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2025.1 RGA SSSA Examination Report

July 2025

2025.1 Rural Generalist Anaesthesia (RGA) SSSA

Examination Report

The RGA-SSSA exam took place on 28th June 2025. It was conducted online via Zoom. Candidates participated from their respective locations, while examiners were present on-site in Melbourne. Examiners were selected from a panel comprising fellows of all three colleges (ANZCA, RACGP and ACCRRM).

The exam consisted of eight viva sessions, each consisting of 2 minutes of reading time and 13 minutes of questioning. An additional three minutes were allocated for transitioning candidates between Zoom rooms. The exam scenarios were designed to align with the RGA curriculum, covering topics such as RGA Roles in Practice, Clinical Fundamentals, and Specialised Study Units.

Candidates were assessed on a variety of clinical scenarios, focusing on their clinical management strategies, responses to evolving clinical situations, resource allocation, quality and safety measures, and the application of their knowledge in rural or remote contexts.

The RGA-SSSA is designed to evaluate clinical judgment in anaesthetic practice, recognising that there are multiple safe and appropriate approaches to patient care in various clinical scenarios. The viva scenarios present different clinical situations to assess candidates' ability to make sound and safe decisions. Examiners assessed candidates on their ability to demonstrate a readiness for independent practice.

Candidates are encouraged to respond to questions by describing their typical actions in specific situations. Stronger responses are tailored to the individual patient context, providing patient-specific answers rather than relying solely on memorised responses.

Effective communication is essential during the viva. Candidates should articulate clear and well-organised responses to demonstrate their expertise and ability to address complex issues. Utilising an appropriate framework can help structure answers and ensure that essential safety aspects are covered. However, avoiding irrelevant frameworks that waste time and detract from the core issues is important.

Completing the entire viva is not mandatory for passing; however, maintaining a steady pace is crucial to adequately cover all topics. High-performing candidates manage their pace effectively while providing concise answers grounded in solid clinical principles. They demonstrate their ability to organise thoughts and make informed decisions, reflecting consultant-level thinking.

In summary, successful viva performance requires a combination of effective communication, efficient time management, organised and concise responses, and

sound decision-making based on clinical knowledge. By focusing on these key aspects, candidates can showcase their expertise and competence in handling various clinical scenarios.

Pass Mark

A total of 20 candidates took the exam. The overall pass rate for the 2025.1 SSSA viva examination was 75%.

The RGA Examination Committee use a set of criteria to determine the pass mark for this exam. Each viva is scored out of 24, with a score of 12 being considered to be the minimum accepted standard. In order to pass overall, candidates must:

- Achieve a pass mark of 50% (96 marks) overall, and
- Achieve a pass mark of 50% (12 marks) in 6 of 8 vivas, and
- Score a minimum of 9 marks for every viva if 2 vivas are not passed, or
- Score a minimum of 6 marks for every viva if 1 viva is not passed, and
- Must be deemed to have demonstrated “safety for independent practice” by a minimum of 13 of 16 examiners.

These criteria may be used as a guide for future exams, but the final decision may depend on the difficulty of the individual questions, examiner feedback and special circumstances as appropriate.

Technical issues

A small number of technical issues arose during the exam when candidates were being connected to the examiner's virtual room. Some were related to the candidate’s internet connection and audio quality, and one was due to a disconnection at the examiner’s end. Most were quickly rectified and additional time allowed, and one viva was rescheduled and held during a bye station.

During the morning session, the usual 2-minute warning bell was absent. This issue was resolved following the break.

It is recommended that candidates choose a location with reliable internet access, properly connected audio/headphones, and fully charged devices. Candidates should ensure that all computers and devices are plugged in or charged and should be familiar enough with their equipment to troubleshoot quickly (for instance, in case of accidental muting or Bluetooth disconnection). The most common problem appears to be Bluetooth disconnection, which is best avoided using a hard-wired audio device. Attending the exam from non-standard or non-compliant venues (for example, an operating theatre) not only causes audio issues for the examiners but also presents a distracting background.

Vivas

Each viva was conducted by a primary examiner who assessed the candidates via Zoom. A second examiner observed the candidates alongside the examiner and provided a second independent assessment.

At the end of the exam day, the court of examiners held a meeting to review the examination process. The court has identified several common issues among candidates that may have affected their performance in these vivas:

1- Providing a rote-learned answer to an evolving clinical scenario without applying it to the context of the patient in question. For example, positioning a patient in the ”sniffing position” for intubation in a trauma scenario where manual inline stabilisation of the cervical spine is expected.
2- The use of vague statements like “multimodal analgesia” without providing any specific medications or doses.
3- Repeating the question, not answering the question or providing irrelevant information, which reduces the time available to finish the viva.
4- Having a limited understanding of the resources available in Scenarioville or the logistics of requesting further investigations. Common examples included requests for “routine” transthoracic ECHO without clinical justification.
5- Having poor knowledge of important guidelines that have implications for anaesthetic practice, for example, guidelines for the management of SGLT2i and GLP-1 agonist medications in diabetics.
6- Poor implementation of recognised algorithms for management of acute crises, such as anaphylaxis and laryngospasm.

Examiners also provided the following advice for future candidates:

1- Candidates are encouraged to ask examiners to repeat any questions or information if they are unclear about what was asked or stated.
2- Candidates are encouraged to highlight how a clinical scenario would cause them to alter their standard practice, rather than describe their standard practice in unnecessary detail.
3- Candidates are advised to describe their usual practice, rather than describing overly complicated techniques that they are clearly unfamiliar with, or that are not justified for the given scenario.
4- Candidates may find it beneficial to practice answering viva questions over an online video platform like Zoom. This allows them to engage with a mock examiner and practice interpreting non-verbal cues during the interaction.
5- Candidates are encouraged to ensure they meet all IT requirements and test their equipment before the exam. Audio issues due to Bluetooth disconnection

can be avoided by using a set of hard-wired headphones. A guide to the IT requirements can be found on the RGA website.

The following key topics and stem areas were covered during all 16 vivas. This information is provided to help candidates prepare for their exams and to provide an example of the level of knowledge required to pass the viva examination successfully.

2025. RGA SSSA Vivas

Viva 1 – Airway Management

You are called to the ED to help with a 65-year-old male who has been involved in a motor vehicle accident (MVA) as the front seat passenger. He was wearing a seat belt. He is obese, (estimated weight 120kg, BMI 36), dyspnoeic and distressed. On assessment, you note he is diaphoretic, has left-sided bruising and crepitus, and a midline trachea.

His vitals are: SpO2 89% on non-rebreather mask oxygen at 15L/min.
RR 30, HR 120, BP 110/75.
Together with the ED team, you decide to intubate the patient.

What factors would you assess to determine the potential for difficult airway management?

Key Topics Assessed:

- Assessment of potential for difficult airway management
- Preparation for intubation
- Hypoxia and hypotension post-induction – assessment and management
- Management of multiple rib fractures and pneumothorax
- Preparation for aeromedical retrieval

Feedback from examiners:
This question was generally well answered. Most candidates could describe a comprehensive airway assessment, but better candidates were able to discuss the impact of trauma and manual in-line stabilisation (MILS) of the cervical spine on airway management. MILS is an essential component of trauma management and cannot be removed to facilitate intubation. A number of candidates failed to recognise the need for MILS or the impact it may have on airway management and stated they would use the "sniffing" position for intubation. Many also failed to recognise the need for Rapid Sequence Induction (RSI) in an unfasted trauma patient, preferring a delayed sequence induction to optimise respiratory mechanics. Candidates are reminded to consider their answers in the context of the patient presented to them and avoid using pre-prepared answers that do not address important features of the case in question.

Most candidates were able to identify the impact of a pneumothorax on the patient's clinical picture and could justify decompression in the context of aeromedical retrieval. Candidates were expected to have a good working knowledge of the retrieval of critically unwell patients.

Viva 2 – General Anaesthesia and Sedation

It is a Sunday afternoon, and you are on call for anaesthetics. The General Surgeon contacts you regarding a 70-year-old male currently in the Emergency Department. He has presented with a 12-hour history of abdominal pain and requires an urgent laparotomy. The surgeon requests your assessment and input before proceeding.

The patient is a smoker and has a medical history of hypertension. His vital signs are: HR 110, BP 90/60, O2 sats 96%, RR 23, temp 38.0 °C.

How do you assess the patient?

Key Topics Assessed:

- Assessment of a patient with an acute abdomen
- Consideration of proceeding in Scenarioville vs transfer to a tertiary centre
- Anaesthetic plan for emergency laparotomy
- Suitability for extubation
- Post-operative analgesia

Feedback from examiners:
This question was well answered, with most candidates recognising the severity of the patient's clinical picture and managing accordingly. Better candidates were able to integrate the rural context of managing a sick patient for emergency major surgery, including the post-operative challenges that they would pose.
The need for optimisation with fluids, invasive monitoring and vasopressors was not clearly demonstrated by some candidates, nor was the need for ongoing monitoring post-operatively. Candidates are reminded that invasive blood pressure monitoring is an essential skill for an RGA when managing critically unwell patients.
Establishing goals of care and exploring Advanced Care Directives can be helpful when considering management options in sick, elderly patients.

Viva 3 – Obstetric Anaesthesia

A 29-year-old pregnant female was a passenger in a motor vehicle accident at 40km/hr. She is 24/40 gestation. She has sustained a left humeral fracture with some bleeding observed from the site. There are no other obvious injuries.

Her left arm is neurologically intact, and you note adequate perfusion.

Her GCS is 15, she is haemodynamically stable and looks well.

She has just arrived in the emergency department.

The orthopaedic surgeon overhears the ambulance handover and asks you about doing the open reduction, external fixation here.

Evaluate the advantages and disadvantages of proceeding at Scenarioville.

Key Topics Assessed:

- Evaluation of risks and benefits of proceeding with non-obstetric surgery in Scenarioville
- Assessment of trauma patient, and implications of pregnancy on trauma management
- Anaesthesia for a pregnant patient for non-obstetric surgery

Feedback from examiners:

Most candidates were able to describe safe care of a pregnant trauma patient, and tailor their usual trauma care accordingly. Recognising that this was non-urgent, and transferring to a centre with appropriate obstetric and paediatric support was widely noted, with better candidates able to also consider the social and financial impacts of transferring away from home and family.

Common pitfalls included the use of permissive hypotension, and failure to recognise aorto-caval compression as a cause of hypotension. Placental perfusion must be maintained at all stages of pregnancy, particularly after 20 weeks gestation, and a left lateral tilt should have been considered.

Some candidates did not consult with obstetric or paediatric teams locally when considering management options. A multi-disciplinary approach involving multiple teams is essential when managing a pregnant trauma patient.

Viva 4 – Paediatric Anaesthesia

You are the on-call RGA, and the surgeon has booked an emergency case of a 5-year-old girl with a deep lower lip laceration.

She is fasted, weighs 20kg, is otherwise well, with a history of infrequent episodic asthma on salbutamol as required. She is distressed and does not have an IV cannula.

You are not able to perform an inhalational induction as she does not tolerate a mask near her face.

Describe your approach to gaining intravenous access in this distressed child.

Key Topics Assessed:

- IV cannulation in a distressed child, including premedication options
- Airway management for a shared airway

- Principles of ventilation in a paediatric patient
- Recognition and management of laryngospasm
- Recognition and management of emergence delerium
- Open disclosure with parents

Feedback from examiners:
This question explored very common issues in paediatric anaesthesia, and candidates who have good clinical paediatric experience were able to move through the scenario quickly.

Candidates are expected to have a good working knowledge of premedication options (including doses), airway equipment and management of common complications without referring to an "app". The use of intramuscular ketamine without attempting distraction techniques or oral / intranasal premedication is traumatic for the child and should be reserved for limited scenarios. Candidates should have a concise approach to laryngospasm management, including airway positioning, PEEP and drug doses. Better candidates were quick to identify emergence delerium and institute management, while also considering and excluding other causes of post-operative agitation.

Examiners were concerned by the number of candidates who mentioned rocuronium in the management of laryngospasm. While there is a clear trend away from suxamethonium for RSI management, in the absence of contraindications to its use, it should still be considered the first line treatment for laryngospasm. Using rocuronium in low doses is likely to be too slow to be effective, and using full RSI dosing necessitates intubation, ongoing sedation and the need for reversal. RGAs working in isolated practice, sometimes with minimal paediatric experience, are encouraged to use well established, safe, effective and practical approaches to time-critical events like laryngospasm.

Viva 5 – Pain Medicine

You are assessing a 62-year-old man in the pre-anaesthetic clinic. He is being considered for a left shoulder replacement for severe degenerative osteoarthritis.

His co-morbidities include depression, hypertension, diabetes, OSA, COPD, and chronic back pain. He is an ex-smoker, has moderate-heavy alcohol intake, has recently become unemployed, and is divorced.

He takes Panadol Osteo 2 tablets bd and oxycodone IR 10mg up to 6 times daily for his pain.

His weight is 105kg (BMI 35.5). He self-reports metabolic equivalent (METs) of 3.

Describe this patient's pre-operative risk factors for developing chronic pain post-operatively.

Key Topics Assessed:

- Risk assessment for chronic post-operative pain
- Pre-operative optimisation of pain management
- Perioperative analgesia planning
- Consideration of wound infusion catheters
- Perioperative management of alcohol dependence
- Recognition and management of local anaesthetic toxicity
- Discharge planning and opioid weaning

Feedback from examiners:

Candidates who were able to approach chronic pain using a biopsychosocial model, incorporating pharmacological and non-pharmacological treatment modalities did better on this question. Discussing multimodal analgesia, including specific mention of clonidine, ketamine, magnesium, pregabalin and other non-opioid analgesics (including doses) did better than vague answers that lacked detail. Some candidates misinterpreted a wound infusion catheter as a brachial plexus catheter, and did not appreciate that it may be a useful adjunct when a brachial plexus catheter is not available.

Many candidates wasted time by repeating the question, not answering the question or giving vague answers that lacked detail. Some were unable to finish the viva due to slow, drawn out or irrelevant answers.

Viva 6- Perioperative Medicine

A 40-year-old male with a large, painful umbilical hernia is booked for surgical repair.

He weighs 118 kg with a BMI of 39.

He has Type 2 Diabetes Mellitus (diagnosed 4 years ago), and his partner reports that he snores loudly.

His medications are:

- Dapagliflozin
- Metformin
- Glargine insulin 40 units nocte
- Liraglutide injections commenced 4 weeks ago.
- Rosuvastatin

BP 135/85, HR 74, SpO2 96% room air.

Please outline your pre-operative assessment of this man, focusing on his diabetes.

Key Topics Assessed:

- Preoperative assessment of Diabetes and OSA
- Preoperative medication management including SGLT2i and GLP1 agonists
- Anaesthetic plan
- Postoperative management of Diabetes and OSA

Feedback from examiners:
Diabetes and OSA are commonly encountered in RGA practice, and a comprehensive assessment and management plan was expected. Preoperative medication planning is essential to safe anaesthesia delivery, and while the GLP1 agonist guideline is relatively new, it has significant implications for RGAs and their patients. Better candidates were able to implement these guidelines, or at least recognise the increased aspiration risk posed by these medications. Candidates who failed to recognise this, and made no attempt to modify their anaesthetic technique accordingly, did not score as well. Candidates are encouraged to be up to date with guidelines that have implications for anaesthetic practice.

Viva 7- Regional Anaesthesia

You are assessing a 68-year-old woman in the pre-operative clinic for a right total hip replacement in 2 weeks. She has a history of :

- Ischaemic heart disease with a drug eluting stent to the right coronary artery in 2019
- Atrial fibrillation
- Hypertension
- Type 2 diabetes

She is taking the following medications:

- Aspirin
- Atorvastatin
- Ramipril
- Metoprolol
- Apixaban
- Metformin
- Semaglutide

She is requesting a spinal anaesthetic similar to the anaesthetic for her left total hip replacement in Scenarioville 12 months ago.

Describe your pre-operative assessment for this patient.

Key Topics Assessed:

- Pre-operative assessment and preparation for surgery
- Preoperative medication management
- Consent for spinal anaesthesia
- Assessment of spinal block and trouble-shooting inadequate block
- Assessment and management of post-operative neurological deficit

Feedback from examiners:
Most candidates were able to provide an adequate pre-operative assessment and medication plan for surgery. Better candidates gave a more thorough assessment of IHD, AF and diabetes, and considered the requirement for bridging anticoagulation, however recognition of limitations in assessment of IHD in patients with very limited mobility was generally poor. Understanding of current GLP1 agonist guidelines was again patchy. Most candidates were able to assess a spinal block, with better candidates able to delineate the motor, sensory and autonomic effects of a spinal block. Some candidates were unable to provide any options other than a general anaesthetic for a block that was deemed inadequate for surgery.

Most candidates recognised the possibility of an epidural haematoma, but many did not appreciate the urgency required when managing it, or arrange a CT locally in Scenarioville.

Viva 8- Resuscitation, Trauma and Crisis Management

It is a weekday morning in Scenarioville, and you are running the emergency theatre list.

Your next patient is a 14-year-old female weighing 50 kg that the general surgeon wants to do a laparoscopic appendicectomy on.

Please outline:

(a) What further information you want from this patient with a focused anaesthetic history and examination?
(b) A <u>detailed</u> plan for the induction of anaesthesia in this patient

Key Topics Assessed:

- Anaesthetic assessment and detailed anaesthetic plan
- Recognition and initial management of anaphylaxis
- Subsequent management of anaphylaxis, including proceeding with surgery

- Long-term follow up of anaphylaxis
- Anaesthetic options for closed reduction of forearm fracture

Feedback from examiners:
The ability to recognise and manage anaphylaxis in a timely fashion is fundamental for any RGA. While this was done well by most candidates, a surprising number failed to institute CPR or administer adrenaline in appropriate doses.

Candidates are advised to be familiar with the ANZAAG guidelines for acute and refractory management of anaphylaxis.

Viva 9- Airway Management

You are asked to help in the emergency department.

There is a 12-year-old (40kg) boy with worsening shortness of breath, audible expiratory wheeze and distress.

He has a past history of a recent upper respiratory tract illness and asthma.

What aspects of your assessment would indicate severe or life-threatening asthma?

Key Topics Assessed:

- Assessment of life-threatening acute asthma
- Assessment of differential diagnoses
- Management of acute asthma
- Plan for intubation and ventilation
- Principles of ventilation in severe bronchospasm, including ventilator settings
- Management of hypoxia and high airway pressures

Feedback from examiners:
Whilst this is not an anaesthetic case per se, RGAs are expected to be called upon to assist with airway and ventilation management in ED, and a detailed knowledge of ventilation in the setting of severe bronchospasm and high airway pressures is expected. Induction plans should have considered medications with bronchodilatory effects (eg ketamine, sevoflurane), the impact of apnoea on oxygenation, and having appropriate assistance, including another RGA. Principles of ventilation in bronchospasm, such as prolonged expiratory time, reduced respiratory rate, permissive hypercapnoea and minimising peak airway pressures were often overlooked. Significant differential diagnoses, including anaphylaxis, were also overlooked. While management of acute asthma may not be commonly encountered during the RGA training year, a

basic understanding of management (including salbutamol, steroids and magnesium) was expected, and ventilation strategies were considered core knowledge.

Viva 10- General Anaesthesia and Sedation

You are providing sedation for an elective gastroscopy for a 35yo male. He has a BMI of 35 and weighs 105kg. He smokes a moderate amount of cannabis daily and also smokes 20 cigarettes per day. He has no other diagnosed medical conditions. He is undergoing gastroscopy for persistent reflux symptoms; he states he uses Quik-Eze daily to help manage his symptoms.

Outline the assessment you undertake prior to providing endoscopy sedation for this patient.

Key Topics Assessed:

- Preoperative assessment for endoscopy sedation
- Strategies to enhance safety of sedation
- Assessment and management of desaturation
- Management of aspiration
- Post-event patient consultation
- Smoking cessation advice

Feedback from examiners:

Candidates who identified potential risk factors for airway complications and pre-empted strategies to minimise airway risks did better than others. Better candidates recognised airway obstruction early, abandoned the procedure and removed the scope. Recognition of aspiration and the need for intubation +/- transfer to a tertiary centre was done well by most, however assessing suitability for extubation was generally done poorly.

Viva 11- Obstetric Anaesthesia

You are assessing a 26-year-old in your outpatient clinic for an elective Caesarean Section in 2 weeks' time, referred by her midwife. She is Gravida 2 Para 1 and had a 3rd degree tear after her previous vaginal delivery. Her booking BMI is 27. The midwife has noted she has a family history of suxamethonium apnoea.

Describe your pre-anaesthetic consultation and pre-operative preparation.

Key Topics Assessed:

- Pre-anaesthetic assessment and preparation
- Implications of family history of suxamethonium apnoea
- Recognition and management of inadequate spinal block for caesarean section
- Assessment and management of post-operative headache

Feedback from examiners:
Most candidates provided a safe pre-operative assessment. Knowledge of suxamethonium apnoea was generally good, however stating that not using suxamethonium in clinical practice somehow precludes needing to know about its pharmacology did not answer the question or attract any marks. Most candidates recognised that a block to T8 was inadequate for surgery, but few considered a second regional technique, and proceeded straight to GA or cancelled the case. The initial approach to a post-operative headache was generally good, however some failed to consider alternative diagnoses (other than post-dural puncture headache), or arrange ongoing review of the patient.

Viva 12- Paediatric Anaesthesia

You have been called to the ward to review a 7-year-old boy with worsening abdominal pain. He underwent an appendicectomy 36 hours ago.

He is otherwise fit and healthy, and weighs 20kg.

How would you assess this child?

Key Topics Assessed:

- Assessment of pain in a child
- Optimisation of paediatric analgesia
- Approaches to cannulation in a distressed child
- IV fluid strategy in a sick child
- Anaesthetic induction in a sick child
- Parental presence in theatre

Feedback from examiners:
This question covered common themes seen in paediatric anaesthesia, and better candidates progressed quickly. Some candidates appeared to have limited clinical experience with paediatrics and were unable to demonstrate strategies for common issues, or discussed techniques they were clearly unfamiliar with. Better candidates considered a broad range of differentials of worsening pain. Some candidates failed to consider the implications of shock, dehydration and pain on induction, or outline a plan

to optimise fluid status, perform an RSI or reduce induction doses accordingly. Better answers calculated drug doses by body weight and justified modifications of dosing to suit the clinical picture. Candidates are encouraged to use reading time to calculate paediatric drug doses, fluid boluses, ETT sizing etc, as many were unable to perform calculations during the scenario.

Viva 13- Pain Medicine

You are the GP anaesthetist in an all-day general surgery list. The current patient on the operating table is a 58-year-old woman who has undergone a laparoscopic cholecystectomy, and the case is finishing up.

Her medical history is significant for central obesity with a weight of 87kg (BMI 34), moderate OSA on CPAP, hypertension, and anxiety.

Justify your post-operative analgesic plan.

Key Topics Assessed:

- Post-operative analgesia plan
- Local Anaesthetic dosing
- Assessment and management of post-operative pain
- PCA prescribing and safe ward management
- Altered conscious state and hypoxia on ward
- Open disclosure discussion with patient

Feedback from examiners:

Examiners were concerned that many candidates gave rote-learned answers that included a “scatter-gun” approach to analgesia, citing a long list of medications that were clearly beyond what was required for a relatively routine case, and does not reflect real world practice. There was a tendency to use “buzz words” like multimodal analgesia and the WHO ladder without elaborating with further details. Opioids were used sparingly, but ketamine, tramadol and heat packs were mentioned frequently. There was little consideration of oxygen requirement on the ward. Management of opioid induced ventilatory impairment (OIVI) and the open disclosure discussion were generally well handled.

Viva 14- Perioperative Medicine

A 64 year old male is booked for a colonoscopy in 1 week following a positive result on a screening faecal occult blood test.

He weighs 78kg. His BMI is 27.

He has Type 2 Diabetes Mellitus.

His medications are:

- Metformin
- Empagliflozin
- Atorvastatin

His Haemoglobin is 98 g/L.

Please outline your pre-operative assessment of this man's diabetes.

Key Topics Assessed:

- Preoperative assessment of diabetes and anaemia
- Preoperative medication management, including SGLT2i medication
- Management of failure to withhold SGLT2i medication
- Preoperative optimisation for bowel resection
- Perioperative blood transfusion

Feedback from examiners:

This question was generally well answered. Most candidates gave a comprehensive assessment of diabetes, but assessment of anaemia was not covered as thoroughly. Most candidates had a practical approach to the continuation of SGLT2i medications and proceeded in a safe manner. Some others cancelled the procedure despite normal BSL, ketones and blood gas, without an appreciation of the impact of cancellation on someone who has had bowel preparation, and has a likely malignancy. Several candidates were unfamiliar with iron supplementation or its impact on the need for blood transfusion. Many candidates failed to consider non-pharmacological forms of optimisation, including nutrition, physio and exercise.

Candidates are again encouraged to be familiar with relevant guidelines, in this case management of SGLT2i medications perioperatively.

Viva 15- Regional Anaesthesia

You are seeing an 80-year-old male scheduled for a Transurethral Resection of Prostate (TURP) in 10 days' time.

His past medical history includes: -

Hypertension

Transient ischaemic attack (last episode was 8 years ago)

Chronic Obstructive Airway Disease (COAD). Stable exercise tolerance of 50m

Ex-smoker. Quit 8 years ago. No alcohol/illicit drug use

His current medications list comprises of: -

1. Bronchodilators (LAMA +LABA +ICS)
2. Telmisartan
3. Clopidogrel

Nil known drug allergies

What are the potential advantages of a spinal block in this case?

Key Topics Assessed:

- Benefits, Risks and Contraindications to spinal anaesthesia
- Preoperative optimisation
- Management of tachycardia and hypotension post-spinal
- Assessment and management of intraoperative agitation
- Recognition and management of hyponatraemia (TURP Syndrome)

Feedback from examiners:

This question was well answered with some excellent answers given. Candidates are reminded to be familiar with the resources available in Scenarioville when preparing patients for surgery. Requesting preoperative investigations such as a ”routine transthoracic ECHO” without justification is not practical, and does not reflect sound rural practice. A number of candidates did not mention or suspect TURP syndrome, and while this is seen less commonly than previously, it is essential to consider surgical complications as a cause of acute deterioration. Better candidates were able to still offer a safe approach to assessment and management without knowing the exact diagnosis. Candidates are advised to consult crisis management manuals when dealing with a crisis of unknown origin, and to maintain a systematic approach in order to avoid missing potential causes.

Viva 16- Resuscitation, Trauma and Crisis Management

It is 6 pm on a weekday.

Your Rural Generalist colleague in the Scenarioville Emergency Department (ED) phones to request your assistance as the ambulance service has notified them to expect TWO (2) adult patients from a motor vehicle accident that occurred 30 minutes ago.

The vehicle hit a kangaroo and then rolled.

The passenger has a significantly altered level of consciousness and has sustained chest and abdominal trauma.

The driver has probable upper and lower limb fractures but is awake and talking.

They are due to arrive at the ED in 15 minutes, at 6.15 pm.

1) **Outline the preparations that you will undertake in the ED whilst awaiting the arrival of the patients; and**
2) **Briefly describe how you assess the patients on their arrival.**

Key Topics Assessed:

- Preparation for multiple trauma patients, resource allocation
- Primary and Secondary survey of trauma patient
- Trauma assessment
- Critical bleeding management
- Emergency trauma laparotomy considerations
- Anaesthesia for trauma laparotomy

Feedback from examiners:

This question was well answered, with candidates applying EMST principles well. Management of bleeding and reversal of warfarin was done well by most, with better candidates also addressing other strategies to maximise haemostasis. Few candidates considered the indication for warfarin in their answers. Most candidates gave a safe induction plan with appropriate monitoring; however, some did not consider the patient's head injury when discussing permissive hypotension. Most candidates demonstrated a good awareness of the challenges of managing trauma patients in a rural setting, and communicated well with tertiary centres.