Ophthalmology: Clinical Guidelines for FRCOphth & FRCS (Ophth)

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For the most up-to-date version of this document, please see:
http://www.londoneyecourse.com/exam-resources.html
IMPORTANT DISCLAIMER

• This document simply collates guidelines which are important to know for the FRCOphth & FRCS (Ophthalmology)

• The most accurate and comprehensive source is the original guideline.

• London Eye Course takes no responsibility for any errors/inaccuracies/outdated information in this document

• Healthcare professionals should refer to the original guidelines for most accurate and up-to-date information

October 2016
CRVO & BRVO

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html

CRVO Medical Investigations

- Recommended in the eye clinic
- Aim to detect conditions that require urgent action
  - Blood pressure
  - Serum glucose
  - FBC
  - ESR
    - If raised consider:
      - inflammatory conditions
      - blood disorders such as myeloma

- Other Investigations
  - Be guided by history and examination or initial test results.

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Non-ischaemic CRVO

Baseline assessment should include:

• VA
• IOP

• Gonioscopy (if ischaemic CRVO suspected)

• OCT macula
• Colour fundus photo
• FFA

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Non-Ischaemic CRVO macular oedema

• VA > 6/12
  – Observe patient for spontaneous resolution

• VA 6/12 - 6/96
  – Intravitreal anti-VEGF or Ozurdex implant

• VA < 6/96:
  – Poor potential for significant VA improvement but some eyes may respond so can offer treatment
  – Watch for NVI/NVA; high risk

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
CRVO macular oedema (MO)

• Ranibizumab or Aflibercept

  – Monthly injections until max VA achieved
  – Defined as stable VA for 3 consecutive months
  – Monitor monthly thereof
  – Restart treatment if VA drops again due to MO
  – Monthly injections until stable VA for 3 months

  – If no improvement over the first three injections, consider treatment cessation

  – If no improvement after 6 injections, treatment cessation is recommended

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
CRVO macular oedema (MO)

- Ozurdex
  - Retreatment may be required 4-6 monthly intervals until VA is stable
  - Occasionally retreatment may be required at shorter intervals (3 monthly)
  - Monitor for raised IOP and cataracts

- Note regarding AntiVEGFs
  - preferred in eyes with a previous history of glaucoma or phakic younger patients.

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
CRVO macular oedema (MO)

• If treatment results in reduction of CMT without improvement of deterioration of VA, this may still be acceptable as a favourable treatment outcome (i.e. preventing loss of VA)

• No evidence to support switching treatment agents, but may be considered.

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Follow up

- VA, OCT macular thickness, IOP at each visit
Ischaemic CRVO

• NVA/NVI and an open angle:
  – Urgent PRP
  – Review at 2 weeks and then until NV regress
  – PRP + intravitreal bevacizumab if NV persist

• NVA/NVI and a closed angle and raised IOP:
  – Urgent PRP + cyclodiodode/tube-shunt surgery
  – If VH can do transcleral diode and retinal cryo
BRVO
BRVO

• Investigations
  – Serum glucose
  – BP
  – FBC
  – ESR

• GP to manage risk factors

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html

Non-ischaemic BRVO

• VA >6/12  
  – observe for 3 months

• VA ≤ 6/12  MO and haemorrhages not masking the fovea:
  – No macular ischaemia (MI):  
    • Observe for 3 months
  – Mild to Moderate MI  
    • Consider Ranibizumab or Ozurdex
  – Severe MI  
    • No Treatment - recommended, observe for NV

• VA ≤ 6/12  MO and haemorrhages masking the fovea:
  – Monthly ranibizumab or baseline Ozurdex for 3 months
  – FFA at 3 months  
    • If severe MI, it is likely that no treatment will prove beneficial

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Non ischaemic BRVO

• At 3m follow up:
  – Modified grid laser if
    • persistent MO
    • minimal macular ischaemia
    • and other treatments unsuccessful or unavailable
  – If VA≥6/9 or no MO
    • If initially observed – continue to observe
    • If on antiVEGF or ozurdex continue as per MO in CRVO

• Further follow up:
  – If observed only, follow up 3 monthly for 18m
  – If recurrence/new MO, consider reinitiation of ranibizumab/ozurdex

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Ischaemic BRVO

• Watch for NV

  – If NVE
    • Sector laser photocoagulation to ischaemic quadrants
    • Off licence bevacizumab may be given with laser

  – Follow up 3 monthly for 24 months

http://www.nature.com/eye/journal/v29/n12/full/eye2015164a.html
Ischaemic BRVO

• Watch for NV

  – If NVE –
  • sector laser to all ischaemic quadrants
  • +/- intravitreal bevacizumab

• Follow up 3 monthly for 24 months
Vigabatrin

• Anti-epileptic for partial epilepsy (second line): GABA inhibitor

• Ocular Risks
  – Prevalence of field loss 30-40%
  – Bilateral concentric VF loss – temporal and mostly macular sparing; can be cause of binasal field defect
  – Not dose related
  – Irreversible

Vigabatrin Guidelines

• Initial suprathreshold VF test Humphrey 120
• If abnormal do threshold 30-2 within 1 month to confirm
• Do every 6m for 5 years, then annually if no VF defect

• The prescribing doctor should warn the patient of the risks of the drug before use
• Warn patient VF defect may worsen if drug used for >5yrs or cumulative dose >5kg (normal dose 2mg/kg daily)

Retinopathy of Prematurity (ROP)

ROP Zones

• Zone I
  – A circle of radius - twice the distance from the disc centre to the centre of the macula

• Zone II
  – Extends from the edge of zone I to the nasal ora serrata

• Zone III
  – The residual crescent of retina anterior to zone II

ROP Stages

• Stage 1
  – Demarcation line.
• Stage 2
  – Elevated ridge.
• Stage 3
  – Extraretinal fibrovascular proliferation
• Stage 4
  – Partial retinal detachment
    • 4a Extrafoveal
    • 4b Foveal
• Stage 5
  -Total retinal detachment.

Plus disease

• Plus Disease
  – Significant level of vascular dilation and tortuosity observed at posterior retinal vessels.
  – Vitreous haze and anterior chamber haze
  – Iris vascular engorgement
  – Poor pupil dilation

• Pre-plus
  – Vascular changes at the posterior pole that cannot be considered as normal but not sufficient to be diagnosed as plus

ROP Guidelines

• Who to screen?
  – Must screen <31 weeks or < 1251g
  – Should screen <32 weeks or <1501g

• When to screen?
  • <27 weeks
    – screen at 31 weeks
  • 27-32 weeks
    – screen after 4-5 weeks
  • >32 weeks but <1501g
    – screen after 4-5 weeks

ROP Guidelines

• How often?
  – Weekly if zone 1 or posterior zone II, any stage 3 or any plus or pre-plus
  – Otherwise twice weekly

• When to stop?
  – If vascularised into zone III
    • (after 36 weeks)
  – If on 2 consecutive exams;
    • No increase in severity
    • Demarcation colour has changed from salmon pink to white,
    • Vessels beyond demarcation line,
    • Replacement of active ROP lesions by scar tissue

ROP Guidelines

• WHO to treat?
  – Zone I any stage with plus
  – Zone I stage 3 without plus
  – Zone II stage 3 with plus
  – Seriously consider treating:
    • Zone II stage 2 with plus

ROP Guidelines

• How to treat…
  – Treat within 48hrs, diode laser, near confluent (1/2 burn apart) burns throughout avascular retina
  – If no diode, use argon or cryotheraphy
  – Review in 5-7 days
  – Retreat 10-14 days if no regression

Hydroxychloroquine
Hydroxychloroquine

• Antimalarial used for SLE and RA
• Ocular features
  – vortex keratopathy and maculopathy (rare)

• RCOphth (2009) recommends no screening programme as maculopathy rare and no reliable test to detect a reversible stage
Guidelines

• Max dose should be <6.5mg/kg LEAN body weight

• Pre-treatment VA and near vision – can commence if N6 or N8
• Referral to ophthalmologist if abnormal at baseline
• If patient notices reduced vision can see optometrist to check vision and should seek advice from the hydroxychloroquine prescriber
• After 5 yrs on continuous meds need local agreement with ophthalmology
What to look for?

• Enquiry about disturbance central vision
• VA and reading acuity
• Amsler Chart
• Slit lamp: cornea deposits
• Stereo slit lamp fundoscopy: Looking for Bull’s eye maculopathy changes
• Central 10-2 visual field: Looking for paracentral scotomas
• OCT Macula: localized thinning of the photoreceptor layers in the parafoveal region
Table 3. Clinical Examination Techniques

<table>
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<th>Recommended Screening Tests</th>
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<td>Primary tests: ideally do both</td>
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<tr>
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</tbody>
</table>

EOG = electro-oculogram; ERG = electroretinogram; FAF = fundus autofluorescence; mfERG = multifocal electroretinogram; SD OCT = spectral-domain optical coherence tomography.
Oncology referrals

*Asked about in April 2016 OSCE*

- **Which centres?**
  - Liverpool, Sheffield and London

- **Refer:**
  - Primary Intraocular tumours (other than naevus), lymphoma or metastatic tumours
  - Conjunctival or epibulbar tumours

Oncology Referrals

- Conjunctival melanocytic tumour if:
  - Involves caruncle, cornea or palpebral conjunctiva
  - Feeder vessel
  - Diameter >3mm especially if without clear cysts
  - Nodular with diffuse pigmentation
Oncology Referrals

*Asked about in April 2016 OSCE*

- Choroidal tumour if:
  - >2mm thickness
  - Collar stud configuration
  - Documented growth

- Or 2 of:
  - >1.5mm thickness
  - Orange pigment
  - serous retinal detachment
  - Symptoms

Oncology referrals

- Iris nodules if:
  - >3mm diameter
  - Marked elevation
  - Secondary glaucoma or localised cataract
  - Involving angle

Oncology Referrals

• Whom not to refer to adult ocular oncology:
  • CHRPE
  • Simple naevi if;
  • Small and flat, or
  • Minimally raised with only drusen on surface
  • Eye lid tumours
  • Orbital tumours

– Retinoblastoma:
  • Refer to retinoblastoma services in London or Birmingham

AMD guidelines

IMPORTANT FLOWCHART:

AMD guidelines

• Smoking cessation: 2-3x increased risk

• Balanced healthy diet

• Pre-treatment: VA, OCT, FFA

• Treat with anti-VEGF if:
  – Active subretinal neovascular membrane
  – Evidence of progression
    • new membrane, visual decline, new haemorrhage or SRF
  – VA 6/12 to 6/96 (NICE guidance)
  – No permanent structural foveal damage
  – Lesion size ≤12dd in greatest linear dimension
  – No previous sensitivity to anti-VEGF

Other considerations for Treatment

• Bilateral CNV:
  – For simultaneous intravitreal injections
    • have separate sets and separate vials for each eye

• Predominant haemorrhagic lesions
  – Can still use anti-VEGF

• Raised IOP
  – Can still use anti-VEGF but must treat IOP

• Intraocular surgery
  – Control CNV activity before cataract surgery
  – After cataract surgery can use anti-VEGF but pay attention to cataract wound

Intravitreal anti-VEGF

• Theatre or dedicated clean room: good illumination, washable floor, ceiling non-particulate in nature
• Must wear surgical gloves, mask if desired
• Preparation:
  – do not need to do VA and IOP on day;
  – topical anaesthesia,
  – povidone 5% for at least 60 seconds

Intravitreal anti-VEGF procedure

- Pt prep
- Eye prep
- Drape pt
- Eyelid speculum
- Iodine
- Patient to look away from injection site
- Mark with calipers from limbus:
  - 3-3.5mm aphakic or pseudophakic;
  - 3.5-4mm phakic
- Insert needle tip aimed to centre of globe
- Inject slowly
- Cotton-bud to site to prevent reflux
- Check VA CF or HM – if not, check central retinal artery
  - do AC paracentesis within 3-5mins, then if VA returning but IOP high give iv diamox

Intravitreal anti-VEGF

• Post-injection
  – Not mandatory to check on slit lamp or IOP
  – Routine post-injection antibiotics not recommended as no evidence of reduced endophthalmitis – can be used at discretion of clinician
  – Clear instructions on what to expect and telephone number for advice

Follow up

• Ranibizumab or aflibercept
  – give three ‘loading’ monthly injections
• Then continue
  – ranibizumab 4 weekly (or aflibercept 8 weekly) if:
    – Persistent evidence of lesion activity
    – Lesion continues to respond to treatment
    – No contraindications to continuing treatment

• (NB can try switching antiVEGF agents)

Follow up

• Stop treatment if:
  – No disease activity (no leakage on FFA, no new haem even if persistent fluid on OCT)
  – No evidence further worsening on OCT once Tx stopped
  – No deterioration in VA attributable to CNV
  – Adverse events: endophthalmitis, RD, uncontrolled uveitis MI/CVA in 3m or hospitalisation
  – VA reduced by 30 letters from baseline – indicates poor prognosis

Extrafoveal CNV

- Can treat with laser, but if large, treat as subfoveal with anti-VEGF

Who can administer intravitreals?

• Non-medical healthcare professionals (HCP) may administer if stipulations are met
  – Pt remains under named consultant
  – HCP fully trained in rationale, effects and complications of treatment
  – HCP fully trained in technique
  – Has immediate access to ophthalmic specialist doctor
  – Continuous audit of injection service provided by HCP with regular pt feedback
  – Hospital Trust management support initiative and appropriate indemnity in place
  – Consent
  – Training of ophthalmic doctors not compromised

Dry AMD Guidelines

• Smoking cessation: 2-3x risk

• Balanced healthy diet

• AREDS2

• Counselling

• Visual rehabilitation

Diabetic Retinopathy (DR)
DR screening referral to HES

- R0 – annual screen
- R1 - annual screen
- R2 - 13 week referral
- R3 (PDR) – 2 week referral
- M0 - (no lesion within 1dd, VA better than 6/12 and no exudates within 1dd) – annual screen
- M1 - (exudates within 1dd, circinate within macula, microaneurysm within 1dd and VA<6/12) – 13 week referral

Pregnancy and DR

- Pregnant women with known DM should be offered retinal assessment (digital imaging) following first antenatal clinic
- If no DR again at 28 weeks
- If DR then again at 16-20 weeks
- If pre-proliferative DR during pregnancy, need ophthalmological FU for at least 6m post partum
- Use tropicamide alone for dilating
Ranibizumab for DMO

• DMO with central retinal thickness (CRT) >400 microns (RESTORE)

• Monthly and continued until maximum VA reached – VA stable for 3 consecutive months

• Then monitor monthly – retreatment if VA loss from DMO

Afiblerecept for DMO (NICE)

- DMO with CRT>400micrometers (VIVID and VISTA vs laser)
  - Afiblerecept 2mg intravitreal injection every month for 5 consecutive months
- Then 1 injection every 2m with no requirement for monitoring between visits
- After first 12m, treatment interval can be extended based on visual and anatomic outcomes
- Discontinue if patient not benefiting

Ozurdex (dex implant) for DMO

• Option for DMO (MEAD trials) if:
  – Pseudophakic
  – DMO not responsive to non-corticosteroid or if alternatives unsuitable
Iluvien (fluocinolone) implant for DMO

• Chronic DMO
  – (FAME A and FAME B) if:
  – Pseudophakic and
  – DMO not responsive to non-corticosteroid or if alternatives unsuitable
CVI Registration

Registration as sight impaired

• VA 3/60 – 6/60 with normal VF

• VA 6/60 – 6/24 with moderate contraction VF, media opacities or aphakia

• VA 6/18 or better with severe VF loss (eg hemianopia, retinitis pigmentosa)

Registration as severely sight impaired

• VA $\leq 3/60$ – 6/60 with very contracted VF

• VA 6/60 or better with very contracted VF

• homonymous or bitemporal hemianopia *excluded*
  – unless VA $< 6/18$

Driving Standards
Driving Standards


• https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive

• Oxford Handbook of Ophthalmology summary
Driving Standards

Visual Acuity Criteria

– Group 1 drivers (car and light vehicles)
  • Read pre 2001 number plate at 20.5m or post 2001 number plate at 20m, and
  • BCVA at least 6>12 with BEO

– Group 2 drivers (LGV and PCV)
  • As for group 1 AND
  • At least 6/7.5 in better eye, AND
  • At least 6/60 in worse eye, AND
  • Glasses \( \leq 8 \)D

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
Driving Standards

- VF
  - Humphrey analyser; Esterman program (binocular)
  - Goldmann VF in exceptional circumstances
  - Max false positives permitted: 20%

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
Driving Standards

- VF
  - Group 1 drivers
    - At least 120 degrees on horizontal (target equivalent to Goldmann III4e setting)
    - with extension of at least 50 degrees left and right, and 20 degrees up and down
    - No defect in binocular field encroaching within radius of the central 20 degrees

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
Driving Standards

• VF
  – Group 2 drivers
    • Horizontal VF at least 160 degrees with extension 70 degrees left and right and 30 degrees up and down, and
    • No defects in central 30 degrees

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
Driving Standards

• Monocularity
  – Group 1 only if adapted to disability, with usual VA requirements and normal monocular VF

• Diplopia
  – Cannot drive with diplopia
  – Can patch one eye if meet criteria for monocularity
  – If stable diplopia >6m DVLA may permit

• Blepharospasm
  – If severe cannot drive
  – If mild, treated, can drive with consultant approval

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
Driving standards

• Diabetes

• Insulin treated
  – Group 1
    • Must meet criteria and notify DVLA
  – Group 2
    • Must meet criteria and notify DVLA
      – criteria include full awareness of hypoglycaemia, no episode of severe hypoglycaemia in the preceding 12 months

• If visual complications
  – Group 1
    • May need to stop driving and notify the DVLA
  – Group 2
    • Must not drive and must notify the DVLA

https://www.gov.uk/guidance/visual-disorders-assessing-fitness-to-drive
RCOphth guidance: Cataract surgery

Based on the 95% distribution biometric measurements should be repeated if:

• Axial length is <21.20 mm or >26.60 mm

• Mean corneal power is <41D or >47D

• Delta K is >2.5D

• Difference in axial length between fellow eyes of >0.7mm

• Difference in mean corneal power of >0.9 dioptres
WHO Checklist

• IMPORTANT


RCOphth guidance: Cataract surgery

Should be able to achieve a refractive outcome within

± 1D

of the ‘target’ in

85% of cases

Endophthalmitis

RCOphth current guidance:

- If local rates of endophthalmitis over a properly audited time frame are similar to those reported in the Bolton study (0.055%), then continuing with whatever preventative/prophylactic measures are in place would seem reasonable.

- If local rates are higher than those reported in the Bolton study then intracameral cefuroxime may be added as part of a package of measures to lower endophthalmitis rates after a suitable analysis of processes has taken place.

Endophthalmitis:

Important to know 2016 guidelines on prevention and read flowchart about dealing with cluster of endophthalmitis:

Corneal transplantation

Eye banks in UK

• CTS eye bank Bristol
• CTS eye bank Manchester
• Queen Victoria Hospital, East Grinstead
• Moorfields Eye Hospital, London

Consent for transplantation

• If person expressed wish to be or not be eye donor (e.g., National Organ Donor Register or in will), cannot be overridden by relatives unless exceptional circumstances.

• If no prior consent, consent given by person in qualifying relationship as defined in Human Tissue Act 2004 (or HT(Scotland)A 2006).

• If death referred to coroner, permission must also be obtained.

Consent for research and training

• Separate consent for this and relatives should always be asked about these additional uses of tissue

• If tissue not going to be used, relatives should be informed that tissue will be disposed of in lawful manner
Consent for blood sample/testing

• Consent should be taken for sample of donor’s blood to test for viral and microbiological markers of transmissible disease
• Relatives should be informed of any positive results that may have implications for our health

Consent for seeking further info

• Relatives asked for permission to seek info regarding donor’s medical history and behavioural background from medical records, GP, other health care professionals
Timing

• Enucleation should be carried out ASAP after death but within 24hrs
• Statutory requirement of Quality and Safety Regulations that blood sample taken within 24hrs of death

Contraindications to ocular tissue transplantation

• Infections
  – HIV/AIDS
  – Viral Hepatitis (A, B, C)
  – HTLC
  – Seropositivity: anti-HIV, HBsAg, anti-HBc, anit-HCV, anti-HTLV, syphilis
  – Behavior leading to risk of HIV, hepatitis, HTLV
  – Tattoos and body piercing within 4m death
  – Acupuncture within 4m death
  – Imprisonment within 12m death
  – Bleeding disorder treated with blood derived coagulation concentrates
  – Viral encephalitis or encephalitis unknown origin, viral meningitis
  – Rabies
  – Congenital rubella
  – TB
  – Reyes
  – PMLE
  – septicaemia

Contraindications

• Previous surgery/medical treatments
  – Immunosuppression
  – Receipt of organ transplant
  – Receipt of dura mater or brain/spinal surgery pre Aug 1992
  – Receipt human pituitary hormones
  – Receipt cornea, sclera or other human tissue allograft

Contraindications

• Unknown aetiology and CNS disorders
  – Death from unknown cause
  – CJD and CNS diseases of unknown aetiology (eg Alzheimer’s, other dementias, Parkinson’s, MS, MND)

• Malignancies
  – Leukaemia, lymphoma, myeloma, polycythaemia, sideroblastic anaemia, myelodysplastic syndrome
Contraindications

• Eye diseases
  – Active ocular inflammation/uveitis
  – Any congenital or acquired disorders of eye, or previous ocular surgery (inc corneal laser surgery)
  – Retinoblastoma
  – Malignant tumours of anterior segment
Local Anaesthesia in Ophthalmic Surgery

• Adapted from
  – Joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists

Joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists:
Local Anaesthesia in Ophthalmic Surgery

• Local orbital blocks should be administered by a trained anaesthetist or ophthalmologist.

• Appropriately trained, indemnified and professionally regulated* non-medical staff may administer topical, subconjunctival or sub-Tenon’s blocks in some cases.

Joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists:
Local Anaesthesia in Ophthalmic Surgery

• Intravenous sedation
  – Administer only under the direct supervision of an anaesthetist, whose sole responsibility is to that list.

• Without sedation
  – An anaesthetist is not essential for topical, subconjunctival or sub-Tenon’s anaesthesia

Joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists:
Abusive Head Trauma and the Eye in Infancy

See:


See summary document in:

- http://www.londoneyecourse.com/exam-resources.html

*Very common and important exam topic. Learn well.*