RACGP Education

Exam report 2024.2 AKT

RACGP

Exam report 2024.2 AKT

Disclaimer

The information set out in this report is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations

contained in this publication must exercise their own independent skill or judgement, or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation

The Royal Australian College of General Practitioners. Exam report 2024.2 AKT. East Melbourne, Vic: RACGP, 2024.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002
Wurundjeri Country

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN: 34 000 223 807

Published August 2024

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-6408

1. Exam psychometrics

Table 1 shows the mean and standard deviation of the entire cohort who sat the exam. These values can vary between exams. The reliability is a measurement of the consistency of the exam.

A candidate must achieve a score equal to or higher than the pass mark to pass the exam. The pass marks for the Applied Knowledge Test (AKT) and Key Feature Problem (KFP) exams are determined by the internationally recognised modified Angoff method, and outcomes may vary between each exam cycle. The Clinical Competency Exam (CCE) pass mark is determined by the borderline regression method (refer to The Royal Australian College of General Practitioners [RACGP] Education **Examination guide** for further details).

The 'pass rate' is the percentage of candidates who achieved the pass mark.

The RACGP has no quotas on pass rates; there is not a set number of candidates who may pass the exam. Pass rates may vary depending on a number of variables.

Table 1. Psychometrics

Mean score (%)	75.67
Standard deviation (%)	10.53
Reliability*	0.91
Pass mark (cut score %)	66.44
Pass rate (%)	82.15
Number sat	829

*Exam reliability is expressed as a value between 0 and 1, in line with international best practice in assessment reporting.

2. Candidate score distribution

Figure 1 shows the range and frequency of final scores for this exam.
The vertical blue line in Figure 1 represents the pass mark.

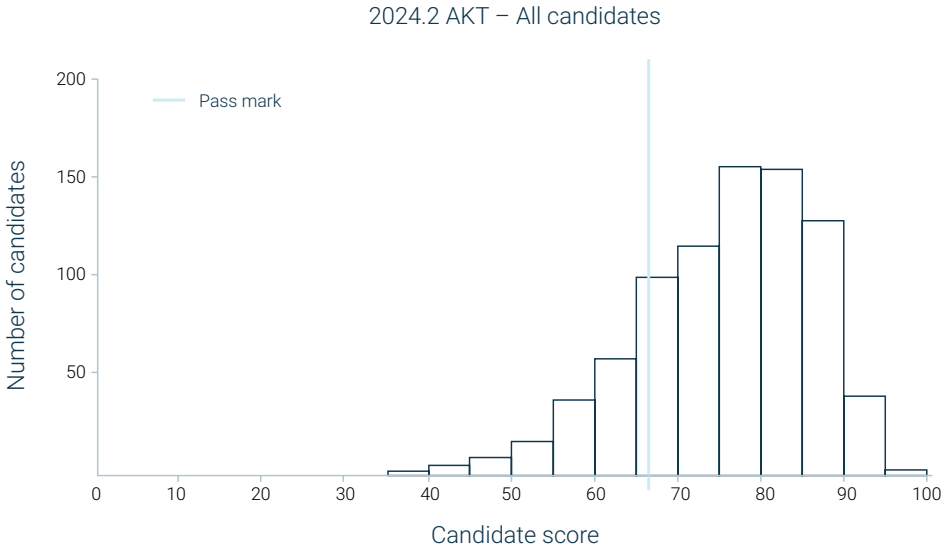

Figure 1. 2024.2 AKT score distribution.

3. Candidate outcomes by exam attempt

Table 2 provides pass rates (%) displayed by number of attempts. A general trend suggests the rate of passing diminishes with each subsequent attempt. Preparation and readiness to sit are important for candidate success.

Table 2. Pass rates by number of attempts

Attempts	Pass rate (%)
First attempt	91.3
Second attempt	72.6
Third attempt	53.8
Fourth and subsequent attempts	23.9

4. Feedback report on 2024.2 AKT

All candidates are under strict confidentiality obligations and must not disclose, distribute or reproduce any part of the exam without the RACGP's prior written consent.

All the questions in the AKT are written by experienced general practitioners (GPs) who currently work in clinical practice, and are based on clinical presentations typically seen in an Australian general practice setting. The questions should be answered based on the context of Australian general practice.

There are two types of question within the AKT: single best answer and modified extended match questions. All questions follow the same format, which includes the stem (case vignette) followed by a lead-in question. Single best answer questions have five answer options. Modified extended match questions have 8–10 answer options. Each question has only one correct answer.

It is important that candidates carefully read the clinical scenario and question. Although more than one option may be plausible, only the most appropriate option for the clinical scenario provided should be selected.

It is useful for candidates to identify any areas of weakness in their clinical practice through self-reflection and feedback. A supervisor, mentor or peer may assist them in developing an appropriate learning plan to assist with future exams and ongoing professional development.

All questions in the AKT undergo extensive quality assurance processes. Questions are rigorously reviewed during the creation, pre-exam and post-exam review processes, and during the standard-setting process following the AKT. Reviews are performed by GPs who are currently in clinical practice across Australia.

This report provides a sample of clinical scenarios from the 2024.2 AKT. The following example cases were selected because:

- the cohort performed poorly on the case
- the case highlights a common error in approaching the AKT
- the case is an example of a serious condition that should not be missed.

Each example case describes alternative options selected by candidates and provides feedback regarding the correct answer to the question.

5. Example cases

Example 1

The clinical scenario described a woman, aged 53 years, who presented with chronic vulval itch and dyspareunia. She had previously trialled a two-week course of combined low-dose topical corticosteroid and antifungal cream with mild improvement in her symptoms. An image consistent with vulval lichen sclerosis was provided.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was to arrange for vulval biopsy. Alternative options included prescription of an oestradiol pessary and prescription of long-term oral fluconazole.

This is a two-step question. It required candidates to identify a case of vulval lichen sclerosis and select the appropriate management. Lichen sclerosis may cause adhesions and scarring if not diagnosed and treated

appropriately. Because it most commonly occurs in women aged over 50 years, it is often incorrectly diagnosed as atrophic vulvovaginitis. Lichen sclerosis should be treated with a potent topical corticosteroid and surveillance because patients are also at increased risk of squamous cell carcinoma of the vulva. Due to the risk of significant long-term sequalae, it is important for GPs to have a high index of suspicion for this condition.

Example 2

The clinical scenario described a man, aged 22 years, presenting with an acute ankle injury. He had sustained the injury when he twisted and fell during a hockey game. A detailed physical examination was provided. This included ankle instability and tenderness over the syndesmosis. Compression of the tibia and fibula at mid-calf level caused increased pain.

The question asked, 'What is the MOST appropriate provisional diagnosis?'. Of the options provided, the most appropriate response was syndesmosis injury. Alternative options included posterior talofibular ligament tear and distal fibula fracture.

Syndesmotic, or 'high', ankle sprains are less common than lateral ligament ankle sprains. The diagnosis is usually suspected clinically and confirmed with stress radiographs, CT scanning or MRI. These injuries are often missed because plain X-rays can be normal. Appropriate treatment usually results in excellent functional outcomes. However, if the diagnosis is missed, there is a risk of chronic ankle instability and arthritis.

Example 3

The clinical scenario described a woman, aged 29 years, who was seven weeks pregnant with her first child presenting for her second catch-up measles, mumps and rubella (MMR) immunisation. Three months earlier, at her pre-pregnancy consultation, it was identified that she had missed her childhood MMR immunisations. The patient was advised she would need two doses of the vaccine, and she received her first dose that day. Her antenatal blood tests identified that she was not immune to rubella. The patient reported an intention to breastfeed her infant once born.

The question asked, 'What is the MOST appropriate management?'. Of the options provided, the most appropriate response was to administer MMR vaccine immediately after the birth of her baby. Alternative responses included administering the MMR vaccine when the patient had finished breastfeeding or to administer the MMR vaccine today.

The MMR vaccine is a live attenuated vaccine that is contraindicated in pregnancy due to the theoretical risk of congenital rubella syndrome. Patients may safely receive the MMR vaccine while breastfeeding. Antenatal care is commonly delivered within Australian general practice. It is important for GPs to be aware of the indications and contraindications for rubella immunisation.

Example 4

The clinical scenario described a woman, aged 76 years, who presented to a rural general practice clinic for her annual type 2 diabetes review. Her medications included metformin, simvastatin and irbesartan. Her HbA1c was to target. Her physical examination identified a significant deterioration in her visual acuity compared with her previous review. A fundoscopy image consistent with diabetic retinopathy was provided.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was urgent referral to an ophthalmologist. Alternative options included referral to an optometrist for updated spectacle prescription and prescription of semaglutide.

Diabetes is a very common condition in Australia, and it is important for GPs to be aware of potentially serious complications and to refer in a timely manner. Diabetic retinopathy is a significant cause of visual impairment. Early treatment may slow progression of the condition and prevent blindness. Patients with sight-threatening diabetic retinopathy should be assessed by an ophthalmologist. Treatment may include pharmacotherapy, laser therapy and/or vitrectomy.

Example 5

The clinical scenario described a woman, aged 32 years, presenting with an erythematous, itchy rash on her breast that had been present for three weeks. The patient was exclusively breastfeeding her five-month-old infant. Her medical history included asthma. An image was provided that demonstrated a well-demarcated pink scaly region on her areola.

The question asked, 'What is the MOST appropriate management?'. Of the options provided, the most appropriate response was prescription of mometasone furoate 0.1% ointment. Alternative responses included prescription of miconazole gel or dicloxacillin.

This is an example of a two-step question. Candidates were required to recognise a clinical diagnosis of eczema in a patient with a history of atopy. Candidates then needed to select the appropriate management, being a topical corticosteroid cream. Breast and nipple thrush is caused by Candida albicans infection and usually presents with pain as the predominant symptom. Patients often describe sensitive nipples and shooting, aching or burning pain that radiates throughout the breast. Mastitis also presents with breast pain and can often include systemic symptoms such as fever and malaise. Breast examination reveals a warm, tender and erythematous area on the breast. Distinguishing between various causes of breast symptoms is an important skill for GPs.

6. Further information

Refer to the RACGP Education Examination guide for exam-related information.

Healthy Profession.
Healthy Australia.

RACGP