The College of Dental Surgeons of Hong Kong
Specialty Exit Examination
in
Paediatric Dentistry

A. General Information

- All sections of the examination will be conducted in the English language.
- Candidates will be graded as having passed or failed separately in the written section and case review section in each section. A candidate who fails a section of the examination may repeat that failed section at a subsequent examination scheduled by the College.

B. Written Section

There will be two, 3 hour written paper. The purpose of this section is to determine the candidate's knowledge and understanding of special topics important to the clinical practice of Paediatric Dentistry, as well as the candidate's recognition and decision-making process in relation to various clinical conditions, diagnosis, treatment planning and patient care.

C. Case Review Section

There will be an oral examination of 60 minutes duration based on four fully documented case histories. The log book of the candidate will also be reviewed. The purpose of this section is to enable the candidate to demonstrate a high standard of diagnosis, treatment planning, and quality of care in these cases.

The cases must be patients that have been treated by the candidate in the last 3 years of training before the examination. The cases submitted must demonstrate high quality clinical care and documentation. Each of the case histories must be written in English, typed and separately bound. A robust flat type A4 format with clear PVC pockets is recommended. Duplicate copies of each complete case history are required, one copy being submitted to the College at the time of making the application for entry to the exit examination, the second being retained by the candidate for reference. Radiographs, photographs, transparencies and any other presentation aids should be provided where

appropriate and these should be clearly described in the text. The originals should form part of the case history retained by the candidate. Study casts (if required) should be brought by the candidate on the day of the Examination.

The candidate's name or initials must not be shown on the material. Only the patient's initial, sex and date of birth should be shown. The addresses of the candidate and the patients should not be indicated. Each fully documented case history should give a brief description of the relevant history and the results following clinical examination and investigations adopted. The candidate should also give his/her assessment of the diagnostic features and discuss the treatment plan advised. Emphasis should be placed on the carefully and complete assessment of the patient's need in the light of all relevant circumstances. The candidate should refer to any further investigations and/or treatment which may be required and comment on any special difficulties which necessitated a modification of the initial treatment plan. Each case history should end with an appraisal of the outcome of the treatment together with a discussion of whether the objectives were fully achieved. Candidates should also indicate if the results provided useful lessons which might influence the management of similar problems in the future. The case histories should be accompanied by a signed statement from the clinician responsible for the direct clinical supervision of the candidate, confirming the candidate's management of the submitted cases. Any treatment procedures that were performed by another clinician should be indicated. This statement should be separately addressed to the Education and Examination Committee in a sealed envelope: it must not be enclosed with the clinical case histories. The clinical case histories will be available for collection following the adjudication and candidates should note that this is their personal responsibility.

The four cases must be selected as follows:

i) At least one case should be selected from each division.
ii) At least three of the five categories of patient care should be selected.

Division 1

Category 1 - Trauma

The case should have required treatment of a primary permanent incisor tooth, with a minimum of 6 months follow-up. The trauma to a primary incisor should be a crown

fracture involving the pulp, or a displacement. The treatment of a permanent incisor should involve either an avulsion, a crown fracture exposing the pulp, a root fracture or a displacement.

Category 2 - Surgical

The case should have involved a procedure which was performed after the raising of a mucoperiosteal flap under general or local anaesthesia. Post-treatment documentation is required 3 months after completion of the surgery.

Category 3 – Interceptive treatment of a malocclusion

The case should have involved the active treatment of a malocclusion.

Division II

Category 4 - Restorative therapy under general anaesthesia

The case should have required restorations of extensive carious lesions and involve pulp therapy and stainless steel crowns. The preventive regimen for the patient must be included. Post-treatment radiographic documentation is required 3 months after completion of all treatment procedures.

Category 5 - Restorative and/or preventive therapy for a child with special needs

The case must document comprehensive restorative care provided for a child who had a significant medical or behavioural problem under local anaesthesia. Post-treatment records are required 6 months after completion of all treatment.

8 April 2009