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MFSRH Part II Handbook

Key information

The MFSRH Part II consists of a Knowledge Assessment Test (KAT) and Objective Structured Clinical Examination (OSCE). The Part II examination relates to the application of clinical science to the practice of sexual and reproductive healthcare.

Candidates are strongly advised to have spent at least two years working as a clinician in the field of sexual and reproductive healthcare before entering the examination. The Part II examination is based on UK clinical practice, candidates may find it helpful to have had a clinical attachment in the UK prior to taking the examination.

The MFSRH Part II examination is open to candidates who have passed the MFSRH Part I. The Part II examination examines all the CIPs across its two components at a level appropriate for an ST5 trainee. On passing the MFSRH Part II candidates will gain Membership of the Faculty of Sexual and Reproductive Healthcare, subject to fee payments.

Further information about eligibility to take the Part II, associated fees and passing criteria are detailed in the MFSRH Examinations Regulations. ¹

Syllabus

The syllabus for the MFSRH Part II is based on the knowledge requirements of the CSRH curriculum capabilities in practice (CIPs). The curriculum and examination are based on UK guidance and practice. Clinical guidelines used for examinations will be those in force at the date when applications for the examination close.

Candidates should revise based only on curriculum and syllabus requirements pertaining to the exam.

A full overview of the examination syllabus and knowledge requirements can be found in the Community Sexual and Reproductive Healthcare MFSRH Syllabus & Knowledge Requirements 2021².

KAT information

The KAT is a 3-hour paper that consists of 50 single best answer questions (SBA) and 70 extended matching questions (EMQ).

Extended matching questions (EMQs)

EMQs are a methodical way of testing clinical knowledge and applicability of this knowledge to individual clinical situations. Developed in 1993, they have been extensively used in

¹ https://www.fsrh.org/documents/mfsrh-membership-examinations-regulations
² https://www.fsrh.org/documents/crsh-knowledge-requirements/
written assessments in medicine. While their reliability and validity is similar to that of traditional multiple-choice questions, EMQs are far more superior in assessing candidates’ problem-solving and clinical reasoning abilities.

EMQs are structured into four parts:

- **Theme** – There is a theme for each EMQ. This can include eliciting a history, questioning of symptoms, relevant investigations, steps towards establishing a diagnosis or exploring option for treatment towards a clinical condition.
- **Options** – Options list is a list of possible answers, tagged to a set of questions. The answer for a specific question must be picked from this options list.
- **Question** – The question, also called the lead-in statement, outlines the clinical scenario and patient history, and asks the question to be matched with the option.
- **Item** - The clinical vignette, also called the item, will usually consist of a clinical problem. There may be more than one clinical vignette for each of the option lists.

Candidates are given an alphabetised list of options from which they are invited to choose the most appropriate relating to a number of clinical scenarios (items).

**Single Best Answers (SBA)**

SBAs test factual knowledge with a greater breadth of sampling. They enable a wide range of topics to be assessed with high reliability. They are more accurate in establishing candidate knowledge than true/false multiple-choice questions. As opposed to part 1 SBAs that predominantly test basic sciences as applied to sexual health, the part 2 SBAs would concentrate on clinical practice relevant to all domains of sexual and reproductive health. Each question has a lead in statement and five possible answers. All answers are plausible, but one is better or more suitable than the others.

Both EMQs and SBAs are aligned to the CSRH curriculum and are blueprinted against relevant clinical knowledge requirements outlined under each capabilities in practice (CiP).

The following is an estimate of spread of questions as approved by the GMC. The examination committee ensures an appropriate spread of knowledge testing across all elements of the exam including the OSCE.

<table>
<thead>
<tr>
<th>Capabilities in Practice (CiPs)</th>
<th>Coverage within KAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CiP 1</td>
<td>8.5%</td>
</tr>
<tr>
<td>CiP 3</td>
<td>3%</td>
</tr>
<tr>
<td>CiP 4 &amp; CiP 5</td>
<td>13%</td>
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<tr>
<td>CiP 7</td>
<td>4.5%</td>
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<tr>
<td>CiP 8</td>
<td>67.5%</td>
</tr>
<tr>
<td>CiP 9 &amp; CiP 10</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

**OSCE information**

The OSCE is designed to assess the candidate’s ability to gather information, apply their clinical skills, demonstrate appropriate patient-centred care, and make evidence-based decisions.
The OSCE is a realistic simulation of real-life consultations, during which candidates interact with a professional actor while being observed and assessed by an examiner. The professional actor may on occasions play roles other than that of a patient, for example a friend or relative of the patient or even another professional that doctors working in Sexual and Reproductive Healthcare may be expected to interact with.

The OSCE consists of ten active stations. Each station lasts 12 minutes, which includes three minutes for initial reading and nine minutes of simulated consultation. The OSCE exam takes between 2 and 3 hours, depending on the number of candidates.

On occasions there may be a number of additional stations which are either ‘preparatory’ or ‘rest’ stations. A ‘preparatory’ station allows candidates to prepare for the active station that follows. During these ‘preparatory’ stations, candidates will be given information to read and may be expected to make notes to take into the station that follows. ‘Rest’ stations are put in place to accommodate the number of candidates attending the OSCE exam that day and will appear if there are more than 10 candidates in a circuit.

Each of the ten active stations are assessed in the context of the context of 4 domains:

- Patient safety
- Communication with patients (occasionally communication with other professionals, family, friends etc)
- Information gathering
- Applied clinical knowledge

The domains are aligned with the GMC’s Guidance for Good Medical Practice and directly reflect assessing a candidate’s performance against knowledge, skills and performance; safety and quality; communication, partnership and teamwork and maintaining trust.

Communication is assessed independently by both the professional actor and the examiner.

Candidate scores for each domain within each station are added to give a total score for that station, and these are summed across the OSCE circuit. This total circuit score will determine whether a candidate has passed or failed the OSCE examination. The pass mark for each of the OSCE stations is set by a team of subject matter experts ahead of the exam day and relies on the process of Modified Angoff Standard Setting. The pass mark for the OSCE exam is derived using the sum of the pass marks for each of the stations.

**Useful learning resources**

The following list of educational resources is for guidance and is not compulsory reading. It should, however, cover the breadth and give an idea of the depth of knowledge required. The reading list is a guide and not considered exhaustive.

Where possible electronic resources are listed. There are other books and websites not listed here that are suitable for study purposes for this examination; this simply details a selection of information found helpful by previous successful candidates.

**Books**

- SBAs and EMQs for MRCOG II: Addressing the New Exam Format by Chinmayee Ratha, Janesh Gupta
• Part 2 MRCOG: 500 EMQs and SBAs - Andrew Sizer, Bidyut Kumar, Guy Calcott
• An Evidence-Based Clinical Textbook in Obstetrics & Gynaecology for MRCOG-2: (2nd Revised edition) By Richa Saxena
• Complete Revision Guide for MRCOG Part 2: SBAs and EMQs (3rd New edition) By Justin C. Konje
• Comprehensive Gynecology, 8th Edition: David M Gershenson & Gretchen M Lentz & Fidel A Valea & Rogerio A. Lobo Date of Publication: 08/2021 (American Edition; please cross-refer to UK clinical practice)

Up to date guidelines can be found on the following websites:
• Faculty of Sexual and Reproductive Healthcare https://www.fsrh.org/
• British Association for Sexual Health & HIV https://www.bashh.org/
• Royal College of Obstetricians and Gynaecologists https://www.rcog.org.uk/
• British Menopause Society https://thebms.org.uk/
• NICE https://www.nice.org.uk/
• British Society for Sexual Medicine http://www.bssm.org.uk/
• NHS Cervical Screening Programme and BNF – see NICE

Please note that other guidelines, both local and international (e.g. WHOMECE), are of great interest but the exam will be based on UK guidance as above. The guidelines used will be those in force on the day that applications for the relevant sitting of the examination close. Any changes to guidelines made after the application close date will not be examined.

Membership of the FSRH

Completion of our MFSRH exam programme results in 'Membership' of FSRH. Membership subscription is payable annually and membership runs from 1 January to 31 December each year.

Recertification

The MFSRH is subject to recertification every five years. All doctors recertifying from 2012 onwards are required to gain 250 credits in each five-year recertification cycle. Doctor should aim to collect credits at a rate of 50 per year.

Information about recertification³ can be found on the FSRH website.

³ https://www.fsrh.org/recertification/recertification-information/
Example KAT questions

CiP 5 Research

1. Researchers investigated the association between left ventricular size and arterial hypertension. A scatter plot of ascending aortic systolic pressure against left ventricular end systolic area was presented. Linear regression analysis was used to examine the association between left ventricular size and degree of arterial hypertension, with a resulting fitted linear regression line. A significant correlation existed between left ventricular end systolic area and aortic systolic pressure (r=0.8; P<0.001). Which of the following statements accurately describes the statistical principles underlying regression and correlation?

A. The regression line quantifies the strength of the linear association of aortic systolic pressure from left ventricular end systolic area
B. The regression line implies that there is a causal association between aortic systolic pressure and left ventricular end systolic area
C. Correlation facilitates the prediction of aortic systolic pressure from left ventricular end systolic area
D. Pearson’s correlation coefficient may be used to quantify the variability in pulmonary artery systolic pressure described by left ventricular end systolic area
E. 50% of variation in aortic systolic pressure is accounted by left ventricular end systolic area

Answer: D

2. The results of a meta-analysis comparing the intervention with control treatment in the occurrence of cervical cancer (following sixty days or more of HPV eradication therapy) were presented in a forest plot as follows: Relative risk 0.66 (95% confidence interval 0.46 to 0.95, test for heterogeneity: I²=0%). In all the six trials the 95% confidence interval for the population risk ratio included the integer 1.0.

Which of the following statements accurately describes the results arising out of this forest plot?

A. All the six trials showed a significant difference between treatment groups in the risk of cervical cancer
B. The forest plot is drawn on a linear scale
C. A risk ratio less than 1.0 indicates a decreased risk of cervical cancer with the control treatment compared with eradication therapy
D. The total overall estimate of the population risk ratio indicated that eradication therapy led to a 34% greater risk of cervical cancer compared with the control treatment
E. Significant homogeneity existed between the sample estimates of the population risk ratio of cervical cancer

Answer: E
CiP 8: KS1 Fertility control

3. High frequency linear array scanning is in progress to locate an impalpable implant in a 20-year-old nullip. She is 1.67 metres tall with a BMI of 25 kg/m². The medial aspect of the arm 10 cm from the elbow joint is being visualized. The consultant points to the ST6 SRH trainee a nerve lying very close to two vessels: the brachial artery and the basilic vein.

At this anatomical scanning plane which of the following nerves lies in between these two vessels?

A. Median nerve
B. Medial cutaneous nerve of the arm
C. Musculocutaneous nerve
D. Radial nerve
E. Ulnar nerve

Answer: A

CiP 8: KS3 Early pregnancy and abortion

4. Options list:

A. Biochemical pregnancy loss
B. Cervical trauma
C. Ectopic pregnancy
D. Failed abortion
E. Late pregnancy loss
F. Molar pregnancy
G. Retained products of conception
H. Uterine perforation
I. Uterine rupture

Instructions: For each clinical scenario described below, choose the single most likely diagnosis from the above list of options. Each option may be used once, more than once, or not at all.

Question: A 23-year-old primigravida undergoes medical abortion at 15 weeks’ gestation. She has heavy vaginal bleeding a few hours after misoprostol administration and passes products of conception. She continues to bleed heavily however and is feeling lightheaded. Her observations reveal a blood pressure of 90/45 mmHg and pulse of 130 bpm. She undergoes a vaginal speculum.

Answer: G
CiP 8: KS5 Abnormal vaginal bleeding

5. Options List:
A. Choriocarcinoma
B. Dysgerminoma
C. Granulosa cell tumour
D. Serous cystadenocarcinoma
E. Sertoli-Leydig cell tumour
F. Transitional cell carcinoma

Instructions: For the scenario below, choose the single most likely pathological diagnosis from the above list of options.

Question: A 20-year-old woman attended your clinic complaining of lower abdominal pain, nausea, and vomiting. She was in a sexual relationship of two years' duration, using the CTP for contraception and running patches together to avoid bleeding. She gave no relevant past medical history. Speculum examination was unremarkable but on vaginal examination she exhibited slight tenderness in the right fornix. Urine PT was positive. A transvaginal USS showed no gestational sac in the uterus. While the left ovary appeared normal, the right ovary contained a solid mass with hypoechoic, irregular septa with dimensions of 45 × 63 × 30 mm. Free fluid was not seen. In hospital a serum βHCG value of 1640 mIU/mL was reported and a laparoscopy showed normal uterus, fallopian tubes, and left ovary. The right ovary looked enlarged but otherwise normal. Inspection of the rest of the pelvis and abdomen showed no abnormalities. Further monitoring over the next week saw the serum βHCG rise to 15,230 mIU/mL with significant bidirectional blood flow noted within the right ovary by doppler.

Answer: A

CiP 8: KS7 Urogynaecology

6. Anticholinergic drugs remain the mainstay of pharmacotherapy of OverActive Bladder Syndrome (OABS) in women.

Which of the following drugs is a non-selective anticholinergic agent?

A. Darifenacin
B. Mirabegron
C. Oxybutynin
D. Solifenacin
E. Tolterodine

Answer: E
CiP 8: KS9 Adolescent SRH

7. Which of the following statements is an accurate reflection of continuous GnRH analogue (GnRHa) treatment for central precocious puberty (CPP) until the time final height is achieved?

A. Adult bone mineral density is reduced by childhood GnRHa therapy.
B. A suppressed FSH response to GnRH testing indicates that the therapy is having the desired effect.
C. Increased adult height is an undisputed benefit of gonadotrophin-releasing analogue treatment, but only in girls less than 6 years old with early-onset CPP.
D. Pubertal manifestations generally reappear within 5 years of stopping GnRHa treatment.
E. Short-acting intranasal GnRHa preparations are as effective as long acting GnRHa preparations.

Answer: C

CiP 8: KS11 Menopause

6. A 52-year-old woman attends clinic. She is a non-smoker, BMI 24kg/m², BP 125/82mmHg with no personal or family history of note. Her LMP was one year ago and she is struggling to cope with menopause type flushes and sweats.

Which of the following statements is most likely to reflect an appropriate counselling point regarding starting HRT in this woman?

A. The risks of HRT outweigh the benefits if started between 50 and 60 years of age.
B. The risk of stroke with HRT use is the same when HRT is commenced between 50 and 60 years of age as opposed to being commenced after 60 years of age.
C. Five years after stopping HRT, the risk of breast cancer is the same for women who have ever used HRT and never users of HRT.
D. The type of progesterone used in a HRT preparation does not affect the risk of developing VTE.
E. Women who start HRT within 10 years of menopause have a higher risk of death from cardiovascular disease.

Answer: C