RACGP Education

Exam report 2025.1 AKT

RACGP

Exam report 2025.1 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 2025.1 AKT. East Melbourne, Vic: RACGP, 2025.

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 March 2025

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-7240

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 (%)	74.36
Standard deviation (%)	11.18
Reliability*	0.92
Pass mark (cut score %)	65.54
Pass rate (%)	79.48
Number sat	765

*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.

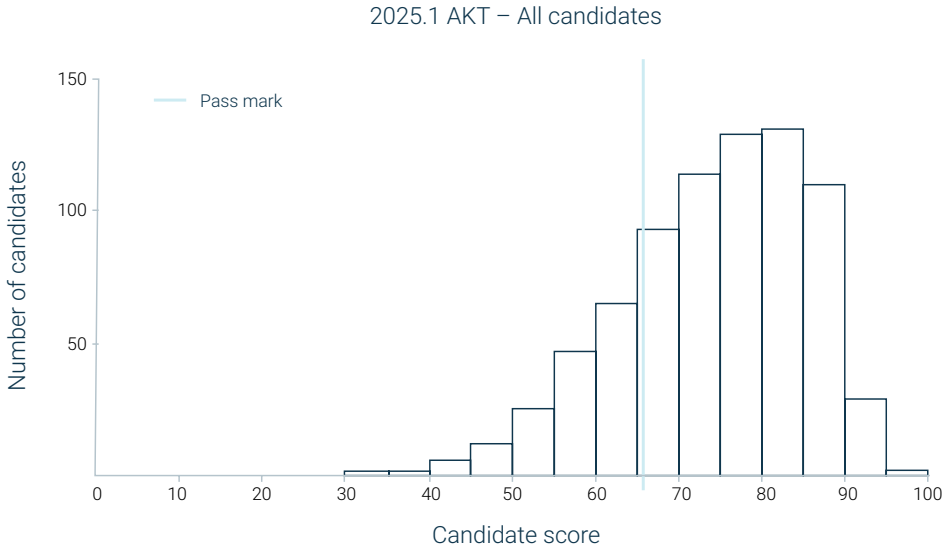

Figure 1. 2025.1 AKT score distribution.

3. Candidate outcomes by exam attempt

Table 2 provides pass rates (%) according to the 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	87.0
Second attempt	49.2
Third attempt	66.7
Fourth and subsequent attempts	33.3

4. Feedback report on 2025.1 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 2025.1 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.

Please note: candidates are not required to provide drug doses within the AKT, KFP and CCE. Candidates may still be required to provide route of administration or frequency of administration.

5. Example cases

Example 1

The clinical scenario described a boy, aged 19 months, who presented with a two-day history of swelling and redness around his right eye. Examination findings, including a normal tympanic temperature and normal ocular movements, were given. An image consistent with periorbital cellulitis was provided.

The question asked, 'What is the MOST appropriate initial management?'. Of the options provided, the most appropriate response was prescription of oral cephalexin four times daily for seven days. Alternative options included transfer to the emergency department for intravenous antibiotics and warm compresses applied to the eyelid four times daily.

This is an example of a two-step question. The question required candidates to identify a case of periorbital cellulitis and to select the most appropriate management. Periorbital cellulitis is infection of the eyelid and surrounding skin and does not affect the orbit. It involves structures that are anterior to the orbital septum and can usually be managed with oral antibiotics. The most important differential diagnosis in this case is orbital cellulitis. Although periorbital and orbital cellulitis are distinct clinical diseases, they can have overlapping clinical features. Orbital cellulitis is infection of the orbit and involves structures that are posterior to the orbital septum. It should be suspected when red flag signs and symptoms are present, such as painful or restricted eye movements, visual impairment, proptosis and/or severe headache. This condition is a surgical emergency with serious complications, including intracranial infection, cavernous sinus thrombosis and vision loss. It is important for GPs to be able to distinguish between, and appropriately manage, periorbital and orbital cellulitis.

Example 2

The clinical scenario described a man, aged 43 years, presenting with painless rectal bleeding for two months. He had also experienced a change in bowel habit with constipation for six months. A physical examination consistent with internal and external haemorrhoids was provided.

The question asked, 'What is the MOST appropriate next step?'. Of the options provided, the most appropriate response was to refer for colonoscopy. Alternative options included prescription of topical glyceryl trinitrate ointment and incision of haemorrhoids under local anaesthetic.

Rectal bleeding is a frequent presentation in Australian general practice. The majority of cases are due to haemorrhoids. However, rectal bleeding mistakenly attributed to haemorrhoids is a common factor contributing to the underdiagnosis of colorectal cancer. It is important for GPs to maintain a high index of suspicion for alternative pathologies, particularly when bleeding is persistent or accompanied by red flag symptoms such as change in bowel habit.

Example 3

The clinical scenario described a man, aged 76 years, presenting with a skin lesion on his forehead that had been present for three months. The lesion was not bothering him, but his wife had encouraged him to have it reviewed. Examination findings, including the size of the lesion and macroscopic and dermatoscopic images consistent with a seborrhoeic keratosis, were provided.

The question asked, 'What is the MOST appropriate management?'. Of the options provided, the most appropriate response was to provide reassurance that the lesion was benign. Alternative options included excision with 6-mm margins and prescription of topical fluorouracil 5% cream.

Seborrhoeic keratoses are benign skin lesions that are very commonly seen in elderly patients. The diagnosis can usually be made clinically and no specific treatment is required, unless requested by the patient. It is important for GPs to be able to be able to recognise seborrhoeic keratoses to avoid unnecessary treatments that may cause morbidity to the patient.

Example 4

The clinical scenario described a woman, aged 70 years, presenting with shortness of breath on exertion for the past 18 months. The patient had a distant smoking history and was a retired cotton farmer. Her physical examination was normal. Spirometry consistent with an obstructive pattern was provided.

The question asked, 'What is the MOST appropriate provisional diagnosis?'. Of the options provided, the most appropriate response was chronic obstructive pulmonary disease (COPD). Alternative options included interstitial lung disease (ILD) and hypersensitivity pneumonitis.

COPD is a very common condition in Australia. Although smoking is the most common risk factor, occupational exposures are also identified as being responsible for 20–30% of COPD cases. Early recognition and management are aimed at optimising function and preventing deterioration. ILD may also present with dyspnoea, and additional symptoms such as fatigue and unintentional weight loss may also be present. Examination findings in ILD may include fine inspiratory crackles and digital clubbing. However, these findings can vary depending on the underlying aetiology of ILD and physical examination can be entirely normal. Spirometry that demonstrates a reduction in forced expiratory volume in one second (FEV_1) and forced vital capacity (FVC) with a normal or elevated FEV_1/FVC ratio is consistent with ILD.

Example 5

The clinical scenario described a person, aged 17 years, presenting with their mother who was concerned about their weight loss over a period of several months. The patient was assigned female at birth but identified as trans non-binary. They held a belief that restricting food intake would inhibit the development of menstruation and keep breast size small. Physical examination demonstrated hypothermia, postural tachycardia and a low body mass index. Investigation results consistent with hyponatraemia and hypokalaemia were provided.

The question asked, 'What is the MOST appropriate initial management?'. Of the options provided, the most appropriate response was to transfer to the emergency department for admission. Alternative options included reviewing the patient in one week and referral to a psychologist specialising in gender dysphoria.

This question required candidates to make the diagnosis of an eating disorder and to recognise that the patient was medically unstable, requiring hospital admission. Patients with severe eating disorders are at risk of cardiac arrhythmia and 'refeeding syndrome', which can potentially cause fatal shifts in fluids and electrolytes. Although psychotherapy is an important aspect of eating disorder management, a medically unstable patient requires inpatient care to provide critical monitoring and intervention.

6. Further information

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

Healthy Profession.
Healthy Australia.

RACGP