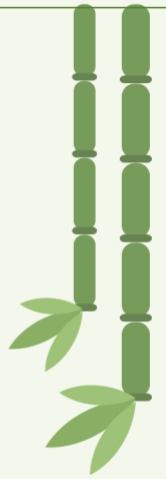




PIPADOR REVISION



MRCOG Part 3 OSCE Stations

Prioritisation Stations:

- *Labour Ward Board*
- *Gynaecology On Call Board*
- *Elective List*

Structured Discussion Task

OSCE STATION PRACTICE PACK

2026 Edition



MRCOG PART 3 — STRUCTURED DISCUSSION

Labour Ward Prioritisation

CANDIDATE'S INSTRUCTIONS

This task is a structured discussion assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues
- Information gathering

Labour Ward, 0800 hours: you are the ST5 registrar and are about to give the handover to the consultant coming on duty in the morning after your night on-call.

Review the LABOUR WARD BOARD and give a complete and thorough prioritised handover.

You have 10 minutes in which you should:

- Prioritise the cases in your order of clinical need
- Define the essential needs in each case
- Describe your provisional diagnosis and proposed management plan
- Demonstrate a mature and communicative approach
- Answer the Duty Consultant's queries and questions

EXAMINER'S OPENING QUESTIONS

- **Which case on the Labour Ward Board is your number one priority and why? How would you manage this case?**
- **Which case is your next priority and why? How would you manage this case? ...and so on until all cases have been discussed and justified.**

If the candidate has not justified a choice, ask them to do so. The candidate must prioritise rather than read out the board; a competent ST5 will state who they are delegating to, who they are calling in, and which cases are running in parallel.

Priority scale used in the examiner keys: URGENT (immediate life- or fetus-threatening; act now) → HIGH (time-critical decision or preparation within minutes) → SOON (review within the hour) → WAITING (plan in place; reassess at set interval) → LOW (no active obstetric need at present).

STATION A — CANDIDATE'S BOARD

LABOUR WARD BOARD

ROOM & NAME	CURRENT PATIENT DETAILS
1. Priti Shah	29 y-o P0, 39+4 weeks, spontaneous labour, epidural; fully dilated at 0630, active pushing since 0700, OP position; oxytocin infusion 12 mU/min, contractions 5 in 10; meconium-stained liquor (grade 2) CTG for last 20 minutes: baseline 165 bpm, variability <5 bpm, late decelerations with most contractions; midwife has asked for a review
2. Fatima Ali	34 y-o P3, 41+3 weeks, BMI 42, consultant-led care; spontaneous labour, admitted 0230; cervix 6 cm at 0500, clear liquor; CTG reactive; BP 120/70, PR 84; previous three vaginal births, last baby 4.3 kg 2 years ago; no analgesia, mobilising
3. Hannah Brooks	26 y-o P0, 30+2 weeks, admitted 0400 with regular painful contractions 3 in 10; cervix 3 cm, membranes intact; betamethasone first dose given 0430; nifedipine commenced; CTG reactive; neonatal unit informed — cot 'being sorted'; MgSO4 not started
4.	For cleaning
5. Chloe Watts	19 y-o P0, 37+0 weeks, arrived 0630; SROM 36 hours ago at home, liquor now offensive; temperature 38.6°C, PR 122, RR 24, BP 95/58, sats 96%; contractions irregular; cervix 2 cm; fetal heart rate 175 bpm; midwife has bled for doctor review, no bloods or cannula yet
6. Lucy Green	38 y-o P1, 36+5 weeks, previous emergency CS 2022 (fetal distress at 7 cm), planned VBAC; spontaneous labour; cervix 4 cm at 0200, 5 cm at 0600; membranes ruptured, clear liquor; epidural; CTG normal; midwife asking whether to start oxytocin
7.	Coming in by ambulance: 24 y-o P0 at 37 weeks, restrained passenger in road traffic collision at 0715; abdominal pain, no PV bleeding; obs stable with paramedics; ETA 15 minutes
8. Kate Doyle	40 y-o P0, 41+5 weeks, IOL day 2 for post-dates; dinoprostone pessary inserted 0800 yesterday, removed 0500 for contractions that have now settled; cervix 2 cm, unfavourable; CTG reactive; BP 128/78; exhausted and asking for a caesarean section
9.	Empty — ready for today's IOL

STATION A — EXAMINER'S INSTRUCTIONS: SUGGESTED PRIORITY ON CURRENT PATIENT DETAILS

Theme: Competing intrapartum emergencies with theatre pressure — pathological CTG in second stage vs maternal sepsis, with preterm labour and a VBAC decision running behind

ORDER	ROOM & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, ESSENTIAL NEEDS AND MANAGEMENT PLAN
1	Room 1 — Priti Shah	URGENT	Pathological CTG (fetal tachycardia, reduced variability, late decelerations) with uterine hyperstimulation in second stage; OP position; meconium Go now. Stop oxytocin, left lateral, IV fluids if hypotensive; consider terbutaline 250 mcg SC for 5:10 contractions Immediate vaginal examination: station, position, caput/moulding — decide between assisted vaginal birth (rotational forceps/ventouse if station at or below spines and safe) and category 1 CS Do not persist with prolonged pushing against a pathological CTG; inform consultant now; theatre and neonatal team alerted, paediatrician at birth (meconium) Anaesthetist to top up epidural; document decision and timing
2	Room 5 — Chloe Watts	URGENT	Maternal sepsis (probable chorioamnionitis after 36-hour SROM) with fetal tachycardia; qSOFA/MEOWS triggering Run in parallel with Room 1: delegate the Sepsis Six immediately — high-flow oxygen, blood cultures, IV broad-spectrum antibiotics within the hour (per local policy), lactate, IV fluid bolus, hourly urine output — while a second doctor and the anaesthetist review Bloods: FBC, U&E, LFT, CRP, clotting, G&S; HVS, MSU; consider 2222 obstetric emergency call if not responding Once stabilised, chorioamnionitis is an indication to expedite birth: reassess cervix and CTG; likely category 2 CS unless progressing rapidly Consultant to be informed — this is a MBRRACE-recognised cause of maternal death; inform neonatal team (early-onset sepsis)
3	Room 3 — Hannah Brooks	HIGH	Established preterm labour at 30+2 with intact membranes Confirm neonatal cot NOW — if none, discuss in-utero transfer only if labour not advanced; otherwise neonatal team must attend Offer IV magnesium sulphate for neuroprotection (4 g load, 1 g/h) — NICE: offer 24+0–29+6, consider 30+0–33+6; monitor for toxicity Second betamethasone dose at 24 h; tocolysis with nifedipine may allow steroid completion; do not tocolyse if infection suspected GBS: intrapartum antibiotics if labour establishes; continuous CTG; discuss mode of birth (cephalic — aim vaginal); reassess cervix 4-hourly
4	Room 7 — Ambulance (RTC)	HIGH	Blunt abdominal trauma at 37 weeks — risk of placental abruption, uterine injury, feto-maternal haemorrhage Prepare before arrival: alert Labour Ward coordinator, anaesthetist and neonatal team; A&E/trauma team lead if significant mechanism On arrival: primary survey with left lateral tilt; CTG for a minimum of 4 hours (longer if contractions, tenderness or bleeding); Kleihauer and anti-D if Rh negative Ultrasound for placental appearance, but a normal scan does not exclude abruption; low threshold for birth if CTG abnormal Do not withhold necessary imaging on grounds of pregnancy; safeguarding/DVLA not relevant unless raised

ORDER	ROOM & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, ESSENTIAL NEEDS AND MANAGEMENT PLAN
5	Room 6 — Lucy Green	SOON	Delay in first stage in a planned VBAC (1 cm in 4 hours) with epidural Oxytocin augmentation in VBAC is a consultant decision — discuss now; if used, cautious titration, continuous CTG, 4-hourly reassessment, low threshold for CS if no progress Assess for signs of scar dehiscence: pain breaking through epidural, CTG changes, fresh bleeding, loss of contractions, maternal tachycardia Counsel the woman: augmentation increases rupture risk (approx. 1.5%) and lowers VBAC success; document informed choice Preterm (36+5) — inform neonatal team
6	Room 2 — Fatima Ali	WAITING	Progressing labour in a grand multiparous woman with BMI 42 and previous 4.3 kg baby Anticipate: shoulder dystocia (experienced attendants, HELPERR ready), PPH (IV access, G&S, active third stage), difficult anaesthesia (anaesthetic review now, not at the emergency) VTE risk assessment and LMWH plan postnatally; consider continuous CTG per local BMI policy; reassess progress at 0900 Confirm named consultant aware; ensure she does not become the forgotten 'normal' labour
7	Room 8 — Kate Doyle	LOW	Slow IOL at 41+5, unfavourable cervix, requesting CS No emergency; sensitive discussion of options: further prostaglandin/balloon, ARM if feasible, rest, or CS — respect her request per NICE while giving balanced information Consultant to review on the ward round; ensure she has eaten, slept and been kept informed; CTG once daily/as per IOL policy If CS chosen, timing depends on the emergency workload today

The competent ST5 will also:

- Recognises that Rooms 1 and 5 are simultaneous emergencies and cannot both be managed personally: attends Room 1 (decision for birth) while delegating the Sepsis Six in Room 5 to the second registrar/midwife/anaesthetist and asks the consultant to come in now
- Identifies the theatre pressure: Room 1 may need CS, Room 5 may follow, the RTC is arriving — alerts the coordinator, second theatre team and neonatal unit early
- Does not accept 'cot being sorted' for Room 3 — makes the phone call and starts MgSO₄
- Understands that oxytocin in a VBAC (Room 6) is not a midwife-led decision
- Communicates with Room 8 with empathy rather than dismissing a low-priority case

Consultant's probing questions:

- You cannot be in Room 1 and Room 5 at the same time — who is doing what, and what have you asked me to do?
- Room 1: what specifically would make you choose caesarean over a rotational instrumental birth?
- Room 3: at 30+2 weeks, is magnesium sulphate indicated, and what would stop you giving it?
- Room 6: what would make you abandon the VBAC?
- What are you going to say to Kate Doyle in Room 8 when she asks for her caesarean this morning?

MRCOG PART 3 — STRUCTURED DISCUSSION

Gynaecology Prioritisation

CANDIDATE'S INSTRUCTIONS

This task is a structured discussion assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues
- Information gathering

Gynaecology on-call, 0800 hours: you are the ST5 registrar and are about to give the handover to the gynaecology consultant of the day after your night on-call. There is ONE emergency theatre, shared with general surgery, and the gynaecology elective list is due to start at 0900 in a separate theatre.

Review the GYNAECOLOGY BOARD and give a complete and thorough prioritised handover.

You have 10 minutes in which you should:

- Rank the patients who need surgery or a surgical decision in order of urgency, and prioritise the emergency theatre by clinical need
- Define the essential needs in each case
- Describe your provisional diagnosis and proposed management plan, including which cases do NOT need theatre
- Demonstrate a mature and communicative approach
- Answer the Duty Consultant's queries and questions

EXAMINER'S OPENING QUESTIONS

- **Which case on the Gynaecology Board is your number one priority for the emergency theatre and why? How would you manage this case?**
- **Which case is your next priority and why? How would you manage this case? ...and so on until all cases have been discussed and justified.**

If the candidate has not justified a choice, ask them to do so. The candidate must prioritise rather than read out the board; a competent ST5 will state who they are delegating to, who they are calling in, and which cases are medical rather than surgical, and how they will sequence the single emergency theatre.

Priority scale used in the examiner keys: URGENT (immediate life-threatening — next into theatre or resuscitation now) → HIGH (time-critical — organ/fertility at risk; theatre within hours) → SOON (surgery or decision today, after the above) → WAITING (managed non-surgically or observed; reassess at set interval) → LOW (no active surgical need; elective or discharge planning).

STATION B — CANDIDATE'S BOARD

GYNAECOLOGY BOARD — 0800

Theatre situation: One emergency theatre, currently free; general surgery have a perforated appendix 'on the list'; gynaecology elective list (three laparoscopic cases) starts 0900 in Theatre 4

BED & NAME	CURRENT PATIENT DETAILS
1. Amira Hassan	34 y-o P1, 7+2 weeks by LMP, admitted 0500 with sudden right iliac fossa pain and shoulder-tip pain; BP 92/54, PR 124, cool peripheries; TVS 0600: empty uterus, 3.5 cm right adnexal mass, moderate free fluid to the kidneys; Hb 98 g/l (booking 128); serum hCG 6,800 IU/l; G&S sent, cross-match requested; two cannulae; nil by mouth
2. Tia Morgan	17 y-o P0, admitted 0300 with sudden severe left iliac fossa pain and vomiting; pregnancy test negative; PR 108, temperature 37.4°C; TVS 0430: 7 cm left ovarian cyst, whirlpool sign, absent venous Doppler; WCC 13; mother present, patient wants 'the ovary saved'
3. Joanne Price	29 y-o P2, 10 weeks, incomplete miscarriage; heavy bleeding with clots since 0630; at 0745: BP 78/46, PR 52, sweaty, felt faint on the commode; speculum not yet performed; Hb 103 g/l last night; IV access x1
4. Sarah Lin	31 y-o P0, 6+4 weeks, admitted from EPU yesterday with left tubal ectopic 2.4 cm, no fetal heart, no free fluid; hCG 1,850 IU/l (48 h earlier 1,600); minimal pain; BP 118/70, PR 76; has read about methotrexate and 'does not want an operation'; on the list 'for laparoscopy today'
5.	Bed for cleaning
6. Helen Baxter	48 y-o, day 1 post total abdominal hysterectomy and BSO for fibroids (EBL 900 ml); at 0730: PR 118, BP 100/64, RR 22, urine output 20 ml/h for 3 hours via catheter, abdomen distended and tender, drain 350 ml dark blood; Hb 84 g/l (post-op 106); nil further given overnight
7.	Coming in by ambulance: 26 y-o P0, positive pregnancy test 6 weeks, collapsed at home; BP 80/50, PR 130 with paramedics; abdominal pain; ETA 10 minutes
8. Priya Sharma	36 y-o P0, admitted 3 days ago with pelvic inflammatory disease and 5 cm right tubo-ovarian abscess; on IV ceftriaxone/metronidazole and doxycycline; temperature 37.6°C (39.2°C on admission), PR 88; CRP falling 210 → 96; eating; asking when she can go home
9. Chloe Dunn	23 y-o, right Bartholin's abscess 5 cm, exquisitely tender, unable to sit; apyrexial; PR 92; nil by mouth since midnight 'for theatre'; on the emergency list since 2200

STATION B — EXAMINER'S INSTRUCTIONS: SUGGESTED PRIORITY ON CURRENT PATIENT DETAILS

Theme: Early pregnancy emergencies competing for one theatre — ruptured ectopic, cervical shock, ovarian torsion in a teenager, postoperative bleeding, and a stable ectopic that may not need surgery at all

ORDER	BED & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, THEATRE DECISION AND MANAGEMENT PLAN
1	Bed 1 — Amira Hassan	URGENT	Ruptured ectopic pregnancy with haemoperitoneum and haemorrhagic shock To theatre now — she is the first case; consultant informed and coming in; anaesthetist and theatre team; cross-matched blood to theatre, O-negative available; tranexamic acid; permissive resuscitation en route Laparoscopic salpingectomy if stable enough and surgeon experienced; laparotomy if unstable or no laparoscopic capacity — do not delay for the elective list; consent includes salpingectomy vs salpingotomy (contralateral tube appearance), blood products Anti-D if Rh negative; post-op Hb; debrief and counselling; EPAU follow-up; document
2	Bed 7 — Ambulance	URGENT	Collapse in early pregnancy with shock — ruptured ectopic until proven otherwise; second theatre case Prepare before arrival: senior second surgeon (consultant) needed because Bed 1 is going to theatre now — ask general surgery/theatre coordinator for a second emergency team or delay the elective list and use Theatre 4 On arrival: ABC, two large-bore cannulae, FBC, G&S/cross-match 4 units, hCG, bedside ultrasound for free fluid — do not wait for formal scan if shocked; straight to theatre Differentials: ruptured corpus luteum, miscarriage with cervical shock — speculum if bleeding
3	Bed 3 — Joanne Price	URGENT	Cervical shock — products of conception distending the cervical os (vagal bradycardia and hypotension) Bedside, not theatre, first: speculum examination now and remove products from the os with sponge forceps — this usually reverses the shock; left lateral, IV fluids, atropine 500 mcg if bradycardic and hypotensive Then: FBC, G&S, oxytocin/ergometrine if bleeding continues; surgical management of miscarriage (manual vacuum aspiration or suction evacuation) later today once stable; anti-D if Rh negative She may not need the emergency theatre at all if the bleeding settles after removal — reassess
4	Bed 2 — Tia Morgan	HIGH	Ovarian torsion in a 17-year-old — time-critical for ovarian salvage Laparoscopy within hours, not 'after the list': detorsion and conservative surgery (cystectomy if possible, leave the ovary even if dusky); do not remove the ovary for appearance alone; consent for possible oophorectomy with her (Gillick competent) and mother Analgesia, antiemetic, NBM, IV fluids, tumour markers not to delay surgery (send AFP, hCG, LDH, CA-125 for a 7 cm cyst in an adolescent); pregnancy test documented Sequence: after Bed 1 and the ambulance; if the elective theatre is free this is the case to put into it
5	Bed 6 — Helen Baxter	HIGH	Postoperative intra-abdominal haemorrhage after TAH/BSO — oliguria, tachycardia, falling Hb, distension

ORDER	BED & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, THEATRE DECISION AND MANAGEMENT PLAN
			Should have been escalated overnight: consultant informed now; FBC, clotting, G&S/cross-match 2–4 units, lactate; fluid resuscitation; transfuse; catheter checked Return to theatre for re-look laparotomy if haemodynamically unstable or Hb continues to fall — this competes with Beds 1, 2 and the ambulance; if stable after transfusion, CT with contrast may identify a bleeding pedicle and allow IR embolisation Antibiotics not indicated for bleeding alone; VTE prophylaxis withheld until bleeding excluded; incident report
6	Bed 4 — Sarah Lin	WAITING	Small unruptured tubal ectopic, hCG <5,000 and plateauing, no fetal heart, no free fluid, minimal pain — meets criteria for methotrexate Take her off the theatre list: offer single-dose methotrexate 50 mg/m² (baseline FBC, U&E, LFT, hCG day 0, 4 and 7) with clear safety-netting and follow-up; surgery remains an option if she prefers or if pain/rupture Explain: no pregnancy for 3 months after methotrexate; 10–15% need a second dose or surgery; avoid NSAIDs, alcohol, folate Anti-D if Rh negative; keep under observation while the unit is busy
7	Bed 8 — Priya Sharma	WAITING	Tubo-ovarian abscess responding to IV antibiotics Continue IV antibiotics until afebrile 24–48 h then oral for 14 days total; no drainage needed while improving; repeat ultrasound if fever recurs or CRP rises; contact tracing; discharge planning when afebrile Not for theatre today
8	Bed 9 — Chloe Dunn	LOW	Bartholin's abscess — needs marsupialisation or Word catheter but not the emergency theatre today Tell her honestly that she will not get to theatre this morning; give analgesia, allow her to eat and drink now; Word catheter under local anaesthetic on the ward is an alternative; add to the end of the day's list or the next available slot Do not let her remain starved for a second night

The competent ST5 will also:

- Realises that two life-threatening cases (Bed 1 and the ambulance) plus a possible return to theatre (Bed 6) exceed one emergency theatre — asks for a second surgical team and negotiates the elective theatre now
- Performs the speculum in Bed 3 personally on the way to theatre rather than waiting for a theatre slot
- Does not let the 17-year-old with torsion slide down the list behind adult 'routine' cases
- Recognises Bed 4 as a candidate for medical management and removes her from the surgical list
- Cancels or defers the Bartholin's abscess honestly instead of leaving her nil by mouth

Consultant's probing questions:

- You have three patients who may need laparotomy in the next two hours and one theatre — what exactly are you asking me and the theatre coordinator to do?
- Bed 3: why are you doing a speculum before anything else, and what would you do if the shock does not respond?
- Bed 2: the ovary looks black at laparoscopy — do you remove it?
- Bed 4: what criteria make her suitable for methotrexate, and what must she be told?

MRCOG PART 3 — STRUCTURED DISCUSSION

Elective Gynaecology List Prioritisation

CANDIDATE'S INSTRUCTIONS

This task is a structured discussion assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues
- Information gathering

Elective gynaecology theatre, 0800 hours: you are the ST5 registrar and are about to lead the WHO team brief with the consultant, anaesthetist and theatre coordinator. The list is overbooked. There are NO emergencies on this list — every patient was booked electively — but several have problems identified at admission today.

Review the ELECTIVE OPERATING LIST and give a complete and thorough prioritised handover.

You have 10 minutes in which you should:

- Decide which patients should proceed today, which need action before they can proceed, and which must be postponed — and justify each by clinical need and patient safety
- Propose a safe running order and explain it (allergies, infection control, diabetes, length of case, HDU and bed capacity)
- If the list overruns or a case must be cut, prioritise by clinical need (cancer and pre-cancer pathways, symptom severity, previous cancellations)
- Demonstrate a mature and communicative approach
- Answer the Duty Consultant's queries and questions

EXAMINER'S OPENING QUESTIONS

- **Which case on the list should go first and why? Which patients would you not operate on today, and why?**
- **Talk me through your running order. Which case would you protect if the list overruns, and which would you cut? ...and so on until every case has been discussed and justified.**

If the candidate has not justified a choice, ask them to do so. The candidate must make decisions rather than read out the list; a competent ST5 will name the action, the person responsible and the deadline for each problem, and will communicate postponements honestly.

Decision scale used in the examiner keys: FIRST (must go first for safety or logistics — latex allergy, diabetes, long/HDU case) → PROCEED (fit, consented, no action needed) → PROCEED AFTER ACTION (a specific problem must be resolved before knife-to-skin) → LAST (infection control or flexible timing) → POSTPONE (unsafe or inappropriate today; reschedule with a plan) → REMOVE (patient choice, wrong list or wrong operation).

STATION C — CANDIDATE'S BOARD

ELECTIVE GYNAECOLOGY OPERATING LIST

List constraints: Theatre 4, 0830–1730 (8 hours); theatre estimate 9 hours of operating; ward has 2 overnight beds; no HDU bed; one consultant, one ST5, one anaesthetist; add-on request from the 2-week-wait coordinator

CASE & NAME	PATIENT DETAILS (pre-operative notes and today's admission checks)
1. Total laparoscopic hysterectomy + BSO — Karen Doyle	47 y-o P2, 18-week fibroid uterus, heavy menstrual bleeding; BMI 39; Hb today 88 g/l (102 at pre-assessment 6 weeks ago, oral iron since); G&S valid; consented; expected blood loss 'moderate'; will need an overnight bed; first on the list as written
2. Laparoscopic sterilisation — Leanne Price	29 y-o P2, day case; LMP 5 weeks ago (cycle normally 4 weeks), unprotected intercourse 'a couple of weeks ago'; no pregnancy test yet today; consented last month with discussion of failure rate, irreversibility and LARC alternatives
3. Diagnostic laparoscopy for chronic pelvic pain — Amy Foster	24 y-o P0, day case; documented latex allergy (anaphylaxis to gloves age 16); pregnancy test negative; consented; listed fourth
4. Vaginal hysterectomy + anterior repair — Brenda Cole	68 y-o P3, uterovaginal prolapse; type 2 diabetes on metformin and gliclazide; capillary glucose 14.1 mmol/l this morning; HbA1c 78 mmol/mol at pre-assessment (GP asked to optimise); ECG normal; consented; overnight bed required
5. Hysteroscopy + endometrial biopsy under GA — Gwen Marsh	61 y-o, postmenopausal bleeding, endometrial thickness 14 mm; outpatient biopsy failed (cervical stenosis); on the suspected cancer pathway, day 21; well; day case; consented
6. Laparoscopic cystectomy for 6 cm endometrioma — Farah Iqbal	33 y-o P0, trying to conceive; consent form signed by the SHO in clinic: 'cystectomy ± oophorectomy if necessary'; today she says she was 'never told the ovary might be removed' and wants to know what it means for IVF; AMH not measured
7. Laparoscopic BSO for 6 cm simple cyst — Pauline Shaw	55 y-o, postmenopausal, simple unilocular cyst, CA-125 18, RMI low; MRSA screen positive at pre-assessment, decolonisation started 3 days ago; consented; day case
8. Hysteroscopy + Mirena insertion under GA — Tanya Reed	41 y-o P3, heavy menstrual bleeding, failed outpatient insertion; BMI 52; snores heavily, daytime somnolence, STOP-BANG 6 at pre-assessment — sleep study requested, not yet done; no anaesthetic consultant review; day case
9. ADD-ON REQUEST — Nicola Hunt	Suspected cancer pathway coordinator asks to add: 39 y-o, endometrial biopsy under GA after failed outpatient sampling; ultrasound suspicious, day 12 of the pathway; fasted on the ward 'in case a slot appears'; consent not yet taken

STATION C — EXAMINER'S INSTRUCTIONS: SUGGESTED PRIORITY ON CURRENT PATIENT DETAILS

Theme: Mixed benign major and day-case list, overbooked by an hour — pre-operative anaemia, poorly controlled diabetes, latex allergy, MRSA, an untreated OSA day case, a consent gap, and a 2-week-wait add-on that needs a slot

Suggested running order: 3 (latex) → 5 (PMB hysteroscopy, day case) → 9 (2WW biopsy, day case) → 2 (sterilisation, after pregnancy test) → 6 (endometrioma, after re-consent) → 7 (MRSA, last). Postpone 1, 4 and 8.

ORDER	CASE & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, ESSENTIAL NEEDS AND MANAGEMENT PLAN
1	Case 3 — Amy Foster (latex)	FIRST	Latex anaphylaxis — theatre must be latex-free and she must be first, before any latex has entered the room Move to first on the list; confirm latex-free equipment, drugs and gloves with the theatre coordinator at the brief; allergy band; anaesthetist aware Otherwise fit and consented; day case
2	Case 5 — Gwen Marsh (PMB)	PROCEED	Suspected cancer pathway — a case to protect if the list is cut Short day case; proceed early so a cancellation later in the day cannot displace her; ensure histology is marked urgent and the pathway tracker informed Cervical stenosis: consider misoprostol/dilators, ultrasound guidance to reduce perforation risk
3	Case 9 — Nicola Hunt (add-on)	PROCEED AFTER ACTION	Suspected cancer pathway add-on — should be accommodated once the two postponements create capacity Accept onto the list: consultant to consent her on the ward this morning (not the ST5 in the anaesthetic room); confirm fasting, pregnancy test, G&S not needed; inform theatre coordinator of the change before the brief ends This is the correct use of the time released by postponing Cases 1 and 4
4	Case 2 — Leanne Price (sterilisation)	PROCEED AFTER ACTION	Possible early pregnancy — LMP 5 weeks, recent unprotected intercourse Urine pregnancy test now; if negative, counsel that a test cannot exclude a luteal-phase pregnancy from intercourse in the last 2 weeks, offer to proceed with that understanding (and consider concurrent evacuation is NOT appropriate — a pregnancy would need separate management) or defer; document If positive — remove from the list, early pregnancy pathway and contraception counselling
5	Case 6 — Farah Iqbal (endometrioma)	PROCEED AFTER ACTION	Consent inadequate for a fertility-affecting operation — taken by a junior without discussion of oophorectomy or ovarian reserve Consultant (operating surgeon) to re-consent personally: discuss ovarian reserve loss with cystectomy, the low but real chance of oophorectomy, fertility implications and IVF timing; offer AMH; document her decision on oophorectomy explicitly (she may refuse it) Proceed only if she is satisfied — if she wants time, postpone without pressure; this is a governance issue about junior consenting
6	Case 7 — Pauline Shaw (MRSA)	LAST	MRSA carrier — infection control ordering Last on the list; infection control precautions, theatre cleaning afterwards; antibiotic prophylaxis to cover MRSA

ORDER	CASE & NAME	PRIORITY	PROVISIONAL DIAGNOSIS, ESSENTIAL NEEDS AND MANAGEMENT PLAN
			(teicoplanin/vancomycin) rather than standard cefuroxime; decolonisation continues; day case if recovery allows
—	Case 1 — Karen Doyle (TLH/BSO)	POSTPONE	Untreated pre-operative anaemia (Hb 88, falling despite oral iron) before major surgery with expected blood loss — benign indication Postpone: IV iron now, tranexamic acid, consider GnRH analogue or ulipristal per licence to control bleeding and shrink fibroids; re-list at 4–6 weeks with Hb >100; explain that operating today converts a likely transfusion into an avoidable one Record the cancellation reason as pre-assessment failure (not patient choice); the freed 2.5 hours and overnight bed go to the cancer pathway cases
—	Case 4 — Brenda Cole (VH/repair)	POSTPONE	Poorly controlled diabetes (HbA1c 78, CBG 14) before elective benign surgery Postpone: national guidance is to defer elective surgery when HbA1c >69 mmol/mol unless the benefit outweighs the risk — prolapse surgery does not; refer back to GP/diabetes team, re-list when HbA1c <69; ring pessary in the interim Explain kindly — she will feel let down; document; the second overnight bed is released
—	Case 8 — Tanya Reed (Mirena under GA)	POSTPONE	Probable severe obstructive sleep apnoea, BMI 52, no anaesthetic pre-assessment — unsafe as an unplanned day case Postpone the GA: anaesthetic consultant review, sleep study and CPAP first; offer outpatient hysteroscopic insertion with local anaesthetic/vaginoscopy in a specialist clinic as an alternative that avoids GA altogether; bridging treatment (tranexamic acid, progestogen) for bleeding Do not 'just try' — this is the case that ends up in ITU

The competent ST5 will also:

- Treats postponement of Cases 1 and 4 as the correct clinical decision, not a failure, and immediately re-uses the capacity for the two cancer-pathway patients
- Puts latex first and MRSA last without prompting and gives the reasons
- Refuses to let an SHO-taken consent for an ovary-threatening operation stand; the operating surgeon re-consents
- Knows a negative pregnancy test does not exclude a luteal-phase pregnancy before sterilisation and counsels accordingly
- Speaks to the postponed women personally and documents the reasons

Consultant's probing questions:

- Case 1: she has waited nine months and is furious — why can she not just have two units of blood and proceed?
- Case 4: what HbA1c threshold do you use and what would change your mind?
- Case 6: the consultant says 'the SHO consented her, that is fine' — what do you say?
- Case 2: her pregnancy test is negative — is she safe to sterilise today?
- What order are you running the list in and why?