FREE SAMPLE

PIPADOR REVISION

MRCOG Part 3

OSCE STATIONS

FREE SAMPLE

Station Bank

28 hand-picked stations from the full 382

One SPT and one SDT from every knowledge area

28	382	14
SAMPLE STATIONS	STATIONS IN THE FULL BANK	KNOWLEDGE AREAS

FREE SAMPLE EDITION

2026 Edition

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SPT Simulated Patient Task SDT Structured Discussion Task

This free sample has one Simulated Patient Task and one Structured Discussion Task from each knowledge area.
The full Station Bank has 382 stations. Find it at **PIPADOR.co.uk**.

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KNOWLEDGE AREA

2

Teaching and Research

Sample: 1 SPT · 1 SDT · 21 stations in the full bank

Stations on pages 6–25

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MRCOG Part 3 OSCE Stations

Critical Appraisal of a Randomised Trial Abstract

Structured Discussion Task | Module 2 | Teaching and research

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Structured Discussion Task

Critical Appraisal of a Randomised Trial Abstract

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
2: Teaching and research	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A structured discussion appraising a (fictional) randomised trial abstract of a new uterotonic for PPH prevention: question, design, randomisation and blinding, analysis, interpreting relative and absolute effects, confidence intervals and NNT, applicability – then a subgroup claim and pressure to change the unit protocol*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST6 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Trial abstract (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST6. At journal club, your consultant asks you to appraise the **abstract** of a recently published trial and advise whether the unit should change its **PPH prevention protocol**.

Please read the **TRIAL ABSTRACT (1)** (fictional). Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Appraise the abstract
- Interpret the results
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST6 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST6 will discuss or mention many of the following:

Patient safety

- * ***Changing practice:*** *Not yet on this abstract alone: methodological concerns (open-label, per-protocol, loss to follow-up), no difference in severe PPH, need* ***full paper***, ***systematic reviews****/meta-analysis (e.g. Cochrane network meta-analysis),* ***NICE/RCOG guidance***, *cost-effectiveness, safety (contraindications, storage – heat-stable?), local stakeholder review; could consider for* ***specific groups*** *if evidence supports.*

Applied clinical knowledge

- * ***Structured appraisal:*** *Framework (e.g.* ***CASP****):* ***clear question (PICO)***; ***design*** *RCT appropriate;* ***randomisation*** *and* ***allocation concealment***; ***blinding*** *(open-label → bias in subjective outcome measurement – estimated blood loss);* ***groups similar*** *at baseline;* ***follow-up*** *(9% loss);* ***intention-to-treat*** *vs per-protocol (ITT preferred for effectiveness);* ***outcome*** *measurement (measured vs estimated blood loss);* ***funding/conflicts***; ***generalisability***.
- * ***Interpreting the results:*** *PPH ≥500 ml:* ***absolute risk reduction 2.5%*** *→* ***NNT = 40***; ***RR 0.80***, *CI excludes 1 → statistically significant;* ***clinically important outcome*** *(≥1000 ml) –* ***CI crosses 1*** *→ no evidence of difference in severe PPH; side effects/cost needed; single trial.*
- **Card A – subgroup analysis: Subgroup analysis** – likely **post hoc**, small numbers, **multiple comparisons** → false positives; need **pre-specified** subgroup with **test for interaction**; treat as **hypothesis-generating**; do not change practice on this basis.

Communicating with colleagues

- * ***Card B – conflict of interest: Conflict of interest*** *– decline inducement; follow Trust* ***procurement***, ***medicines management committee/drugs and therapeutics committee*** *process;* ***declaration of interests*** *(NHS England managing conflicts of interest guidance); decisions based on evidence and cost-effectiveness, not incentives; inform clinical director.*
- * *Clear presentation at journal club*
- Uses governance routes (D&T committee)
- Escalates inducement

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST6.

Task synopsis:
Fictional RCT (UTERO-1): 4,000 women vaginal birth, carbetocin-X vs oxytocin; primary outcome PPH ≥500 ml 10.0% vs 12.5% (RR 0.80, 95% CI 0.67–0.96); ≥1000 ml 2.0% vs 2.4% (RR 0.83, 0.55–1.26); open-label; per-protocol analysis primary; 9% lost to follow-up; industry-funded; single country. Card A: subgroup claim "benefit doubled in BMI >35" (n=210, p=0.04, no interaction test). Card B: company rep offers free supply if protocol changes.

Open the discussion with the following:

> *"Talk me through how you would appraise this abstract."*

Then ask the following questions:

1. **How would you appraise it?**
2. **Interpret the results.**
3. **Would you change practice?**
4. **Hand the candidate SCENARIO CARD A. "Should we use it for women with BMI >35?"**
5. **Hand the candidate SCENARIO CARD B. "How would you respond?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "What is the NNT?"
- "Why does the confidence interval matter?"
- "What is intention-to-treat?"
- "Why be cautious about subgroups?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Recommends immediate protocol change = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot calculate NNT or interpret CI = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Accepts inducement = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

TRIAL ABSTRACT (1)

Haywain General Hospital NHS Trust
UTERO-1 TRIAL (fictional) – ABSTRACT

Objective	Does **carbetocin-X** reduce PPH compared with **oxytocin 10 IU IM** after vaginal birth?
Design	Multicentre **open-label RCT**, one country; **industry-funded**
Participants	4,000 women ≥37 weeks, singleton vaginal birth; **9% lost to follow-up**
Primary outcome	PPH ≥500 ml (**estimated**): **10.0% vs 12.5%**; RR 0.80 (95% CI 0.67–0.96); **per-protocol analysis**
Secondary	PPH ≥1000 ml: **2.0% vs 2.4%**; RR 0.83 (95% CI 0.55–1.26)
Conclusion	"Carbetocin-X should replace oxytocin for all vaginal births."

SCENARIO CARD A (question 4)
Full paper – subgroup table

"In women with **BMI >35** (n = 210) the effect was **doubled** (RR 0.42, **p = 0.04**)." No test for interaction reported; 12 subgroups analysed.

SCENARIO CARD B (question 5)
After journal club

A pharmaceutical representative offers **free supply for 6 months** and **sponsorship of the departmental conference** "if the protocol changes".

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6. RCOG INSTRUCTIONS

Module(s) examined	2: Teaching and research
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × TRIAL ABSTRACT (1); 1 × each SCENARIO CARD A–B

Sources: Critical Appraisal Skills Programme (CASP) RCT checklist; CONSORT 2025 statement; Cochrane Handbook (risk of bias); Gallos I et al. Cochrane network meta-analysis of uterotonics for PPH prevention (2018); NICE NG235 Intrapartum care – third stage; NHS England Managing conflicts of interest in the NHS (2017, updated); ABPI Code of Practice.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Critical appraisal in one line

Is it valid (randomisation, blinding, ITT, follow-up), are the results important (ARR, NNT, CI on clinically important outcomes), and do they apply to us?

Measure	This trial
ARR (PPH ≥500 ml)	12.5% − 10.0% = 2.5%
NNT	1 / 0.025 = 40
RR	0.80 (CI 0.67–0.96)
Severe PPH ≥1000 ml	CI crosses 1 – no clear difference
Biases	Open-label, per-protocol, 9% lost, industry-funded

VALIDITY

- Randomisation + concealment
- Blinding
- Intention-to-treat
- Follow-up
- Conflicts of interest

SUBGROUPS

- Pre-specified?
- Interaction test?
- Multiple comparisons
- Hypothesis-generating only

Say it simply

"It's an RCT, but open-label with estimated blood loss, per-protocol analysis and 9% lost to follow-up. You'd treat 40 women to prevent one PPH over 500 ml, and there's no clear difference in severe PPH. The BMI subgroup is hypothesis-generating. I wouldn't change the protocol until we've seen the full paper, systematic reviews and guidance."

Common ways to lose marks

Accepting conclusion • No NNT • Ignoring CI • Believing subgroups • Accepting gifts

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MRCOG Part 3 OSCE Stations

Explaining Risk with Numbers: "HRT Doubles Breast Cancer Risk"

Simulated Patient Task | Module 2 | Teaching and research

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Explaining Risk with Numbers: "HRT Doubles Breast Cancer Risk"

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
2: Teaching and research	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Explaining absolute and relative risk to a 52-year-old woman who wants to stop HRT after reading a newspaper headline: using natural frequencies and visual aids, putting risk in context with other factors, and supporting an informed decision – hidden severe symptoms and a lifestyle risk factor*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Newspaper headline and clinic letter (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are the ST5 in the menopause clinic. **Mrs Julie Barker**, aged 52, has been on **combined HRT** (oestradiol gel and micronised progesterone) for **18 months** with excellent symptom control. She has brought a **newspaper article** and wants to **stop HRT immediately**.

Please read the **NEWSPAPER HEADLINE AND CLINIC LETTER (1)**.

You have 10 minutes in which you should:

- Explore her concerns
- Explain the risk in a way she understands
- Discuss her options
- Agree a plan

You will not be expected to examine the patient. A risk communication chart (1,000 women) is available if you wish to use it.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Julie Barker**, aged 52, a head teacher. Before HRT you had **20 hot flushes a day, drenching night sweats and low mood**; you nearly **resigned**. A friend was **diagnosed with breast cancer** last month. You read "**HRT doubles risk**".

Only if asked:

- You drink about **3 large glasses of wine most evenings** (~35 units/week).
- BMI 29; you don't exercise much.
- Mother: no breast cancer; no family history.
- Mammogram 1 year ago normal.
- You **don't understand percentages** – "just tell me if it's dangerous".

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"It says HRT doubles your risk of breast cancer – I want to stop today."*

About numbers

> *"What does 'doubles' actually mean for me?"*

About alternatives

> *"Is there anything safer?"*

About stopping

> *"What happens if I stop?"*

Acting requirements

- Anxious; teacher-like – wants a clear explanation.
- Reveal alcohol intake only if asked about lifestyle.
- Visibly relieved by natural frequencies and pictures; makes an informed choice.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Combined HRT 18 months, severe symptoms controlled; frightened by relative-risk headline
- Hidden: alcohol ~35 units/week (comparable or greater breast cancer risk), BMI 29
- Key numbers (MHRA 2019, ages 50–69): ~63 per 1,000 never-users diagnosed; 5 years of HRT adds ~5 (oestrogen-only), ~14 (sequential combined – her regimen) or ~20 (continuous combined) per 1,000; excess risk falls after stopping but some persists; alcohol and obesity also increase risk

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * *Does not dismiss concern; ensures **breast screening** up to date, **breast awareness***
- * *If stopping: explains **symptom recurrence**, gradual taper option, non-hormonal alternatives*
- Addresses **alcohol** as a modifiable risk (brief intervention)

Applied clinical knowledge

- * ***Relative vs absolute risk**; uses **natural frequencies** (per 1,000 women, ages 50–69) and **icon arrays** (MHRA 2019: 63/1,000 never-users aged 50–69; +5 oestrogen-only, +14 sequential, +20 continuous combined after 5 years)*
- * *Combined HRT small increase related to **duration**; **oestrogen-only** (after hysterectomy) little or no increase; micronised progesterone may carry lower risk (limited data); risk **declines after stopping***
- Benefits: symptom relief, bone protection; individual decision

Communicating with patients and families

- * *Explores **ideas, concerns, expectations** (friend's diagnosis)*
- Avoids jargon; checks understanding (teach-back)
- Shared decision; written information

Information gathering

- * *Symptom history and impact*
- * ***Breast cancer risk factors**: family history, alcohol, BMI, screening*
- Her preferences

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Ignores screening or dismisses concern = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot explain absolute vs relative risk = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Uses only percentages/jargon without checking understanding = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

No breast cancer risk factor history = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

NEWSPAPER HEADLINE AND CLINIC LETTER (1)

Haywain General Hospital NHS Trust HEADLINE AND CLINIC LETTER	
Headline	"**HRT DOUBLES BREAST CANCER RISK**, major study finds"
Clinic letter (6 months ago)	"Excellent response to estradiol gel 2 pumps + micronised progesterone 200 mg (days 1–12). **Vasomotor symptoms resolved**; mood much improved."
Background	Age 52; LMP age 50; no hysterectomy; mammogram (NHS screening) normal 1 year ago
Available	Risk chart: 1,000 women icon array

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6. RCOG INSTRUCTIONS

Module(s) examined	2: Teaching and research
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 45–60
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × NEWSPAPER HEADLINE AND CLINIC LETTER (1); optional icon-array chart

Sources: MHRA Drug Safety Update: HRT – further information on the known increased risk of breast cancer (2019); NICE NG23 Menopause: identification and management (updated November 2024); Collaborative Group on Hormonal Factors in Breast Cancer, Lancet 2019; Winton Centre for Risk and Evidence Communication – principles; GMC Decision making and consent (2020).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Risk communication in one line
Turn "doubles" into "how many extra out of 1,000 women like me", use pictures, compare with other risks, and let her decide.

DO	DON'T
• Absolute numbers (per 1,000) • Same time frame (ages 50–69) • Icon arrays • Compare with alcohol / weight • Teach-back	• Relative risk alone • Percentages only • "It's nothing to worry about" • Decide for her

Say it simply

"'Doubles' sounds frightening, but it's about a small number to start with. Picture 1,000 women between 50 and 70: about 63 get breast cancer without HRT; with 5 years of your type of HRT, about 14 more would – so most women on HRT don't get breast cancer. Cutting down alcohol and weight also lowers your risk. Many women feel the benefit is worth it – it's your choice, and either way we'll support you."

Common ways to lose marks

Relative risk only • Dismissive • No lifestyle discussion • Stopping abruptly without plan • No screening check

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PIPADOR REVISION

KNOWLEDGE AREA

3

Core Surgical Skills

Sample: 1 SPT · 1 SDT · 20 stations in the full bank

Stations on pages 27–46

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MRCOG Part 3 OSCE Stations

Complaint: Foot Drop after Prolonged Lithotomy

Simulated Patient Task | Module 3 | Core surgical skills

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Complaint: Foot Drop after Prolonged Lithotomy

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
3: Core surgical skills	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A complaint meeting with a woman who developed a foot drop after a 4-hour laparoscopic hysterectomy in lithotomy: listening, explaining positioning-related nerve injury, prognosis and referral, apology, the investigation and complaints process – and identifying her return-to-work and driving concerns*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST6 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Complaint and operation record (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are the ST6. **Mrs Jean Morris**, aged 54, had a **total laparoscopic hysterectomy and BSO** for endometriosis 6 weeks ago (operating time **4 hours 20 minutes**). She developed **right foot drop** and **numbness on the top of her foot**. She has made a **formal complaint**. Neurology has confirmed **common peroneal nerve palsy**.

Please read the **COMPLAINT AND OPERATION RECORD (1)**. A complaints officer is present.

You have 10 minutes in which you should:

- Listen to her concerns
- Explain what is likely to have happened
- Discuss prognosis and support
- Explain next steps

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Jean Morris**, aged 54, a **delivery driver**. You **can't drive** and are on **sick pay**. Nobody warned you about nerve damage. You noticed it the day after surgery and the ward said "**it's from lying in bed**".

Only if asked:

- You are worried about **losing your job**.
- You **trip** at home; you have fallen twice.
- You were told the operation would take "**about 2 hours**".
- You want to know if it will **get better**.
- You want an **apology** and assurance it won't happen again.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"I went in for a hysterectomy and came out unable to walk properly."*

About cause

> *"How can an operation on my womb damage my leg?"*

About recovery

> *"Will it get better?"*

About work

> *"I can't drive – what am I supposed to do?"*

Acting requirements

- Angry at first; tearful about job.
- Mentions falls and work if asked about daily life.
- Calms with apology and practical help.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Common peroneal nerve compression at fibular head from leg support/stirrups during prolonged lithotomy (>2–4 h increases risk); not recognised on ward
- Most positioning neuropraxias improve over weeks–months; some persist; physio, ankle-foot orthosis, neurology/nerve conduction follow-up
- Not consented for nerve injury risk; operation longer than expected; ward dismissed symptom → incident, learning response, candour; complaints process; DVLA driving advice, occupational health/fit note

The competent ST6 candidate will discuss and mention many of the following:

Patient safety

- * *Addresses **falls risk**: **physiotherapy**, **ankle–foot orthosis**, home safety*
- * ***Driving**: advise not to drive until safe (inform insurer; DVLA guidance if persistent); fit note/occupational support*
- **Incident report**/learning response (positioning, duration, padding, repositioning checks, ward recognition)

Applied clinical knowledge

- * *Mechanism: **compression of common peroneal nerve** at fibular head (lateral leg against stirrup) in **prolonged lithotomy**; femoral/sciatic/obturator nerve injuries also possible*
- * *Prognosis: most **neuropraxias recover** over weeks to months; nerve conduction studies; neurology follow-up*
- Prevention: padding, correct stirrup type/position, minimise time, reposition, consent includes nerve injury for long procedures

Communicating with patients and families

- * ***Listens**; **sincere apology**; acknowledges consent and ward-response failings*
- Honest, non-defensive
- Explains complaints process (written response, advocacy, PHSO)

Information gathering

- * ***Impact** on daily life, work, driving, falls*
- Symptoms progression
- What she wants from complaint

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Ignores falls/driving risk = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot explain positioning nerve injury = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Defensive or no apology = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not explore impact = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

COMPLAINT AND OPERATION RECORD (1)

Haywain General Hospital NHS Trust
COMPLAINT AND OPERATION RECORD

Complaint	"I was **not warned** about nerve damage. I told the ward my foot was numb and was **ignored**. I can't work."
Operation	TLH + BSO, severe endometriosis; **4 h 20 min**; Lloyd-Davies **lithotomy** in boot stirrups
Positioning record	"Pressure areas checked" at start; **no repositioning recorded**
Consent form	Risks listed: bleeding, infection, bladder/bowel/ureter injury, VTE – **nerve injury not listed**
Neurology	**Right common peroneal neuropathy** (axonotmesis vs neuropraxia – NCS repeat at 3 months)

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6. RCOG INSTRUCTIONS

Module(s) examined	3: Core surgical skills
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 45–65 (complaints officer non-speaking)
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × COMPLAINT AND OPERATION RECORD (1)

Sources: AfPP Standards for safe perioperative practice (patient positioning); NatSSIPs 2 (CPOC, 2023); GMC Decision making and consent (2020) / Montgomery (2015); Local Authority Social Services and NHS Complaints (England) Regulations 2009; PHSO NHS Complaint Standards; DVLA – assessing fitness to drive; CQC Regulation 20 Duty of candour.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Positioning nerve injury in one line

Long lithotomy can compress the peroneal nerve at the fibular head – apologise, get physio and a splint, keep her safe from falls and driving, and fix positioning practice and consent.

HER CARE	SYSTEM LEARNING
• Physio + ankle–foot orthosis • Neurology/NCS follow-up • No driving until safe • Fit note; occupational support • Falls prevention	• Consent for long cases: nerve injury • Padding, stirrup position • Reposition / time checks • Ward escalation of new numbness • Incident + learning response

Say it simply

"I'm very sorry. During long operations with legs in supports, pressure on the outside of the knee can bruise the nerve that lifts the foot. Most people improve over weeks to months. You should have been told about this risk, and your symptoms should have been taken seriously on the ward. We'll get you physio and a splint, help with work, and we're reviewing how we position patients."

Common ways to lose marks

Defensive • No falls/driving advice • "It's from lying in bed" • No prognosis • No complaints process

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Laparoscopic Entry and Its Complications

Structured Discussion Task | Module 3 | Core surgical skills

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Laparoscopic Entry and Its Complications

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
3: Core surgical skills	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A structured discussion of safe laparoscopic entry: Veress needle versus open entry, Palmer's point, entry in obese and very thin women, and checks – then major vascular injury at primary entry and recognition of a bowel injury*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Theatre list (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 starting a **laparoscopy list**. Your consultant asks you to talk through **safe abdominal entry** for the three patients on the list.

Please read the **THEATRE LIST (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss entry techniques for each patient
- Discuss checks and recognition of injury
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * ***Safe Veress entry***: *bladder empty, patient **flat** (not head-down), vertical intra-umbilical incision, lift abdominal wall, controlled insertion; **opening pressure <10 mmHg**; insufflate to **20–25 mmHg** for primary trocar, then **12–15 mmHg**; **inspect beneath** the entry site immediately*
- * ***Adapts entry***: *obese – umbilicus, Veress at **90°**, longer needle; previous midline laparotomy/adhesions – **Palmer's point** (3 cm below left costal margin, midclavicular line; stomach emptied) or **open (Hasson)** entry; very thin – care (aorta close); secondary ports under vision avoiding inferior epigastric vessels*
- * ***Major vascular injury***: ***leave trocar in place***, *call for help*, ***immediate midline laparotomy***, ***direct pressure***, *major haemorrhage protocol, cell salvage*, ***vascular surgeon***
- * ***Suspected bowel injury***: *do not close; inspect bowel; general/colorectal surgeon; repair, washout, antibiotics*
- Inspects under all ports and at the end of the procedure

Applied clinical knowledge

- * *Up to **15% of bowel injuries are not recognised** at the time; **thermal injury** may perforate days 3–7*
- * *Post-operative red flags: pain increasing not decreasing, fever, tachycardia, ileus → low threshold for CT/re-look*
- Serious complications ~1–2 per 1,000 laparoscopies; risk higher with adhesions and extremes of BMI

Communicating with colleagues

- * ***Early call*** *to vascular/general surgeons and anaesthetist*
- Clear major haemorrhage communication
- Documentation, **duty of candour** to patient, incident report and debrief

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
List: (1) BMI 23, no surgery – Veress at umbilicus; (2) BMI 48 – umbilicus vertical, Veress perpendicular, higher pressure; (3) previous midline laparotomy – Palmer's point or open entry. Card A: after primary trocar insertion in a thin woman, BP falls, blood wells up, retroperitoneal haematoma enlarging. Card B: during closure, faecal smell and bile-stained fluid noticed near the umbilical port.

Open the discussion with the following:

> *"How would you enter the abdomen in each of these women?"*

Then ask the following questions:

1. **Describe safe Veress needle entry.**
2. **How would entry differ for obese women and after previous surgery?**
3. **How are bowel injuries recognised and why are they missed?**
4. **Hand the candidate SCENARIO CARD A. "What would you do?"**
5. **Hand the candidate SCENARIO CARD B. "What would you do?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "What intra-abdominal pressure confirms correct Veress placement?"
- "Where is Palmer's point?"
- "Would you remove the trocar if a vessel is injured?"
- "Why are bowel injuries missed?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Removes trocar/continues laparoscopically with major vascular injury = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot describe safe entry or Palmer's point = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Does not call for specialist help = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

THEATRE LIST (1)

Haywain General Hospital NHS Trust GYNAECOLOGY LAPAROSCOPY LIST	
1	Ms A, 28 – **BMI 23**, no previous surgery – diagnostic laparoscopy
2	Mrs B, 41 – **BMI 48** – laparoscopic BSO
3	Ms C, 35 – **previous midline laparotomy** (bowel resection) – laparoscopic ovarian cystectomy
Note	Consultant available in the department

SCENARIO CARD A (question 4)
Patient 1 (thin, BMI 18)

After primary trocar insertion: **BP 70/40**, HR 130; **blood welling** in pelvis; **enlarging retroperitoneal haematoma** near the sacral promontory.

SCENARIO CARD B (question 5)
Patient 3

At the end of the procedure, you notice a **faecal smell** and **brown-stained fluid** under the umbilical port site.

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6. RCOG INSTRUCTIONS

Module(s) examined	3: Core surgical skills
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × THEATRE LIST (1); 1 × each SCENARIO CARD A–B

Sources: RCOG Green-top Guideline No. 49 Preventing entry-related gynaecological laparoscopic injuries (2008); BSGE/ESGE guidance on laparoscopic entry; RCOG Consent Advice No. 2 Diagnostic laparoscopy (2017); NICE NG24 Blood transfusion; CQC Regulation 20 Duty of candour.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Laparoscopic entry in one line
Flat, bladder empty, vertical umbilical incision, Veress with checks (opening pressure <10), 20–25 mmHg for entry, look underneath – Palmer's point or open entry after midline surgery.

Patient	Entry
Normal BMI	Umbilical Veress ~45°; checks
Obese	Umbilical Veress at 90°; long needle
Very thin	Care – aorta close; consider open
Previous midline / adhesions	Palmer's point (empty stomach) or open (Hasson)
Vascular injury	Leave trocar, call vascular, laparotomy, pressure

Say it simply
"For the woman with the midline scar I'd use Palmer's point with an empty stomach, or open entry. If a major vessel is injured, I'd leave the trocar in, call for help and the vascular surgeon, open the abdomen and apply pressure while we activate the major haemorrhage protocol."

Common ways to lose marks
Head-down at entry • No pressure checks • Removing trocar • Not inspecting under ports • Late help

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PIPADOR REVISION

KNOWLEDGE AREA

4

Postoperative Care

Sample: 1 SPT · 1 SDT · 31 stations in the full bank

Stations on pages 48–67

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Post-ITU Debrief: Hysteroscopic Fluid Overload

Simulated Patient Task | Module 4 | Postoperative Care

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Post-ITU Debrief: Hysteroscopic Fluid Overload

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
4: Postoperative Care	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Day 3 after hysteroscopic resection of a submucous fibroid with monopolar glycine: 2.4 L fluid deficit, sodium 113, pulmonary oedema, seizures and ITU. A debrief with the patient's daughter (a solicitor) at the patient's request – explaining fluid overload honestly, the duty of candour, the "negligence" question – and spotting a new warning sign of osmotic demyelination*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Debrief Summary (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in gynaecology. **Mrs Obiageli Oduya**, aged 68, had a **hysteroscopic resection of a submucous fibroid 3 days ago**. She developed **severe hyponatraemia and fluid overload** and needed ITU care. She is now on the ward.

Mrs Oduya has capacity and has **asked that her daughter, Ms Chiamaka Oduya, receives the explanation on her behalf**. You are meeting Ms Oduya **on her own**; her mother is resting.

Please read the **DEBRIEF SUMMARY (1)** carefully.

You have 10 minutes in which you should:

- Explain what happened and why
- Address her questions and concerns
- Explain what happens next
- Agree a plan for her mother's care

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Ms Chiamaka Oduya**, 42, a commercial solicitor and Mrs Oduya's only daughter. Your mother, a retired nurse, came in for what you were told was a routine "fibroid removal through the womb" and **nearly died**: ITU, a breathing mask, **two seizures**. You are precise, frightened and controlled. You have read that surgeons should stop at a set fluid limit. You are not threatening legal action yet, but you will ask directly whether this was negligence.

Only if asked:

• **This morning:** when you visited, Mum's **speech sounded slurred** and she **coughed and spluttered when drinking tea**; she seemed more muddled than last night. The nurse said she was tired. Say this only if asked how your mother seems now or whether you have noticed anything new.

• **Background:** your mother takes amlodipine for blood pressure; she was told about "bleeding, infection and perforation" but not about fluid problems or ITU.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"I'm here as her daughter, not as a lawyer – at least not yet. She came in for a routine procedure and nearly died. Nobody has explained why."*

About the guideline

> *"I've read surgeons should stop at about a litre. She absorbed 2.4 litres. Was the guideline followed?"*

About her brain

> *"She had seizures. Will she be the same person?"*

The direct question

> *"I'll ask you directly: does this sound like negligence to you?"*

About consent

> *"Was she told this could happen? That she could end up in intensive care?"*

Acting requirements

- Calm, precise and controlled; soften when treated as a daughter and given straight answers; become cold with jargon or evasion.
- Mention the slurred speech and coughing when drinking only if asked about how she is now.
- If the candidate says "I can't comment" or "it was nobody's fault", press harder.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- 68, TCRF with **monopolar glycine 1.5%**: **deficit 2.4 L**, **Na 113**, pulmonary oedema, NIV, **two seizures**; Na 131 today; patient has capacity and consented to her daughter's debrief
- Hidden: **new slurred speech and coughing on drinking today** – possible **osmotic demyelination** after sodium correction; needs urgent medical/neurology review and MRI

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * ***Acts on the new symptoms****: dysarthria and dysphagia on day 2–6 after sodium correction may be* ***osmotic demyelination*** *– urgent senior/neurology review,* ***sodium and correction history****, MRI, swallow assessment / nil by mouth until safe*
- * ***Statutory duty of candour****: notifiable safety incident (ITU, seizures = at least moderate harm) – apology, true account, written follow-up,* ***share investigation findings****; incident reported and* ***PSIRF*** *learning response*
- Confirms the mother's consent to share and offers a joint meeting with her and the consultant

Applied clinical knowledge

- * *Explains* ***fluid absorption****: glycine is* ***salt-free****; absorbed fluid dilutes blood sodium, causing* ***brain swelling (confusion, seizures) and fluid on the lungs***
- * ***Guidance (BSGE/ESGE)****: for hypotonic media, stop at a deficit of* ***1000 mL*** *in healthy women and* ***750 mL*** *in older women or with comorbidity; monitor deficit continuously (ideally automated);* ***bipolar systems with isotonic saline*** *are preferred where possible (but overload still occurs, threshold 2500 mL)*
- * ***Sodium correction****: in acute symptomatic hyponatraemia 3% saline boluses for seizures; limit the rise to* ***about 10 mmol/L in 24 h*** *(8 thereafter) to reduce osmotic demyelination risk*

Communicating with patients and families

- * *Sees* ***the daughter, not just the solicitor****;* ***sincere apology****; honest that* ***something went wrong*** *and that the deficit* ***exceeded the guideline*** *without pre-judging the investigation*
- * *On "negligence": does not endorse or deny – explains the* ***investigation*** *and that legal standards are for independent assessment;* ***apology is not an admission of liability****; explains PALS, complaints, right to independent advice*

Information gathering

- * *Asks* ***how her mother seems now*** *and finds the* ***slurred speech and coughing when drinking***
- * *Checks what she already knows, her mother's wishes and consent to share, and her main concerns*

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not recognise or act on the new speech and swallowing symptoms = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Inaccurate or minimising account of the fluid deficit, or claims the guideline was followed = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

No apology, or answers "negligence" evasively ("I can't comment") or by agreeing it was negligent = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask how her mother is now = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

DEBRIEF SUMMARY (1)

Haywain General Hospital NHS Trust
GYNAECOLOGY – MRS OBIAGELI ODUYA | DAY 3 AFTER TCRF

Patient	Mrs Obiageli Oduya, 68. Hypertension (amlodipine). Type 1 submucous fibroid 4.2 cm. Has capacity; consents to daughter receiving debrief
Operation (day 0)	TCRF under GA, **monopolar** resectoscope, **glycine 1.5%**. 75 minutes. Glycine in 18,000 mL; out 15,600 mL; **deficit 2,400 mL** (time first recorded: not documented)
Recovery	Confused, agitated, vomiting, breathless. SpO2 84% air. **Na 113 mmol/L**
ITU (days 0–2)	NIV 18 h. 3% saline. Two generalised seizures day 1 (lorazepam). Na: 113 → 121 (24 h) → 127 (day 2)
Day 3 (08:00)	Ward. Na 131. BP 138/82. HR 78. SpO2 97% air. Neurology review day 2: no focal deficit
Governance	Incident reported. Learning response commissioned. Written candour letter: pending

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6. RCOG INSTRUCTIONS

Module(s) examined	4: Postoperative Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 35–50
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × DEBRIEF SUMMARY (1)

Sources: BSGE/ESGE: Management of fluid distension media in operative hysteroscopy (Umranikar et al. Gynecol Surg 2016); NICE IPG / RCOG Consent Advice: operative hysteroscopy; Spasovski G et al. European clinical practice guideline on hyponatraemia (2014); CQC Regulation 20: Duty of candour; NHS Resolution: Saying sorry; NHS England PSIRF (2022).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Hysteroscopic fluid overload in one line

Know your medium and your limit: hypotonic glycine – **stop at 1000 mL (750 mL if older or comorbid)**. After overload, correct sodium **slowly**, watch for **demyelination**, and be **honest** with the family.

Fluid deficit limits (BSGE/ESGE)

Hypotonic, healthy	Hypotonic, comorbid	Isotonic, healthy	Isotonic, comorbid
Stop at 1000 mL	Stop at 750 mL	Stop at 2500 mL	Stop at 1500 mL

If overload happens

Stop, measure deficit	Na, osmolality, ABG	O_2 ± diuretic, ICU	3% saline if seizures	Slow correction, MRI if signs

Three things examiners look for

EXPLAIN SIMPLY	DEMYELINATION	"NEGLIGENCE?"
• Salt-free fluid absorbed	• Days 2–6 after correction	• Don't endorse or deny
• Diluted blood salt	• Slurred speech	• Something went wrong
• Brain swelling → seizures	• Swallowing problems	• Investigation will say
• Fluid on the lungs	• Confusion, weakness	• Sorry ≠ liability

Say it simply

"The fluid used to open up the womb has no salt in it. Too much was absorbed into your mother's blood, which lowered her salt level and made her brain and lungs swell. That is why she had seizures and needed intensive care. The amount was more than the guidance says, and I am very sorry."

Common ways to lose marks

Missing the new speech signs • "Guideline was followed" • "Can't comment" • Agreeing it was negligence • Jargon • Ignoring the daughter

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Ureteric Injury after Difficult TAH and BSO

Structured Discussion Task | Module 4 | Postoperative Care

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Ureteric Injury after Difficult TAH and BSO

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
4: Postoperative Care	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *Day 1 after a difficult TAH and BSO for a large fibroid uterus with left broad ligament extension and haemostatic suturing at the left uterine pedicle: loin pain and low urine output. Recognising ureteric injury, the differential for oliguria, CT urography, stent vs nephrostomy vs repair, urinoma and fistula, and candour*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Ward Record (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 on call for gynaecology. **Mrs Priya Shah**, aged 45, had a **difficult total abdominal hysterectomy and BSO yesterday** for a large fibroid uterus. The nurse reports **left loin pain** and **very little urine** in her catheter bag.

You have assessed her. Your consultant has come in to discuss her care with you.

Please read the **WARD RECORD (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Present your assessment and differential diagnosis
- Discuss investigations
- Discuss management with your consultant
- Discuss two further developments and governance

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * ***Oliguria differential:*** *check/flush the catheter; hypovolaemia or bleeding (Hb, fluid challenge); AKI – persistent oliguria after fluid with loin pain is* ***not pre-renal until proven otherwise****; marked oliguria with one normal kidney raises concern for* ***bilateral or bladder injury***
- * ***Kidney protection: urgent same-day urology referral****; avoid nephrotoxins (NSAIDs, gentamicin); an* ***infected obstructed kidney needs urgent drainage***
- * ***Card A – stent fails: percutaneous nephrostomy*** *to decompress the kidney; antegrade stent attempt or repair (usually* ***reimplantation ± psoas hitch****), timing decided by urology*

Applied clinical knowledge

- * ***Risk factors and sites:*** *large fibroids,* ***broad ligament extension displacing the ureter****, heavy bleeding with blind sutures, distorted anatomy; injury at the infundibulopelvic ligament,* ***where the uterine artery crosses****, the vault*
- * ***Investigations:*** *U&E/creatinine, ultrasound (hydronephrosis),* ***CT urogram*** *(site, obstruction vs leak, urinoma); retrograde study at cystoscopy is diagnostic and therapeutic*
- **Management (urology-led):** retrograde **JJ stent** first; nephrostomy if it fails; repair for transection or unrelieved ligation; late complications – **stricture**, fistula
- * ***Card B – ureterovaginal fistula:*** *CT urogram, stent or nephrostomy, delayed repair; prevention – pre-operative imaging, identify the ureter,* ***consider*** *stents or cystoscopy in high-risk cases*

Communicating with colleagues

- * ***Handover:*** *structured SBAR to urology (operation, risk factors, timing, CT findings, creatinine); operating consultant involved*
- * ***Candour and governance:*** *honest with Mrs Shah early; unplanned procedure is notifiable –* ***duty of candour****, incident report; learning without hindsight bias or blame*

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
Day 1 after difficult midline TAH/BSO (left broad ligament fibroid displacing the ureter; blind haemostatic sutures at the left uterine pedicle; EBL 900 mL; no cystoscopy): left loin pain, 30 mL urine in 3 h, creatinine 68 → 124, no response to a fluid challenge; CT urogram shows left mid-pelvic ureteric obstruction at the pedicle with a small urinoma. Card A: retrograde study – complete block 5 cm above the bladder, guidewire will not pass. Card B: 3 weeks later, continuous watery vaginal leakage with normal voiding (ureterovaginal fistula).

Open the discussion with the following:

> *"Thanks for seeing Mrs Shah. What do you think is happening?"*

Then ask the following questions:

1. **What is your differential diagnosis and what in her history worries you?**
2. **What investigations do you want and what do the results show?**
3. **How should this be managed and by whom?**
4. **Hand the candidate SCENARIO CARD A. "What has happened and what are the options?"**
5. **Hand the candidate SCENARIO CARD B. "What does this suggest and how do you respond?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Why might urine output be so low with one ureter blocked?"
- "What is the first-line procedure?"
- "What if a stent cannot be passed?"
- "What would you tell Mrs Shah today?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Attributes oliguria to dehydration with no assessment for ureteric injury despite loin pain, or delays urology = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not arrange imaging of the urinary tract (CT urogram or equivalent) = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No plan to inform Mrs Shah honestly (duty of candour) = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

WARD RECORD (1)

Haywain General Hospital NHS Trust
GYNAECOLOGY WARD – MRS PRIYA SHAH | DAY 1 POST-OP

Patient	Mrs Priya Shah, 45. BMI 28. No medical history. No previous pelvic surgery. No allergies
Pre-op MRI	Uterus ~780 mL. 11 cm anterior fibroid; left broad ligament fibroid displacing the left ureter medially
Operation (day 0)	TAH + BSO, midline. Brisk bleeding from left uterine pedicle – haemostatic sutures, view limited. EBL 900 mL; 2 units RBC. 185 min. Cystoscopy not performed
Day 1 (10:00)	Left loin pain 6/10. Urine 30 mL in 3 h (catheter), no haematuria. T 37.1 °C. HR 88. BP 118/74. SpO2 98%
Bloods	Hb 98 g/L. Creatinine 124 µmol/L (pre-op 68). K^+ 4.6
Fluid challenge	500 mL crystalloid at 10:30: urine 15 mL in next hour
CT urogram (14:00)	Left ureter obstructed in the mid-pelvis at the level of the uterine pedicle; no contrast below. Delayed left nephrogram. Small left perinephric collection. Right ureter normal. Bladder intact

SCENARIO CARD A
Theatre, same afternoon – urology

Cystoscopy: bladder intact. Retrograde study: complete block in the left ureter about 5 cm above the bladder. Guidewire will not pass. Right ureter normal.

SCENARIO CARD B
Three weeks after discharge

Mrs Shah phones: she is constantly wet with clear watery vaginal discharge, needing pads day and night, though she still passes urine normally.

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6. RCOG INSTRUCTIONS

Module(s) examined	4: Postoperative Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × WARD RECORD (1); 1 × each SCENARIO CARD A–B

Sources: RCOG Consent Advice No. 4: Abdominal hysterectomy for benign conditions (ureteric injury risk); European Association of Urology guidelines on urological trauma (iatrogenic ureteral injury); BAUS guidance on iatrogenic ureteric injury; CQC Regulation 20: Duty of candour; NHS England PSIRF (2022).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Ureteric injury after hysterectomy in one line

Loin pain + oliguria + difficult surgery = ureteric injury until proven otherwise. Check the catheter and volume, then **CT urogram** and **urology the same day**: stent, nephrostomy or repair – and tell her honestly.

Where the ureter is at risk

Pelvic brim	Uterine artery	Vault	Broad ligament
Infundibulopelvic ligament	Ureter passes beneath	Close to the angles	Fibroids displace it

Management ladder

Catheter, fluids, U&E	CT urogram	Retrograde JJ stent	Nephrostomy if fails	Repair / reimplant

Three things examiners look for

PRESENTATIONS	PREVENTION	GOVERNANCE
• Loin pain, fever	• Pre-op imaging	• Urology same day
• Oliguria / rising creatinine	• Identify the ureter	• Duty of candour
• Ileus, urinoma	• Avoid blind sutures	• Incident report
• Watery vaginal loss (fistula)	• Consider stents / cystoscopy	• Learning, not blame

Say it simply

"The tube that drains urine from your left kidney may have been caught by a stitch while we were stopping bleeding during your operation. A scan shows it is blocked. The urology surgeons will try to pass a small tube through it today to protect your kidney. I am very sorry this has happened."

Common ways to lose marks

"She's just dry" • No CT urogram • Delaying urology • Ignoring creatinine • Missing a fistula later • No candour

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KNOWLEDGE AREA

5

Antenatal Care

Sample: 1 SPT · 1 SDT · 55 stations in the full bank

Stations on pages 69–88

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Anti-D Antibody Detected at 28 Weeks

Structured Discussion Task | Module 5 | Antenatal Care

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Anti-D Antibody Detected at 28 Weeks

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
5: Antenatal Care	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A RhD-negative woman attending for routine anti-D prophylaxis at 28 weeks has anti-D at 0.2 IU/mL, eight weeks after anti-D immunoglobulin for a fall. Passive or immune? Whether to give prophylaxis today, then confirmed sensitisation, rising levels and suspected fetal anaemia, and the future*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Antenatal summary (1), laboratory report (2) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 in the antenatal clinic. **Mrs Rachel Penrose**, 31, is RhD negative and 28+3 weeks pregnant. She has come for her routine antenatal anti-D prophylaxis. The midwife has asked you to see the laboratory report on the blood sample taken today **before** the injection.

Please read the **ANTENATAL SUMMARY (1)** and the **LABORATORY REPORT (2)**. Your consultant (the examiner) will discuss these and further information with you.

You have 10 minutes in which you should:

- Interpret the result
- Discuss today's management
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * ***Gives the anti-D prophylaxis today****: passive and immune anti-D cannot be told apart in the laboratory, and prophylaxis continues unless the anti-D is immune* ***beyond doubt*** *(BSH)*
- * *Card A:* ***immune anti-D*** *–* ***no further anti-D Ig*** *(34 weeks or after birth); informs the transfusion laboratory (antibody-compatible blood; recent samples for crossmatch)*
- Incident review and SHOT report for new immune anti-D; check whether anti-D Ig was given after her first birth

Applied clinical knowledge

- * *Passive vs immune: anti-D Ig 500 IU 8 weeks ago; passive anti-D* ***rarely exceeds 0.4 IU/mL****, and* ***falls****; immune anti-D persists or rises. Confirm the dose from the other hospital*
- * ***Monitor as if it could be immune****: repeat quantification every 2 weeks;* ***offer fetal RHD genotyping*** *– an RhD-negative fetus is not at risk*
- * *Levels (IU/mL):* ***under 4*** *HDFN unlikely;* ***4–15*** *moderate;* ***over 15*** *high – refer to* ***fetal medicine at 4*** *or rising levels;* ***MCA-PSV*** *Doppler (over 1.5 MoM suggests anaemia)*
- Card B: suspected fetal anaemia – urgent fetal medicine; transfusion in utero or birth depending on gestation; steroids; neonatal team; cord blood tests

Communicating with colleagues

- * *Gives a clear, ordered* ***summary****, including the key negatives (antibody-negative at booking; one documented dose of anti-D Ig)*
- * *Plans joint working with the* ***transfusion laboratory****,* ***fetal medicine*** *and* ***neonatal team****, and explains to Rachel honestly what this means now and for future pregnancies*
- Documents the plan; letter to GP and the other hospital

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
RhD-negative woman, 28+3 weeks. Anti-D 0.2 IU/mL on the pre-prophylaxis sample; 500 IU anti-D Ig at 20+5 weeks after a fall. Then two short cases on cards.

Open the discussion with the following:

> *"Please summarise Rachel's situation. What could this result mean?"*

Then ask the following questions:

1. **How would you tell whether this anti-D is passive or immune?**
   Look for: History and dates of anti-D Ig; confirm with the other hospital; level (≤0.4 IU/mL fits passive); no laboratory test separates them; trend on repeat samples.
2. **The midwife asks whether to give the injection today. What do you advise, and what else would you arrange?**
   Look for: Give it – continue prophylaxis unless immune beyond doubt; monitor as if immune; repeat level in 2 weeks; offer fetal RHD genotyping.
3. **Hand the candidate SCENARIO CARD A. "What does this mean, and what is your plan?"**
   Look for: Immune anti-D; stop anti-D Ig; 2-weekly levels; fetal medicine if ≥4 IU/mL or rising; transfusion laboratory; neonatal team; incident review; plan birth.
4. **Hand the candidate SCENARIO CARD B. "How would you manage this?"**
   Look for: Moderate risk and raised MCA-PSV: urgent fetal medicine; options of transfusion in utero vs birth; steroids; neonatal unit; blood for the baby.
5. **How would you explain this to Rachel, including future pregnancies?**
   Look for: Honest, calm; antibody is permanent; this baby closely monitored; future RhD-positive babies at risk, possibly more severe; early referral and fetal genotyping next time.

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Can the laboratory tell us which it is?"
- "What if she had never received anti-D immunoglobulin?"
- "What if the fetus is RhD negative?"
- "When should she give birth?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Withholds today's anti-D prophylaxis on the basis of this result = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not recognise immune anti-D in Card A = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No coherent summary or plan = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ANTENATAL SUMMARY (1)

Haywain General Hospital NHS Trust
ANTENATAL CLINIC

Patient	Mrs Rachel Penrose, 31. G2 P1. **Group O RhD negative.** Today 28+3 weeks
First pregnancy	Vaginal birth 3 years ago at another hospital. Baby's blood group and postnatal anti-D not recorded in our notes
This pregnancy	Booking (11 weeks): **no red cell antibodies**. Fetal RHD genotyping not performed. Normal anomaly scan
20+5 weeks	Fall on ice; seen in maternity triage at another hospital. Discharge letter: **"anti-D Ig 500 IU given IM"**; Kleihauer negative
Today	Routine anti-D prophylaxis due. Sample taken before injection. Fetal growth normal

LABORATORY REPORT (2)

Haywain General Hospital NHS Trust
TRANSFUSION LABORATORY

Group	O RhD negative
Antibody screen	**Positive – anti-D**
Anti-D quantification	**0.2 IU/mL**
Comment	Could be passive anti-D Ig or immune anti-D. Please confirm dates and doses of anti-D Ig given.

SCENARIO CARD A (question 3)
32+3 weeks

Anti-D **1.8 IU/mL**. Fetal RHD genotyping: **RHD positive**. Rachel feels well; growth scan normal.

SCENARIO CARD B (question 4)
34+2 weeks

Anti-D **9 IU/mL**. Middle cerebral artery peak systolic velocity **1.6 MoM**. No hydrops.

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6. RCOG INSTRUCTIONS

Module(s) examined	5: Antenatal Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ANTENATAL SUMMARY (1); 2 × LABORATORY REPORT (2); 1 × each SCENARIO CARD A–B

Sources: Regan F et al. Guideline for the investigation and management of red cell antibodies in pregnancy: a British Society for Haematology guideline. Transfusion Medicine 2025;35:3–23 (incorporating RCOG Green-top Guideline No. 65); Qureshi H et al. BCSH guideline for the use of anti-D immunoglobulin for the prevention of HDFN. Transfusion Medicine 2014; NICE TA156 Routine antenatal anti-D prophylaxis; NICE DG25 High-throughput non-invasive fetal RHD genotyping; SHOT annual report – immune anti-D in pregnancy.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Anti-D found before prophylaxis – in one line

Passive and immune anti-D look the same in the lab. **If in doubt, give the prophylaxis** and **monitor as if immune**. Once immune anti-D is certain, **stop anti-D Ig**, check levels 2-weekly and refer to fetal medicine at **4 IU/mL**.

Passive or immune?

History	Level	Trend	Before any dose
Anti-D Ig given? When? Dose?	Passive rarely over 0.4 IU/mL	Passive falls; immune stays or rises	Anti-D present = immune

Anti-D level and risk (IU/mL)

Under 4: HDFN unlikely	4–15: moderate – refer	Over 15: high – refer	Levels 4-weekly to 28 wk, then 2-weekly	MCA-PSV over 1.5 MoM = anaemia

Three things examiners probe

TODAY	IF IMMUNE	GOVERNANCE AND FUTURE
• Give RAADP • Confirm the earlier dose • Repeat level in 2 weeks • Offer fetal RHD genotyping	• No more anti-D Ig • Fetal medicine at 4 IU/mL • Transfusion lab aware • Neonatal team; cord bloods	• Incident review; SHOT • Permanent antibody • Next RhD+ baby at risk • Early referral next time

Say it simply

"The test picked up a small amount of anti-D. It's most likely left over from the injection after your fall, but we can't be certain yet. So we'll still give today's injection – it can't do harm – and check your blood every two weeks to be sure."

Common ways to lose marks

Withholding RAADP "until clarified" • Using US titres (1:16) instead of IU/mL • Giving anti-D Ig once immune • No fetal medicine referral at 4 IU/mL • Forgetting the neonatal team

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Primary Cytomegalovirus (CMV) Infection at 10 Weeks

Simulated Patient Task | Module 5 | Antenatal Care

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Primary Cytomegalovirus (CMV) Infection at 10 Weeks

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
5: Antenatal Care	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A 32-year-old teacher, 10 weeks pregnant, has serology showing recent primary CMV infection. Explaining the results and realistic risks, valaciclovir, amniocentesis and scans, correcting a misconception about the source, and hygiene advice*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Virology results (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the antenatal clinic. **Mrs Sarah Jennings**, aged 32, a primary school teacher, is **10+2 weeks** pregnant with her first baby. Her GP checked her blood after a recent illness and has referred her urgently with the results. **She has come on her own.**

Please read the **VIROLOGY RESULTS (1)** carefully.

You have 10 minutes in which you should:

- Take a focused history
- Explain the results
- Discuss management
- Address her concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Mrs Sarah Jennings**, 32, a Year 3 teacher. This is a planned first pregnancy. Your GP rang and said "CMV" – you looked it up and read about brain damage and deafness. You are frightened and trying to stay calm. Your husband Tom is at work.

Only if asked:

• **The illness:** about **3 weeks ago (7–8 weeks pregnant)**: fever, sore throat, swollen neck glands, aches and exhaustion for about 10 days. You feel better now.

• **Contact with young children:** you look after your sister's **18-month-old son** every Friday, including nappy changes, and often finish his food with his spoon.

• No medical problems or medicines other than folic acid. No previous CMV test. Tom is well.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"My GP said it was urgent. Is my baby all right?"*

About the results

> *"What does "low avidity" mean? Does it definitely mean I caught it while pregnant?"*

About the source

> *"Two children in my class had hand, foot and mouth just before I got ill. That caused this, didn't it?"*

About risk

> *"What are the actual chances my baby is affected? I need a number."*

About treatment

> *"Is there a medicine? Is it safe – will it cure the baby?"*

About testing

> *"What's an amniocentesis? Could it cause a miscarriage? Do I have to have one?"*

About work and Tom

> *"Should I stay off work? And Tom asked whether he needs to do anything."*

Acting requirements

- Become tearful when CMV is first named. Settle if the candidate gives clear numbers in proportion.
- If the candidate uses jargon, say: "Sorry – can you say that more simply?"
- If asked about young children, mention your nephew and then ask: "Is that how I caught it?"

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- CMV IgM and IgG positive, low avidity (18%): recent primary infection, most likely at 7–8 weeks
- Hidden: weekly care of an 18-month-old (nappies, shared spoon); worried about hand, foot and mouth

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * ***Urgent fetal medicine referral***; *discusses* ***valaciclovir 8 g/day*** *(off-label; may be offered after first-trimester primary infection; best started soon after infection)*
- * ***Amniocentesis*** *for CMV PCR* ***from about 20–21 weeks*** *(after 17, ideally after 20 weeks, and 6–8 weeks after infection); miscarriage risk* ***below 0.5%****; her choice*
- Scans every 2–3 weeks; neonatal urine or saliva test within 21 days; hearing follow-up

Applied clinical knowledge

- * *Interprets* ***low avidity*** *as infection within about 3 months – i.e. in pregnancy, matching her illness*
- * *Gives* ***figures****: after first-trimester infection about* ***1 in 3*** *babies are infected; of those, about* ***1 in 4–5*** *have long-term hearing or developmental problems; overall about* ***4–5%*** *born with symptoms*
- * *Valaciclovir reduced fetal infection from about* ***30% to 11%*** *in a trial; it does not treat a baby who is already affected*
- Hand, foot and mouth is a different virus; CMV spreads in the saliva and urine of under-3s

Communicating with patients and families

- * *Explains in* ***plain language****; neither catastrophises nor falsely reassures; checks understanding*
- * *Corrects the source* ***without blame****; gives hygiene advice (****share, kiss, wash with care****); no need to stop work*
- Non-directive; offers CMV Action and ARC; invites Tom to the next visit

Information gathering

- * *Establishes the* ***timing and symptoms*** *of her illness*
- * *Asks about* ***contact with young children*** *under 3 (likely source)*
- Explores what she has read and her main worries

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not arrange urgent fetal medicine referral = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Misinterprets the results as past infection, or says the baby is definitely infected = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Gives false reassurance or catastrophises = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not establish when she was unwell = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

VIROLOGY RESULTS (1)

Haywain General Hospital NHS Trust
VIROLOGY – MRS SARAH JENNINGS

Gestation	10+2 weeks (dated by scan). G1 P0
CMV IgM	**Positive**
CMV IgG	**Positive**
CMV IgG avidity	**Low – 18%**
EBV serology	No evidence of recent infection
Hepatitis A, B and C	Negative
Other bloods	FBC normal. ALT 52 U/L (mildly raised). CRP 12 mg/L

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6. RCOG INSTRUCTIONS

Module(s) examined	5: Antenatal Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 25–38
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × VIROLOGY RESULTS (1)

Sources: Khalil A et al. Congenital cytomegalovirus infection: update on screening, diagnosis and treatment. RCOG Scientific Impact Paper No. 56 (2nd edition). BJOG 2025;132:e42–e52; Shahar-Nissan K et al. Valaciclovir to prevent vertical transmission of CMV after maternal primary infection: a randomised, double-blind, placebo-controlled trial. Lancet 2020; RCOG Green-top Guideline No. 8: Amniocentesis and chorionic villus sampling (2021).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Primary CMV in one line

Low avidity = **recent infection**. After first-trimester infection about **1 in 3** babies are infected, and a minority of those have problems. Refer to **fetal medicine**, discuss **valaciclovir**, offer **amniocentesis at 20–21 weeks**, and give **hygiene advice** – without blame.

Reading the serology (RCOG SIP 56)

IgM +	Avidity <30%	Avidity 30–60%	Avidity >60%
Recent or reactivated – not enough alone	Primary infection within 3 months	Primary cannot be excluded	Past or non-primary infection

Timing of maternal infection matters

1st trimester: ~37% infected	If infected: ~23% long-term problems	2nd trimester: ~40%, rarely harmed	3rd trimester: ~66%, rarely harmed	Overall 1st tri: 4–5% symptomatic

Three things examiners look for

VALACICLOVIR	AMNIOCENTESIS	AFTERWARDS
• 8 g a day; off-label	• After 17, ideally 20+ weeks	• Scans every 2–3 weeks
• May be offered, 1st trimester	• 6–8 weeks after infection	• MRI 28–32 weeks if infected
• Start soon after infection	• PCR sensitivity 85–95%	• Baby tested within 21 days
• ~30% → 11% in trial	• Risk below 0.5%	• Hearing follow-up

Say it simply

"The test shows you caught CMV for the first time recently – probably when you were ill. In about 2 out of 3 pregnancies like yours the baby doesn't catch it, and most babies who do are well. There's a tablet that lowers the chance of it passing to the baby, and a test later on can tell us if the baby has it."

Common ways to lose marks

"It's an old infection" • No numbers • Amniocentesis now • Quoting a 1% procedure risk • "Valaciclovir will cure the baby" • Agreeing hand, foot and mouth was the cause

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KNOWLEDGE AREA

6

Maternal Medicine

Sample: 1 SPT · 1 SDT · 32 stations in the full bank

Stations on pages 90–109

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Epilepsy on Valproate: Pre-Pregnancy Counselling

Simulated Patient Task | Module 6 | Maternal Medicine

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Epilepsy on Valproate: Pre-Pregnancy Counselling

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
6: Maternal Medicine	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Generalised epilepsy well controlled on sodium valproate; she wants to plan a pregnancy. Honest risks, the Pregnancy Prevention Programme, switching drugs safely, folic acid – and finding she stopped the pill 5 weeks ago and her period is late*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Neurology letter (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the pre-pregnancy clinic. **Miss Zara Hussain**, aged 24, has **epilepsy** treated with **sodium valproate**. She would like to plan a pregnancy and her GP has referred her. **She has come on her own.**

Please read the **NEUROLOGY LETTER (1)** carefully.

You have 10 minutes in which you should:

- Take a focused history
- Explain the risks of valproate in pregnancy
- Agree a plan with her
- Address her concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Miss Zara Hussain**, 24, an administrative assistant. You have had **tonic-clonic seizures since age 16**. **Valproate** has stopped them – none for 18 months. You read online that valproate causes birth defects, and a friend said you "won't be allowed" to get pregnant. You are frightened. Your partner **Kieran** is at work.

Only if asked:

• **Contraception and periods:** you **stopped the combined pill 5 weeks ago** "to get it out of your system before trying". Your **period is 9 days late**. You haven't done a test because you're scared.

• **Background:** you take valproate 1 g daily and folic acid 400 micrograms from the chemist; no other medicines; you drive; seizures used to happen with sleep deprivation.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"My friend says I'm not allowed to get pregnant on valproate. Is that true?"*

About the risks

> *"What are the actual chances of something being wrong with the baby?"*

About switching

> *"Can I just switch to a safer tablet today? Or stop it?"*

Kieran's question

> *"Kieran wants to know: why was she kept on it if it's that risky?"*

Acting requirements

- Be anxious and tearful when the developmental risk is explained; settle with clear, kind information.
- Mention stopping the pill and the late period only if asked about contraception, periods or whether you could be pregnant.
- If told to stop valproate straight away, ask: "What if I have a fit?"

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- **Generalised epilepsy**, seizure-free 18 months on **valproate 1 g**; Pregnancy Prevention Programme form signed 8 months ago
- Hidden: **stopped the combined pill 5 weeks ago; period 9 days late** – she may already be pregnant

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * ***Pregnancy test today***; *whatever the result,* ***do not stop valproate abruptly*** *(risk of seizures, SUDEP);* ***urgent neurology review this week***; *if pregnant – early scan, detailed anomaly scan, fetal medicine*
- * *If not pregnant:* ***highly effective contraception*** *until the switch is complete – IUD, IUS or implant preferred; if a user-dependent method, add a barrier method and pregnancy tests (PPP)*
- **Folic acid 5 mg** daily (not 400 micrograms); seizure safety (bathing, sleep); DVLA rules if a seizure occurs during a switch

Applied clinical knowledge

- * *Valproate in pregnancy:* ***about 1 in 10 babies have a major birth defect*** *(e.g. spina bifida, heart, cleft, limb) and* ***30–40% of children have neurodevelopmental problems***; *dose-related; she must not be told she cannot have a baby*
- * ***Lamotrigine and levetiracetam are the safer options*** *(MHRA review); the* ***switch is planned by neurology over weeks–months***, *with seizure control confirmed before trying*
- Lamotrigine levels **fall in pregnancy** (and with oestrogen) – monitor and adjust; continue specialist care; **epilepsy is not a reason for caesarean**; breastfeeding usually possible

Communicating with patients and families

- * ***Non-directive and non-judgemental***; *corrects the "not allowed" myth; honest numbers with context (9 in 10 without a major defect)*
- Answers **Kieran's question** honestly: valproate is very effective and was kept under the PPP; today's plan is to make pregnancy safer; no blame

Information gathering

- * *Asks about* ***contraception and last period*** *and finds* ***stopped pill and late period***
- * *Establishes* ***seizure type, control and triggers***, *medicines (folic acid dose), driving, and her* ***understanding and goals***

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Tells her to stop valproate today, or switches drugs without neurology = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not explain the neurodevelopmental risk of valproate = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Tells her she cannot or should not have a baby = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask about contraception or her last period = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

NEUROLOGY LETTER (1)

Haywain General Hospital NHS Trust
NEUROLOGY CLINIC | MISS ZARA HUSSAIN

Patient	Miss Zara Hussain, 24. G0
Diagnosis	**Idiopathic generalised epilepsy** (tonic-clonic seizures from age 16). Triggers: sleep deprivation
Treatment	**Sodium valproate MR 1,000 mg daily.** Previous trial of lamotrigine at age 17 stopped after 3 weeks (rash)
Control	Last seizure **18 months ago**
Pregnancy Prevention Programme	Annual Risk Acknowledgement Form signed **8 months ago**. Contraception: **combined oral contraceptive pill**
Plan (8 months ago)	"Stable. Continue valproate. Review in 12 months."
GP note (this month)	"Wishes to plan a pregnancy – please advise."

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6. RCOG INSTRUCTIONS

Module(s) examined	6: Maternal Medicine
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 20–32
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × NEUROLOGY LETTER (1)

Sources: MHRA Drug Safety Update: Antiepileptic drugs in pregnancy – updated advice following comprehensive safety review (2021); MHRA: Valproate Pregnancy Prevention Programme and January 2024 measures; NICE NG217: Epilepsies in children, young people and adults (2022); RCOG Green-top Guideline 68: Epilepsy in pregnancy (2016); FSRH UKMEC.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Valproate and pregnancy in one line

About 1 in 10 birth defects and 30–40% neurodevelopmental problems. Never stop it abruptly; **neurology switches it**, usually to lamotrigine or levetiracetam; **highly effective contraception** until then; **5 mg folic acid**; and always ask whether she might already be pregnant.

Antiseizure medicines in pregnancy (MHRA 2021)

Valproate	Topiramate, phenytoin	Carbamazepine	Lamotrigine, levetiracetam
~10% defects; 30–40% neurodevelopmental	Increased defect risk	Dose-related defect risk	Safer options

Today's plan

Pregnancy test	Do not stop valproate	Urgent neurology	Folic acid 5 mg	LARC until switch complete

Three things examiners look for

HONESTY	SAFETY	IN PREGNANCY
• Real numbers	• Ask about periods	• Lamotrigine levels fall
• With context	• No abrupt stopping	• Joint epilepsy clinic
• No "not allowed"	• PPP contraception	• Detailed anomaly scan
• Her decision	• SUDEP awareness	• Vaginal birth usual

Say it simply

"No one can tell you that you can't have a baby. But valproate does carry real risks – about 1 in 10 babies have a birth defect and 3 or 4 in 10 children have learning or developmental problems. So first, let's do a pregnancy test – and please don't stop your tablets. Your neurologist can move you to a safer medicine."

Common ways to lose marks

Not asking about periods • "Stop valproate now" • "You can't get pregnant" • 400 micrograms folic acid • Missing neurodevelopmental risk • Relying on the pill alone

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Myasthenia Gravis in Pregnancy

Structured Discussion Task | Module 6 | Maternal Medicine

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Myasthenia Gravis in Pregnancy

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
6: Maternal Medicine	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *AChR-antibody-positive myasthenia gravis at 18 weeks with borderline blood pressure. Drugs to avoid (above all magnesium sulphate), neonatal myasthenia, the birth plan, then severe pre-eclampsia at 33 weeks and a postnatal deterioration on gentamicin*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Antenatal clinic record (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 in the antenatal (obstetric medicine) clinic. **Mrs Katrin Vogel**, 31, is **18+0 weeks** into her first pregnancy. She has **myasthenia gravis** and has been referred by her neurologist. The specialty registrar who saw her first has written a plan in the notes.

Please read the **ANTENATAL CLINIC RECORD (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss the risks to Mrs Vogel and her baby
- Discuss her plan for pregnancy and birth
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * ***Magnesium sulphate must be avoided*** *– it reduces acetylcholine release and can cause a* ***myasthenic crisis and respiratory failure****;* ***alert on all records****, birth plan, labour ward, anaesthetists*
- * *Other drugs to avoid or use with care:* ***aminoglycosides (gentamicin), fluoroquinolones, macrolides, beta-blockers and calcium-channel blockers*** *(labetalol, nifedipine – caution),* ***neuromuscular blockers*** *(anaesthetic plan);* ***do not stop pyridostigmine, prednisolone or azathioprine***
- Card B: **gentamicin stopped**; **forced vital capacity** (not SpO2) to monitor breathing; **HDU/ICU, neurology, anaesthetics**; IVIG or plasma exchange; alternative antibiotic

Applied clinical knowledge

- * *Course* ***unpredictable****: about* ***one-third worsen****, most often in the* ***first trimester and the months after birth****; infection, stress, surgery and some drugs trigger exacerbations*
- * ***Transient neonatal myasthenia*** *in about* ***10–20%*** *(maternal IgG crosses the placenta): weak suck, cry, floppy, breathing;* ***not predicted by her severity****; resolves over weeks; birth where there is a* ***neonatal unit****; baby observed for at least 48 h;* ***arthrogryposis*** *rare – watch fetal movements*
- Birth: **uterus (smooth muscle) is unaffected**; **vaginal birth**; **early epidural** advised; **assisted second stage** if fatigue; caesarean for obstetric reasons; **stress-dose steroids** (on prednisolone); **parenteral neostigmine** if she cannot take oral pyridostigmine

Communicating with colleagues

- * ***Corrects the registrar*** *clearly and respectfully, explaining why;* ***structured summary*** *(SBAR)*
- * ***MDT plan in writing****: neurology, obstetric anaesthesia (third-trimester review), neonatology, midwifery, pharmacy; respiratory baseline; Card A: senior decisions shared with neurology and ICU*

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
Generalised AChR-positive myasthenia gravis; thymectomy for thymoma; pyridostigmine, prednisolone 15 mg, azathioprine; 18+0 weeks; BP 132/86; registrar plans magnesium if pre-eclampsia. Then two short cases on cards.

Open the discussion with the following:

> *"Please summarise Mrs Vogel's case. The registrar has written: 'If she gets pre-eclampsia we will give magnesium sulphate as usual.' Do you agree?"*

Then ask the following questions:

1. **Which other drugs are a problem for her, and how will you make sure no one gives them?**
   Look for: Aminoglycosides, fluoroquinolones, macrolides, beta-blockers (caution), neuromuscular blockers; alert on records and drug chart; pharmacy; birth plan; continue her MG medicines.
2. **She asks: "Will my baby have myasthenia?" What do you tell her?**
   Look for: Transient neonatal MG about 10–20%; antibodies cross the placenta; not linked to her severity; resolves; neonatal team, observation ≥48 h; rare arthrogryposis – fetal movements and scans.
3. **How will you plan the rest of her pregnancy and her birth?**
   Look for: Neurology review; FVC baseline; aspirin if pre-eclampsia risk factors; vaginal birth; early epidural; assisted second stage if tired; IV hydrocortisone cover; parenteral neostigmine if nil by mouth; postnatal close follow-up.
4. **Hand the candidate SCENARIO CARD A. "How will you manage her?"**
   Look for: Severe pre-eclampsia plus new bulbar weakness (MG worsening – FVC, neurology); avoid magnesium; IV hydralazine; labetalol or nifedipine only with caution and close monitoring of weakness; seizure prophylaxis alternative (e.g. levetiracetam) agreed with neurology; steroids; plan birth; anaesthetic and neonatal teams.
5. **Hand the candidate SCENARIO CARD B. "What is happening and what will you do?"**
   Look for: Myasthenic exacerbation after birth, worsened by infection and gentamicin; stop gentamicin; FVC monitoring; HDU/ICU; neurology; IVIG or plasma exchange; safe antibiotic; Datix; check baby.

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Would her MG make the baby's condition worse if her own disease is mild?"
- "Her oxygen saturation is 97% – is she safe?"
- "Should she have a caesarean to avoid tiring in labour?"
- "Can she breastfeed on her medicines?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Agrees to give magnesium sulphate, or continues gentamicin in card B = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not recognise a myasthenic exacerbation in card B = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Unable to give a structured summary or escalate appropriately = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ANTENATAL CLINIC RECORD (1)

Haywain General Hospital NHS Trust
ANTENATAL CLINIC – MRS KATRIN VOGEL

Patient	Mrs Katrin Vogel, 31. G1 P0. **18+0 weeks.** Singleton. Weight 64 kg
Myasthenia gravis	Generalised. **Acetylcholine receptor antibody positive.** Diagnosed aged 26. **Thymectomy aged 27** (thymoma, completely removed). No crisis or ventilation ever
Medicines	**Pyridostigmine 60 mg four times daily. Prednisolone 15 mg daily. Azathioprine 100 mg daily.** Folic acid 400 micrograms
Symptoms	Tired by evening; occasional double vision late in the day. No swallowing or breathing problems
Today	**BP 132/86.** Urine: no protein. HR 80. SpO2 98% on air
Results	FBC and LFTs normal. Booking bloods normal. Combined screening: low chance
Registrar's plan	"Continue meds. Routine care. **If pre-eclampsia develops: magnesium sulphate as usual.** Review at 28 weeks"

SCENARIO CARD A (question 4)
33+0 weeks – maternity assessment unit

BP 166/112 and 162/110. Urine protein:creatinine ratio 96 mg/mmol. Headache; brisk reflexes. Platelets 98. ALT 72. CTG normal. **New slurred speech and drooping eyelids by evening** for 2 days.

SCENARIO CARD B (question 5)
Day 3 after vaginal birth – postnatal ward

Temp 38.4 °C, tender uterus. The FY1 started **IV gentamicin** and co-amoxiclav 12 hours ago. She now has **double vision, difficulty swallowing and is short of breath talking**. **SpO2 97%** on air. **FVC 1.4 L** (2.9 L antenatally). Baby feeding well.

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6. RCOG INSTRUCTIONS

Module(s) examined	6: Maternal Medicine
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ANTENATAL CLINIC RECORD (1); 1 × each SCENARIO CARD A–B

Sources: International consensus guidance for management of myasthenia gravis (MGFA, 2016; updated 2021); Gilhus NE. Myasthenia gravis can have consequences for pregnancy and the developing child. Front Neurol 2020;11:554; Myasthenia gravis in pregnancy: UK practice review, ACNR; Lake AJ et al. Severe pre-eclampsia in the setting of myasthenia gravis. Case Rep Obstet Gynecol 2017; NICE NG133: Hypertension in pregnancy (magnesium sulphate cautions).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Myasthenia in pregnancy in one line

No magnesium, no gentamicin, care with beta-blockers. Keep her MG medicines going, plan an **early epidural** and a **neonatal team at birth**, and watch her **breathing (FVC)** most closely **after the birth**.

Drugs and myasthenia

Avoid	Caution	Continue	Rescue
Magnesium sulphate; aminoglycosides	Fluoroquinolones, macrolides, beta-blockers, calcium-channel blockers, muscle relaxants	Pyridostigmine, prednisolone, azathioprine	IVIG or plasma exchange; ICU

Through pregnancy

Alert on all records	Neurology + anaesthetic plan	FVC baseline; fetal movements	Early epidural; assisted 2nd stage	Neonatal team; watch her 3–6 months

Three things examiners probe

PRE-ECLAMPSIA	THE BABY	AFTER BIRTH
• No magnesium	• Neonatal MG ~10–20%	• Highest-risk time
• Hydralazine first	• Not linked to her severity	• FVC, not SpO2
• Labetalol / nifedipine: caution	• Observe ≥48 h	• Check every new drug
• Anticonvulsant via neurology	• Rare arthrogryposis	• Breastfeeding usually fine

Say it simply

"Some babies of mothers with myasthenia are a bit floppy or slow to feed for a few weeks because your antibodies cross over. It doesn't mean the baby has myasthenia, it isn't linked to how bad yours is, and it passes. The baby's team will be there at the birth."

Common ways to lose marks

Accepting "magnesium as usual" • Gentamicin for endometritis • Reassured by SpO2 • Stopping her MG medicines • Caesarean "to avoid fatigue" • No neonatal plan

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PIPADOR REVISION

KNOWLEDGE AREA

7

Management of Labour

Sample: 1 SPT · 1 SDT · 35 stations in the full bank

Stations on pages 111–130

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Fetal Monitoring Governance on the Labour Ward

Structured Discussion Task | Module 7 | Management of labour

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Fetal Monitoring Governance on the Labour Ward

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
7: Management of labour	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A structured discussion on labour ward safety: themes from MNSI referrals involving delayed escalation of abnormal CTGs, fetal monitoring training and competency (Saving Babies' Lives Element 4, Maternity Incentive Scheme), hourly "fresh eyes" reviews and escalation culture – then audit data and a midwife raising staffing concerns*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST7 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Governance report (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are an ST7 and the deputy fetal monitoring lead. Three recent cases referred to **Maternity and Newborn Safety Investigations (MNSI)** involved **delayed escalation of abnormal CTGs**.

Please read the **GOVERNANCE REPORT (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Interpret the findings
- Discuss your improvement plan
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST7 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST7 will discuss or mention many of the following:

Patient safety

- * ***Improvement plan: QI programme****: standardised* ***fresh eyes proforma*** *with escalation algorithm,* ***consultant presence*** *criteria,* ***ward rounds/huddles*** *with acuity tool, protected training time for obstetricians,* ***simulation (PROMPT)*** *with human factors, electronic CTG alerts/central monitoring, audit cycles (PDSA), psychological safety ("speak up"), feedback of MNSI learning, board-level reporting via safety champions.*
- **Card A – fresh eyes compliance:** Poor process compliance → redesign: make fresh eyes **part of the workflow** (electronic prompts, buddy assignment), simplify proforma, education, real-time audit and feedback, celebrate improvement; set targets and re-audit in 3 months.

Applied clinical knowledge

- * ***Key themes: Situational awareness*** *(not considering the whole clinical picture),* ***missing hourly systematic reviews ("fresh eyes")****,* ***escalation failures*** *(hierarchy, unclear thresholds), consultant attendance,* ***staffing/acuity****,* ***training gaps (obstetric staff)****, documentation; human factors rather than individual blame.*
- * ***National standards: SBL v3 Element 4: annual fetal monitoring training and competency assessment*** *for all staff who care for women in labour, a* ***fetal monitoring lead*** *(midwife and obstetrician),* ***hourly systematic CTG review*** *with buddy/fresh eyes, risk assessment at onset and during labour;* ***Maternity (Perinatal) Incentive Scheme*** *training and SBL compliance requirements;* ***RCOG Roles and responsibilities of the consultant*** *(attendance criteria); MNSI referral criteria.*

Communicating with colleagues

- * ***Card B – midwife speaking up:*** *Thank and support the midwife (****speaking up****); escalate via* ***datix and staffing escalation policy****, inform* ***Head/Director of Midwifery*** *and* ***maternity safety champions****; consider* ***Birthrate Plus*** *acuity data, red flag events (delays, missed 1:1 care); incorporate into incident reviews; ensure safe staffing actions (divert, on-call); board reporting.*
- * *Leads MDT improvement; psychological safety and speaking up*
- Engages safety champions, board, MNVP
- Feeds back learning to staff and families

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST7.

Task synopsis:
3 MNSI cases (2 babies cooled, 1 early neonatal death): themes – hourly CTG review not done, failure to consider whole clinical picture, junior doctor not escalating to consultant, consultant not attending. Training compliance: midwives 92%, obstetricians 68%. Card A: audit – fresh eyes reviews documented 45%; escalation proforma used 30%. Card B: band 7 midwife emails that staffing was 6 midwives short on two of the nights.

Open the discussion with the following:

> *"What themes do you see?"*

Then ask the following questions:

1. **What are the key themes?**
2. **What do national standards require?**
3. **What is your improvement plan?**
4. **Hand the candidate SCENARIO CARD A. "What do you make of this?"**
5. **Hand the candidate SCENARIO CARD B. "How do you respond?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "What does fresh eyes mean?"
- "Who must complete fetal monitoring training?"
- "When should a consultant attend?"
- "How do you build an escalation culture?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Ignores the staffing concern = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

No awareness of national training/monitoring standards = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Blame-focused approach to individuals = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

GOVERNANCE REPORT (1)

Haywain General Hospital NHS Trust
MATERNITY GOVERNANCE – QUARTER 3

MNSI referrals	**3 cases**: 2 babies with HIE (cooled), 1 early neonatal death
Common findings	Hourly CTG reviews missing; pathological traces not escalated for 60–120 min; consultant not called in 2 cases
Fetal monitoring training	Midwives **92%**; obstetric doctors **68%**
Staffing	"Several red-flag nights" noted
Request	"Develop an improvement plan"

SCENARIO CARD A (question 4)
Audit

Audit of 60 labours on continuous CTG: **hourly fresh-eyes review documented 45%**; **escalation proforma used 30%**; consultant informed of pathological CTG within 15 min **50%**.

SCENARIO CARD B (question 5)
Email

A band 7 midwife emails you: on two of the MNSI nights the unit was **6 midwives short**, 1:1 care was not possible, and her escalation to the manager "went nowhere".

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6. RCOG INSTRUCTIONS

Module(s) examined	7: Management of labour
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × GOVERNANCE REPORT (1); 1 × each SCENARIO CARD A–B

Sources: NHS England Saving Babies' Lives Care Bundle v3 (2023; v3.2) – Element 4; NHS Resolution Maternity (Perinatal) Incentive Scheme (Year 8, 2026); Maternity and Newborn Safety Investigations (MNSI) programme; NHS England PSIRF (2022); RCOG Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2022); NICE NG229 Fetal monitoring in labour (2022); NICE NG4 Safe midwifery staffing.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Fetal monitoring safety in one line

Train everyone annually, review every hour with fresh eyes, escalate early, and fix the system – not the individual.

Analyse themes (MNSI)	**Training + competency (all staff)**	**Hourly fresh-eyes + escalation tool**	**Consultant attendance criteria**	**Audit, PDSA, feedback**

SYSTEM FIXES	CULTURE
• Electronic prompts / central monitoring • Buddy system • Protected training time • Simulation with human factors • Acuity / staffing tools	• Psychological safety • Speak up guardian • Safety champions • Share learning • Just culture

Say it simply

"The common thread is that abnormal traces weren't reviewed systematically or escalated. I'd get obstetric training compliance up, embed hourly fresh-eyes reviews with a clear escalation pathway and consultant attendance criteria, and act on the staffing concerns – then re-audit and feed back."

Common ways to lose marks

Blaming individuals • Ignoring staffing • No training plan • No audit • No feedback loop

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Labour in Type 1 Diabetes

Simulated Patient Task | Module 7 | Management of labour

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Labour in Type 1 Diabetes

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
7: Management of labour	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Planning intrapartum glucose management for a woman with type 1 diabetes on an insulin pump: capillary glucose targets, variable-rate insulin infusion versus pump continuation, neonatal hypoglycaemia prevention – with hidden hypoglycaemia unawareness and a recent severe hypo*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST4 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Diabetes antenatal plan (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST4 on the labour ward. **Mrs Natalie Price**, aged 29, with **type 1 diabetes**, is **37+4 weeks** and has been admitted for **induction of labour**. She uses an **insulin pump** and wants to "manage it myself".

Please read the **DIABETES ANTENATAL PLAN (1)**.

You have 10 minutes in which you should:

- Take a focused history
- Discuss glucose management in labour
- Address her concerns
- Agree a plan

You will not be expected to examine the patient. If asked, the examiner will tell you that capillary glucose now is 5.8 mmol/L, and the latest HbA1c was 52 mmol/mol.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Natalie Price**, aged 29, a software engineer. You have had type 1 diabetes since age 9 and use an **insulin pump with continuous glucose monitoring**. You know your diabetes better than anyone and do not want "a drip that someone else controls".

Only if asked:

• **You no longer feel your hypos coming on** – it has got worse in pregnancy.

• **Last week you had a severe hypo** at night; your partner gave you **glucagon** and called an ambulance. You did not tell the diabetes team.

• You often run your glucose "a bit low" to protect the baby.

• Retinal screening in pregnancy showed "a few changes".

• You plan to breastfeed.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"I want to keep my pump running in labour – is that OK?"*

About targets

> *"What sugar levels do you want?"*

About the baby

> *"Will my baby's sugar drop after birth?"*

About after birth

> *"What happens to my insulin after the baby is born?"*

Acting requirements

- Confident and knowledgeable; dislikes being "managed".
- Disclose hypo unawareness and the glucagon episode only if asked about hypos.
- If the doctor dismisses your expertise, become irritated; if the doctor collaborates, agree a shared plan.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- T1DM on pump/CGM, IOL at 37+4 weeks
- Hidden: impaired hypoglycaemia awareness; severe hypo needing glucagon last week (unreported); proliferative retinopathy changes

The competent ST4 candidate will discuss and mention many of the following:

Patient safety

- * *Recognises **impaired hypo awareness + recent severe hypo** → safety: **hourly capillary glucose**, low threshold to switch to **variable-rate IV insulin + glucose**, hypo treatment available, partner aware*
- * *Agreed **written plan with the diabetes team**: pump continuation only if she is **alert, able to self-manage, and glucose in target**; switch to VRII if not (e.g. epidural sedation, GA, out of range)*
- Postnatal: **reduce insulin immediately after birth** (return to pre-pregnancy doses or lower) – **high hypo risk**, especially breastfeeding

Applied clinical knowledge

- * *NICE NG3: maintain capillary glucose **4–7 mmol/L** in labour; hourly monitoring*
- * *Baby: **neonatal hypoglycaemia** risk – early feeding within 30 min and every 2–3 h, **blood glucose at 2–4 hours**, neonatal team*
- Retinopathy: not a contraindication to vaginal birth (proliferative – discuss with ophthalmology if active); continuous CTG

Communicating with patients and families

- * *Respects her expertise; shared planning*
- Explains why safety thresholds matter given recent hypo
- Supportive about not reporting the hypo
- Checks understanding

Information gathering

- * ***Hypoglycaemia awareness and severe episodes***
- * *Pump/CGM settings, recent control*
- Complications (retinopathy, renal)
- Feeding plans

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not explore hypoglycaemia history / no monitoring plan = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Incorrect glucose targets or no postnatal insulin reduction = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Dismisses her self-management expertise = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask about hypos = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

DIABETES ANTENATAL PLAN (1)

Haywain General Hospital NHS Trust
JOINT DIABETES ANTENATAL CLINIC – BIRTH PLAN

Patient	Mrs Natalie Price Age: 29 G1 P0 37+4 weeks
Diabetes	Type 1; **insulin pump + CGM**
Plan	"IOL 37+4. Pump may continue if self-managing; otherwise VRII. Target 4–7 mmol/L."
Postnatal	"**Halve basal rate after delivery** – review"
Retinal screening	"Pre-proliferative changes – ophthalmology aware"

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6. RCOG INSTRUCTIONS

Module(s) examined	7: Management of labour
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 24–34
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × DIABETES ANTENATAL PLAN (1)

Sources: NICE NG3 Diabetes in pregnancy (2015, updated 2020); Joint British Diabetes Societies for Inpatient Care (JBDS) Management of glycaemic control in pregnant women with diabetes on obstetric wards and delivery units (2017, updated); JBDS guidance on insulin pumps in hospital; BAPM Identification and management of neonatal hypoglycaemia in the full-term infant (2017, updated 2024).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

T1DM in labour in one line

Glucose 4–7 mmol/L, checked hourly. Pump only if she can self-manage and stays in range – otherwise **VRII**.
Cut insulin straight after birth. Feed baby early; check glucose at 2–4 h.

PUMP CAN CONTINUE IF	SWITCH TO VRII IF
• Alert and able to self-manage • Glucose in target • No GA / heavy sedation • Agreed written plan	• Out of range • Hypo unawareness concerns • Unable to self-manage • GA / caesarean / unwell

Target	Monitoring	Baby glucose
4–7 mmol/L	Hourly	2–4 h after birth

Say it simply

"You know your diabetes best, and you can keep your pump going while you're able to manage it and your levels stay between 4 and 7. Because you've lost your hypo warnings and had a bad hypo last week, we'll check hourly and switch to a drip if needed – and your insulin will need cutting right down as soon as the baby's born."

Common ways to lose marks

Ignoring hypo history • Wrong targets • No postnatal reduction • Dismissing expertise • No neonatal plan

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PIPADOR REVISION

KNOWLEDGE AREA

8

Management of Delivery

Sample: 1 SPT · 1 SDT · 21 stations in the full bank

Stations on pages 132–152

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Complaint Resolution Meeting after Sequential Instruments

Simulated Patient Task | Module 8 | Management of delivery

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Complaint Resolution Meeting after Sequential Instruments

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
8: Management of delivery	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A local resolution meeting with a couple who have made a formal complaint after a failed ventouse followed by forceps: listening, explaining what happened and why, acknowledging failings in consent and communication, apologising, explaining the complaints process, and uncovering ongoing physical and emotional symptoms*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST6 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Complaint letter and birth summary (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are the ST6. **Mrs Aisha Begum**, aged 28, and her husband **Imran** have made a **formal complaint** about the birth of their son **8 weeks ago** – a **failed ventouse followed by forceps**. The **complaints team** has arranged a **local resolution meeting** and asked you (on behalf of the consultant, who is on leave) to meet them. A complaints officer is present and will take notes.

Please read the **COMPLAINT LETTER AND BIRTH SUMMARY (1)**. You have reviewed the notes.

You have 10 minutes in which you should:

- Listen to and clarify their concerns
- Explain what happened and why
- Respond to the concerns raised
- Explain the next steps

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Aisha Begum**, aged 28, a pharmacist. Your son Zayn is 8 weeks old and well now, though he had a **large swelling on his head** and was watched on the neonatal unit for 24 hours. Your husband **wrote the complaint**. You are tired and still upset.

Only if asked:

• **Nobody told you forceps might be used** – you only agreed to "the suction cup".
• You were **not offered a debrief** before discharge.
• You still have **pain during sex** and **leak urine when you cough**. You have not told your GP.
• You have **flashbacks** and avoid driving past the hospital.
• You want: an **honest explanation**, an **apology**, to know **what will change**, and **reassurance for next time**. You are **not** looking to sue – but Imran mentions a solicitor.

If not covered by the candidate, you could ask the following questions:

Opening statement (Imran)

> *"We want to know why two instruments were used and why nobody asked us."*

About fault

> *"Was the doctor not good enough?"*

About the baby

> *"Could Zayn have brain damage from this?"*

About outcome

> *"What actually happens to our complaint now?"*

Acting requirements

- Imran leads and is angry; Aisha is quiet and tearful.
- Calm down if the candidate listens without interrupting, acknowledges failings and apologises.
- Aisha mentions symptoms only if asked directly how she is now.
- If the candidate is defensive or uses jargon, Imran says he will "go to the Ombudsman".

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Formal complaint: (1) consent – forceps not discussed; (2) sequential instruments; (3) baby admitted for observation; (4) no debrief
- Notes: ventouse consent documented verbally only; 2 pulls + 1 detachment then low-cavity forceps for pathological CTG; reasons documented; baby: chignon + small cephalhaematoma, normal head circumference, discharged well
- Hidden: dyspareunia, stress incontinence, flashbacks; not seeking litigation

The competent ST6 candidate will discuss and mention many of the following:

Patient safety

- * *Identifies and acts on **ongoing symptoms**: **pelvic floor physiotherapy**, perineal clinic review, **GP and perinatal mental health** referral (flashbacks/avoidance – possible birth trauma)*
- * *Identifies **learning**: consent should cover **possible change of instrument/caesarean**; debrief before discharge; feeds into **Datix/governance** and departmental teaching*
- Neonatal follow-up if any concern; reassures accurately about baby's outcome

Applied clinical knowledge

- * *Explains why sequential instruments may be used (baby needed to be born quickly, low station) and that this **increases risk** – guidance advises against routine use; documentation of reasons*
- * ***NHS complaints process**: local resolution (Regulations 2009) – written response after meeting; right to an **independent complaints advocate**; escalation to the **Parliamentary and Health Service Ombudsman** if unresolved; complaint does not affect future care*
- Next birth: most women have a vaginal birth next time; antenatal plan/debrief offered

Communicating with patients and families

- * ***Listens** without interrupting; summarises their concerns; **sincere apology** for their experience and where care fell short*
- Honest, non-defensive, avoids blaming individuals; plain language
- Agrees **what they want from the complaint**; clear follow-up commitments

Information gathering

- * *Clarifies the **specific concerns** and **desired outcomes***
- * ***Current physical and emotional wellbeing***
- Baby's current health; future plans

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not identify or act on ongoing symptoms = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Incorrect or no explanation of the complaints process = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Defensive, blames a colleague or no apology = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not clarify concerns or desired outcomes = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

COMPLAINT LETTER AND BIRTH SUMMARY (1)

Haywain General Hospital NHS Trust
FORMAL COMPLAINT (summary) AND BIRTH SUMMARY

Complaint (Mr Begum)	"**Two instruments** were used on my wife without asking us. Our son had to go to the **neonatal unit**. Nobody explained anything. **Nobody came to talk to us** before we went home."
Acknowledged	By complaints team within 3 working days; meeting offered
Birth	Delay in second stage + **pathological CTG**; Kiwi ventouse in room: **2 pulls, 1 detachment** → **low-cavity forceps** (1 pull); reasons documented
Consent	"**Verbal consent for ventouse**" – no mention of forceps/caesarean
Mother	Mediolateral episiotomy + 2nd-degree tear; sphincter intact; EBL 700 ml
Baby	3.6 kg; Apgars 6/9; pH 7.18; chignon + cephalhaematoma; **NNU 24 h for observation**; discharged well

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6. RCOG INSTRUCTIONS

Module(s) examined	8: Management of delivery
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 25–35, with male partner (second role-player or examiner); complaints officer non-speaking
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × COMPLAINT LETTER AND BIRTH SUMMARY (1)

Sources: Local Authority Social Services and National Health Service Complaints (England) Regulations 2009; Parliamentary and Health Service Ombudsman NHS Complaint Standards (2022); RCOG Green-top Guideline No. 26 Assisted vaginal birth (2020); RCOG Consent Advice No. 11 Operative vaginal delivery; GMC Good medical practice (2024) and Decision making and consent (2020); CQC Regulation 20 Duty of candour; NICE NG194 Postnatal care (2021).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Complaint meeting in one line
Listen, summarise, apologise sincerely, explain honestly, find out what they want, act on ongoing symptoms – and explain the process including the Ombudsman.

Introductions; who is present; purpose	Listen – let them tell the story	Summarise concerns + ask what they want	Explain what happened (plain language)	Apologise; say what will change	Address current health; next steps + written response

Complaints process	Detail
Acknowledge	Within 3 working days
Local resolution	Investigation, meeting, written response (agreed timescale)
Support	Independent NHS complaints advocacy
Escalation	Parliamentary and Health Service Ombudsman
Care	Must not be affected by complaining

Say it simply
"I'm very sorry – you should have been told that forceps might be needed, and someone should have talked it through with you before you went home. The ventouse wasn't working and Zayn needed to be born quickly, which is why forceps were used. We're changing how we explain this, and I'd like to get you some help with the symptoms you've mentioned."

Common ways to lose marks
Defensive • Blaming colleague • Missing symptoms • No process explained • Jargon

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Patient Safety Incident Investigation (PSIRF): Retained Vaginal Swab after Perineal Repair

Structured Discussion Task | Module 8 | Management of delivery

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Patient Safety Incident Investigation (PSIRF): Retained Vaginal Swab after Perineal Repair

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
8: Management of delivery	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A structured discussion of the response to a retained vaginal swab after perineal repair under the Patient Safety Incident Response Framework: immediate actions, choosing the learning response, a systems-based Patient Safety Incident Investigation, engagement with the woman and staff, and safety actions – then a draft report that blames an individual and a second similar incident*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST7 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Incident report (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are an ST7 and the maternity patient safety lead has asked you to be part of the team responding to an incident. **Mrs Jess Holloway**, aged 26, presented to triage **10 days after a vaginal birth** with **offensive discharge, fever and pain**; a **vaginal swab (tampon) was found and removed**. It had been inserted during repair of a **second-degree tear** in a birth room.

Please read the **INCIDENT REPORT (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss the immediate response
- Discuss how the incident should be investigated
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST7 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST7 will discuss or mention many of the following:

Patient safety

- * ***Immediate actions:*** *Clinical care of Mrs Holloway (sepsis screen, antibiotics, review perineum);* ***statutory duty of candour*** *– tell her, apologise, explain, follow up in writing;* ***record on LFPSE/Datix***; ***immediate safety check*** *(other rooms, count boards, tampon practice); support staff involved (no blame); escalate to patient safety team; classify – meets the* ***Never Event*** *criteria (retained foreign object post-procedure); framework remains in place while NHS England reviews it, with learning responses under* ***PSIRF***.
- * ***Card B – recurrence:*** *Safety actions* ***not effective or not implemented*** *– review action plan, monitoring/measures;* ***thematic review***; *escalate to* ***board, LMNS/ICB***; *consider* ***national learning*** *(patient safety alert routes); audit compliance with count/handover standard; involve staff in redesign; duty of candour for second woman; regional sharing.*

Applied clinical knowledge

- * ***PSIRF and choice of learning response: PSIRF (NHS England 2022)*** *replaced the Serious Incident Framework –* ***no distinction between "serious incidents" and other incidents***; *principles:* ***compassionate engagement*** *with patients, families and staff,* ***systems-based approach*** *to learning,* ***proportionate responses***, ***supportive oversight***; *organisations have a* ***Patient Safety Incident Response Plan***. ***Patient Safety Incident Investigation (PSII)*** *is required nationally for* ***Never Events*** *and deaths thought more likely than not due to problems in care; other tools –* ***After Action Review, SWARM huddle, MDT review, thematic review***. *Here:* ***PSII*** *(plus immediate After Action Review/SWARM). (Maternity: MNSI investigates specific intrapartum/neonatal outcomes – not this case.)*
- **Conducting the investigation: Trained, independent investigator(s)** not involved in care; agreed **terms of reference**; **engage Mrs Holloway** early – her questions shape the scope, a named contact, share findings; **staff interviews** framed as learning (**just culture**); **systems analysis** (e.g. **SEIPS**: people, tasks, tools, environment, organisation) – shift change, count process, tampon not on board, room design, workload, no tail/tag on tampon; **work-as-imagined vs work-as-done**; produce **safety actions** (strong system-level, e.g. **tampons with tape tail, standard count board in every room, "tampon in/out" on handover tool, two-person count**) with owners and measures; **oversight** by board/ICB; share learning (LMNS).

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Communicating with colleagues

- * ***Card A – the draft report:*** *Not acceptable under PSIRF:* ***individual blame****, weak action;* ***"retraining" is a weak control****; reframe to* ***contributory system factors*** *(handover timing, count design, equipment, workload); individual performance concerns – only if evidence of reckless behaviour, handled separately (Just Culture guide);* ***strong actions*** *(design changes, standardisation, forcing functions); support for the ST2; check the woman's questions are answered.*
- * *Compassionate engagement with woman and* ***staff*** *(no blame)*
- Challenges a blaming report constructively
- Oversight and sharing learning (board, LMNS/ICB)

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST7.

Task synopsis:
Retained vaginal tampon after perineal repair (meets Never Event criteria – retained foreign object post-procedure); infection, readmission for IV antibiotics. Repair by ST2 at shift change; count done for swabs but tampon not on count board; no whiteboard in room; handover at 20:00. Card A: draft report concludes "ST2 failed to follow policy – refer for retraining". Card B: 3 months later a second retained tampon in another unit area.

Open the discussion with the following:

> *"What are the immediate actions?"*

Then ask the following questions:

1. **What are the immediate actions?**
2. **What is PSIRF and what learning response would you choose?**
3. **How would the investigation be carried out?**
4. **Hand the candidate SCENARIO CARD A. "What is your response to this draft?"**
5. **Hand the candidate SCENARIO CARD B. "What does this tell you and what would you do?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Which framework applies?"
- "Who should investigate?"
- "How do you involve the woman?"
- "What makes a strong safety action?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

No duty of candour or immediate safety check = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Unaware of PSIRF / proposes root-cause blame approach = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Accepts individual blame and retraining as the outcome = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

INCIDENT REPORT (1)

Haywain General Hospital NHS Trust
LFPSE INCIDENT REPORT – SUMMARY

Patient	Mrs Jess Holloway 26 P1
Event	**Retained vaginal tampon** found 10 days after perineal repair (2nd-degree tear); offensive discharge, fever 38.4 °C; readmitted for IV antibiotics
Repair	Birth room; **ST2** (supervision available by phone); started **19:40**, finished **20:15**
Count	Swab and needle count recorded "correct"; **tampon not listed** on count
Context	**Shift handover at 20:00**; midwife changed mid-procedure; no count board in room
Harm	**Moderate** (readmission, IV antibiotics)

SCENARIO CARD A (question 4)
Draft investigation report – conclusions

"**Root cause: the ST2 failed to follow the swab-count policy.** Recommendation: the ST2 to complete **retraining** and a reflective piece. **Policy to be re-circulated** to all staff."

SCENARIO CARD B (question 5)
3 months later

A **second retained vaginal tampon** after perineal repair is reported from the **birth centre**. The safety action plan from the first incident shows "policy re-circulated – complete".

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6. RCOG INSTRUCTIONS

Module(s) examined	8: Management of delivery
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × INCIDENT REPORT (1); 1 × each SCENARIO CARD A–B

Sources: NHS England Patient Safety Incident Response Framework (PSIRF, 2022) and supporting guidance (engaging and involving patients, families and staff; learning response toolkit; safety action development); NHS England Never Events policy and framework (2018) and 2024 consultation findings (September 2025); NHS England Just Culture Guide; SEIPS 101 (NHS England 2022); CQC Regulation 20 Duty of candour; Learn from Patient Safety Events (LFPSE) service; MNSI investigation criteria.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

PSIRF in one line

Look after her, be candid, check it can't happen tonight, then learn as a system: PSII for Never Events, compassionate engagement, no blame, strong safety actions.

PSIRF learning response	Use
PSII	Never Events; deaths likely due to care problems; local priorities
After Action Review	Quick structured team reflection
SWARM huddle	Immediately after incident, while fresh
MDT review	Complex cases, several teams
Thematic review	Recurring themes across incidents

WEAK ACTIONS	STRONG ACTIONS
• Retraining • Re-circulating policy • Reminders / posters • Individual reflection	• Tampons with tape tail • Count board in every room • Handover tool "tampon in/out" • Standardised packs / forcing functions

Say it simply

"I'd make sure Mrs Holloway is treated and told honestly, check our rooms tonight, and support the staff involved. This meets Never Event criteria, so under PSIRF it needs a Patient Safety Incident Investigation – systems-focused, involving her and the team – leading to strong design changes rather than retraining one doctor."

Common ways to lose marks

Blaming the ST2 • "Retraining" as main action • No duty of candour • Ignoring staff wellbeing • No monitoring of actions

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PIPADOR REVISION

KNOWLEDGE AREA

9

Postpartum Problems

Sample: 1 SPT · 1 SDT · 19 stations in the full bank

Stations on pages 154–173

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Postnatal Headache after an Epidural

Simulated Patient Task | Module 9 | Postpartum problems

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Postnatal Headache after an Epidural

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
9: Postpartum problems	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Assessing a woman with headache on day 2 after a vaginal birth with an epidural: distinguishing post-dural puncture headache from postpartum pre-eclampsia, cerebral venous sinus thrombosis and other serious causes – and finding red flags that change the plan*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST4 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Postnatal observations (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are the ST4 on the postnatal ward. **Ms Kate Morrison**, aged 29, had a **spontaneous vaginal birth** 40 hours ago. She had an **epidural** (the anaesthetist noted "**two attempts**"). She has a **headache** and the midwife asks you to see her.

Please read the **POSTNATAL OBSERVATIONS (1)**.

You have 10 minutes in which you should:

- Take a focused history
- Explain the likely diagnoses
- Agree a management plan
- Address her concerns

You will not be expected to examine the patient. Ask the examiner for any examination findings.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Kate Morrison**, aged 29, a nurse. First baby, girl, breastfeeding. You want to **go home today**. Your headache started yesterday when you first got up.

Only if asked:

- The headache is **at the front and back of the head**, much **worse sitting or standing**, **better lying flat**.
- Neck feels stiff; **ringing in ears**.
- **Today it has changed** – it is there even lying down and you **vomited twice**; you had **blurred vision** for a few minutes.
- No fever; no history of migraine; you had some swelling of ankles.
- You had **mild pre-eclampsia**? – "**No**, but my BP was a bit high at the end of labour".

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"It's just a headache from the epidural, isn't it? Can I go home?"*

About the epidural

> *"Did they do the epidural wrong?"*

About treatment

> *"What's a blood patch?"*

About feeding

> *"Can I still breastfeed with painkillers?"*

Acting requirements

- Want to go home; minimise symptoms at first.
- Reveal the change in headache, vomiting and blurred vision only if asked about how it has changed and associated symptoms.
- Agree to stay if the candidate explains why.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Postural headache from day 1 after epidural with two attempts – consistent with PDPH
- Red flags today: non-postural, vomiting, visual disturbance, BP 152/98, proteinuria 2+ → exclude **postpartum pre-eclampsia**; consider **CVST**/subdural (complications of PDPH); neurological examination normal

The competent ST4 candidate will discuss and mention many of the following:

Patient safety

- * *Recognises **red flags**: change in character (non-postural), **vomiting, visual disturbance, raised BP/proteinuria**, focal signs, fever, seizures*
- * *Plan: **BP control** (NICE: treat ≥150/100), **pre-eclampsia bloods** (FBC, U&E, LFT, PCR), **senior and anaesthetic review**, neurology/**imaging** (MR venography for CVST) if atypical; **not discharged***
- Escalation if seizure: magnesium sulphate

Applied clinical knowledge

- * *PDPH: postural, fronto-occipital, neck stiffness, tinnitus/photophobia; risk after accidental dural puncture*
- * *Management: simple analgesia, fluids, caffeine (limited evidence), **epidural blood patch** (effective, risks: back pain, infection, repeat dural puncture)*
- Differentials: pre-eclampsia, **CVST**, subdural haematoma, PRES, meningitis, migraine, caffeine withdrawal

Communicating with patients and families

- * *Explains why she should stay; honest about epidural complication without blame*
- Breastfeeding-compatible analgesia (paracetamol, ibuprofen; avoid codeine)
- Checks understanding

Information gathering

- * *Headache character, **postural** nature, **change over time***
- * *Associated: visual, vomiting, neurological, fever*
- Epidural details; BP history

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Discharges her or labels as PDPH without addressing red flags = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Unaware of key differentials (pre-eclampsia, CVST) = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Dismissive = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask about change in headache/associated symptoms = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

POSTNATAL OBSERVATIONS (1)

Haywain General Hospital NHS Trust
POSTNATAL OBSERVATIONS – DAY 2

Patient	Ms Kate Morrison 29 P1 40 h postpartum
Epidural	Anaesthetic note: "**2 attempts**, ?wet tap – no CSF seen"
Labour BP	Max 146/94 (single reading)
Today 08:00	BP 138/88; HR 80; temp 36.8
Today 14:00	**BP 152/98**; HR 84; temp 36.9; urinalysis **protein 2+**
Examiner findings (if asked)	Neurology normal; no papilloedema seen; no neck rigidity on flexion; reflexes brisk

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6. RCOG INSTRUCTIONS

Module(s) examined	9: Postpartum problems
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 20–35
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × POSTNATAL OBSERVATIONS (1)

Sources: OAA Treatment of obstetric post-dural puncture headache (2019); NICE NG133 Hypertension in pregnancy (2019, updated 2023); MBRRACE-UK Saving Lives, Improving Mothers' Care (neurology and pre-eclampsia chapters); NICE NG194 Postnatal care (2021); NHS England Maternal Care Bundle (2026).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Postnatal headache in one line

Not every headache after an epidural is a PDPH. If it changes, stops being postural, or comes with high BP, vomiting or visual symptoms – think pre-eclampsia, CVST, bleed.

PDPH	RED FLAGS
• Postural – better lying flat • Fronto-occipital, neck stiffness • Tinnitus, photophobia • Analgesia, fluids → blood patch	• Non-postural / changing • Vomiting, visual symptoms, seizures • BP ≥150/100, proteinuria • Focal signs, fever

Say it simply

"Your headache may well be from the epidural, but today it's changed, your blood pressure is up and there's protein in your urine – that can be pre-eclampsia after birth. I'd like you to stay, treat your blood pressure, do some blood tests and get our anaesthetist and senior doctor to see you."

Common ways to lose marks

Labelling everything PDPH • Discharging • Ignoring BP • No imaging when atypical • Codeine while breastfeeding

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MRCOG Part 3 OSCE Stations

Postpartum Urinary Retention

Structured Discussion Task | Module 9 | Postpartum problems

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Postpartum Urinary Retention

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
9: Postpartum problems	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A structured discussion of bladder care after birth: risk factors, monitoring of first void and volumes, diagnosis and catheter management of postpartum urinary retention – then a missed 2.4-litre retention and a service audit of bladder care*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Postnatal record (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 on the postnatal ward. A midwife asks your advice about **Mrs Lucy Hart**, aged 30, who had a **ventouse birth with an epidural** and a **second-degree tear** 7 hours ago and **has not passed urine** since birth.

Please read the **POSTNATAL RECORD (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss assessment and management
- Discuss follow-up and prevention
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * ***Assessment and management:*** *Assess: symptoms,* ***bladder palpation****,* ***bladder scan****, perineal pain/oedema (analgesia), fluid balance; encourage voiding (privacy, warm bath/shower, analgesia, mobilise); if* ***not voided within 6 hours*** *of birth (or epidural removal) or bladder scan large →* ***in-out catheter*** *and* ***measure residual****; document volumes on* ***fluid balance chart****.*
- * ***Card A – 2.4 L retention:*** *Catheterise and* ***record drained volume*** *(2.4 L);* ***indwelling catheter 1–2 weeks*** *(local guidance),* ***urodynamic/urogynaecology*** *follow-up, TWOC with residuals; ISC teaching if needed; UTI treatment;* ***duty of candour*** *(moderate harm), LFPSE report, learning response; explain prognosis honestly.*

Applied clinical knowledge

- * ***Definitions and management: Overt****: unable to void within 6 h;* ***covert****: post-void residual* ***>150 ml*** *(local definitions vary); if residual large (e.g. >500 ml) →* ***indwelling catheter*** *(often 24–48 h) then* ***trial without catheter (TWOC)*** *with residual measurement; repeat if residual persists;* ***UTI*** *screen;* ***intermittent self-catheterisation*** *teaching if persistent; urogynaecology follow-up; most recover.*
- **Risks if missed: Bladder overdistension** → **detrusor damage**, long-term **voiding dysfunction**, overflow incontinence, UTI/pyelonephritis, pain; can also contribute to **PPH** (atony); significant litigation risk.

Communicating with colleagues

- **Card B – bladder care pathway: Standardised bladder care pathway**: risk assessment; **time and volume of first void** recorded; **trigger** – no void by 6 h or small volumes (<200 ml ×2) → **bladder scan/catheter**; fluid balance chart; **discharge criterion** (adequate void documented); electronic record prompts; training; patient information; re-audit; link to NICE intrapartum bladder care guidance (2025 update).
- * *Supports midwifery team; clear pathway*
- Audit/QI
- Candour and incident learning

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
Risk factors: epidural, instrumental birth, perineal trauma, long labour, primiparity. Not voided 7 h; mild suprapubic discomfort. Card A: another woman – passed small volumes, discharged; returns day 3 with 2.4 L retention and overflow. Card B: audit – 40% of women had no first-void volume recorded; no trigger for bladder scan.

Open the discussion with the following:

> *"What would you advise?"*

Then ask the following questions:

1. **How would you assess and manage her now?**
2. **How do you define and manage retention?**
3. **What are the risks if retention is missed?**
4. **Hand the candidate SCENARIO CARD A. "How would you manage this?"**
5. **Hand the candidate SCENARIO CARD B. "What would you change?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "When should she have passed urine?"
- "What residual volume is abnormal?"
- "Why does this matter long term?"
- "What would you audit?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

No catheterisation/volume measurement plan = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Unaware of consequences of overdistension = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No pathway/audit approach = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

POSTNATAL RECORD (1)

Haywain General Hospital NHS Trust
POSTNATAL RECORD – 7 HOURS AFTER BIRTH

Patient	Mrs Lucy Hart 30 P1
Labour	Epidural; **14-hour labour**; **ventouse**; 2nd-degree tear repaired; catheter removed at birth
Since birth	**No void**; drinks 1.2 L; "mild lower tummy ache"
Perineum	Swollen, painful; paracetamol given
Uterus	Fundus **deviated to the right**, above umbilicus

SCENARIO CARD A (question 4)
Another woman

Passed "**small amounts**" twice after birth (volumes not recorded); **discharged day 1**. Returns **day 3**: constant dribbling, lower abdominal swelling. Catheter drains **2.4 litres**.

SCENARIO CARD B (question 5)
Audit – 200 vaginal births

First void volume recorded in 60%; **no documented action** in 12 women who had not voided by 6 h; no bladder scanner on postnatal ward; **no discharge criterion** for voiding.

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6. RCOG INSTRUCTIONS

Module(s) examined	9: Postpartum problems
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × POSTNATAL RECORD (1); 1 × each SCENARIO CARD A–B

Sources: NICE NG235 Intrapartum care (2023; bladder care and fluid balance recommendations updated 2025); NICE NG194 Postnatal care (2021); RCOG/BSUG and local postpartum bladder care guidelines; NICE NG123 Urinary incontinence and pelvic organ prolapse in women (2019); CQC Regulation 20 Duty of candour.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Postpartum bladder care in one line

Record time and volume of first void; no void by 6 hours or small volumes → scan or catheterise and measure. Overdistension can damage the bladder for life.

Risk factors: epidural, instrument, tear, long labour	**First void within 6 h – measure**	**Not voided / small volumes → bladder scan**	**Large residual → indwelling catheter**	**TWOC + residuals; ISC if persistent**	**Urogynaecology follow-up**

Say it simply

"She has risk factors and hasn't passed urine for 7 hours, and her uterus is pushed to one side – her bladder is probably full. I'd catheterise, measure the volume and leave a catheter in if it's large, then do a trial without catheter. And we should record first-void volumes for every woman."

Common ways to lose marks

Waiting longer • Not measuring volumes • Discharge without void • No follow-up • No pathway

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KNOWLEDGE AREA

10

Gynaecological Problems

Sample: 1 SPT · 1 SDT · 33 stations in the full bank

Stations on pages 175–194

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MRCOG Part 3 OSCE Stations

Haematocolpos: a Teenager and Her Mother

Simulated Patient Task | Module 10 | Gynaecological problems

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Haematocolpos: a Teenager and Her Mother

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
10: Gynaecological problems	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families

Task synopsis: *A 14-year-old with primary amenorrhoea, cyclical pain and urinary retention from an imperforate hymen, seen with her protective mother: explaining the diagnosis to both, consent for hymenotomy – and a cultural concern about virginity and a question Maya is too embarrassed to ask*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patients' Directions**	Two role-players: daughter and mother
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	ED referral (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families

You are the gynaecology ST5 on call. **Maya Khan**, aged 14, has been referred from the emergency department with 3 days of severe lower abdominal pain and difficulty passing urine. She has not started her periods. She is with her mother, **Mrs Khan**.

Please read the **ED REFERRAL (1)**.

You have 10 minutes in which you should:

- Explain the diagnosis to Maya and her mother
- Discuss the management
- Address their concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENTS' DIRECTIONS

Maya Khan (aged 14)

You are shy and embarrassed. You have had **monthly cramping pain for 6 months**, which you thought was "normal". You have never used tampons and are not sexually active. Your tummy is very sore and you cannot pass urine properly.

You have a question you are too embarrassed to ask in front of your mum: **"Will I be able to use tampons and have sex normally later?"** Ask it only if the doctor offers to speak to you alone, or makes clear that any question is OK.

Mrs Khan (Maya's mother)

You are worried and protective and answer questions for Maya. Your family is religious and you are anxious about **"her virginity"** and "what people will say". You accept the operation if it is explained sensitively and your concerns are taken seriously.

If not covered by the candidate, you could ask the following questions:

Mrs Khan – opening

> *"Can't you just give her painkillers and wait for her periods to come?"*

Mrs Khan – virginity

> *"Will this operation mean she is no longer a virgin?"*

Mrs Khan – the future

> *"Will this affect her having children?"*

Maya – if given the chance

> *"Will I be able to use tampons and have sex normally later?"*

Acting requirements

- Mrs Khan answers for Maya unless the doctor gently includes Maya.
- Maya becomes more relaxed if the doctor speaks to her directly and checks she understands.
- If the doctor dismisses the virginity concern or appears judgemental: Mrs Khan becomes defensive and asks for "someone more senior".
- If offered time alone, Maya asks her question.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read both role-players' directions and discuss the clinical details with them. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Imperforate hymen with haematocolpos and urinary retention: needs catheter, analgesia and EUA with hymenotomy
- Hidden: cultural concern about virginity; Maya's private question about tampons and sex

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * ***Treats the urinary retention now*** *(catheter) and gives analgesia*
- * ***No needle aspiration*** *of the haematocolpos (risk of pyocolpos); definitive surgery –* ***EUA and hymenotomy*** *by an experienced surgeon*
- * ***Consent****: Maya (if Gillick competent) with her mother; escalate to the consultant/PAG service if anatomy is atypical*
- Antibiotics if signs of infection; follow-up to check that menses flow normally

Applied clinical knowledge

- * *Explains* ***imperforate hymen*** *with blood trapped in the vagina (haematocolpos)*
- * *Differential:* ***transverse vaginal septum*** *(introitus normal; needs MRI and specialist surgery)*
- Fertility outlook is excellent with a normal uterus; small risk of endometriosis from retrograde flow
- Normal kidneys on ultrasound; renal anomalies are more typical of Müllerian anomalies

Communicating with patients and families

- * ***Includes Maya directly****, checks her understanding and wishes, and* ***offers time alone***
- * *Addresses the* ***virginity concern sensitively and factually****: the hymen does not define virginity; this is a necessary medical operation*
- Uses diagrams and plain language; no collusion or judgement
- Answers Maya's question: tampons and sex will be possible after healing

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patients's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Suggests waiting, painkillers only, or needle drainage = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not explain the diagnosis = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Simulated Patients's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Speaks only to the mother throughout = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ED REFERRAL (1)

Haywain General Hospital NHS Trust
EMERGENCY DEPARTMENT – GYNAECOLOGY REFERRAL

Patient	Maya Khan DoB: 05.01.2012
Presentation	3 days of severe lower abdominal pain; difficulty passing urine. **Primary amenorrhoea.**
Examination	Breast development Tanner 4, pubic hair present. Tender lower abdominal mass. On gentle inspection: **bulging, bluish, intact membrane at the introitus.**
Bladder scan	**600 mL** residual
Transabdominal USS	**Distended vagina with echogenic fluid (9 cm)**; normal uterus; both kidneys present

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6. RCOG INSTRUCTIONS

Module(s) examined	10: Gynaecological problems
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families
Links to another question	No
Simulated patient	Two role-players: female aged 14–17 (adult actor playing younger) and her mother, aged 35–50
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ED REFERRAL (1)

Sources: British Society for Paediatric and Adolescent Gynaecology (BritSPAG) guidance; RCOG StratOG: Paediatric and adolescent gynaecology; GMC 0–18 years: guidance for all doctors; Lee KH et al. Imperforate hymen: a comprehensive systematic review. J Clin Med 2019.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Haematocolpos in one line

Puberty without periods + cyclical pain + **bulging bluish membrane** = imperforate hymen. **Catheterise, analgesia, EUA and hymenotomy** – never needle drainage – and talk to the teenager, not just the parent.

Imperforate hymen vs transverse vaginal septum

Feature	Imperforate hymen	Transverse vaginal septum
Introitus	**Bulging bluish membrane**	Normal; short blind vagina
Incidence	About 1 in 1,000–2,000	About 1 in 30,000–80,000
Imaging	USS usually enough	**MRI** (level and thickness)
Surgery	Hymenotomy	Specialist excision; stenosis risk
Associated anomalies	Rare	Urinary tract and Müllerian

Management

Catheter for retention	**Analgesia**	**EUA + hymenotomy**	**No needle aspiration**	**Review: periods flowing**

Talking to teenagers

Include her	Time alone	Competence	Culture
Speak to her, not over her	Ask privately	Gillick for consent	Respectful, factual

Say it simply

"Maya, the opening at the bottom of your vagina is closed, so your period blood has been trapped and is pressing on your bladder. A small operation under anaesthetic opens it. It won't affect having children, using tampons or having sex in the future."

Common ways to lose marks

Talking only to the mother • "Let's wait and see" • Needle drainage • Dismissing cultural concerns • Forgetting the retention

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MRCOG Part 3 OSCE Stations

Prioritising the Gynaecology Emergency Board

Structured Discussion Task | Module 10 | Gynaecological problems

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Structured Discussion Task

Prioritising the Gynaecology Emergency Board

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
10: Gynaecological problems	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *An evening on-call board with two shocked patients, post-operative sepsis, suspected torsion and a shared theatre: recognising cervical shock, sequencing theatre, delegating safely, escalating early – and a later bowel injury needing duty of candour*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Emergency board (1) and scenario card A
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

It is **20:00** on a weekday. You are the **ST5 gynaecology registrar on call**. The consultant is non-resident (20 minutes away). Your team is an **ST2** and an **FY2**. There is **one emergency theatre**, shared with general surgery, who have a laparotomy booked to start at 21:00.

Please read the **EMERGENCY BOARD (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Prioritise the patients
- Allocate your team
- Explain your initial management of each patient
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * *Sees **B first**: bradycardia + hypotension = **cervical shock** – speculum and remove products from the os (a bedside fix that cannot wait), resuscitate; **A in parallel**: haemorrhagic shock – resuscitation, **major haemorrhage protocol**, theatre immediately; no tunnel vision*
- * *Recognises **C** as time-critical: possible **bowel or urinary tract injury with sepsis** – Sepsis Six, bloods and lactate, **urgent CT with contrast**, involve general surgery*
- * ***Escalates to the consultant now** (A, B and C)*
- **Card A – bowel injury:** resuscitate; consultant gynaecologist and **general surgeon to theatre together**; Datix/LFPSE report; **duty of candour** conversation led by the consultant; support and debrief the team

Applied clinical knowledge

- * ***Theatre order A → D → G**: D needs ovary-sparing laparoscopy – **Doppler flow does not exclude torsion**; G at the end of the list or next day*
- * *Correct initial management: **E** transfusion, tranexamic acid, high-dose norethisterone; **F** IV ceftriaxone 2 g daily + doxycycline 100 mg BD + metronidazole 400 mg BD (14 days total)*
- G: Word catheter or marsupialisation – not urgent; H: clinic or USS, condoms until IUD located

Communicating with colleagues

- * ***Delegates clearly and within competence** with closed-loop handover: ST2 – resuscitation of A, then review C; FY2 – cannulas, bloods, prescribing; tasks for E, F and H as above*
- * ***Negotiates the theatre** with the general surgical registrar, anaesthetist and theatre coordinator; considers a second theatre; escalates to consultants if conflict*
- Structured SBAR call to the consultant
- Informs the bed manager and nurse in charge; supports the team after the incident

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the on-call consultant on the telephone** with the candidate as your ST5.

Task synopsis:
Eight patients: ruptured ectopic with shock (A), cervical shock in miscarriage (B), sepsis day 2 after laparoscopic hysterectomy (C), suspected torsion (D), HMB with Hb 68 (E), PID (F), Bartholin's abscess (G), lost IUD threads (H). Then a card: C has a bowel injury.

Open the discussion with the following:

> *"Talk me through your board – who are you seeing first, and why?"*

Then ask the following questions:

1. **Who needs to be seen first, and what will you do for them?**
2. **How will you use the theatre?**
3. **What is your concern about patient C and what will you do?**
4. **How will you allocate your team and what will they do?**
5. **Hand the candidate SCENARIO CARD A. "What happens now?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Why is patient B bradycardic?"
- "Does Doppler flow exclude torsion?"
- "Would you call me now or later?"
- "Who will speak to the general surgeons?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not recognise cervical shock or delays the ruptured ectopic = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Wrong theatre order (e.g. torsion or abscess before A) = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Does not escalate to the consultant = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

EMERGENCY BOARD (1)

Haywain General Hospital NHS Trust
GYNAECOLOGY ON-CALL BOARD – 20:00

Location	Patient	Summary
ED cubicle 3	A – 28F	Positive pregnancy test, LMP 7 weeks. Left iliac fossa and shoulder-tip pain. **HR 124, BP 84/50.** Free fluid on bedside scan
ED resus	B – 30F	9 weeks pregnant, heavy bleeding with clots. **HR 48, BP 82/48**, pale, clammy
Ward 12	C – 36F	**Day 2 after laparoscopic hysterectomy.** Temp 38.4, HR 112, abdominal distension, urine 15 mL/h for 4 hours
ED cubicle 5	D – 19F	Sudden right iliac fossa pain 3 hours ago, vomiting. USS: 6 cm right dermoid, Doppler flow present. HR 96, BP normal
Gynae unit	E – 45F	HMB, fibroids. **Hb 68 g/L**, HR 102, BP normal. Bleeding now moderate
Gynae unit	F – 22F	Lower abdominal pain, temp 38.6, cervical motion tenderness. Pregnancy test negative. USS: no collection
ED cubicle 7	G – 31F	4 cm left Bartholin's abscess, systemically well
Gynae unit	H – 26F	Cannot feel IUD threads; asymptomatic. Pregnancy test negative

SCENARIO CARD A (question 5)
02:00 – patient C

CT shows **free gas and fluid consistent with a small bowel injury**.
She is now HR 128, BP 92/58, lactate 4.1.

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6. RCOG INSTRUCTIONS

Module(s) examined	10: Gynaecological problems
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × EMERGENCY BOARD (1); 1 × SCENARIO CARD A

Sources: NICE NG126 Ectopic pregnancy and miscarriage (updated 2023); RCOG Green-top Guideline No. 21, Diagnosis and management of ectopic pregnancy (2016); BASHH UK national guideline for the management of pelvic inflammatory disease (2019); NHS England Patient Safety Incident Response Framework (2022); CQC Regulation 20: Duty of candour.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Emergency prioritisation in one line

ABCDE first: shocked patients before stable ones. Spot **cervical shock** (slow pulse), **escalate early**, sequence theatre by **threat to life, then organ**, and delegate within competence.

Priority on this board

Priority	Patients	Why
1 – Immediate	B, A	Shock: cervical shock (bedside fix) and haemorrhage needing theatre
2 – Urgent (<1 hour)	C, D	Post-operative sepsis; torsion threatens the ovary
3 – Soon (hours)	E, F	Stable but need treatment (transfusion, antibiotics)
4 – Can wait	G, H	Day-case list or clinic

CERVICAL SHOCK

- Bradycardia + hypotension
- Products in the cervical os
- Remove with sponge forceps
- Recovers quickly

HAEMORRHAGIC SHOCK

- Tachycardia + hypotension
- Free fluid; ruptured ectopic
- Resuscitate; MHP
- Theatre immediately

Communicating on call

SBAR to consultant	Negotiate theatre early	Delegate with closed loop	Inform bed manager	Debrief after incidents

Say it simply

"I'd go straight to patient B – a slow pulse with heavy bleeding suggests cervical shock, which I can reverse in minutes by removing the tissue from the cervix. At the same time my ST2 starts resuscitating A, and I'm calling you and theatre now."

Common ways to lose marks

Missing cervical shock • Torsion before the ectopic • Not calling the consultant • Ignoring post-op sepsis • FY2 left with unstable patients

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PIPADOR REVISION

KNOWLEDGE AREA

11

Subfertility

Sample: 1 SPT · 1 SDT · 19 stations in the full bank

Stations on pages 196–215

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Male Factor Subfertility: Varicocele

Simulated Patient Task | Module 11 | Subfertility

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Male Factor Subfertility: Varicocele

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
11: Subfertility	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A fit 32-year-old PE teacher with low semen parameters on two samples and a left grade II varicocele. Explaining the results, the option of treating the varicocele and its limits, smoking, and when genetic tests would be needed – while answering "Have I let her down?"*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Referral summary (1) and results (2)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the fertility clinic. **Mr Zaid Hassan**, aged 32, and his wife Amira (30) have been trying to conceive for 14 months. Zaid has had two semen analyses, and his GP found a scrotal swelling. Amira is at work, so **Zaid has come on his own** for his results.

Please read the **REFERRAL SUMMARY (1)** and the **RESULTS (2)** carefully.

You have 10 minutes in which you should:

- Take a focused history
- Explain the results
- Discuss management
- Address his concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Mr Zaid Hassan**, 32, a secondary school PE teacher. You go to the gym 4–5 times a week and run half marathons. Your fitness is part of who you are, so this is hard to take. You cover it by being brisk and competitive ("How bad is it? What do I do to fix it?").

Only if asked:

• **Smoking:** 10 cigarettes a day since university. You are defensive about it.

• **Gym:** protein shakes only. You have **never** used steroids or testosterone ("A lad at the gym offered me some – I said no"). Hot tub after the gym 2–3 times a week.

• No mumps, testicular injury, undescended testis or operations. No medicines. Alcohol 6–8 units at weekends. Sex 2–3 times a week.

• **Feelings:** you feel you are "holding things up" for Amira, who has had normal tests.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"The GP said there's something wrong with my sperm and a vein thing on my testicle. How bad is it?"*

About fitness

> *"I'm probably the fittest person in this building. How does that happen?"*

About smoking

> *"I know you'll mention the smoking. It's ten a day and my lungs are fine. Does it really matter?"*

About treatment

> *"Can the vein be fixed? If I have the operation, will we get pregnant naturally?"*

About tests

> *"The GP mentioned genetic tests. Do I need those?"*

For Amira

> *"Amira asked me to ask – is there anything she can do, and honestly, what are our chances?"*

Closing

> *"(quietly, dropping the front) I feel like I've let her down. Is there actually hope?"*

Acting requirements

- Be brisk and slightly defensive at first. If smoking is raised as a lecture, fold your arms and say less; if it is raised briefly and respectfully, say "Fair enough – I'll work on it."
- Sit forward when you hear there is a treatment option. If told it is guaranteed to work, accept it eagerly.
- Deliver the closing question quietly. If answered warmly and honestly, say "Thanks. I needed that."

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with him. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Low count, motility and shape on two samples (about 10 million/mL); normal hormones; left grade II varicocele; Amira's tests normal
- Hidden: smoker; hot tubs; offered but declined steroids; feels guilty

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * *Does **not** promise a cure: treatment may improve the chance of pregnancy, but whether it improves live birth is uncertain (Cochrane 2021)*
- * *Advises against **anabolic steroids or testosterone** – they switch off sperm production*
- Refers to urology/interventional radiology to discuss options and risks (hydrocele, recurrence); recheck semen 3 months later

Applied clinical knowledge

- * *Explains the results in plain terms (fewer sperm, less movement, fewer normal shapes; WHO 2021) and the **varicocele** – a vein problem that warms the testis, unrelated to fitness*
- * ***NICE NG257**: consider surgical or radiological treatment for a varicocele felt on examination with reduced semen parameters, when trying to conceive naturally; microsurgical subinguinal repair has lower recurrence*
- * ***Genetic tests** not needed now: Y-chromosome microdeletion if under 1 million/mL or azoospermia; consider karyotype if persistently under 5 million/mL*
- Smoking, heat and alcohol; no proven role for supplements; IVF/ICSI is the back-up

Communicating with patients and families

- * *Raises smoking **briefly and respectfully**, without lecturing*
- * *Answers **"Have I let her down?"** with warmth: a medical finding, not a failure; honest, realistic hope*
- Answers Amira's question; offers a joint appointment, written information and counselling

Information gathering

- * *Asks about **anabolic steroids, testosterone** and other medicines or supplements*
- * *Asks about **smoking, heat** (hot tubs) and alcohol, and about mumps, testicular injury, undescended testis or surgery*
- Explores how he is coping and what he already knows

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Promises that varicocele treatment will restore natural fertility = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot explain the semen results or what a varicocele is = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Lectures about smoking, or dismisses "Have I let her down?" = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask about anabolic steroids or testosterone = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

REFERRAL SUMMARY (1)

Haywain General Hospital NHS Trust
FERTILITY CLINIC – REFERRAL SUMMARY

Patients	Mr Zaid Hassan (32), PE teacher; Mrs Amira Hassan (30), dental hygienist. Trying to conceive for 14 months. No previous pregnancies.
Amira	Regular 28-day cycles; mid-luteal progesterone 35 nmol/L; BMI 22. Investigations normal.
Zaid	BMI 23. GP examination: left-sided scrotal swelling, feels like "a bag of worms" when standing, not visible.

RESULTS (2)

Haywain General Hospital NHS Trust
ANDROLOGY – MR ZAID HASSAN

Semen analysis	Sample 1	Sample 2 (6 weeks later)	WHO 2021 lower limit
Volume	2.8 mL	3.1 mL	1.4 mL or more
Concentration	**9.2 million/mL**	**10.8 million/mL**	16 million/mL or more
Progressive motility	**22%**	**25%**	30% or more
Total motility	**35%**	**38%**	42% or more
Normal forms	**2%**	**2%**	4% or more

Hormones	FSH 8.9 IU/L; LH 5.2 IU/L; testosterone 14.8 nmol/L – all normal
Scrotal Doppler ultrasound	**Left varicocele** with reflux on Valsalva. Both testes normal size; no mass; no right varicocele

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6. RCOG INSTRUCTIONS

Module(s) examined	11: Subfertility
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Male, aged 25–40
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × REFERRAL SUMMARY (1); 2 × RESULTS (2)

Sources: NICE NG257 Fertility problems: assessment and treatment (March 2026), recommendations 1.17, 1.24 and 1.28; Persad E et al. Surgical or radiological treatment for varicoceles in subfertile men. Cochrane Database Syst Rev 2021 (CD000479); WHO laboratory manual for the examination and processing of human semen (6th edition, 2021).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Varicocele in one line

A varicocele **felt on examination** with **reduced semen parameters** in a couple trying naturally: **consider** surgical or radiological treatment (NICE NG257) – it may improve pregnancy rates, but live-birth benefit is unproven. Stop smoking; no steroids.

Grading (clinical)

Subclinical	Grade I	Grade II	Grade III
Ultrasound only – do not treat	Felt only on Valsalva	Felt at rest, not visible	Visible through the skin

The plan

Explain results; not about fitness	**Stop smoking; avoid heat; no steroids**	**Consider surgery or embolisation**	**Repeat semen ~3 months after**	**IVF/ICSI if no pregnancy**

Three things examiners look for

HONEST EVIDENCE	GENETIC TESTS	THE MAN IN FRONT OF YOU
• Pregnancy ~21% untreated	• Y deletion: <1 million/mL	• Fitness ≠ sperm production
• 22–48% after treatment	• or azoospermia	• Smoking: brief, no lecture
• Live birth: uncertain	• Karyotype: <5 million/mL	• Ask about steroids
• Microsurgical: less recurrence	• Not needed for Zaid now	• "Not a failure"

Say it simply

"Being fit doesn't protect sperm – this is a plumbing problem. The swollen vein warms the testicle, and sperm need it cool. Fixing it may improve our chances, but I can't promise it will. Stopping smoking is the one thing you can start today."

Common ways to lose marks

"The operation will fix it" • Smoking lecture • No steroid question • Genetic tests at 10 million/mL • Ignoring "Have I let her down?"

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Ovulation Induction

Structured Discussion Task | Module 11 | Subfertility

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Ovulation Induction

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
11: Subfertility	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A 28-year-old with polycystic ovary syndrome, BMI 31 and a very high AMH who is not ovulating. The WHO classification of anovulation, letrozole as first-line treatment, second-line gonadotrophins or ovarian drilling, monitoring and the risks of multiple pregnancy and OHSS – then an over-response to gonadotrophins, and hypothalamic amenorrhoea*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Clinic summary (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 in the fertility clinic. **Mrs Efua Adjei**, aged 28, and her husband **Mr Kwame Adjei**, aged 31, have been trying to conceive for 14 months. Their investigations are complete.

Efua has read about "fertility tablets" and would like to **start treatment straight away**.

Please read the **CLINIC SUMMARY (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss the diagnosis
- Discuss ovulation induction and its risks
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * *Recognises a **high risk of multiple pregnancy and OHSS** (PCOS, AMH 42.6): ultrasound monitoring; if gonadotrophins, **low-dose step-up**, with risks explained and cancellation criteria agreed beforehand*
- * ***Letrozole is off-label**: explains this, gives written information and documents consent; no evidence of more birth defects than with other ovulation induction drugs*
- * *Card A: **cancels the cycle** – no hCG trigger, avoid unprotected intercourse, restart at a lower dose; warns about OHSS symptoms*
- Folic acid 5 mg daily (BMI 30 or more); weight support offered without making it a barrier to treatment
- Card B: oral agents will not work; assess bone health and screen sensitively for disordered eating

Applied clinical knowledge

- * ***WHO classification**: I – low FSH, LH and oestrogen (hypothalamic); II – normal FSH and oestrogen (mostly PCOS); III – high FSH (ovarian insufficiency, donor eggs). Hyperprolactinaemia – cabergoline*
- * ***Letrozole first-line** for anovulatory PCOS (International PCOS Guideline 2023): 2.5–7.5 mg on days 2–6; in Legro 2014, live birth **27.5% vs 19.1%** with clomifene and twins 3.4% vs 7.4%*
- * ***Second-line**: gonadotrophins or laparoscopic ovarian drilling (drilling may slightly lower live birth but means fewer multiples and less OHSS – Cochrane 2020); **IVF third-line***
- Clomifene, with or without metformin, also second-line; metformin mainly for metabolic features
- Card B: WHO I – weight gain and less exercise; then pulsatile GnRH or gonadotrophins with LH activity (NICE NG257)

Communicating with colleagues

- * *Gives a clear, ordered **summary**: anovulatory PCOS (WHO II), patent tubes, normal semen, very high AMH – with a stepwise plan*
- * *Recognises the need for a **monitored ovulation induction service** and weight-management support; in Card B, eating-disorder or sports-medicine input*
- Notes NICE NG257 has withdrawn its PCOS recommendations pending a NICE PCOS guideline; documents the plan

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
PCOS with anovulation, BMI 31, AMH 42.6 pmol/L; patent tubes; normal semen. She wants "fertility tablets" now. Then two short cases on cards.

Open the discussion with the following:

> *"Please summarise Mrs Adjei's results. Why isn't she conceiving?"*

Then ask the following questions:

1. **How does the WHO classification of anovulation guide treatment?**
2. **What would you offer her first, and how would you keep her safe?**
3. **She does not ovulate on letrozole. What next?**
4. **Hand the candidate SCENARIO CARD A. "What would you do?"**
5. **Hand the candidate SCENARIO CARD B. "Would you give her clomifene?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Why letrozole rather than clomifene?"
- "Does she have to lose weight before we treat her?"
- "Why is her AMH relevant?"
- "Is ovarian drilling as good as injections?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Gives the trigger in Card A, or gonadotrophins without monitoring = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Offers clomifene or letrozole for WHO group I = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No coherent summary or plan = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

CLINIC SUMMARY (1)

Haywain General Hospital NHS Trust FERTILITY CLINIC	
Patients	Mrs Efua Adjei (28), HR manager; Mr Kwame Adjei (31), accountant. Trying to conceive for 14 months. No previous pregnancies.
Efua – history	Periods every 35–60 days (6–8 a year). Hirsutism and acne. **BMI 31.2.** Non-smoker. Taking folic acid 400 micrograms.
Hormones	FSH 5.1 IU/L; LH 9.8 IU/L; oestradiol 220 pmol/L; prolactin 312 mIU/L; TSH normal; testosterone 2.8 nmol/L
Ovulation	Luteal progesterone 3.2 nmol/L – **anovulatory**
Ovarian reserve	**AMH 42.6 pmol/L**; antral follicle count 18 and 17 – polycystic ovarian morphology
Tubes (HyCoSy)	Both patent
Kwame – semen ×2	Normal (WHO 2021)
Diagnosis	Polycystic ovary syndrome (revised Rotterdam criteria)

SCENARIO CARD A (question 4)
A different patient – day 11 of a gonadotrophin cycle

A 30-year-old with PCOS on FSH 75 IU daily. Scan today: **four follicles of 16–18 mm** and six of 12–14 mm. She is due to have her hCG trigger tonight.

SCENARIO CARD B (question 5)
A different patient

A 24-year-old long-distance runner with **no periods for 14 months**. BMI 17.5. **FSH 0.8 IU/L, LH 0.4 IU/L, oestradiol under 50 pmol/L**; prolactin and TSH normal. She asks for clomifene.

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6. RCOG INSTRUCTIONS

Module(s) examined	11: Subfertility
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × CLINIC SUMMARY (1); 1 × each SCENARIO CARD A–B

Sources: Teede HJ et al. Recommendations from the 2023 International Evidence-based Guideline for the Assessment and Management of PCOS. Hum Reprod 2023; NICE NG257 Fertility problems (March 2026), recommendations 1.30, 1.32 and 1.33, and update information; Legro RS et al. Letrozole versus clomiphene for infertility in PCOS. N Engl J Med 2014;371:119–29; Bordewijk EM et al. Laparoscopic ovarian drilling for ovulation induction in anovulatory PCOS. Cochrane Database Syst Rev 2020 (CD001122).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Ovulation induction in one line

Classify first (WHO I, II or III). For PCOS: weight support, then **letrozole**, then **low-dose gonadotrophins or ovarian drilling**, then **IVF** – with **monitoring at every step** to prevent multiple pregnancy and OHSS.

WHO classification of anovulation

Group I	Group II	Group III	High prolactin
Low FSH, LH, oestrogen – GnRH pump or gonadotrophins with LH	Normal FSH and oestrogen; mostly PCOS – letrozole	High FSH; ovarian insufficiency – donor eggs	Cabergoline

PCOS: the treatment ladder (International Guideline 2023)

Weight support; folic acid 5 mg if BMI 30+	Letrozole 2.5–7.5 mg (off-label)	Clomifene ± metformin	Low-dose gonadotrophins or drilling	IVF third-line

Three things examiners probe

LETROZOLE vs CLOMIFENE	GONADOTROPHINS	OVARIAN DRILLING
• Live birth 27.5% vs 19.1% • Ovulation per cycle 62% vs 48% • Twins 3.4% vs 7.4% • (Legro, NEJM 2014)	• Low-dose step-up • Ultrasound monitoring (NICE) • Too many follicles: cancel • No hCG; avoid intercourse	• May slightly lower live birth • Fewer multiple pregnancies • Less OHSS • (Cochrane 2020)

Say it simply

"You're not releasing an egg each month, which is common with PCOS. A tablet called letrozole helps you ovulate – it isn't officially licensed for this, but it's the recommended first choice. We'll scan you, because your ovaries can over-respond and twins are a risk."

Common ways to lose marks

Clomifene for WHO group I • Triggering an over-response • No monitoring with high AMH • Making weight loss a barrier • Not mentioning off-label consent

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PIPADOR REVISION

KNOWLEDGE AREA

12

Sexual and Reproductive Health

Sample: 1 SPT · 1 SDT · 40 stations in the full bank

Stations on pages 217–236

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Contraception after Breast Cancer with a BRCA1 Variant

Simulated Patient Task | Module 12 | Sexual and reproductive health

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Contraception after Breast Cancer with a BRCA1 Variant

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
12: Sexual and reproductive health	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A 33-year-old BRCA1 carrier treated for breast cancer, on tamoxifen, wanting contraception: why hormonal methods are avoided, the copper IUD, tamoxifen teratogenicity, planning pregnancy after cancer and risk-reducing surgery – with a hidden decision to stop tamoxifen and recent unprotected sex*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Oncology letter (1)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the gynaecology clinic. **Ms Laura Bennett**, aged 33, has been referred by the breast oncology team.

Please read the **ONCOLOGY LETTER (1)**.

You have 10 minutes in which you should:

- Take a focused history
- Discuss contraception
- Discuss her future plans
- Address her concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Laura Bennett**, aged 33, a solicitor. You carry a **BRCA1** variant and had **breast cancer 2 years ago** (mastectomy, chemotherapy). You are meant to be on **tamoxifen**. You have been using condoms but find them unreliable. You have heard "the coil makes your periods awful".

Only if asked:

• **You stopped tamoxifen yourself 2 months ago** because of hot flushes and because **you and your partner want a baby**. You have not told the oncologist.

• **You had unprotected sex 3 days ago.** Your periods have just returned.

• You had **embryos frozen before chemotherapy** (4 embryos).

• You know you are advised to have your **ovaries and tubes removed by about 35–40** but feel "it's too soon".

• Your mother died of ovarian cancer at 48.

<u>If not covered by the candidate, you could ask the following questions:</u>

Opening statement

> *"Can I have the hormone coil? My friend loves hers."*

About a baby

> *"Is it safe for me to get pregnant after cancer?"*

About surgery

> *"Do I really have to have my ovaries out?"*

About tamoxifen (if raised)

> *"Is it really that bad that I stopped?"*

<u>Acting requirements</u>

- Articulate, organised, but emotional about fertility.
- Disclose stopping tamoxifen only if asked directly about medicines and how you take them.
- Disclose UPSI only if asked about recent sex or condom problems.
- If the doctor is critical about stopping tamoxifen, become defensive.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- BRCA1, breast cancer 2 years ago (ER-positive), prescribed tamoxifen
- Hidden: stopped tamoxifen 2 months ago (wants pregnancy), UPSI 3 days ago, frozen embryos, mother died of ovarian cancer at 48

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * ***Emergency contraception*: *copper IUD*** *(UPSI 3 days ago) – avoids hormones; pregnancy test*
- * ***Hormonal contraception (including LNG-IUS) avoided*** *after breast cancer (**current UKMEC 4; past with no disease for 5 years UKMEC 3**)*
- Informs/encourages her to tell the **oncologist** about stopping tamoxifen – pregnancy and recurrence planning must be joint
- **Tamoxifen is teratogenic** – stop and wait about 2–3 months before conceiving (washout)

Applied clinical knowledge

- * ***Copper IUD*** *is the method of choice (UKMEC 1; up to 10 years); condoms; sterilisation/vasectomy options*
- * *Pregnancy after breast cancer is generally **not associated with worse survival**; timing agreed with oncology (often ≥2 years; POSITIVE trial – planned pause of endocrine therapy)*
- **BRCA1**: **risk-reducing bilateral salpingo-oophorectomy by 35–40** (after family complete); salpingectomy with delayed oophorectomy only in trials
- Fertility: **frozen embryos** (consider **PGT-M**); breastfeeding possible from remaining breast

Communicating with patients and families

- * *Empathic, non-judgemental about stopping tamoxifen*
- Balances her wish for a child with safety
- Explains copper IUD bleeding honestly and options to manage it
- Clear joint plan with oncology and genetics

Information gathering

- * ***Current medicines and adherence*** *(tamoxifen)*
- * ***Recent UPSI***; *LMP*
- Pregnancy plans, fertility preservation, family history
- Cancer details (receptor status, stage), surveillance

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Inserts or recommends the LNG-IUS / hormonal method = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Does not mention the copper IUD = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Dismisses her wish for a pregnancy = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not check tamoxifen use = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ONCOLOGY LETTER (1)

Haywain General Hospital NHS Trust
BREAST ONCOLOGY – CLINIC LETTER

Patient	Ms Laura Bennett Age: 33 P0
Diagnosis	Left breast cancer, **ER-positive**, 2 years ago; **BRCA1 pathogenic variant**
Treatment	Bilateral mastectomy, chemotherapy; **tamoxifen 20 mg daily** (planned 5–10 years)
Request	"Please advise on non-hormonal contraception and RRSO timing."
Fertility	Embryo storage prior to chemotherapy

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6. RCOG INSTRUCTIONS

Module(s) examined	12: Sexual and reproductive health
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 28–38
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ONCOLOGY LETTER (1)

Sources: CoSRH UK Medical Eligibility Criteria (UKMEC 2025); CoSRH Intrauterine Contraception (2023, amended 2025); RCOG Scientific Impact Paper on pregnancy and breast cancer; NICE CG164 Familial breast cancer (updated 2023); BGCS/UKCGG guidance on risk-reducing salpingo-oophorectomy; Partridge AH et al. NEJM 2023 (POSITIVE trial).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Breast cancer and contraception in one line

No hormones – copper IUD. Tamoxifen is **teratogenic** (stop ~2–3 months before trying). BRCA1: **RRSO by 35–40** when the family is complete.

AVOID	USE
• LNG-IUS, implant, DMPA, POP • Combined methods • Conceiving on tamoxifen	• Copper IUD (also EC) • Condoms • Sterilisation / vasectomy • Joint plan with oncology

UKMEC hormonal	Tamoxifen washout	BRCA1 RRSO
4 current; 3 past (>5 y)	~2–3 months	35–40 years

Say it simply

"After breast cancer, hormones – even in the coil – are best avoided, so the copper coil is ideal, and fitting it today also works as emergency contraception. Wanting a baby is completely reasonable – let's plan it safely with your oncologist, as tamoxifen needs to be out of your system first."

Common ways to lose marks

Fitting LNG-IUS • Missing UPSI • Judging her for stopping tamoxifen • No oncology liaison • Forgetting RRSO

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MRCOG Part 3 OSCE Stations

Pregnancy with a Copper IUD in Situ

Structured Discussion Task | Module 12 | Sexual and reproductive health

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Pregnancy with a Copper IUD in Situ

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
12: Sexual and reproductive health	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A positive pregnancy test with a copper IUD in situ: excluding ectopic pregnancy, removal before 12 weeks when threads are visible, risks of leaving it, options if she does not wish to continue – then an ectopic pregnancy and a continuing pregnancy with non-visible threads*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST4 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Early pregnancy unit referral (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are an ST4 in the early pregnancy unit. **Mrs Rachel Evans**, aged 30, has a **copper IUD fitted 2 years ago** and a **positive pregnancy test**.

Please read the **EPU REFERRAL (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss your assessment
- Discuss management
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST4 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST4 will discuss or mention many of the following:

Patient safety

- * ***Excluding ectopic: Ectopic pregnancy*** *– IUDs prevent intrauterine pregnancies more than extrauterine, so* ***a higher proportion of IUD failures are ectopic****. Assess haemodynamic status, pain,* ***TVUS*** *± serial hCG (NICE NG126).*
- * ***Card A – ectopic:*** *Ectopic pregnancy, hCG 2,400, stable: discuss* ***methotrexate vs laparoscopic salpingectomy*** *per NICE NG126 (adnexal mass size, pain, hCG <5000, no heartbeat, able to follow up) – right adnexal mass with pain → often surgery; remove IUD (or leave as contraception if she wishes – discuss); anti-D if surgical management and Rh negative.*
- **Card B – device above the sac:** Threads not visible and device **above the sac**: **do not attempt blind removal**; counsel about risks of leaving in situ; **inform maternity team**; increased surveillance for infection/preterm labour; confirm the device is delivered/expelled at birth – if not found, **abdominal X-ray postpartum** (to exclude perforation/translocation).

Applied clinical knowledge

- **Not continuing:** Options: **surgical (vacuum aspiration) with IUD removal** at the same time; for **medical abortion the IUD should be removed first**; contraception afterwards (new IUD can be inserted at the end of a surgical abortion).

Communicating with colleagues

- * ***Continuing pregnancy with IUD:*** *Leaving the IUD in situ increases* ***miscarriage, second-trimester loss, preterm birth and infection (septic miscarriage)****.* ***Remove it if <12 weeks and threads visible/easily retrievable*** *– removal reduces risks but has a small risk of miscarriage. Gentle traction, ideally with USS; document; inform maternity team.*
- * *Clear handover to maternity/obstetric team about retained device*
- Liaises with sonographer for USS-guided removal
- Documents device type and outcome; reports method failure

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Free sample · Full Station Bank at PIPADOR.co.uk

3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST4.

Task synopsis:
Rachel, 30, Cu-IUD (T380) 2 years; LMP 6+4 weeks; mild lower abdominal pain; threads visible on speculum. TVUS today: intrauterine gestation sac with yolk sac and fetal pole, heartbeat present, CRL 6+2; IUD in lower uterine cavity below the sac. She wishes to continue. Card A: alternative – empty uterus, right adnexal mass, hCG 2,400. Card B: alternative – IUP 9 weeks, threads not visible, IUD above the sac.

Open the discussion with the following:

> *"How would you assess Mrs Evans?"*

Then ask the following questions:

1. **What must you exclude first, and why?**
2. **The scan shows a viable intrauterine pregnancy and she wishes to continue. What do you advise?**
3. **What if she did not wish to continue the pregnancy?**
4. **Hand the candidate SCENARIO CARD A. "How would you manage this?"**
5. **Hand the candidate SCENARIO CARD B. "What would you advise?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Why are IUD failures more often ectopic?"
- "Should you remove it if she wants to continue?"
- "What is the upper gestation limit for removal?"
- "What if you can't see the threads?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not consider ectopic pregnancy = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Advises leaving a removable IUD in situ in a wanted pregnancy without discussing removal = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No communication with maternity about a retained device = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

EPU REFERRAL (1)

Haywain General Hospital NHS Trust
EARLY PREGNANCY UNIT – REFERRAL

Patient	Mrs Rachel Evans Age: 30 G2 P1
Contraception	**Copper IUD (T380) inserted 2 years ago**
LMP	6+4 weeks ago
Symptoms	Mild lower abdominal cramping; no bleeding
Speculum (GP)	**Threads visible**
TVUS today	**Single intrauterine pregnancy, fetal heart present, CRL = 6+2 weeks.** IUD in lower uterine cavity, below the gestation sac

SCENARIO CARD A (question 4)
Alternative scenario

Same patient, but TVUS: **empty uterus, IUD correctly sited, 2.5 cm right adnexal mass, small amount of free fluid**. **hCG 2,400 IU/L.** Right iliac fossa pain; observations normal.

SCENARIO CARD B (question 5)
Alternative scenario

Same patient, but at **9 weeks**: viable intrauterine pregnancy. **Threads not visible** on speculum. IUD seen **above the gestation sac**, near the fundus. She wishes to continue the pregnancy.

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6. RCOG INSTRUCTIONS

Module(s) examined	12: Sexual and reproductive health
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × EPU REFERRAL (1); 1 × each SCENARIO CARD A–B

Sources: FSRH Clinical Guideline: Intrauterine Contraception (March 2023, amended 2025); NICE NG126 Ectopic pregnancy and miscarriage (2019, updated 2023); RCOG/AEPU Green-top Guideline No. 21 Diagnosis and management of ectopic pregnancy (2016); NICE NG140 Abortion care (2019).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Pregnancy with an IUD in one line

Exclude ectopic first. Intrauterine, <12 weeks, threads visible → **remove**. Threads not visible → leave, inform maternity, **account for it at delivery**.

Positive test + IUD	TVUS ± hCG: exclude ectopic	IUP <12 weeks, threads seen → remove	Not removable → inform maternity	Device not found at birth → X-ray

RISKS IF LEFT IN SITU

- Miscarriage
- Second-trimester loss
- Preterm birth
- Infection / septic miscarriage

IF ENDING PREGNANCY

- Surgical: remove at the same time
- Medical: remove IUD first
- New IUD after surgical abortion

Say it simply

"First I'd exclude an ectopic, as a higher proportion of IUD failures are ectopic. As this is a viable intrauterine pregnancy at 6 weeks with visible threads, I'd advise removing the coil now – it lowers the risks of miscarriage, preterm birth and infection, though removal itself carries a small risk of miscarriage."

Common ways to lose marks

Forgetting ectopic • Blind removal • Leaving removable IUD • Medical TOP with IUD in • No delivery check

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PIPADOR REVISION

KNOWLEDGE AREA

13

Early Pregnancy Care

Sample: 1 SPT · 1 SDT · 19 stations in the full bank

Stations on pages 238–261

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Heterotopic Pregnancy After IVF Treatment

Simulated Patient Task | Module 13 | Early Pregnancy

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Heterotopic Pregnancy After IVF Treatment

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
13: Early Pregnancy Care	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Breaking the news of a heterotopic pregnancy (live intrauterine pregnancy + right tubal ectopic) after a third IVF cycle; treating the ectopic while protecting the wanted pregnancy*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Ultrasound report (1) and blood results with IVF summary (2)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the Early Pregnancy Unit and you are about to see **Mrs Fatima Al-Rashid**, aged 36, an accountant. She is attending for an early scan after her **third IVF cycle**; two day-5 embryos were transferred 26 days ago. She has been trying to conceive for 4 years. She has had a dull right-sided pelvic ache for 3 days and no bleeding.

The sonographer has told her that "there is something the doctor needs to discuss with you". Her husband, Tariq, is in the waiting room.

Observations	BP 112/72 mmHg | Pulse 94 bpm | SpO_2 99% | Temp 36.7 °C

Please read and assess the **ULTRASOUND REPORT (1)** and the **BLOOD RESULTS AND IVF SUMMARY (2)** carefully.

You have 10 minutes in which you should:

- Obtain a brief, focused history
- Explain the scan findings and their implications
- Establish and answer the patient's concerns
- Outline and justify a management plan

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Mrs Fatima Al-Rashid**, a 36-year-old accountant, married to Tariq. You have been trying for a baby for 4 years. You were told both your tubes are blocked, which is why you needed IVF. Two IVF cycles failed. This time two embryos were put back; your pregnancy test two weeks ago was positive and you have been overjoyed – secretly hoping for twins.

Presenting history:

For 3 days you have had a dull ache low on the right. You thought it was from the fertility drugs. No bleeding. **This morning, when you lay down, you had an odd ache in the tip of your right shoulder** – mention this only if asked about shoulder pain. No fainting. You feel a little bloated but you are passing urine normally and are not breathless.

Past history:

One natural pregnancy 3 years ago ended in an early miscarriage. No operations. No medical problems.

Medicines: progesterone pessaries 200 mg twice daily and aspirin 75 mg daily (from the fertility clinic). **No allergies.**

Other information (only if asked): you ate breakfast about 3 hours ago. You know you are rhesus negative and had anti-D in your last pregnancy.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"The sonographer said there's something to discuss. Please just tell me – is the pregnancy all right?"*

About the diagnosis

> *"So there IS a baby with a heartbeat in my womb, and another pregnancy in my tube? How can both be true?"*

About the tubes

> *"My tubes are blocked – that's why I needed IVF. How can a pregnancy be in my tube?"*

About methotrexate

> *"My friend had an injection for her ectopic. Can't I just have that instead of an operation?"*

About the operation

> *"Could the operation harm the baby in my womb? What are the real chances it will be OK?"*

About follow-up

> *"How will you know the ectopic has gone? Do I need the anti-D injection? Should I keep taking my progesterone?"*

About the future

> *"If I lose this baby too, can we try IVF again?"*

Acting requirements

- Cautiously hopeful at first, with a bad feeling. Tearful with relief when told there is a heartbeat in the womb.
- When told about the ectopic: "Oh no. Not now. Not after all this."
- Push for the injection: "It would be easier than surgery." Accept if the doctor explains it could harm the pregnancy in the womb.
- If asked about pain, say: "I should have said something earlier – is that why this is serious?"
- Ask for Tariq to come in. If the doctor offers this without being asked, look grateful.

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Heterotopic pregnancy after IVF: live intrauterine pregnancy at 6+3 weeks and a right tubal ectopic with free fluid
- New shoulder-tip pain and a pulse of 94 – possible haemoperitoneum
- Methotrexate contraindicated; hCG cannot be used for follow-up; anti-D not needed under 12 weeks

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * *States methotrexate must not be used – it would harm the wanted intrauterine pregnancy*
- * *Recognises possible bleeding (shoulder-tip pain, free fluid, pulse 94): admits, IV access, FBC, crossmatch, senior review; surgery today*
- * *Explains hCG cannot show whether the ectopic has resolved because the intrauterine pregnancy keeps producing it – follow-up is by ultrasound*
- Surgery planned to protect the pregnancy: no uterine manipulator or instrumentation; experienced surgeon; continue progesterone
- Notes she ate 3 hours ago and takes aspirin – informs the anaesthetist; no allergies
- Explains anti-D is **not** needed: she is under 12 weeks (NICE NG126, June 2026 – not offered up to 11+6 weeks, even with surgery)

Applied clinical knowledge

- * *Interprets the scan: live intrauterine pregnancy **plus** a separate right adnexal ring with vascularity and free fluid = heterotopic pregnancy*
- * *Options (RCOG GTG 21): laparoscopic salpingectomy (usual choice, especially with pain or free fluid); ultrasound-guided potassium chloride or hyperosmolar glucose into the ectopic sac in specialist centres if unruptured; expectant care only if small, stable and pain-free*
- Incidence: about 1 in 30,000 natural pregnancies but up to about 1 in 100 after IVF; risk rises with tubal disease and more than one embryo transferred
- Explains distal tubal blockage leaves the inner part of the tube open, so an embryo can still enter it
- Outcome: about two-thirds of intrauterine pregnancies continue to a live birth after treatment of the ectopic
- Considers ovarian hyperstimulation as a differential for her pain and bloating
- Above standard: hydrosalpinges are usually treated (salpingectomy or occlusion) before further IVF – NICE CG156

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Communicating with patients and families

- * *Breaks the news in a balanced way – the heartbeat in the womb is real, and the ectopic is a serious risk to her and to that pregnancy*
- * *Explains why the injection is not an option in a way she accepts, rather than simply refusing*
- Acknowledges 4 years of infertility and the shock; allows pauses; offers to bring Tariq in
- Honest about the risk of miscarriage after surgery without false reassurance
- Plans joint follow-up with the fertility clinic; offers support (Ectopic Pregnancy Trust, Fertility Network UK)

Information gathering

- * *Asks about symptoms of bleeding: shoulder-tip pain, dizziness, fainting, worsening pain – elicits this morning's shoulder-tip pain*
- * *Establishes current medicines (progesterone, aspirin), allergies and when she last ate*
- Asks about symptoms of ovarian hyperstimulation: bloating, breathlessness, urine output
- Confirms IVF details: number of embryos transferred and the reason for IVF

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Offers systemic methotrexate, OR plans discharge / expectant care = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Fails to recognise a heterotopic pregnancy = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Fails to explain why methotrexate cannot be used = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Fails to ask about symptoms of internal bleeding = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ULTRASOUND REPORT (1)

Haywain General Hospital NHS Trust
EARLY PREGNANCY UNIT – TRANSVAGINAL ULTRASOUND REPORT

Name	Mrs Fatima Al-Rashid	**DoB**	08.05.1990
Gestation (IVF)	6+3 weeks	**Embryos transferred**	2 (day 5)

Uterus	**Single intrauterine gestational sac** with yolk sac and fetal pole. CRL 7 mm (6+3 weeks). **Fetal heart activity present.**
Right adnexa	Right ovary enlarged (stimulated) with multiple follicles. **Separate** 24 × 21 mm echogenic ring with an anechoic centre, between the ovary and the uterus. Peripheral vascularity on colour Doppler. Moves separately from the ovary.
Left adnexa	Left ovary enlarged (stimulated). No other mass.
Pouch of Douglas	**Small volume of echogenic free fluid.**
Comment	Discussed with EPU doctor. Please review today.

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BLOOD RESULTS AND IVF SUMMARY (2)

Haywain General Hospital NHS Trust
PATHOLOGY AND FERTILITY CLINIC SUMMARY

Test	Result	Normal range
Serum hCG IU/L	**18,400**	–
Haemoglobin g/L	**121**	115–160
Platelet count ×10⁹/L	**254**	150–400
White cell count ×10⁹/L	**8.1**	4.0–11.0
Blood group	**A RhD NEGATIVE**	
Antibody screen	**Negative**	

Indication for IVF	Bilateral distal tubal blockage with hydrosalpinges on HSG (tubes not removed)
This cycle	Third cycle. Fresh transfer of 2 day-5 blastocysts, 26 days ago. Positive pregnancy test 2 weeks ago.
Previous	Two failed IVF cycles. One natural pregnancy – miscarriage at 7 weeks.
Current medication	Progesterone pessaries 200 mg twice daily; aspirin 75 mg daily
Allergies	None known

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6. RCOG INSTRUCTIONS

Module(s) examined	13: Early Pregnancy Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 30–40
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ULTRASOUND REPORT (1); 2 × BLOOD RESULTS AND IVF SUMMARY (2)

Sources: RCOG Green-top Guideline No. 21, Diagnosis and Management of Ectopic Pregnancy (2016); NICE NG126, Ectopic pregnancy and miscarriage (anti-D recommendations updated June 2026); NICE CG156, Fertility problems (hydrosalpinges before IVF); Clayton HB et al. A comparison of heterotopic and intrauterine-only pregnancy outcomes after assisted reproductive technologies. Obstet Gynecol 2007;109:1084–9.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Heterotopic pregnancy in one line

An intrauterine pregnancy **and** an ectopic at the same time. About **1 in 30,000** natural pregnancies but up to about **1 in 100 after IVF**. Easy to miss: a normal intrauterine sac is falsely reassuring – **always look at the adnexa** in IVF pregnancies with pain.

Why it happens after IVF

More than one embryo	Tubal disease	Stimulated ovaries
Two chances to implant in different places	Distal blockage leaves the inner tube open for an embryo to enter	Pain and fluid can be put down to hyperstimulation

Three rules that change everything

NO METHOTREXATE	NO hCG FOLLOW-UP	PROTECT THE UTERUS
It would harm the wanted pregnancy in the womb	The intrauterine pregnancy keeps hCG high – use ultrasound	No uterine manipulator; continue progesterone

Management options (RCOG GTG 21)

LAPAROSCOPIC SALPINGECTOMY	LOCAL INJECTION	EXPECTANT
• Usual choice • First choice if pain, free fluid or rupture • Experienced surgeon • No uterine instruments	• Ultrasound-guided KCl or hyperosmolar glucose into the ectopic sac • Unruptured, stable women • Specialist centres	• Only if small, stable, pain-free, no free fluid • Close scan follow-up • Not for her

Her red flags

Shoulder-tip pain today	Free fluid on scan	Pulse 94	Ate 3 hours ago; on aspirin

= admit, crossmatch, theatre today, tell the anaesthetist.

The numbers to quote

About **two-thirds** of intrauterine pregnancies continue to a live birth after the ectopic is treated. **Anti-D not needed** under 12 weeks (NICE NG126, 2026).

Common ways to lose marks

Offering methotrexate • Planning hCG follow-up • Missing the shoulder-tip pain • Stopping progesterone • Giving anti-D • Leading only with bad news

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Recurrent Miscarriage: Antiphospholipid Antibodies Found

Structured Discussion Task | Module 13 | Early Pregnancy

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Recurrent Miscarriage: Antiphospholipid Antibodies Found

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
13: Early Pregnancy Care	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: Interpreting antiphospholipid antibody results in recurrent miscarriage; 'triple positive' and when to start treatment; completing the work-up; treatment and surveillance in pregnancy; treatment failure

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Antibody results (1), other investigations (2), scenario cards A and B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are an ST5 in the recurrent miscarriage clinic. **Mrs Amara Osei**, a 34-year-old practice manager, is waiting to be seen with her husband Emmanuel. She has had **four first-trimester miscarriages** over 3 years (at 7, 8, 9 and 10 weeks), all missed miscarriages confirmed on ultrasound. She has no living children and no medical history of note.

After her third miscarriage, her local hospital tested for antiphospholipid antibodies and asked her to repeat the test 12 weeks later. The repeat was not done. Her GP started **aspirin 75 mg daily** "just in case". The tests were repeated in this clinic last week.

Mrs Osei has read about antiphospholipid syndrome online. She asks:

"Am I 'triple positive'? Should I start the injections now, before I get pregnant?"

Please read and assess the **ANTIPHOSPHOLIPID ANTIBODY RESULTS (1)** and **OTHER INVESTIGATIONS (2)** carefully. Your consultant (the examiner) will discuss the case with you before you see the couple.

You have 10 minutes in which you should:

- Interpret the investigation results
- Discuss her antibody results and her questions
- Identify any gaps in her investigations
- Outline and justify a management plan for her next pregnancy

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * *Recommends low-dose aspirin plus prophylactic LMWH from a positive pregnancy test until at least 34 weeks (RCOG GTG 17, 2023)*
- * *Does not offer IVIg or corticosteroids after treatment failure – no evidence of benefit and real risks*
- * *Does not test for inherited thrombophilia (protein C, antithrombin, MTHFR) after first-trimester losses, and does not give aspirin or heparin for unexplained recurrent miscarriage*
- Notes aspirin was started before APS was confirmed; checks for contraindications before LMWH (bleeding history, platelets, renal function, allergy); weight-based dosing; injection teaching and sharps disposal
- Aspirin until birth for pre-eclampsia prevention (APS is a high-risk factor – NICE NG133); LMWH timing around birth and regional anaesthesia planned with the anaesthetist
- Postnatal LMWH for 6 weeks (she needed antenatal LMWH – RCOG GTG 37a)
- Avoid oestrogen-containing contraception with positive antiphospholipid antibodies (UKMEC 4); haematology input for long-term thrombosis risk
- Card A: **start LMWH today** alongside aspirin; viability scan

Applied clinical knowledge

- * *Applies the revised Sapporo criteria: clinical criterion met (≥3 unexplained losses < 10 weeks); lupus anticoagulant positive on two occasions ≥ 12 weeks apart =* ***APS confirmed***
- * *Recognises she is* ***not*** *triple positive: anti-β2GPI 18 U/mL is below the medium/high threshold, and aCL has been medium titre only once (28 → 52) – repeat in 12 weeks*
- * *Identifies gaps (RCOG GTG 17): TPO antibodies; cytogenetics on tissue from any future miscarriage; parental karyotype re-offered as no tissue was tested*
- Mechanism: antibodies impair trophoblast invasion and activate complement in early pregnancy; thrombosis of the placental bed later; heparin works on both, not just as an anticoagulant
- Evidence: live birth rate ~70% with aspirin + heparin vs ~40% with aspirin alone (Rai 1997); untreated as low as 10%
- Surveillance: consultant-led care; uterine artery Doppler at 20–24 weeks; serial growth scans from the late second trimester; BP and urine checks
- Progesterone (400 mg vaginal micronised twice daily to 16 weeks) if she bleeds in early pregnancy
- After treatment failure: tissue karyotype; specialist / haematology review; hydroxychloroquine only within specialist care or research
- Above standard: knows the 2023 ACR/EULAR criteria are for research classification and give recurrent early loss low weight

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- No NK cell, infection or inherited thrombophilia screens – not supported by evidence

Communicating with colleagues

- * *Explains her antibody profile clearly and accurately (APS confirmed by lupus anticoagulant; not triple positive) and makes sure the notes record the correct diagnosis*
- * *Responds to a colleague who tests everyone for inherited thrombophilia with evidence (RCOG GTG 17), without confrontation*
- Gives a clear, structured summary of the case and results
- Writes to the GP: confirmed diagnosis, who prescribes LMWH at a positive test, and how to self-refer early
- Involves haematology / obstetric medicine as needed; suggests teaching or audit of the clinic's APS testing pathway
- Explains to the couple that the correction does not change the treatment plan

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your registrar.

Task synopsis:
A 34-year-old with four first-trimester miscarriages has persistent lupus anticoagulant, confirming APS. She asks whether she is "triple positive" and whether to start injections before conception. Her work-up is incomplete.

Open the discussion with the following:

> *"Before we see Mr and Mrs Osei, please summarise her history and results. Does she have antiphospholipid syndrome?"*

Then ask the following questions:

1. She asks whether she is "triple positive" and whether to start injections now. What would you tell her?
2. **What gaps are there in her investigations, and what would you add?**
3. **What treatment would you recommend for her next pregnancy, and why?**
4. **Hand the candidate SCENARIO CARD A. "What would you do now, and how would you plan the rest of her pregnancy?"**
5. **Hand the candidate SCENARIO CARD B. "What would you advise her?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "What are the laboratory criteria for APS?"
- "Why would heparin help before the placental circulation is established?"
- "A colleague tests every patient for factor V Leiden and MTHFR – 'it can't hurt'. What would you say?"
- "At 24 weeks she asks whether she can stop the injections."
- "What contraception would you advise after the pregnancy?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Does not recommend aspirin + LMWH from a positive pregnancy test, OR offers IVIg / steroids = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot state the laboratory criteria for APS, OR accepts "triple positive" = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

Cannot explain her antibody profile accurately = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

ANTIPHOSPHOLIPID ANTIBODY RESULTS (1)

Haywain General Hospital NHS Trust
HAEMATOLOGY – ANTIPHOSPHOLIPID ANTIBODY SCREEN

Patient	Mrs Amara Osei DoB: 21.09.1992
Notes	Samples taken 11 months apart. Not pregnant and not anticoagulated at either test.

Test	11 months ago (local hospital)	Last week (this clinic)	Threshold
Lupus anticoagulant (dRVVT)	Weak positive	**POSITIVE**	Positive / negative
Anticardiolipin IgG (GPL U/mL)	28	**52**	> 40 = medium/high
Anticardiolipin IgM (MPL U/mL)	Not done	**8**	> 40 = medium/high
Anti-β2 glycoprotein I IgG (U/mL)	Negative	**18**	> 40 (or > 99th centile)
Anti-β2 glycoprotein I IgM (U/mL)	Negative	**Negative**	> 40 (or > 99th centile)

OTHER INVESTIGATIONS (2)

Haywain General Hospital NHS Trust
RECURRENT MISCARRIAGE CLINIC – RESULTS SUMMARY

3D pelvic ultrasound	Normal uterine cavity. No congenital anomaly.
Thyroid function	TSH 1.8 mU/L, free T4 14 pmol/L (normal). TPO antibodies: not tested.
Pregnancy tissue cytogenetics	Not performed on any of the four miscarriages.
Parental karyotype	Offered at local hospital – declined.
FBC	Hb 131 g/L, platelets 245 ×10⁹/L, WCC 6.9 ×10⁹/L
Renal and liver function	Normal
ANA / anti-dsDNA	ANA positive, low titre 1:80 (speckled). Anti-dsDNA negative.
BMI	24 kg/m². Non-smoker. Alcohol < 4 units/week.

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SCENARIO CARDS – *examiner hands each card to the candidate at the question shown*

SCENARIO CARD A (question 4)
Five months later

Mrs Osei attends the early pregnancy unit at **6+2 weeks** with a positive pregnancy test.

She is taking aspirin 75 mg daily. **She has not started LMWH** – nobody prescribed it.

Weight 68 kg. Platelets 238 ×10⁹/L. Creatinine 64 µmol/L.

Transvaginal scan: single intrauterine sac with yolk sac; fetal pole 2 mm; no heartbeat yet (consistent with dates).

SCENARIO CARD B (question 5)
A different outcome

Despite aspirin and LMWH from 6 weeks, Mrs Osei has a **fifth miscarriage at 9 weeks**.

She says: *"I've read about immunoglobulin drips and steroids. They sound stronger – can I have them next time?"*

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6. RCOG INSTRUCTIONS

Module(s) examined	13: Early Pregnancy Care
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × ANTIPHOSPHOLIPID ANTIBODY RESULTS (1); 2 × OTHER INVESTIGATIONS (2); 1 × SCENARIO CARD A; 1 × SCENARIO CARD B

Sources: RCOG Green-top Guideline No. 17, Recurrent Miscarriage (2023); Miyakis S et al. International consensus statement (revised Sapporo criteria). J Thromb Haemost 2006;4:295–306; Barbhaiya M et al. 2023 ACR/EULAR APS classification criteria. Ann Rheum Dis 2023;82:1258–70; Rai R et al. BMJ 1997;314:253–7; NICE NG133, Hypertension in pregnancy; RCOG Green-top Guideline No. 37a; UKMEC 2016.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

APS in one line

Persistent antiphospholipid antibodies **plus** a clinical event. Found in about **15%** of women with recurrent miscarriage – the most important **treatable** cause. Live birth rate untreated can be as low as **10%**; about **70%** with aspirin + heparin.

Diagnosis = 1 clinical + 1 laboratory criterion (revised Sapporo)

CLINICAL – any one	LABORATORY – any one, positive TWICE ≥ 12 weeks apart
• ≥ 3 unexplained consecutive losses < 10 weeks • ≥ 1 unexplained fetal death ≥ 10 weeks • ≥ 1 birth < 34 weeks for severe pre-eclampsia / placental insufficiency • Arterial or venous thrombosis	• Lupus anticoagulant • Anticardiolipin IgG/IgM > 40 (medium/high) • Anti-β2GPI IgG/IgM > 99th centile • Test off anticoagulants, not in pregnancy

Her antibody profile – read it carefully

Antibody	Test 1	Test 2	Meaning
Lupus anticoagulant	✔	✔	**PERSISTENT – confirms APS**
Anticardiolipin IgG	28 ✘	52 ✔	**Medium once only – repeat**
Anti-β2GPI IgG	neg ✘	18 ✘	**Below threshold**

= APS confirmed, but NOT "triple positive". Lupus anticoagulant is the strongest predictor of poor pregnancy outcome.

Why heparin works – not just a blood thinner

Trophoblast	Complement	Thrombosis
Reverses antibody damage to invasion	Reduces inflammation at the implantation site	Protects the placental bed later in pregnancy

Her pregnancy plan

Aspirin 75 mg pre-conception	**+ LMWH from positive test**	**Uterine artery Doppler 20–24 wk**	**Serial growth scans**	**LMWH to ≥ 34 wk; aspirin to birth**	**6 weeks postnatal LMWH**

Recurrent miscarriage work-up (RCOG GTG 17, 2023)

✔ OFFER	! 2nd TRIMESTER ONLY	✘ DO NOT
• Antiphospholipid antibodies ×2 • Cytogenetics on 3rd+ loss • Parental karyotype if tissue unbalanced or not tested • 3D ultrasound • TFTs + TPO antibodies • Lifestyle: BMI 19–25, no smoking	• Factor V Leiden • Prothrombin gene mutation • Protein S • (ideally in research)	• Protein C, antithrombin, MTHFR • NK cells, HLA, cytokines • Aspirin / heparin if unexplained • IVIg or steroids for APS

Common ways to lose marks

✘ Accepting "triple positive" ✘ Diagnosing APS from one test	✘ Stopping LMWH early because "all is well" ✘ Offering IVIg or steroids	✘ Testing for MTHFR / factor V Leiden ✘ Forgetting postnatal LMWH and UKMEC 4 for combined pill

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KNOWLEDGE AREA

14

Gynaecological Oncology

Sample: 1 SPT · 1 SDT · 18 stations in the full bank

Stations on pages 263–283

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Management of CGIN (Cervical Glandular Intraepithelial Neoplasia)

Simulated Patient Task | Module 14 | Gynaecological Oncology

OSCE STATION PRACTICE PACK

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MRCOG Part 3 OSCE: Simulated Patient Task

Management of CGIN (Cervical Glandular Intraepithelial Neoplasia)

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
14: Gynaecological Oncology	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *Explaining high-grade CGIN with an involved endocervical margin to a 38-year-old who asks for a hysterectomy; why a repeat excision comes first, the place of hysterectomy, and follow-up*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	Screening and colposcopy summary (1) and histopathology / MDT outcome (2)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the colposcopy clinic. You are about to see **Mrs Nadia Siddiqui**, a 38-year-old solicitor. Her screening test showed HPV and **glandular neoplasia (endocervical type)**. Four weeks ago she had colposcopy and a **LLETZ**.

The histology has been discussed at the colposcopy MDT. She has two children, aged 8 and 10.

Please read the **SCREENING AND COLPOSCOPY SUMMARY (1)** and the **HISTOPATHOLOGY AND MDT OUTCOME (2)** carefully.

You have 10 minutes in which you should:

- Explain the result to her
- Obtain any relevant history
- Discuss and agree a management plan
- Address her concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Mrs Nadia Siddiqui**, a 38-year-old solicitor, married with two children (8 and 10). You are precise and analytical, and you have brought a notebook. You have barely slept since the colposcopy. Your sister had "something similar" and had a hysterectomy.

Only if asked:

• **You have had bleeding after sex** on and off for 3 months. Periods otherwise regular, not heavy.

• You think your family is complete, but you and your husband have occasionally talked about a third child – **you are not 100% sure**.

• Contraception: condoms. Non-smoker. No medical problems, no medicines, no allergies.

If not covered by the candidate, you could ask the following questions:

Opening statement

> *"I've waited four weeks. Is it cancer?"*

About CGIN

> *"How is this different from the abnormal cells other women get?"*

About the margin

> *"You removed it, but the edge isn't clear – so some could still be there?"*

About hysterectomy

> *"I've had my children. Can't you just take my womb out? Would I keep my ovaries?"*

About another loop

> *"Why have another loop if a hysterectomy is the definite answer?"*

About the future

> *"What if we decide we want another baby?"*

Acting requirements

- Composed but tense; you write down key points. You relax if treated as an intelligent adult.
- If "cancer" is used without context: "Wait – I thought this was pre-cancer?"
- If hysterectomy is refused without explanation: "But why can't I just have it?"
- At the end: "So what exactly happens next, and when?"

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- High-grade CGIN with CIN2; **endocervical margin involved**; no invasion seen. MDT: repeat excision to clear margins and exclude invasion
- Hidden: post-coital bleeding for 3 months; not completely certain her family is complete

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * *Recommends a **repeat excision first** (deep/cylindrical LLETZ or cone) to remove residual disease and **exclude hidden invasive cancer** – MDT recommendation*
- * *Explains why not straight to hysterectomy: if a hidden cancer were present, a simple hysterectomy would be the wrong operation*
- Hysterectomy (ovaries kept) can be considered later if her family is complete – e.g. if margins remain involved or abnormal tests persist – after invasion is excluded
- Post-coital bleeding adds to the need to exclude invasion; safety-net for bleeding
- Follow-up: test of cure (cytology + HPV) at 6 and 18 months; if both negative, recall in 3 years

Applied clinical knowledge

- * *Explains CGIN: pre-cancerous change in the **glandular cells inside the cervical canal** – precursor of adenocarcinoma; not cancer*
- * *Explains why CGIN differs from CIN: harder to see at colposcopy, can extend up the canal and occur in patches, so complete excision with clear margins matters more*
- Involved margin = some CGIN may remain
- Concurrent CIN is common (she has CIN2) – removed by the same excision
- Repeat excision can shorten the cervix – small increase in preterm birth risk if she has another baby
- Endocervical-type glandular change: endometrial assessment only if endometrial-type cells or abnormal bleeding pattern

Communicating with patients and families

- * *Answers "is it cancer?" clearly and early: no – it is a pre-cancer, and the aim is to stop it becoming cancer*
- * *Respects her wish for a hysterectomy while explaining the reasoning clearly; shared decision; time to think*
- Checks understanding; avoids jargon; supports her note-taking; written information
- Offers a follow-up appointment and nurse contact; partner welcome

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Information gathering

- * *Asks about symptoms – elicits post-coital bleeding*
- * *Explores fertility plans carefully – elicits that she is not completely sure her family is complete*
- Asks about contraception, smoking, medical history and allergies
- Establishes her understanding and her sister's experience

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Offers surveillance alone, or books hysterectomy without excluding invasion = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot explain the significance of the involved margin = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Leaves her believing she has cancer = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not explore fertility wishes = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

SCREENING AND COLPOSCOPY SUMMARY (1)

Haywain General Hospital NHS Trust
COLPOSCOPY CLINIC

Patient	Mrs Nadia Siddiqui DoB: 09.03.1988 Para 2
Screening sample	hrHPV **positive**. Cytology: **high-grade glandular neoplasia, endocervical type**.
Colposcopy	Subtle acetowhite change at the os. Upper limit of the transformation zone **not seen**.
Treatment	LLETZ (type 3, cylindrical) under local anaesthetic. Uncomplicated.

HISTOPATHOLOGY AND MDT OUTCOME (2)

Haywain General Hospital NHS Trust
CELLULAR PATHOLOGY / COLPOSCOPY MDT

Histology	**High-grade CGIN** with CIN2. **No invasive disease seen.**
Margins	**Endocervical margin involved by CGIN.** Ectocervical and deep lateral margins clear.
MDT recommendation	**Repeat excision** to obtain clear margins and exclude invasive disease. Discuss hysterectomy only once invasion excluded, if family complete.

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6. RCOG INSTRUCTIONS

Module(s) examined	14: Gynaecological Oncology
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 35–45
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × SCREENING AND COLPOSCOPY SUMMARY (1); 2 × HISTOPATHOLOGY AND MDT OUTCOME (2)

Sources: NHS Cervical Screening Programme: programme and colposcopy management (GOV.UK, updated 2025); Cervical screening care pathway (GOV.UK).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

CGIN in one line

A **pre-cancer of the glandular cells** inside the cervical canal (precursor of adenocarcinoma). It needs **excision with clear margins**; if a margin is involved, **re-excise first to exclude invasion** – hysterectomy comes later, if at all.

CIN vs CGIN

CIN (squamous)	CGIN (glandular) – her
• Surface of the cervix • Usually seen well at colposcopy • Involved margin < 50 years: test of cure, no routine re-excision	• Inside the canal • Often hard to see; may be patchy • Involved margin: MDT, usually repeat excision

Her pathway

Repeat excision (cone / deep LLETZ)	**Clear margins, no invasion?**	**Yes → test of cure 6 + 18 months**	**Both negative → 3-year recall**	**Persistent / involved → consider hysterectomy**

Why not hysterectomy straight away?

Hidden cancer? Must be excluded first – it would need a different (radical) operation	**Post-coital bleeding** Another reason to exclude invasion	**Not 100% sure about family** Repeat excision keeps her options open

If hysterectomy is chosen later	Common ways to lose marks
Simple (total) hysterectomy; **ovaries kept** at 38. Vault follow-up depends on whether disease was completely excised in the specimen.	Booking hysterectomy before excluding invasion • Offering surveillance alone • Saying "cancer" carelessly • Not asking about bleeding or fertility plans • Removing ovaries

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Vulval Melanoma: Diagnosis and Management

Structured Discussion Task | Module 14 | Gynaecological Oncology

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Vulval Melanoma: Diagnosis and Management

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
14: Gynaecological Oncology	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: A vulval melanoma with an involved margin; she asks for "the same operation as for vulval cancer". How melanoma differs from SCC, least-radical R0 surgery, when sentinel node biopsy is justified, mutation testing and systemic therapy, and a pigmented lesion the GP wants to watch

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST6 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Histology report (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST6 in gynaecological oncology. **Mrs Eleanor Whitaker**, aged 68, had an excision biopsy of a 1.8 cm pigmented lesion on the right labium minus. It is a **vulval melanoma** with an involved margin.

She has read about vulval cancer surgery and asks:
"Should I have the whole vulva and the glands in both groins removed, to be sure it's all gone?"

Please read the **HISTOLOGY REPORT (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss her question about radical surgery
- Explain how vulval melanoma differs from squamous cell carcinoma
- Outline staging and management
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST6 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST6 will discuss or mention many of the following:

Patient safety

- * *Does not offer radical vulvectomy or groin dissection: aim for an R0 margin (microscopically clear, >1 mm) in the least radical way; radical surgery does not improve survival*
- * ***Lymphadenectomy only with proven nodal disease*** *(FNA or core biopsy of any palpable node); sentinel node biopsy only if it would direct adjuvant treatment or trial entry*
- Staging before surgery: CT thorax, abdomen and pelvis including the groins; MRI pelvis; PET-CT and brain MRI if radical surgery is being considered
- Card B: a pigmented vulval lesion in a postmenopausal woman needs **excision biopsy**, not watchful waiting
- Adjuvant radiotherapy is not routine after complete excision
- Card B: **full-thickness excision biopsy** with a narrow margin – not a shave biopsy; "unchanged" does not exclude melanoma

Applied clinical knowledge

- * *Melanoma is a **separate disease** from SCC: not HPV or UV related; staged with the **AJCC melanoma system (Breslow thickness, ulceration)**, not FIGO; different surgery and systemic treatment*
- * ***BRAF and KIT mutation testing*** *routinely (plus NRAS/NF1); KIT mutations more and BRAF mutations less common than in skin melanoma*
- * *Card A: metastatic disease – **immunotherapy (anti-PD-1 ± anti-CTLA-4)** first; **KIT inhibitor** (e.g. imatinib) an option for an exon 11 mutation; BRAF inhibitors not applicable; clinical trial*
- Her T stage: Breslow 2.4 mm, no ulceration = pT3a
- Prognosis worse than skin melanoma; adjuvant immunotherapy may be considered for high risk of relapse

Communicating with colleagues

- * *Explains, with reasons, why radical surgery is not recommended, and how this will be explained to Mrs Whitaker*
- * *Refers to a **joint MDT** with the specialist skin/melanoma team, melanoma pathologist and oncologist*
- Clear summary of histology and plan
- Card B: explains to the GP why the lesion needs removal; psychosexual support for patients after vulval surgery
- Card A: melanoma oncology and **palliative care** input

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST6.

Task synopsis:
Vulval melanoma, Breslow 2.4 mm, involved margin, groins normal. She asks for radical vulvectomy and bilateral groin dissection "to be sure". Then two short cases on cards.

Open the discussion with the following:

> *"She is asking for radical vulvectomy and removal of the groin nodes. What would you advise?"*

Then ask the following questions:

1. **How does vulval melanoma differ from vulval squamous cell carcinoma?**
2. **How would you stage her and manage the primary?**
3. **What about her groins?**
4. **Hand the candidate SCENARIO CARD A. "What are her treatment options?"**
5. **Hand the candidate SCENARIO CARD B. "How would you respond?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Which staging system would you use?"
- "What margin are you aiming for?"
- "Which mutations would you test for?"
- "How would you follow her up?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Agrees to radical vulvectomy with groin dissection = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Stages or treats it as squamous cell carcinoma = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No referral to the melanoma team = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

HISTOLOGY REPORT (1)

Haywain General Hospital NHS Trust
CELLULAR PATHOLOGY

Patient	Mrs Eleanor Whitaker DoB: 04.09.1958
Specimen	Excision biopsy, right labium minus, 1.8 cm pigmented lesion
Diagnosis	**Malignant melanoma**, mucosal lentiginous type; S100, SOX10 and Melan-A positive
Microstaging	**Breslow thickness 2.4 mm**; **no ulceration**; mitoses 2/mm²; no lymphovascular invasion
Margins	**Lateral margin involved** by invasive melanoma; deep margin clear
Clinical	Groins clinically normal. Lichen sclerosus. No skin melanoma history.

SCENARIO CARD A (question 4)
Mrs Whitaker – 8 months later

Re-excision achieved clear margins. Tumour mutation testing: **BRAF wild-type, KIT exon 11 mutation, NRAS wild-type.**

Surveillance CT: **multiple lung nodules** consistent with metastases. ECOG 1.

SCENARIO CARD B (question 5)
A GP telephone call

A 55-year-old has a **1 cm blue-black lesion** on the left labium majus. "She says it's been there 2 years and hasn't changed – can I just keep an eye on it?"

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6. RCOG INSTRUCTIONS

Module(s) examined	14: Gynaecological Oncology
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × HISTOLOGY REPORT (1); 1 × each SCENARIO CARD A–B

Sources: Smith HG et al. Ano-uro-genital mucosal melanoma UK national guidelines. Eur J Cancer 2020;135:22–30 (NICE-accredited; Melanoma Focus); AJCC Cancer Staging Manual, 8th edition (melanoma); NICE NG14 Melanoma: assessment and management.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Vulval melanoma in one line

Not vulval cancer with a different colour. Stage by **Breslow thickness (AJCC)**, excise to a **clear margin in the least radical way**, touch the groins **only if nodes are proven** (or a sentinel node would change treatment), **test BRAF and KIT**, and manage in a **joint melanoma MDT**.

Melanoma vs squamous cell carcinoma

VULVAL SCC	VULVAL MELANOMA
• HPV or lichen sclerosus	• Not HPV, not UV (mucosal)
• FIGO 2021 staging	• AJCC: Breslow + ulceration
• Radical local excision	• R0 (>1 mm) – least radical
• Sentinel node if unifocal <4 cm	• Nodes only if proven / SLN if it changes treatment
• Chemoradiotherapy if advanced	• Immunotherapy, KIT or BRAF inhibitors

AJCC T stage (Breslow)

T1	T2	T3 – her	T4
≤1.0 mm	>1.0–2.0 mm	>2.0–4.0 mm	>4.0 mm

a = no ulceration, b = ulceration (T1 also splits at 0.8 mm).

Her pathway

CT TAP + groins; MRI pelvis	Re-excise to R0	BRAF / KIT testing	Joint melanoma MDT	Surveillance to 10 years

Follow-up (UK AUG guideline)

3-monthly for years 1–3, 6-monthly for years 4–5, annually to year 10, with scheduled CT imaging. Rapid access between visits.

Common ways to lose marks

Radical vulvectomy • Routine groin dissection • Using FIGO staging • No mutation testing • BRAF inhibitor for BRAF wild-type • Watching a pigmented lesion

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KNOWLEDGE AREA

15

Urogynaecology and Pelvic Floor Problems

Sample: 1 SPT · 1 SDT · 19 stations in the full bank

Stations on pages 285–306

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Bladder Symptoms with Undisclosed Recreational Ketamine Use

Simulated Patient Task | Module 15 | Urogynaecology

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Simulated Patient Task

Bladder Symptoms with Undisclosed Recreational Ketamine Use

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
15: Urogynaecology	Simulated patient task (role-player)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with patients and families | Information gathering

Task synopsis: *A 23-year-old with severe bladder symptoms, a small thick-walled bladder, bilateral hydronephrosis and abnormal kidney and liver tests. The diagnosis – ketamine uropathy – only appears if the candidate asks about recreational drugs without judgement. Then: what it means, urgent upper tract care, stopping, and a possible pregnancy*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Simulated Patient's Directions**	Role-player brief, questions and acting requirements
3	**Examiner's Information & Standard Setting**	What the competent ST5 candidate covers; * = critical points
4	**Clinical Examiner's Mark Sheet**	Four domains, 0 / 1 / 2 marks
5	**Props**	GP letter (1) and results (2)
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

This is a simulated patient task assessing the following clinical skills:

- Patient safety
- Applied clinical knowledge
- Communicating with patients and families
- Information gathering

You are an ST5 in the urogynaecology clinic. **Miss Chloe Barrett**, a 23-year-old marketing assistant, has been referred urgently by her GP with 6 months of severe frequency, urgency, bladder pain and blood in the urine. Two courses of antibiotics have not helped.

Please read the **GP LETTER (1)** and the **RESULTS (2)** carefully.

You have 10 minutes in which you should:

- Take a focused history
- Explain the likely diagnosis and its significance
- Discuss the next steps
- Address her concerns

You will not be expected to examine the patient.

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2. SIMULATED PATIENT'S DIRECTIONS

You are **Miss Chloe Barrett**, 23, working in marketing and living with flatmates; you have a boyfriend. For 6 months you have needed the toilet up to 20 times a day, with sudden urgency, burning, pain low in your tummy and blood in your urine. You have leaked twice. You are exhausted and scared.

Only if asked about recreational drugs in a non-judgemental way:

• You **snort ketamine 3–4 times a week** and have done for about 18 months; the amount has gone up. Your bladder is worst after using. You get bad stomach cramps ("K-cramps").

• You also drink at weekends. No other drugs.

If asked only about "medicines", or in a judgemental tone: "No, nothing – just a drink at the weekend."

Only if asked:

• **Your last period was 7 weeks ago**; periods are usually regular. You use condoms "most of the time".

• Some ache in both loins. No fevers. No allergies.

<u>If not covered by the candidate, you could ask the following questions:</u>

Opening statement

> *"I've had antibiotics twice and it keeps getting worse. What is wrong with me?"*

After disclosure

> *"Everyone I know uses it. Why me?"*

About her kidneys

> *"My kidneys? Have I damaged them for good?"*

About confidentiality

> *"Will this go to the police? Does my GP have to know?"*

About stopping

> *"I don't know how to stop and still have a social life."*

About the future

> *"Will I need an operation? I'm 23."*

<u>Acting requirements</u>

- Guarded and defensive at first; disclose hesitantly once you feel safe.
- Visibly shocked when told ketamine is the cause, then tearful about your kidneys.
- If lectured or judged: shut down and say "I just want my bladder sorted."
- By the end, willing to accept help: "What do I do first?"

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3. EXAMINER'S INFORMATION & STANDARD SETTING

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS**. Please read the simulated patient's directions and discuss the clinical details with her. Plan the approach to the task together.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

Task synopsis:

- Ketamine uropathy with small thick-walled bladder, bilateral hydronephrosis, raised creatinine and abnormal LFTs – features of stage 3 on the BAUS consensus staging
- Hidden: ketamine use (revealed only to a non-judgemental question); possible pregnancy (period 7 weeks late); loin ache

The competent ST5 candidate will discuss and mention many of the following:

Patient safety

- * *Recognises **upper tract involvement with renal impairment** as urgent: same-week **urology referral** (specialist centre), repeat renal function, CT urogram or MAG3; may need **nephrostomy**; hepatology referral for abnormal LFTs*
- * ***Pregnancy test today** – period 7 weeks late; counsels about ketamine and imaging/medicines in pregnancy*
- Refers to **substance misuse services** (with consent) – support to stop, not just advice
- Safety-net: fever, worsening loin pain, being unable to pass urine, heavy bleeding → emergency attendance
- Stops further empirical antibiotics; harm-reduction advice while she works towards stopping

Applied clinical knowledge

- * *Explains **ketamine uropathy**: ketamine and its breakdown products in urine inflame and scar the bladder lining, shrinking the bladder; it can narrow the ureters and back-pressure the kidneys*
- * ***Stopping ketamine is the single most important treatment**; early changes may improve, but scarring of the bladder and kidney damage may be permanent*
- Investigations: urine culture, renal function, LFTs, FBC; ultrasound then CT urogram/MAG3; cystoscopy ± biopsy (often under anaesthetic); bladder diary
- Treatment: analgesia and pain team; anticholinergic or β3-agonist for early urgency; bladder instillations after a month of abstinence; intradetrusor botulinum toxin; **reconstruction only after at least 6 months' confirmed abstinence**

Communicating with patients and families

- * *Asks about recreational drugs **explicitly, with a normalising and non-judgemental frame** ("I ask everyone…")*
- * *Answers confidentiality honestly: drug use is **not reported to the police**; information is shared with her GP and the team for her care, discussed with her*
- Delivers serious news about her kidneys honestly without blame; acknowledges how hard stopping is socially
- Checks understanding; written information; agrees a clear first step

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Information gathering

- * *Takes a **drug and alcohol history** – substance, route, frequency, amount, duration, escalation*
- * *Asks about **menstrual history and contraception***
- Asks about haematuria, loin pain, fever, abdominal cramps, leakage
- Asks about mood, support and readiness to stop

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4. CLINICAL EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Simulated Patient's Name: ……

Task Number: …… Session: …… Day: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the space provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

No urgent action on hydronephrosis with raised creatinine = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Diagnoses infection or bladder pain syndrome only = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …….. Examiner's Name: ……..

Simulated Patient's Name: ……..

Task Number: ….. Session: ….. Day: M / T / W / Th / F (please circle)

CLINICAL EXAMINER'S MARK SHEET (continued)

Communicating with patients and families

- Establishes rapport and puts the patient at ease, encouraging dialogue
- Demonstrates empathy, active listening and ability to discuss the difficult topic in a sensitive and appropriate manner
- Acknowledges and addresses patient's concerns
- Demonstrates clear appreciation of the relative risks of proposed management
- Understands joint clinical decision making and consent

Examiner's justifications

Judgemental or threatens police involvement = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Information gathering

- Conducts a relevant clinical history, with no major omissions
- Signposts and guides the consultation
- Establishes the patient's concerns
- Checks and ensures patient understanding at appropriate intervals
- Appreciates the need to consider all the available evidence

Examiner's justifications

Does not ask about recreational drugs = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

GP LETTER (1)

Haywain General Hospital NHS Trust
URGENT REFERRAL

Patient	Miss Chloe Barrett DoB: 02.02.2003 Nulliparous
Problem	6 months: frequency up to 20/day, urgency, suprapubic pain, dysuria, **visible haematuria**. Two courses of antibiotics – no benefit.
GP comment	"?Interstitial cystitis – but very severe and rapid for her age."
Medication	None. Non-smoker.

RESULTS (2)

Haywain General Hospital NHS Trust
PATHOLOGY AND RADIOLOGY

Urine	MSU ×2: **white cells, no growth**. Dipstick blood +++, protein +
Ultrasound	**Small-capacity, thick-walled bladder. Bilateral hydronephrosis** (right > left)
Renal function	**Creatinine 98 µmol/L** (6 months ago 64)
Liver function	**ALT 72, ALP 180, GGT 95 IU/L** (all raised)

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6. RCOG INSTRUCTIONS

Module(s) examined	15: Urogynaecology
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with patients and families • Information gathering
Links to another question	No
Simulated patient	Female, aged 18–30
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × GP LETTER (1); 2 × RESULTS (2)

Sources: Belal M et al. British Association of Urological Surgeons consensus statements on the management of ketamine uropathy. BJU Int 2024 (doi:10.1111/bju.16404); Advisory Council on the Misuse of Drugs, ketamine harms assessment (January 2026).

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Ketamine uropathy in one line

A young person with **severe bladder pain, frequency and haematuria, sterile urine** and a small bladder – **ask about ketamine**, kindly and directly. **Stopping** is the treatment; **protect the kidneys**; involve **urology and substance misuse services**.

BAUS staging (2024)

STAGE 1	STAGE 2	STAGE 3 – her features
• Inflammation only • Kidneys and liver normal • Stopping + tablets may resolve it	• Small, thick bladder • Kidneys normal; liver ± abnormal • Instillations, bladder botulinum toxin	• Hydronephrosis, renal impairment • Abnormal liver tests • Specialist centre; reconstruction after abstinence

Asking about drugs

Normalise: "I ask everyone"	**Ask directly: which drugs?**	**How, how often, how much, how long**	**Explain confidentiality honestly**	**No judgement – offer help**

Her plan

Today	This week	Stop ketamine	Later
Pregnancy test; repeat U&E; safety-net	Urology: CT urogram/MAG3; ± nephrostomy	Substance misuse service; analgesia	Cystoscopy, instillations; surgery only after 6 months clean

Say it simply

"Ketamine is the cause. It damages the lining of the bladder and is starting to affect your kidneys. The most important thing is stopping, and we'll get you real help with that – and protect your kidneys now."

Common ways to lose marks

Not asking about drugs • Judging her • Promising total secrecy • Missing the hydronephrosis • No pregnancy test • "Just stop" with no support

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PIPADOR REVISION

MRCOG Part 3 OSCE Stations

Surgical Management of Stress Urinary Incontinence

Structured Discussion Task | Module 15 | Urogynaecology

OSCE STATION PRACTICE PACK

2026 Edition

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MRCOG Part 3 OSCE: Structured Discussion Task

Surgical Management of Stress Urinary Incontinence

Station Overview

Module	Task Type	Timing	Clinical Skills Domains
15: Urogynaecology	Structured discussion (examiner as consultant)	2 min reading + 10 min task	Patient safety | Applied clinical knowledge | Communicating with colleagues

Task synopsis: *A 49-year-old with stress incontinence after failed pelvic floor training, who asks for the "quick tape operation" a friend had. The mesh restriction, colposuspension versus autologous fascial sling, urethral bulking, consent – then voiding failure after a sling and recurrent stress incontinence with a fixed urethra*

What is in this pack

1	**Candidate's Instructions**	Read in the 2 minutes before entering
2	**Examiner's Instructions (1)**	What the competent ST5 candidate covers; * = critical points
3	**Examiner's Instructions (2)**	Opening question, five questions and prompts
4	**Examiner's Mark Sheet**	Three domains, 0 / 1 / 2 marks
5	**Props**	Clinic summary (1) and scenario cards A–B
6	**RCOG Instructions**	Module, domains and props list
7	**Key Knowledge Points**	One-page visual revision summary for candidates

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1. CANDIDATE'S INSTRUCTIONS

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

- Patient safety
- Applied clinical knowledge
- Communicating with colleagues

You are the ST5 in the urogynaecology clinic. **Mrs Grace Danso**, aged 49, has stress urinary incontinence that has not responded to 20 weeks of supervised pelvic floor muscle training. She would like surgery.

She has heard about **"the quick tape operation"** a friend had and would like the same.

Please read the **CLINIC SUMMARY (1)**. Your consultant (the examiner) will discuss this and further information with you.

You have 10 minutes in which you should:

- Discuss her assessment and her request
- Discuss the surgical options and how to choose between them
- Discuss consent
- Discuss the further information you are given

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2. EXAMINER'S INSTRUCTIONS (1)

Familiarise yourself with the **CANDIDATE'S INSTRUCTIONS** and the information below on the standards required of a competent candidate at ST5 level.

For each clinical skills domain, marking of the **'*' statements** is as follows:
One missed/incorrect = no more than **1 mark**; **two or more** missed/incorrect = **0 marks**

The competent candidate at ST5 will discuss or mention many of the following:

Patient safety

- * *Does not simply book a tape: mesh tape for stress incontinence has been under a **high vigilance restriction** in England **since July 2018**, and it remains in place – for most women mesh should not be offered; any tape needs strict conditions, a specialist surgeon and **registration on the national database***
- * *All women considering surgery for stress incontinence need **review by the local MDT** and a full discussion of **all options using the NICE patient decision aid** – consent is a process, not a signed form*
- * *Before an **autologous fascial sling**: voiding difficulty is more likely than after colposuspension – she must be **willing and able to self-catheterise** if needed (Card A)*
- Card A: catheter (indwelling or intermittent self-catheterisation), exclude UTI, review; if voiding does not recover, refer back to the surgeon for sling release – do not leave it
- Card B: previous surgery for stress incontinence → urodynamics and **regional MDT** before further surgery; no mesh outside the restricted pathway

Applied clinical knowledge

- * *NICE NG123 options after failed conservative treatment: **colposuspension** (open, or laparoscopic by an experienced surgeon), **autologous rectus fascial sling**, **retropubic mid-urethral mesh sling** (with extra information and restrictions); **urethral bulking** if these are not suitable or acceptable; **not transobturator** as a primary option*
- * *Compares colposuspension and fascial sling: in **SISTEr (2007)** the sling had higher success but **more voiding difficulty, UTIs and urgency incontinence**; colposuspension can lead to posterior prolapse; both carry **new urgency** and failure risks; the sling adds a rectus fascia harvest wound*
- * ***Bulking agents** (e.g. polyacrylamide hydrogel): local anaesthetic, quick recovery, but **less effective than surgery**, effect may wear off and **repeat injections** are often needed*
- Urodynamics **not needed before primary surgery** for stress incontinence shown on examination; needed if urgency, voiding symptoms, prolapse or **previous SUI surgery**
- Card B: low urethral closure pressure with a **fixed urethra** suggests **intrinsic sphincter deficiency** – colposuspension works less well; options are bulking or a sling; artificial urinary sphincter only in a specialist centre

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Communicating with colleagues

- * *Gives a clear, ordered **summary of the case** and a logical plan*
- * *Recognises the need for **local MDT review** and plans to see Mrs Danso again with the **decision aid** before any operation is booked*
- Explains the reasoning for each option; documents the plan
- Card A: notes that self-catheterisation was not discussed before surgery – feeds this back and reviews the consent process

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3. EXAMINER'S INSTRUCTIONS (2)

This task requires you to have a structured colleague discussion, **acting as the consultant** with the candidate as your ST5.

Task synopsis:
Stress incontinence after failed supervised pelvic floor training. Urodynamic stress incontinence. She asks for a tape; not yet discussed at MDT. Then two short cases on cards.

Open the discussion with the following:

> *"Please summarise Mrs Danso's assessment and tell me how you would proceed."*

Then ask the following questions:

1. **What surgical options can we offer her?**
2. **How would you help her choose between colposuspension and a fascial sling?**
3. **When would you offer a urethral bulking agent, and what would you tell her?**
4. **Hand the candidate SCENARIO CARD A. "How would you manage this?"**
5. **Hand the candidate SCENARIO CARD B. "What would you do?"**

Please ensure the candidate answers all questions in the allocated time. You may use the following prompts:

- "Is mesh banned?"
- "She just wants the tape her friend had – can't we book it?"
- "Which operation is more likely to leave her unable to empty her bladder?"
- "Did she need urodynamics at all?"

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4. EXAMINER'S MARK SHEET

Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

Please justify your judgement for each clinical skill domain in the spaces provided on this mark sheet.

Patient safety

- Understands processes and procedures to keep both individual patients and patient populations safe
- Presents pros and cons of proposed management in a balanced way
- Recognises the limits of their clinical abilities and refers on appropriately
- Highlights all governance issues and necessary actions
- Identifies any drug allergies and demonstrates safe and accurate prescribing techniques

Examiner's justifications

Books a mesh tape without MDT review or discussion of options = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

Applied clinical knowledge

- Demonstrates a sound and comprehensive evidence-based clinical knowledge
- Interprets and explains the clinical findings accurately
- Justifies further investigations, management options and demonstrates a rationale for each
- Synthesises a comprehensive and well-organised management plan based on interpretation of clinical information

Examiner's justifications

Cannot name the non-mesh surgical options = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

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Candidate Number: …… Examiner's Name: ……

Task: …… Circuit: …… Session: M / T / W / Th / F (please circle)

EXAMINER'S MARK SHEET (continued)

Communicating with colleagues

- Makes clear the reasons for the interaction (clinical explanation, justification of actions, management plan)
- Gives a clear clinical summary demonstrating ordered clinical information, including important negatives, and any examination and investigative findings
- Describes a clear and logical problem list and demonstrates an ability to formulate an appropriate management plan
- Demonstrates an ability to discuss difficult or sensitive issues with colleagues objectively

Examiner's justifications

No coherent summary or plan = 0

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☐ DEFAULT MARK = 0	☐ BORDERLINE MARK = 1	☐ STANDARD MET = 2

EXAMINER'S FEEDBACK FOR CANDIDATE

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5. PROPS

CLINIC SUMMARY (1)

Haywain General Hospital NHS Trust
UROGYNAECOLOGY CLINIC

Patient	Mrs Grace Danso DoB: 21.06.1977 P2 (vaginal births). Periods regular. BMI 26. Non-smoker.
Symptoms	Leaks with coughing, sneezing, running and lifting; 3 pads/day. No urgency, no nocturia, no voiding symptoms. No bulge.
Examination	Stress leakage on coughing. No significant prolapse.
Treatment so far	20 weeks of supervised pelvic floor muscle training – some improvement, not enough
Urodynamics	Urodynamic stress incontinence; no detrusor overactivity; normal voiding; post-void residual 18 mL; urethral hypermobility
Her request	Would like "the quick tape operation" a friend had. Not yet discussed at MDT.

SCENARIO CARD A (question 4)
Mrs Danso – day 2 after an autologous fascial sling

After removal of her catheter she has passed only small amounts. Bladder scan after voiding: **550 mL**. Her notes do not record any discussion of self-catheterisation.

SCENARIO CARD B (question 5)
A different patient

A 64-year-old has recurrent stress incontinence 2 years after a fascial sling. Her urethra is **fixed and immobile** on examination; urodynamics show stress incontinence with a **low maximum urethral closure pressure**.

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6. RCOG INSTRUCTIONS

Module(s) examined	15: Urogynaecology
Lay examiner	No
Domains examined	Patient safety • Applied clinical knowledge • Communicating with colleagues
Links to another question	No
Props required	Yes – laminated paper copies: 2 × CANDIDATE'S INSTRUCTIONS; 2 × CLINIC SUMMARY (1); 1 × each SCENARIO CARD A–B

Sources: NICE NG123 Urinary incontinence and pelvic organ prolapse in women: management (2019) and patient decision aid on surgery for stress urinary incontinence; NHS England / NHS Improvement: Vaginal mesh – high vigilance restriction period (July 2018); RCOG: About mesh; Albo ME et al. Burch colposuspension versus fascial sling (SISTEr). N Engl J Med 2007;356:2143–55.

This station was developed for MRCOG Part 3 revision. Management should follow current guidance and local protocols at the time of the examination.

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7. KEY KNOWLEDGE POINTS

Stress incontinence surgery in one line

After **supervised pelvic floor training for at least 3 months**: **local MDT**, **decision aid**, then **colposuspension or fascial sling** – mesh tape only under the **restriction**, bulking if surgery is not suitable or wanted. **Self-catheterisation** discussion before a sling; **new urgency** with any operation.

The options (NICE NG123)

Colposuspension	Fascial sling	Retropubic mesh tape	Bulking agent
Open or laparoscopic; no mesh	Rectus fascia; no mesh	Under the 2018 restriction; national database	If surgery not suitable or acceptable

Before any operation

Supervised PFMT ≥3 months	**Urodynamics only if indicated**	**Local MDT (regional if previous surgery)**	**NICE decision aid; all options**	**Consent: failure, urgency, voiding, CISC**

Comparing them

COLPOSUSPENSION	FASCIAL SLING	BULKING
• Lifts bladder neck to Cooper's ligament • Best for a mobile urethra • Less voiding difficulty than a sling • Risk: posterior prolapse, new urgency	• Higher success than colposuspension (SISTEr) • Works with a fixed or mobile urethra • More voiding difficulty – CISC discussion • Harvest wound; new urgency	• Local anaesthetic, day case • Less effective than surgery • Repeat injections often needed • Written details of the agent

Say it simply

There are several operations that can help, and the tape your friend had is now used only in very limited circumstances. Our team will review your case, and I'll go through each option with you using a decision aid so you can choose what suits you.

Common ways to lose marks

"Mesh is banned" or "TVT is first-line" • No MDT or decision aid • No self-catheterisation discussion before a sling • Forgetting new urgency • Colposuspension for a fixed urethra

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10	Gynaecological Problems	33 stations
11	Subfertility	19 stations
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