra, B.D. Williams, I.N.F. McQueen, P.E. Hutchinson, J. Rhodes, C.A.R. Pippen, A.J. Birtwell, P.M. Smith, A.G. Knight, S. Richards, A.G. Karseras, J.P. Thomas, C.N.A. Matthews, P.J. Sykes, M.L. Insley, P.I. Williams, B.S.D. Sastry, J.H. Jones, M.Y. Khan, the late J.D. Spillane, K. Tayton, G.M. Tinker, A. Compston, B.A. Thomas, H.J. Lloyd, G.B. Leitch, the late B. Calcraft, O.M. Gibby, G.O. Thomas, E. Graham Jones, Byron Evans, D.J. Fisher, G.S. Kilpatrick, L.E. Hughes, P. Harper, G. Griffiths, A.D. Holt-Wilson, D.B. Foster, D.L.T. Webster, J.H. Lazarus, D. Beckingham, J.E. Cawdery, R. Prosser, M.F. Scanlon, M. Wiles, I.A. Hughes, the late O.P. Gray, E. Waddington and L. Beck. Figure 3.42b has already been published in *An Atlas of*

*Clinical Neurology* by Spillane and Spillane (Oxford University Press) and Figs 3.97b and 3.114 from the UHW Medical Illustration archives are also published in *A Picture Quiz in Medicine* by Ebden, Peiras and Dew (Lloyd-Luke Medical Books Ltd). Figures 3.115a (i) and (ii) are published with the permission of the Department of Medical Photography, Leicester Royal Infirmary and Fig. 3.110 with the permission of the University of Newcastle upon Tyne, holders of the copyright.

Our thanks go to colleagues who advised us on points of uncertainty in their fields of interest; especially A.C., B.H.D., M.J.D., L.G.D., R.H., T.M.H., M.H., T.P.K., I.N.F.M., M.D.M., M.F.S., H.S., P.M.S., S.S. and B.D.W.

We are obliged to: Andrea Hill for typing and retyping the manuscript; Janet Roberts for secretarial help with the survey; Jill Manfield for telephoning, chasing and writing again in pursuit of patient consents and for numerous minor secretarial chores; Alan Peiras for some nifty detective work in Edinburgh during the survey; Steve Young for the cover photograph for the book; and to certain pharmaceutical companies for financial assistance (including Astra Pharmaceuticals Ltd, CIBA Laboratories, May and Baker Ltd, Roche Products Ltd, Merck Sharp and Dohme Ltd and Thomas Morson Pharmaceuticals). Our particular thanks to Bayer UK Ltd for sponsoring the colour photographs.

Most of all we thank our long-suffering families without whose forbearance and help the book would never have been finished.

*Bob Ryder*

*Afzal Mir*

*Anne Freeman*

1986

# Introduction

*‘The result comes as a particular shock when you have been sitting exams for many years without failing them.’\**

From June 2001, the Royal College of Physicians replaced the traditional MRCP ‘clinical’ examination, consisting of 30 minutes of short cases, a long case lasting 1 hour and 20 minutes and a viva lasting 20 minutes, with the MRCP PACES exam (Practical Assessment of Clinical Examination). In Autumn 2009, the College changed the format of Station 5 of this exam. The candidate who reaches the MRCP PACES examination has already demonstrated considerable knowledge of medicine by passing the MRCP Part I and MRCP Part II written examinations. The PACES exam is divided into five stations, each of which is timed for precise periods of 20 minutes. Stations 1 and 3 are divided into two substations of 10 minutes each. The stations are:

Station 1	Respiratory system Abdominal system
Station 2	History-taking skills
Station 3	Cardiovascular system Central nervous system
Station 4	Communication skills and ethics
Station 5	Integrated clinical assessment

Stations 2 and 4 are dealt with in Volume 2 of *An Aid to the MRCP PACES*. For this new edition of *An Aid to the MRCP PACES*, a third volume has been added to deal with the new Station 5. Stations 1 and 3 represent a more structured version of the old MRCP short cases exam that we dealt with in the first two editions of *An Aid to the MRCP Short Cases* and are dealt with in Volume 1.

The marking system for PACES is subject to change and you should study it at [www.mrcpuk.org](http://www.mrcpuk.org). At the time of writing, marking was being done in the skills of:

- Physical examination
- Identifying physical signs
- Clinical communication
- Differential diagnosis
- Clinical judgement
- Managing patient concerns
- Managing patient welfare.

The following table shows, at the time of writing, the stations at which each of these skills are tested.

Skill	Station 1:	Station 1:	Station 3:	Station 3:	Station 4	Station 5:	Station 5:
	Respiratory	Abdominal	Station 2	Cardiovascular	Neurological	Brief clinical consultation 1	Brief clinical consultation 2
Physical examination	✓	✓	✗	✓	✓	✗	✓
Identifying physical signs	✓	✓	✗	✓	✓	✗	✓
Clinical communication	✗	✗	✓	✗	✗	✓	✓
Differential diagnosis	✓	✓	✓	✓	✓	✗	✓
Clinical judgement	✓	✓	✓	✓	✓	✓	✓
Managing patient concerns	✗	✗	✓	✗	✗	✓	✓
Managing patient welfare	✓	✓	✓	✓	✓	✓	✓

\*Vol. 2, Section F, Quotation 374.

At the time of writing the system is that, on the mark sheet, the examiner in the station concerned gives for each skill being tested in that station one of the following marks:

Satisfactory	mark = 2
Borderline	mark = 1
Unsatisfactory	mark = 0

If you study the marking system, and you can be bothered to do the analysis, you will be able to work out the minimum number of scores of 2 that you need assuming all other scores are 1. However, in practice this is probably of limited use because undoubtedly you will be trying to get a score of 2 in everything regardless. Two things are important however.

1. At the time of writing the College states on its website that:

*'The onus is on the candidate to demonstrate each of the skills noted on the marksheet for each encounter (see above table) and, in the event that any one examiner decides that a skill was not demonstrated by a candidate in any one particular task, an unsatisfactory mark (score = 0) will be awarded for this skill.'*

Thus, it is important to always be aware of the station that you are in and to be proactive, in as far as you can, in ensuring that you attempt to demonstrate your abilities in each of the headings concerned – the ones that are relevant to that station according to the above table. For example, with regard to Station 1 and 3, with only 10 minutes, it may easily occur that the bell has gone signalling the end of the 10 minutes before all of Physical examination, Identifying physical signs, Differential diagnosis, Clinical judgement and Managing patient welfare have been addressed. If you are still addressing differential diagnosis as the time is coming to an end it may be that you could deliberately move on to discussing management relevant to the patient concerned to demonstrate some knowledge in the area to give the opportunity to the examiner to give a score under the heading of clinical judgement other than zero.

2. It is essential to remember as you move from station to station that all 10 examiners mark independently and as you go into the next station the examiners have no idea how you did in the station you have just left so essentially you start with a blank sheet with them. If you have done badly in a station and fear you have scored some zeros these can be compensated for by scoring more 2s in other stations. In the five minutes between stations it is crucial to recharge yourself psy-

chologically, forget what has just happened in the station you have left and give yourself a complete fresh start – see 'Getting psyched up' in Section A.

Over the years, all have been agreed that the short cases examination is the major hurdle in MRCP Part II and with the advent of PACES the cases appearing remain as challenging as ever. For many who do fail, it is the first examination they have ever failed and it may also be the only examination they have taken that does not have some form of syllabus.

The exam is a practical test which assesses various facets of clinical competence in many subtle ways. Although it is generally accepted that clinical competence cannot be acquired from textbooks, a book such as this can provide indirect help towards that objective. We hope that the examination *routines* (Section B) together with the *checklists* (Appendix 1) may assist candidates in developing a keen sense of clinical search and detection. The short case *records* (Section C, Volume 1 and Section I, Volume 3) should provide the framework, i.e. the main clinical features, the discipline of how to look for them, how to differentiate the diagnostic from the incidental or associated findings, and how and when to be alert to other possibilities. By basing our book on the results of surveys of MRCP candidates (see below) we have *created a form of syllabus*, which we hope will be of value to future candidates. Not only do the results of the surveys advise as to what you are required to know and do, but they also grade these requirements in order of importance.

## The examination in Stations 1 and 3

*'I am sure they assess you very quickly...and decide whether they would like you to be in charge of their patients.'*\*

Two examiners will each take you for half of each 20-minute station. They each record a separate mark. At each case you will be given a written instruction, for example, 'This 48-year-old man has had a heart valve operation. He complains of recent shortness of breath on exertion but not at rest. Examine the cardiovascular system to see if you can establish the cause.' Nevertheless it is clear from our PACES survey that candidates translate the instruction into the traditional one: 'Examine this patient's heart'. We would counsel you to be careful on this point. Sometimes there is an important clue in the instruction. For example, one candidate in our survey (see Vol. 2, Section F, Experience 26) was asked to look at the patient and then listen to the heart. The

\*Vol. 2, Section F, Quotation 423.

diagnosis was Marfan's syndrome with a prosthetic heart valve and the clue in the instruction was that the candidate was specifically asked to look before examining. In the case of the patient with acromegaly and homonymous hemianopia described on the second page of Section B, the candidates were given the written instruction to inspect the patient and then undertake a visual field assessment. Many undertook their visual field examination without spotting the acromegaly and then got into difficulty putting the whole thing together accordingly.

During the examination the examiners are constantly testing your ability to *elicit and interpret physical signs*. Many examiners say that, in the final analysis, whether a candidate will pass or fail depends very much on the general air of competence or incompetence which prevails during his/her clinical performance. Many candidates who fail feel that the exam is unfair in one way or another (see Vol. 2, Section F, Experience 237). However, candidates are not in a good position to judge their performance. A candidate who diagnosed a patient with aortic stenosis (which the last three candidates before him all diagnosed correctly) as having mitral stenosis may never know of his error. Furthermore, it is more than just a question of getting the right diagnosis. One candidate who failed complained that he knew, because he had a contact at the examination centre, that he had got the right diagnosis in all except two of the cases he saw. He was reporting this during the feedback session of a subsequent mock exam which he had also failed. During that mock exam, after examining the wasted legs of a patient with myotonic dystrophy, his first suggestion as to the cause of the signs in the legs was 'cauda equina lesion'. He eventually got to the correct diagnosis but his initial responses left a poor impression on the mock examiners, especially since other candidates in the same mock exam noticed, at once and without prompting, that the patient had gross generalized wasting, indicating that the problem was not one confined to the legs. In similar ways he had performed poorly on many of the other cases in the mock exam and as a mock examiner one could easily see how he had failed in the real exam whilst he thought he was getting the right diagnosis. Most agree that the move to PACES has increased the fairness of the exam, in particular because of the break between stations followed by 'starting again' with two new examiners who are not influenced by what occurred in the previous station. It is clear from our survey that this may have interrupted in some cases what may otherwise have gone on to become a 'down-

ward spiral' disaster (see Vol. 2, Section F, Experiences 18, 20 and 28). Nevertheless, some continue to feel unfairly treated (see Vol. 2, Section F, Experiences 24 and 31). However, experience suggests, as one senior membership examiner put it, that the MRCP will usually pick out those who should fail; it will also usually pick out those who should pass – but not necessarily on the current attempt! Given the importance of clinical competence and the fact that this can only be assessed through a clinical exam (and clinical exams by their very nature will always have some in-built inadequacies), it seems unlikely that one could ever improve on this situation. In the old short cases exam the mark for each case was out of 12. As testimony to the precision of the marking system, it was an impressive fact that examiners, though marking independently, rarely differed by more than one mark in the scores out of 12 that they gave. The degree to which, generally, the examiners' marks concur suggests that the exam is probably as good as it can be. Our aim in this book, if you are one of those who should pass, is to try to help you to let the examiners know this on the current attempt or the next, rather than on the next attempt or the one after!

## The surveys of MRCP short cases

*'Certain "favourite" topics seem to recur. Make sure you know these.\**

### First edition

This survey has been introduced in the Preface to the first edition. In the first part of this survey, questionnaires were obtained from a number of doctors who had gained the MRCP during the previous 10 years. In the second part all the successful candidates at a single sitting were circulated. The questionnaires obtained in the two parts of the survey included both the pass and the previous fail attempts of those candidates. Altogether we collected accounts of 248 attempts at the MRCP short cases, covering over 1300 'main focus' short cases as well as over 500 'additional' short cases (a short case could have a main focus, e.g. exophthalmos, and additional features, e.g. goitre and pretibial myoedema). The diagnoses given by these candidates were graded according to the confidence each candidate had in his retrospective assessment. Pass attempt diagnoses were given more weight than fail attempt ones. As a result we hoped that the rather complex analysis performed produced a picture which was as near to the

\*Vol. 2, Section F, Quotation 351.

truth as possible. Analysis of the first part of the survey covering candidates' attempts over several years was essentially the same as the analysis of the second part. This suggested that the cases used and the skills tested tend to remain constant. This comparison also gave some support to the accuracy of our method of analysis. The figures are used wherever they may be helpful throughout this volume. Apart from figures, the organization of our suggested examination *routines* (Section B) and the contents of our short case *records* (Volume 1, Section C and Volume 3, Section I) have been closely guided by this original, as well as subsequent, surveys. For light entertainment, but with ingrained lessons, a number of Experiences, Anecdotes and Quotations from the survey are given in Volume 2, Section F of *An Aid to the MRCP PACES*.

### **Second edition**

As discussed in the Preface to the second edition, the original surveys were embellished for the second edition with several surveys conducted between the two editions. We collected accounts of a further 379 attempts covering nearly 2300 additional 'main focus' short cases. Although the second edition surveys were more extensive than those for the first edition, the analysis of them was more superficial and, therefore, the analysis from the first edition surveys remained the bedrock of the book.

### **Third (first PACES) edition**

As discussed in the Preface to the third edition, we were able to undertake a small initial PACES survey which

provided, despite its size, considerable valuable information for us to modify our book accordingly. We used for the survey the first 50 PACES questionnaires that we received during the first 12 months. This gave us accounts of 400 short cases – 200 from Stations 1 and 3 and 200 from Station 5. The questionnaires gave accounts from the first three PACES sittings with one questionnaire from the fourth sitting. Wherever the data from this survey was sufficient to supersede that from previous surveys, it was thus used. We were also able to give a number of complete PACES Experiences written in the first person at the end of Volume 2 of *An Aid to the MRCP PACES*.

### **Current (second PACES) edition**

For the current edition, we were able to enhance the data from previous surveys with the data from about 100 online questionnaires submitted at [www.ryder-mrcp.org.uk](http://www.ryder-mrcp.org.uk) from recent PACES experiences. Some before, and some after, the changes to Station 5 in Autumn 2009. Using this, we have been able to update the examination frequencies for the short cases in the current volume, as well as adding four new ones (see Preface) and to provide some recent full PACES Experiences (since Autumn 2009) written in the first person at the end of Volume 2, Section F of *An Aid to the MRCP PACES*. By studying these, the first-timer, in particular, can be given considerable insight into what the exam is actually like.

# Section A Preparation

*'Expressionless and without comment they led me away.'*\*

\*Vol. 2, Section F, Experience 140.

These books exist as they are because of many previous candidates who, over the years, have completed our surveys and given us invaluable insight into the candidate experience. Please give something back by doing the same for the candidates of the future. For all of your sittings, whether it be a triumphant pass or a disastrous fail . . .

**Remember to fill in the survey at [www.ryder-mrcp.org.uk](http://www.ryder-mrcp.org.uk)**

THANK YOU

The clinical skills required for the MRCP examination, particularly in relation to the short cases, can only be acquired by thoughtful preparation, experience and purposeful practice. Tutors and examiners alike agree that it is more important to spend time examining patients than reading textbooks. The examiners are not looking for encyclopaedic knowledge – they are just anxious to ascertain that you can be trusted to carry out an adequate clinical examination and make a competent clinical assessment. This book aims to help you organize your overall preparation to meet that objective. We have provided preparatory aids including examination *routines* and short case *records* (see below). We also aim to give you some insight into what most candidates experience in the examination and we hope to help you prepare psychologically. We would like to stress that although the written examination may appear a formidable hurdle, it often turns out to be less of an obstacle than the PACES. You would be wise to err on the side of safety and prepare for the PACES before, during and after your preparations for the written exam. Thus, we begin with some basic principles of practice and preparations at work.

### **Clinical experience in everyday work**

*‘Imagine you are seeing the cases in a clinic and carrying out a routine examination.’\**

The intention of the College in the examination is to gain a reflection of your usual working-day clinical competence for the examiners to judge. In arriving at their final verdict, the examiners may take particular note of factors such as your approach to the patient, your examination technique, spontaneity of shifting from system to system in pursuit of relevant clinical signs, fluidity in giving a coherent account of all the findings and conclusions, and your composure throughout. Though you can acquire all this for the day only, as some successful candidates do who are experts at passing examinations, it would be preferable if you could adopt many of these good habits into your everyday clinical approach. In either event, a long, diligent and disciplined practice is required if your aim is to be able to perform a smooth and polished clinical examination, to display the subtle confidence of a skilled performer, and to suppress signs of anxiety.

One simple approach to the task is that, whatever your job, you should consider all the patients you see as PACES patients from one station or another. Such a practice should not only improve your readiness for the

examination but also improve your standard of patient care – the primary objective of every clinician. Look out for all the ‘good signs’ passing through your hospital and use as many of these as possible as practice short cases. Ask your colleagues to let you know of every heart murmur, every abnormal fundus, every case with abnormal neurology, etc. If you are in, or can get to, a teaching hospital, make regular trips not only to clinical meetings and demonstrations but also, more importantly, to *visit the specialist wards* – neurology, cardiology, chest, rheumatology, dermatology, etc. It is useful to study the signs and conditions even when you know the diagnosis in order to further familiarize yourself with them. It is also a good practice to see cases ‘blind’ to the diagnosis and to try to simulate the examination situation. Imagine that two examiners are standing over you and there is a need to complete an efficient, once-only examination followed by an immediate response to the anticipated questions: ‘What are your findings?’ ‘What is the diagnosis?’ or ‘How would you manage this patient?’.

### **Simulated examination practice**

*‘I had a lot of practice presenting short cases to a “hawk” of a senior registrar. This experience was invaluable.’†*

If a constant effort is made to improve your clinical skills by seeing as many cases as possible, there is no reason why the spontaneity and competence so acquired should not show up on the day. As with all examinations, however, much can be learned about the deficiencies requiring special attention when you put your composite clinical ability to the test in ‘mock’ examinations. In most district general, and all teaching, hospitals, the local postgraduate clinical tutors organize Membership teaching and ‘mock’ examination sessions, and you should find out about, and join in, as many of these as you can manage. Unfortunately, a lot of these, though useful, tend to teach in groups and discuss management or look at X-rays, rather than provide the intensive ‘on-the-spot’ practice on patients that is the ideal preparation for PACES. It is, therefore, advisable to supplement these sessions with simulated examination practice arranged by yourself. This requires the cooperation of a ‘mock’ examiner (consultant, experienced registrar and, on occasion, a fellow examinee) on a *one-to-one basis*. If you can practise with a variety of ‘mock’ examiners, you will not only broaden the assessment of your imperfections but also learn to respond to the varied approaches of different examiners.

\*Vol. 2, Section F, Quotation 428.

†Vol. 2, Section F, Quotation 356.

## Examination routines

*'The most important point is to look professional – as if you have done it a hundred times before.'*<sup>\*</sup>

The short cases are a very important part of the Membership examination because they are designed to test critically two major areas of clinical competence. The first and more important of these is your ability to detect abnormal physical signs, interpret them correctly and put them together into a reasonable diagnosis or differential diagnosis. The second is your competence in conducting a professional and efficient clinical examination (see Vol. 2, Section F, Experience 142). As said above, these are generally considered to arise from day-to-day work and your conduct in the examination will reflect your experience in performing clinical tasks, presenting your assessments of patients to your seniors and getting their constant constructive criticism. If you are lucky enough to have worked with a good teacher, you may have acquired a firm foundation upon which you could build a structured clinical examination for all systems. As most candidates are engaged in busy clinical jobs and their seniors are often overburdened by administrative chores, etc., useful clinical dialogue between them may be limited. As a result, there may be little improvement in the weaknesses acquired during the undergraduate years.

The enormous task of preparing for the Membership examination provides an ideal opportunity to remedy any deficiencies in one's clinical methods. We would suggest that you work out the exact number and sequence of clinical steps for the examination of each subsystem, particularly those you would need to take in response to a particular command from the examiner, then practise going through these steps. Practise them over and over again<sup>†</sup> on your spouse, or any other willing person, until all the steps become as automatic as driving a car. Practise them on patients until you are confident of being able to pick up or demonstrate any abnormal physical signs. You should be able to maintain the same sequence and run through it rapidly and comprehensively in a way that is second nature to you. The sequence of clinical steps required for the examination of each system or subsystem is collectively referred to as the examination *routine* in this book. In Section B we suggest various examination *routines* (which you may wish to adopt or adapt) for you to practise in

response to particular commands. In Appendix 1 we provide *checklists* which summarize the major points in each examination *routine*. The *checklists* are designed to help in practising the *routines*.

## Short case records

*'The more practice at presenting short cases the better.'*<sup>‡</sup>

A knowledge of the possible short cases that may be used in the examination is important so that you can become familiar with the physical signs associated with each, and know what you are looking for as you work through the examination *routine*. Having a good grasp of the clinical features of the case may enable you to score extra marks by looking for additional signs that may be present. Such extra marks distinguish the above-average candidate from the average ones. Furthermore, by becoming acquainted with descriptions of typical cases, you will find it easier to present the case to the examiner using acceptable descriptive terms. In this book, under each short case, we have presented the typical clinical features for you to remember, and to 'regurgitate' what you see (hence the descriptive term *record*), omit what you do not find and add what you find new. Thus, when confronted with the face of a man with Parkinson's disease which you diagnose at once on seeing his tremor, instead of stuttering and stumbling as you try to think of the right words to describe his face, the terms depressed, expressionless, unblinking, drooling and titubation will immediately surface for you to use. In Section C, under the headings of each PACES substation, we have covered the overwhelming majority of cases which could occur and we have put them in order of priority according to the likelihood of occurrence as assessed from our surveys.

## Getting 'psyched up'

*'Do not be distracted by mistakes made (or imagined) in preceding cases or the examiners' mannerisms or approach (I was and suffered for it). Being very nervous does not necessarily fail you and one bad case should not put you off.'*<sup>§</sup>

It is common to hear candidates agonizing over their feeling that they failed to give a performance commensurate with their actual capabilities, simply because they were discouraged by the 'examination ordeal'. Though it is true that knowledge and competence tend to generate

<sup>\*</sup>Vol. 2, Section F, Quotation 352.

<sup>†</sup>MRCP = Methods Require Constant Practice.

<sup>‡</sup>Vol. 2, Section F, Quotation 355.

<sup>§</sup>Vol. 2, Section F, Quotation 382; see also Quotations 384–391 and 418.

confidence and capability, it is also true that extreme anxiety can seriously impair the performance of even the most knowledgeable and competent candidate.

### **The downward spiral syndrome\***

*'After the first case there was a long pause as if they were waiting for me to say more – I went to pieces after this.'*†

The candidate, an otherwise able and experienced doctor, enters the PACES examination room extremely anxious and lacking in confidence. He is just hovering on the edge of despair and the slightest upset is going to push him over. On one or more of the cases, he convinces himself that he is doing badly (whether or not he actually is) and over the edge he goes. The first stage of a rapid 'downward spiral' sets in, the dispirited candidate gets worse and worse and actually gives up before the end in the certainty that he has failed. Months of intensive bookwork and bedside practice, not to mention the examination fee, go to waste because of *inadequate psychological preparation*. To avoid this, there are four basic rules that are well worth noting.

#### **1 You never know you have failed until the list is published**

*'Don't be put off if you get a few things wrong. I made a lot of mistakes that I know of and still passed.'*‡

In the same way as it is said of the greatest saints that they considered themselves to be the greatest sinners, many successful candidates leave the examination centre feeling certain that they have failed. Good candidates may have a heightened awareness of the imperfections of their performance and thereby may exaggerate the impact of their mistakes on the examiner. Furthermore, the 'hawk' examiner may make you feel that you are doing badly, or you may deduce it from his mannerism, regardless of your performance. By the same token, the newcomer may slide through the stations unaware of any errors and with the examiners acting benignly, and then express great surprise as the inevitable 'thin' envelope arrives. It is not really important whether or not you think you have failed during the days between the examination and the arrival of the result. However, if you become convinced that you are

\*It should be noted that the downward spiral syndrome is not the absolute rock bottom. Candidates have experienced even worse – see Vol. 2, Section F, Anecdote 107.

†Vol. 2, Section F, Quotation 386; see also Vol. 2, Section F, Experience 19.

‡Vol. 2, Section F, Quotation 381.

failing while you are still sitting the examination, the thought can be disastrous and impair your performance to the extent that your conviction becomes a reality (e.g. see Vol. 2, Section F, Experiences 108 and 109, Anecdote 271 and Quotation 389).

#### **2 Do not be put off by the examiners or their reactions**

*'The most off-putting aspect of each case is the lack of feedback from the examiners as to whether you are right or wrong. This is much more disconcerting than outright criticism.'*§

Many first-timers, despite excellent clinical experience, are stunned by the sombre and restrained atmosphere of the examination, which is unlike anything in their past experience (except perhaps the driving test!). It is as well, therefore, to be aware that the examiners tend to wear a 'poker face' and usually give no feedback or encouragement. The 'hostile hawk' may appear dissatisfied with everything you do and say, but this is not necessarily a guide as to whether you are doing badly or not. A positive atmosphere is no guide either: the smiling ('smiling death!') and pleasant ('deadly dove!') examiner (and the apparently uninterested one) can be as deadly as a black widow spider if you get yourself into a diagnostic maze! Bear in mind that 'hawks' and 'doves' tend to have similar rates of passing and failing candidates. Disregard the atmosphere and concentrate on what the examiner asks you to do rather than on what he looks like, and recall and use your *routines* and *records*.

#### **3 The cases are easy and you have seen it all before**

*'My cases were more straightforward than I had been led to believe. Nothing was particularly rare.'*¶

The psychological scenario of the examination is such that many candidates enter it with the distorted view that behind every case and every question there will be some catch, some clever trap, something never seen before or

§Vol. 2, Section F, Quotation 397. This quotation refers to the 'poker-face' examiner (see also Vol. 2, Section F, Quotation 344). The candidates in our survey give similar warnings regarding the 'hawk' ('The examiners may appear irritable and unsympathetic – don't worry') and the 'dove' ('Don't be fooled by the apparent relaxed nature of the examiners'). Remember, 'if your examiner challenges, don't assume it means you have said something wrong'.

¶Vol. 2, Section F, Quotation 411.

a diagnosis never heard of. In fact, these suspicions are rarely justified. The *vast majority* of cases and questions are straightforward and a realization of this is likely to produce a confident, straightforward answer from the start instead of the hesitancy born of a mind filled with suspicion and struggling to solve the hidden catch. A study of Membership short cases\* reveals that there are two broad groups. The first group includes common conditions which you are well used to seeing in everyday clinical practice such as rheumatic heart disease, cirrhosis of the liver, rheumatoid hands and so on. These should surely present little difficulty (especially if you have tailor-made *routines* and *records*). In the second broad group are the rarities with good physical signs such as Osler–Weber–Rendu syndrome, pseudoxanthoma elasticum, Peutz–Jeghers syndrome, etc. You should be well used to these from the study of colour atlases, etc. that you will have done in preparation for the MRCP written examination. These too, therefore, should be easy (once you recognize the condition, all you have to do is ‘play the *record*’!).

#### **4 You have already passed and you have just got to keep it that way**

*‘It’s like skating on thin ice – if you keep going and don’t fall through, you make it.’†*

Confidence in one’s ability is a very important ingredient in any form of competition. As you go into the examination, imagine that you have a clean sheet with a 100% mark and that you just have to keep it that way as the examiners show you cases that you are perfectly capable of coping with as you pass through the various stations. Such an attitude should replace the more usual ‘Everybody fails this examination; it’s too difficult; how can I possibly pass?’. The examination on clinical short cases for the MRCP has been well described (Royal Northern course) as ‘like walking up a path full of puddles without stepping in the puddles; and you make the puddles yourself’. Remember the way to success is ‘*Readiness, Routines, Records and Right frame of mind*’.

\*The cases covered in these volumes form a list far more comprehensive than you probably need in order to pass. If you have studied all the cases it would be excessively rare for you to be surprised by a condition not met before.

†Vol. 2, Section F, Quotation 396.

# Section B

## Examination *Routines*

*'Work out the best method for examination and practise it until it is second nature to you.'*\*

\*Vol. 2, Section E, Quotation 348.

These books exist as they are because of many previous candidates who, over the years, have completed our surveys and given us invaluable insight into the candidate experience. Please give something back by doing the same for the candidates of the future. For all of your sittings, whether it be a triumphant pass or a disastrous fail . . .

**Remember to fill in the survey at [www.ryder-mrcp.org.uk](http://www.ryder-mrcp.org.uk)**

THANK YOU