



**REGULATIONS AND SYLLABUS RELATING TO
THE DIPLOMA IN
MUSCULOSKELETAL MEDICINE**

EXAMINERS:

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THE DIPLOMA IN MUSCULOSKELETAL MEDICINE

The Diploma in Musculoskeletal Medicine was originally instituted by the Society of Apothecaries of London in 1992 and is now run by the British Institute of Musculoskeletal Medicine. It is open to medically qualified candidates who have made a special study of the non-surgical treatment of musculoskeletal disorders.

It is the intention of the Examinations Board that this qualification will indicate that a practitioner is able to manage independently patients with common musculoskeletal problems in a primary or secondary care setting.

DATE AND PLACE OF THE EXAMINATION

The Examination is held at St. Georges Hospital, London on Monday 12th (written) and Thursday April 22nd (clinical) 2010

REGULATIONS

FOR ADMISSION TO THE EXAMINATION FOR THE DIPLOMA IN MUSCULOSKELETAL MEDICINE

The examination is open to any doctor :

- currently registered with the UK General Medical Council and holding a licence to practice.
 - who has completed a Foundation programme or an equivalent period of general professional training
 - who has an active interest in, and involvement with, musculoskeletal medicine
1. Medical graduates who have qualified outside the United Kingdom (UK) who are not registered with the General Medical Council in the UK, but who are registered with an equivalent national medical council, may be admitted to the examination with the approval of the Court of Examiners.

Given the variety of routes by which experience and skill in musculo-skletal medicine can be obtained candidates are not required to have completed specific types or periods of training.

Candidates should however be aware that to pass the exam they will need to demonstrate:

- A broad knowledge of all aspects of musculoskeletal medicine as detailed in the published syllabus
- Skill and fluency in clinical examination of the musculoskeletal system..
- Experience and judgement in the diagnosis and management of a range of musculoskeletal problems

It is considered very unlikely that a candidate would reach the necessary standard or produce an acceptable case-book unless they had undertaken a significant period of supervised practice and / or advanced post-graduate training such as the BIMM modular course.

If in doubt as to the eligibility of your post-graduate training or the suitability of your experience the exam Convenor will advise. Please contact the exams administrator.

4. The examination will consist of

- **Case studies:** Six case studies and a 30 minute Oral case-based discussion.
- **Written examination:** a 2-hour paper to include a combination of Single Best Answer, Extended Matching Item and Short Answer Questions;
- **Clinical examination:** a ten-station Objective Structured Clinical Examination (OSCE),

An overall pass grade must be achieved in each section. Some compensation is permitted within each section as detailed below but there will be no compensation between sections of the exam.

If a single section is failed the whole exam must be retaken but the case studies may be reused for one further attempt.

Case studies. Candidates are required to submit six detailed case studies of patients seen personally in the previous two years. The cases should consist of:

- 2 relating to spinal problems
- 2 relating to upper limb problems
- 2 relating to lower limb problems

They should be spread across the following categories with no more than two cases from any one group:

- Inflammatory disease
- Degenerative disease
- Dysfunction and biomechanical problems
- Acute trauma
- Sports related problems
- Occupational health issues and ergonomics
- Chronic pain

Three of the cases will be selected for a structured case-base discussion constituting the Oral examination.

Each case should include details of presentation, diagnosis, treatment and outcome, followed by a discussion section. The discussion should provide a critical appraisal of the diagnostic and management decisions taken with appropriate references. Each case study should be between 750 and 2000 words. Two copies should be submitted in typescript, and an electronic copy on disk should accompany the hard copy. The anonymity of patients must be strictly preserved and candidates must include a written declaration that the cases are their own work.

The pass grade will be determined in advance using recognised standard setting techniques. Compensation is allowed between cases but an overall pass grade must be achieved.

Written examination:

This will consist of

- 20 x Single Best Answer (SBA)
- 8 x Extended Matching Items (EMI)
- 5 x Short Answer Questions (SAQ)

The pass standard is criterion based and determined in advance by the exam board using recognised standard setting techniques.

Clinical Examination (OSCE)

This will consist of ten stations, falling into four groups:

1. 2 stations requiring examination of an area of the spine
2. 2 stations dealing with communication with the patient
3. 3 stations dealing with peripheral joint examination
4. 3 broadly rheumatological stations:
 - a. 1 station dealing with a neurological aspect of a musculoskeletal problem
 - b. 1 station dealing with a rheumatoid/inflammatory aspect of a musculoskeletal problem
 - c. 1 station dealing with the practical accomplishment of injection technique on mechanical model

Stations will be graded Clear Fail / Borderline Fail / Borderline Pass and Clear Pass. No more than two Clear Fails will be allowed and these may not be within the same group. Up to two borderline fails may be compensated by Clear Passes in a different group. Other stations must be at least Borderline passes.

5. Details of examination and other dates and the fees are published in the Guidance for candidates. Forms A and B and the casebook, or Form R for re-entry, and the fee must be received by the published closing date.
6. Candidates who present themselves for written examinations after the start time stated in the admission document will be admitted if they arrive within 30 minutes of this time, but may not be admitted if they arrive thereafter. In any case, candidates will forfeit the time lost. In exceptional circumstances, where all candidates are affected by delays, the examination timings may be amended.

7. Successful candidates are entitled to use the letters D M-S Med after their names.
8. The examination fee will be determined from time to time by the Examining Board and published in the **Guidance for Candidates**. Candidates who withdraw from the examination after the closing date will forfeit 50% of the fee.
9. On the day of the written examination, candidates are forbidden to bring books, papers, calculators, mobile telephones or any other electronic aid into the examination rooms. It is strictly forbidden for candidates to talk to, or to attempt in any other way to communicate with each other whilst a written examination is in progress.
10. The Examining Board reserves the right to refuse to admit to the examination, or to proceed with the examination of, any candidate who infringes a regulation or who refuses to comply with the reasonable request of an officer of the Institute.
11. Candidates' completed examination scripts become the property of, and will be retained by, the Examining Board. Under no circumstances will they be available for study.
12. **Review and Appeal Procedures.** The stages of the review and appeal procedures are as follows:
 - a. Feedback – first, compulsory stage;
 - b. Re-mark – second, optional stage;
 - c. Appeal – third, optional stage.
14. **Feedback (compulsory).** Feedback on examination performance will be available to unsuccessful candidates at their request. Requests must be made in writing and be received by the Administrator within 28 days of the receipt of results.
15. **Re-mark (optional).** A request by a candidate for a re-mark of a paper must be received in writing within 28 days of the receipt of feedback. A request for a re-mark cannot be made without first going through the feedback stage. There is a fee of £150 for a re-mark.
16. **Appeal (optional).** An appeal to the Institute's Examinations Board is open to a candidate who is not satisfied with the decision of the Examination Panel, feedback or the Re-mark Panel. The appeal must be received in writing within 28 days of the candidate being notified of the feedback or re-marking report. It is not necessary to seek a re-mark before appealing. There is a fee of £150 for an appeal.
17. If the appellant is dissatisfied with the report of the Examinations Board Appeal Tribunal and wishes to make an appeal, this should be communicated to the Convenor within 28 days of the receipt of the decision of the Appeal Tribunal.
18. The processes outlined in paragraphs 13-17 will be dealt with according to the Review and Appeal Procedures agreed by the Examining Board, which is available to candidates on request. In no circumstances should a candidate make representations directly to an examiner.
19. Candidates will be expected to know:
 - i. Structure and function of cartilage, synovium, joint capsule, menisci, ligaments and intervertebral discs; pathology and repair processes.
 - ii. Structure and function of muscle, tendon, enthesis; control of posture, proprioception and muscular activity; pathology and repair processes.
 - iii. Structure and function of bone, control of bone growth and mass and its disorders (osteoporosis, osteomalacia and Paget's disease); pathology and repair processes.

- iv. Structure and function of peripheral nerves, nerve roots, the dorsal horn, spinal pathways and the autonomic nervous system; response to injury of nerve roots and peripheral nerves and their repair processes; referred pain.
- v. Musculoskeletal functional anatomy.

Sufficient knowledge of spinal and regional disorders, diagnosis and management to work at an ‘advanced’* primary care level:

- vi. Principles of diagnosis, history taking, physical examination (including segmental examination of spine), use of investigations and imaging.
- vii. Aetiology and pathology of osteoarthritis, inflammatory arthritis, seronegative arthropathies and the common connective tissue diseases, crystal arthropathy, diagnosis and management at an ‘advanced’ * primary care level.
- viii. Neurophysiology of acute and chronic pain mechanisms; measurement of pain, disability and assessment of illness behaviour in the context of the biopsychosocial model.
- ix. ‘Red flag’ conditions (serious pathology) and musculoskeletal emergencies to be able to take appropriate action in management and referral.
- x. All candidates should meet the generic GPSI competencies (see 12 key competencies at <http://rheumatology.oxfordjournals.org/cgi/content/full/ke1357/DC1>)

20. * The following syllabus serves as a guide to the depth and breadth of knowledge, skills and attitudes expected of a candidate. This should be read in conjunction with the tables of competencies expected of a General Practitioner with Special Interest in Musculoskeletal Medicine working in a variety of primary, intermediate or secondary care based settings.

(see: <http://rheumatology.oxfordjournals.org/cgi/content/full/ke1357/DC1>)

- a. **Spine:** Functional anatomy of cervical spine, thoracic spine, lumbar spine, pelvis and sacroiliac joints, associated bones, joints and discs, associated muscles and soft tissues; nerve root entrapment; imaging of the spine; X rays, CT, MRI, radioisotope scans, discography. Segmental dysfunction; disc degeneration and prolapse; osteoarthritis; facet joint pathology and dysfunction; Sacroiliac joint dysfunction; spinal stenosis; spondylolysis and spondylolisthesis; Ankylosing spondylitis; Osteoporosis; Paget's disease.

b. Upper limb:

Shoulder - clinical anatomy and biomechanics, acromioclavicular joint pathology, glenohumeral capsulitis, bursitis, tendinopathy, rotator cuff tears, impingement and instability, osteoarthritis, brachial plexus lesions, thoracic outlet syndromes;

Elbow - clinical anatomy and biomechanics, arthritis, muscle and tendon lesions, ulnar nerve lesions, forearm soft tissue pathology;

Wrist - clinical anatomy and biomechanics, carpal joint injury and instability, arthritis, muscle and tendon lesions, carpal tunnel syndrome, ulnar nerve compression;

Hand - clinical anatomy and biomechanics, soft tissue pathology, arthritis, nerve compression manifestations, tenosynovitis, Dupuytren's, trigger finger and manifestation of arthritides.

c. **Lower limb**

Hip - clinical anatomy and biomechanics, arthritis, muscle and tendon lesions, bursitis, femoro acetabular impingement, differential diagnosis of groin pain;

Knee - clinical anatomy and biomechanics, osteochondral lesions and arthritis, patellofemoral syndromes, internal derangement, ligament injuries and instability, muscle and tendon lesions, bursitis;

Ankle and lower leg - clinical anatomy and biomechanics, stress fractures, osteochondral injuries, ligament injuries and instability, muscle and tendon lesions, compartment and overuse syndromes, nerve entrapment;

Foot - clinical anatomy and biomechanics, postural/structural foot disorders, stress fractures, arthritis, plantar fasciitis, Morton's neuroma, muscle and tendon lesions.

21. Candidates will be expected to have a sufficient knowledge of **Specific Treatment Methods and their evidence base, to enable them to make informed choices in management and make appropriate referrals:**

- i. **Manual therapy:** Principles and schools of thought; Relative importance of motor control, joint and muscle dysfunction; indications and contraindications for mobilisation and manipulation; soft tissue treatments.
- ii. **Injection therapy:** Theory of musculoskeletal injection; Steroids - effects and hazards; **all** candidates should be able to **perform** the full range of joint and soft tissue injection and **know** the indications and hazards of epidural steroid, nerve root, and facet joint injections;
- iii. **Use of dry needling** and Acupuncture; Transcutaneous nerve stimulation.
- iv. **Physiotherapy:** Electrotherapy; Hydrotherapy; mobilisation, Massage and specific and general exercise therapy.
- v. **Occupational therapy:**
- vi. **Rehabilitation:** general principles and specific types of programmes for musculoskeletal pain and disability including psychological aspects; Principles of returning the injured to work, place of occupational health, family and society.
- vii. **Orthopaedic surgery:** Indications for spinal surgery and arthroscopy; Indications for joint replacement, late complications; Principles of fracture management.
- viii. **Orthotics:** Principles of orthotic prescribing; Podiatry, chiropody.
- ix. **Drug therapy:** Analgesics; NSAIDs; Corticosteroids; Centrally acting pain modulating drugs; Drugs for specific disorders e.g. gout; Disease modifying antirheumatic drugs (DMARDs) for Inflammatory arthritis.
- x. **Assessment:** Clinical audit, Outcome measures.

22. Candidates will be expected to have a detailed knowledge of **Practical Therapy by Region, Condition and Structure:**

- a. Examination of the musculoskeletal system (including manual diagnosis of segmental dysfunction of the spine);
- b. Injection treatments;
- c. Other treatment methods (as above)

Table 1: Supplementary tables of competencies: for Spinal Disorders (neck, thoracic, lumbar pain)

NB: Figures after items refer to the list of learning objectives of the BIMM Modular Course. E.g. 1 = module number

Condition	Knowledge	Skills
<p>All spinal conditions</p>	<p>The structure of the spine, and its muscle, fascia and ligamentous support. 2(ii); 3(viii); 4(ii).</p> <p>The structure of the spinal cord and nerves including the peripheral autonomic system. The physiological and biomechanical bases on which the axial skeleton functions. 2(vii).</p> <p>Awareness of neuromuscular functions of motor and proprioceptive control. 1(iii); 2(iv)</p> <p>Neurophysiology of acute and chronic pain, types of pain, and their clinical manifestations. 1(i).</p> <p>The biopsychosocial model and its relevance to spinal pain disorders. 1(ii); 1(iv).</p> <p>To know the indications and contraindications, advantages and disadvantages of imaging and other investigations. 3(v).</p> <p>Management – drug and non-drug options including recent evidence. 1(vi); 2(i); 2(vii); 3(iii); 3(iv); 3(xi); 3(xii); 4(ii); 4(vi).</p>	<p>History and physical examination, including assessment of posture, gait and movement patterns, segmental dysfunction. 1(ii); 1(iv); 1(v); 1(vi); 1(vii); 3(viii); 2(v); 2(vii); 3(xii); 4(ii).</p> <p>To recognise, quantify and manage adverse factors in cognition, affect, behaviour and interpersonal and societal maladaptation. 1(ii);</p> <p>To communicate effectively securing concordance in treatment plans to modify these (pain management techniques). Referral as appropriate. 1(vi); 1(vii); 2(vii); 3(xi); 4(iii).</p> <p>Appropriate referral for X-Ray and MRI scan and ability to interpret the report. 3(v)</p> <p>Ability to request appropriate blood tests and interpret the results. 3(ii).</p> <p>Appropriate use of analgesics and adjuvant agents. 3(iii).</p> <p>Appropriate referral within and without the NHS. 3(ix).</p>

Red flag conditions	Clinical features of: Infection of bone or disc space. 1(v); 3(ii); 3(iii) Tumour - primary and secondary. 1(v). Trauma 1(v) Cauda equina syndrome 2(iii).	How to diagnose and arrange appropriate urgent referral to secondary care. 3(ix); 4(iii).
Other important diagnoses	Clinical features of: Osteoporotic fracture 3(iv) Inflammatory spinal disorders 3(iii)	Appropriate investigation and referral (e.g. complex osteoporosis) 3(ii).
Lumbar and disc prolapse	Clinical features, natural history. 2(iii); 3(viii). Epidemiology 2(iii); Knowledge of treatments available. 2(i); 4(v); 4(vi).	Assessment. 1(iv); 1(v). Initial investigation Principles of conservative treatment, 2(iii). Appropriate referral for surgery or pain management or further investigation. 3(xi).
Degenerative disc disease, osteoarthritis, spondylosis, non-specific back pain i.e. spinal somatic dysfunction, sacroiliac dysfunction and facet syndrome	Clinical features including significance of potential red flag symptoms (e.g. thoracic pain) 1(iv); 1(v); 1(vi). Natural history, epidemiology; relevance (or lack of) to clinical presentations 2(ii); 2(iii); 2(iv). Treatments available. 2(i).	Managing these patients with reassurance and advice recognising fears, misconceptions harmful health beliefs, counselling using basic cognitive behavioural approaches. 1(viii); Assessment and appropriate use and interpretation of imaging. 3(v) Management strategies - appropriate use of medication, providing and/or referring for exercise and education. 1(vii); 2(vii) Knowing when to refer for a surgical opinion or multidisciplinary pain management. 3(xi).
Spondylolysis and spondylolisthesis	Types, causes, relevance at different ages 2(iii). Know significance in relation to sport participation. Understanding of fears, expectations, role of parents and sports coach in dynamics of presentation	Investigation and management, knowing when to refer. Ability to counsel re sports participation

Table 2: The Lower Limb – competency framework

Condition	Knowledge	Skills
<p>All lower limb conditions</p>	<p>The range of conditions that can give rise to lower limb problems at different ages and being able to differentiate between them. 6 (iv)</p> <p>Natural history and epidemiology.</p> <p>Red flags (e.g. malignancy/ infection/trauma/inflammation) 6 (iv)</p> <p>The role of allied health professionals/complementary medicine/podiatry and when to refer. 6 (v&vi).</p> <p>An awareness of the impact of their condition on their lives. 1 (ii&iv).</p> <p>Risk factors for lower limb disorders e.g. the patient's occupation, hypermobility. 6 (i)</p> <p>Management – drug and non- drug:</p> <ul style="list-style-type: none"> - Drug treatment e.g. analgesia. - Non-drug treatment including simple exercises. - Injections (see specific joints). - Manipulation. - Complementary therapies. - Recent evidence 6 (iv,v,vi) 	<p>Problem orientated approach</p> <ul style="list-style-type: none"> - History and detailed examination. 1 (iv,v,vi) <p>Investigation Skills</p> <ul style="list-style-type: none"> - Radiology: Understanding the role, referring appropriately (as per Royal College of Radiologists guidelines) and being able to interpret the report. (X-ray/ultrasound/MRI/bone scans) - Blood tests – ability to request appropriate blood tests and interpret the results. (Haematology/Biochemistry/Immunology (RhF only)/ESR/CRP) <p>Early referral for inflammatory arthritis.</p> <p>Injection Techniques</p> <ul style="list-style-type: none"> - See hip/knee/ankle/foot 6 (iv) <p>Appropriate Referral 6 (ii,iii,vi)</p> <ul style="list-style-type: none"> - within and without the NHS - urgent or emergency referral - knowing what services are available to help and how to access (e.g. benefits, occupational health, aids and appliances, orthotics) 8 (iii,iv,v)
<p>Hip</p>	<p>A knowledge of the anatomy of the hip joint and the surrounding area.</p> <p>A knowledge of the range of conditions that can give rise to pain in the hip at different ages and being able to differentiate between them. 6(iv)</p> <p>A knowledge of the clinical features and course of:</p> <p>Osteoarthritis of the hip</p> <p>Referred pain (e.g. from back, or to knee)</p> <p>Soft tissue disorders – trochanteric pain</p> <p>Biomechanical hip pain – e.g. leg length inequality, foot problems</p> <p>Polymyalgia</p> <p>Septic arthritis</p> <p>Inflammatory arthritis of the hip</p> <p>Crystal arthropathies – e.g. gout</p> <p>Myofascial and soft tissue disorders</p> <p>Hypermobility</p> <p>3 (iii)</p> <p>A knowledge of the role of allied health professionals/ complementary medicine and</p>	<p>Appropriate examination to allow differentiation between true hip pain/referred pain from the back/referred pain to the knee. Also to be able to identify local myofascial and soft tissue disorders. 6 (iv) 1 (v).</p> <p>Referring appropriately for surgery and being able to co-ordinate the non-surgical management of OA hip. 6 (vi)</p> <p>Therapeutic Skills:</p> <ul style="list-style-type: none"> - Analgesia - Inject soft tissue disorders (trochanteric pain) 6 (iv) 3 (vii)

	when to refer. 6 (vi), 8 (v). A knowledge of the role of manual therapy relating to the hip. 6 (iv)	
Knee	<p>A knowledge of the anatomy of the knee joint and the surrounding area.</p> <p>A knowledge of the range of conditions that can give rise to pain in the knee and being able to differentiate between them. 6 (iv)</p> <p>A knowledge of the clinical features and course of: Pain from other sources e.g. hip and spine; Anterior knee pain and biomechanical factors; Osteoarthritis of the knee; Inflammatory arthritis; Crystal arthropathies e.g. gout/pseudogout; Internal derangements; Bursae – anserine, pre-patella; Hypermobility; Soft tissue strains and sprains; Tendinopathy/myopathy 3 (i,iii) Septic arthritis.</p>	<p>Therapeutic Skills: Analgesia 6 (iv) 3 (vii) Injection techniques – knee joint, anserine bursa, collateral ligaments.</p> <p>Referring appropriately for surgery/physio and for further investigation. Being able to co-ordinate the non-surgical management of OA knee. 6 (vi) Early referral for possible inflammatory arthritis.</p>
Foot and ankle	<p>A knowledge of the anatomy of the foot and ankle and its variations e.g. high arch/flat feet (dynamic-static-rigid). 6 (v)</p> <p>A knowledge of the range of conditions that can give rise to pain in the foot and ankle and being able to differentiate between them. 6 (iv) Osteoarthritis Biomechanical Hypermobility Soft tissue strains and sprains Tendinopathy/myopathy Plantar fasciitis Tarsal Tunnel Syndrome Hallux valgus/rigidus Intermetatarsal neuroma/bursa Tibialis posterior tendon dysfunction. 3(I,iii) Septic Arthritis Inflammatory arthritis Crystal Arthropathies – e.g. gout</p>	<p>Appropriate examination skills leading to differential diagnosis and assessment of function.</p> <p>Recognition of red flags for onward referral. Early referral of possible inflammatory arthritis</p> <p>Appropriate use of simple / shock absorbing appliances and advice on suitable footwear 6 (i)</p> <p>Appropriate referral to podiatrist, orthotist, orthopaedics, rheumatology 6 (vi).</p> <p>Appropriate use of steroid injection in plantar fasciitis 6 (ii,iv).</p>

Table 3: Upper Limb Disorders – Competency framework

Condition	Knowledge	Skills
All upper limb conditions	<p>Functional anatomy including joints, ligaments, muscles, nerve supply.</p> <p>Range of conditions that can give rise to upper limb problems.</p> <p>Red flags: malignancy, infection, trauma, infection 5 (ii,iii,iv).</p> <p>Presenting features of inflammatory arthritis 3 (ii,iii)</p> <p>Prognosis and epidemiology 5 (i)</p> <p>Impact of upper-limb conditions on peoples' lives 1 (ii)</p> <p>Role of allied health professionals</p> <p>Management options (drug and non-drug) including recent evidence</p> <p>Knowledge of other resources 5 (vi) 8 (v) (ARC, Arthritis care etc)</p>	<p>Problem orientated approach – history and examination 1 (iv,v)</p> <p>Investigations:</p> <p>Investigation Skills</p> <p>Radiology: Understanding the role, referring appropriately (as per Royal College of Radiologists guidelines) and being able to interpret the report. (X-ray/ultrasound/MRI/bone scans) 3 (v)</p> <p>Blood tests – ability to request appropriate blood tests and interpret the results. 3 (ii) (Haematology/Biochemistry/Immunology (RhF only)/ESR/CRP)</p> <p>Early referral for inflammatory arthritis.</p>
Shoulder	<p>Clinical features of articular and periarticular problems. 3 (iii) 5 (i-v)</p> <p>Red flags,(referred pain, bony pain, septic arthritis, polymyalgia, angina)</p> <p>Indications and contraindications for injections 3 (iii) 5 (i-v)</p>	<p>Ability to make a differential diagnosis 5 (ii-v)</p> <p>Assess function and disability 1 (v,vi)</p> <p>Injection skills: acromioclavicular joint, sub-acromial space, glenohumeral joint. 5 (ii)</p> <p>Ability to explain and educate regarding self-help.</p>
Elbow and forearm	<p>Recognising capsular and periarticular soft tissue problems</p> <p>Functional anatomy and pathophysiology (including work-related upper limb disorder and hypermobility) 5 (i-v)</p> <p>Awareness of orthotics etc (epicondylitis splint) 5 (vi)</p>	<p>Ability to make a differential diagnosis 5 (iii)</p> <p>Injection of medial and lateral epicondyle. Aspirate olecranon bursa and joint 5 (iii)</p> <p>Recognising precipitating cause and adjusting activity.</p> <p>Ergonomic advice 5 (i)</p>
Wrist	<p>Carpal Tunnel: Investigation, awareness of associated conditions (Thyroid) 3 (v,vi) 5 (iv)</p> <p>Appropriate use of investigations including radiology ultrasound and electrophysiology. 3 (v,vi)</p> <p>Awareness of notifiable work related conditions (WRULD/RSI) 5 (i)</p>	<p>Ability to make a differential diagnosis 5 (iv)</p> <p>Injection – Carpal tunnel and wrist joint. De quervains. 5 (iv)</p>
Hand	<p>Pattern of joint involvement in inflammatory conditions 3 (iii)</p> <p>Recognition of evidence of neurological deficit (e.g. thenar wasting) 1 (v)</p> <p>Awareness of e.g. Dupuytrens 5 (iv)</p>	<p>Ability to make a differential diagnosis 5 (iv)</p> <p>Early recognition and referral for inflammatory arthritis</p> <p>Inject trigger fingers/thumb, CMC joint, flexor tenosynovitis.</p> <p>Aspirate ganglions 5 (iv)</p>

Table 4: Chronic Widespread Musculoskeletal Pain (fibromyalgia syndrome) – competency framework

Condition	Knowledge	Skills
Chronic widespread pain	<p>Understands bio-psychosocial aspects of pain perception. 1 (ii)</p> <p>Pain pathways 1 (i)</p> <p>Understands the ACR 1990 criteria for the diagnosis of fibromyalgia syndrome and its limitations</p> <p>WHO analgesic ladder in relation to non cancer pain and pharmacology of drugs commonly used in pain relief 7 (iv)</p> <p>Understands the chronic pain/deconditioning cycle 7 (i,ii)</p> <p>Knows the evidence for treatment interventions antidepressants exercise programmes CBT 7 (iii,vi)</p> <p>Local knowledge of voluntary sector resources, self management programmes and health service professional networks for referral 7 (iii)</p>	<p>Higher level communication skills 7 (vi)</p> <p>Educational and motivational skills for patients and Primary Health Care Teams 1 (vi,vii,viii)</p> <p>Diagnostic skills to recognise this syndrome as distinct from arthritis or connective tissue disorder (or concomitantly) 3 (iii)</p> <p>Diagnostic skills to recognise specific cognitive factors and peripheral pain generators which may drive the condition 1 (v,vi)</p> <p>Utilises the team approach and patient self management skills to best effect 8 (v,vi)</p>

Table 5: Rheumatic diseases – competency framework

Condition	Knowledge	Skills
Crystal arthropathy	<p>Recognise characteristics of crystal arthropathy 3 (ii,iii)</p> <p>Awareness of associated morbidity (hypertension, hyperlipidaemia, diabetes etc)</p> <p>Identify predisposing factors (medication etc)</p> <p>Knowledge of treatment of acute phase and prevention</p>	<p>Ability to diagnose</p> <p>Interpret blood tests and x rays (inc chondrocalcinosis)</p> <p>Aspirate and inject large joints (issues re analysis of aspirate) 3 (ii,vii)</p> <p>Ability to educate patients appropriately</p>
Polymyalgia rheumatica	<p>Recognise characteristics of typical and atypical presentations and differentials (e.g. myeloma, polymyositis, TA, early rheumatoid) 3 (iii)</p> <p>Awareness of need for appropriate steroid therapy 3 (iii)</p> <p>Awareness of adverse effects of therapy</p> <p>Awareness of current best practice</p>	<p>Assessment using history and examination</p> <p>Education of patient re long term steroid use</p> <p>Appropriate use of bone protection and drug monitoring</p> <p>Appropriate referral to secondary care</p>

BRITISH INSTITUTE OF MUSCULOSKELETAL MEDICINE

DIPLOMA IN MUSCULOSKELETAL MEDICINE

APPLICATION FOR ADMISSION
TO THE EXAMINATION

Date _____ Title _____

Surname _____ Forenames _____

Address _____

Post code _____

Telephone (home) _____ Telephone (mobile) _____

Email _____

Qualifications and dates _____

Qualifications and dates _____

Date of Registration/professional body _____

GMC registration number ** _____

Current appointment _____ Courses attended (and dates) _____

Approved on behalf of the Examining Board

Date _____ Registrar

*This application must be forwarded to the Registrar with evidence showing that the applicant is in course of or has had the training and/or experience required by the regulations. Form A must be approved before Form B can be accepted. ** If not registered with the GMC – evidence of registration in own jurisdiction must be enclosed.*

Data Protection - I consent to the details on this form being held on the Society's database and to my name, if the Diploma is awarded, being disclosed in any enquiry concerning diplomates.

Aug 20th 2009

BRITISH INSTITUTE OF MUSCULOSKELETAL MEDICINE

DIPLOMA IN MUSCULOSKELETAL MEDICINE

EXAMINATION ENTRY FORM

This Form, completed by the Candidate, is to be forwarded to the Registrar accompanied by Form A, previously accepted by the Society, together with the case studies and current fee, not later than THE APPLICATION DEADLINE STATED IN THE *GUIDANCE TO CANDIDATES*.

Date _____ **Title** _____

Surname _____ **Forenames** _____

Address _____

Post code

I desire my name to be entered for the Examination beginning on _____ **20** _____

I enclose:

- Completed Form A;
- Case studies,
- The fee.

Signature _____

It is the policy that candidates with special needs are not disadvantaged and, where appropriate, arrangements will be made to make provision for a candidate's disability without giving an unfair advantage over other candidates. Candidates requesting special arrangements for examination must submit Form Q (available from the Registrar) before the closing date.

Data Protection

I consent to the details on this form being held on the database and to my name, if the Diploma is awarded, being disclosed in any enquiry concerning diplomates.

BRITISH INSTITUTE OF MUSCULOSKELETAL MEDICINE

DIPLOMA IN MUSCULOSKELETAL MEDICINE

EXAMINATION RE-ENTRY FORM

This Form, completed by the Candidate, is to be forwarded to the Registrar together with the case studies and the current fee, not later than THE DEADLINE STATED IN THE *GUIDANCE TO CANDIDATES*.

Date _____ Title _____

Surname _____ Forenames _____

Address _____

Date of last entry _____ 20 _____

I desire my name to be entered for the Examination beginning on _____ 20 _____

I enclose:

- The Case studies;
- The fee.

Signature _____

It is the policy that candidates with special needs are not disadvantaged and, where appropriate, arrangements will be made to make provision for a candidate's disability without giving an unfair advantage over other candidates. Candidates requesting special arrangements for examination must submit Form Q (available from the Registrar) before the closing date.

Data Protection

I consent to the details on this form being held on the database and to my name, if the Diploma is awarded, being disclosed in any enquiry concerning diplomates.