

**NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA**



**LOGBOOK FOR SUBSPECIALTY OF PAEDIATRIC  
OPHTHALMOLOGY AND STRABISMUS**

**FACULTY OF OPHTHALMOLOGY**

**APPROVED BY THE SENATE ON 1<sup>ST</sup> JUNE, 2023**

**DR F. A. AROGUNDADE, MD FMCP  
COLLEGE REGISTRAR**



NATIONAL POSTGRADUATE COLLEGE OF NIGERIA

FACULTY OF OPHTHALMOLOGY

THE LOGBOOK

FOR

PAEDIATRIC OPHTHALMOLOGY AND STRABISMUS SUBSPECIALTY

2023

Resident's Name .....

Name of Training Institution

.....

.....

Date of Commencement of Training .....

Name and Signature of Supervisor(s)

.....

.....

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## PREAMBLE

The training is directed at ensuring acquisition of advance knowledge and skills in the management of eye conditions of childhood that are prevalent in our society including strabismus in adults while taking cognizance of the global environment in which we live and work. There will be a general emphasis on cataract, glaucoma, refractive errors/low vision, paediatric retinal eye diseases, paediatric ocular cancers, child eye health promotion, development of structures and linkages for early detection, referral for treatment of various child eye problems as well as ethics/professionalism, and research methods.

## GRADES OF PERFORMANCE SCORES

- 70% or more -- A
- 60 -69% ----- B
- 50 -59 % ----- -C
- 40 -49% -----D
- 39% and below- E

## COMPETENCE BASED GRADING OF PERFORMANCE

PERFORMANCE GRADE	DESCRIPTION
A	Adequate knowledge; Performs skill without supervision; can reproduce skill on request; five to six points on Affective domain.
B	Adequate knowledge; performs skill with minimal supervision; reproduces skill with minimal guidance; four to five points on Affective domain.
C	Adequate knowledge; performs skill with supervision; barely reproduces skill; 3-4 points on Affective domain.
D	Inadequate knowledge; performs skill with supervision; Unable to reproduce skill; 2 - 3 points on Affective domain.
E	Gross inadequate knowledge; unable to perform task; unable to reproduce skill; 1-2 points on Affective domain.

## ROTATIONS COMPLETED

Posting	Dates Attended		Comments	Name & Signature of Consultant
Corneal and Anterior segment				
Ophthalmic Plastic Surgery				
Neuro-ophthalmology				
Public health and community eye health				
Conference participation and presentations (OSN etc)				

## 1<sup>st</sup> Year Senior Residency FORMATIVE ASSESSMENT

(Should be done every 3 months)

<b>Name of Resident:.....Year of Training</b> <b>Hospital:.....</b>						
<b>DATES</b>	<b>From</b>					
	<b>To</b>					
<b>Overall Rating for the Year (Average)</b>						
<b>ATTITUDINAL ASSESSMENT (Grade A-E)</b>						
General Appearance						
Punctuality						
Relationship with Patients						
Relationship with other team Members						
Ethics – Awareness and Application						

Flexibility and Response to Correction					
Administrative/leadership skills					
<b>CLINICAL SKILLS ASSESSMENT (Grade A-E)</b>					
Applied Basic Sciences knowledge					
Clinical management (Judgement, appropriate use of investigations, follow up etc)					
Emergency Care and Resuscitation					
Industry/Initiative					
Reliability					
Communication Skills					
<b>Overall Score</b>					
<b>Name &amp; Signature of Consultant</b>					

**GRADES:** Write the appropriate grade in the column using the key below.

Consistently exceeds expectations = A      Sometimes exceeds expectations = B      Generally meets expectations = C      Inconsistently meets expectations = D      Rarely meets expectations = E      Insufficient contact with student to judge = X

## 2<sup>nd</sup> Year Senior Residency FORMATIVE ASSESSMENT

(Should be done every 3 months)

<b>Name of Resident:.....Year of Training</b> <b>Hospital:.....</b>					
<b>DATES</b>	<b>From</b>				
	<b>To</b>				
<b>Overall Rating for the Year (Average)</b>					
<b>ATTITUDINAL ASSESSMENT (Grade A-E)</b>					
General Appearance					
Punctuality					
Relationship with Patients					
Relationship with other team Members					
Ethics – Awareness and Application					
Flexibility and Response to Correction					
Administrative/leadership skills					
<b>CLINICAL SKILLS ASSESSMENT (Grade A-E)</b>					
Applied Basic Sciences knowledge					
Clinical management					

(Judgement, appropriate use of investigations, follow up etc)					
Emergency Care and Resuscitation					
Industry/Initiative					
Reliability					
Communication Skills					
<b>Overall Score</b>					
<b>Name &amp; Signature of Consultant</b>					

**GRADES:** Write the appropriate grade in the column using the key below.

Consistently exceeds expectations = A      Sometimes exceeds expectations = B      Generally  
meets expectations = C      Inconsistently meets expectations = D      Rarely  
meets expectations = E      Insufficient contact with student to judge = X

### 3<sup>rd</sup> Year Senior Residency FORMATIVE ASSESSMENT

(Should be done every 3 months)

<b>Name of Resident:.....Year of Training</b> <b>Hospital:.....</b>					
<b>DATES</b>	<b>From</b>				
	<b>To</b>				
<b>Overall Rating for the Year (Average)</b>					
<b>ATTITUDINAL ASSESSMENT (Grade A-E)</b>					
General Appearance					
Punctuality					
Relationship with Patients					
Relationship with other team Members					
Ethics – Awareness and Application					
Flexibility and Response to Correction					
Administrative/leadership skills					
<b>CLINICAL SKILLS ASSESSMENT (Grade A-E)</b>					
Applied Basic Sciences knowledge					
Clinical management (Judgement, appropriate use of investigations, follow up etc)					
Emergency Care and Resuscitation					
Industry/Initiative					
Reliability					
Communication Skills					



<i>Overall Score</i>					
<i>Name &amp; Signature of Consultant</i>					

**GRADES:** Write the appropriate grade in the column using the key below.

Consistently exceeds expectations = A      Sometimes exceeds expectations = B      Generally  
meets expectations = C      Inconsistently meets expectations = D      Rarely  
meets expectations = E      Insufficient contact with student to judge = X

**Supervising consultants's Comments**

.....  
.....  
.....  
.....  
.....

**Supervising consultants's name & signature.....**

**Date.....**

**Stamp.....**

**Head of Department's Comments**

.....  
.....  
.....  
.....  
.....

**Head of Department's name & signature.....**

**Date.....**

**Stamp.....**

**Signature of Resident.....      Date.....**

			<u>SIMULATION/</u>	<u>WET- LAB</u>	<u>-SUTURING ON PIG/</u>	<u>GOAT HEAD</u>	(20 PROCEDURES)		
Serial numbe	Date	Incision depth	Suture bite	Radiality	Knot placement (5-7)	Knot tension/ optimal wound closure	Overall comments	Name of Supervisor	Signature of Supervisor
1									
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	CATARACT SURGERY : Preparation and Outcome (Minimum-30)																			
S/N	Date	Hosp No.	Age	Sex	VA	Cornea size/clarity	Pupil	Lens Morphology	BIOMETRY		IOL Calculated/used Power	Surgical procedure	GA-Type	P/PS/AA	Complications	VA/IOP Day I	VA /IOP ≥6weeks	Clarity of Visual Axis 4month 1 year	Overall Comments	Name & signature of Supervisor
									AXL	K1...K2..... .....										
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	Cataract Surgery (SICS) ± Vitrectomy ± IOL- Minimum 20													
Serial no	Date	Hosp. No	Scleral Tunnelling/Corne al Entry	Paracente sis	Capsulorrhexi s	Hydro dissection	Nucleus Prolapse/Extract ion	Soft Lens matter Clearance	Post Capsulecto my/Vitrecto my	IOL Insertion	Suturing of wound	Overall comments	Name of Supervisor	Signature- Supervisor
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		Secondary IOL Implantation Cataract Surgery (SICS) ± Vitrectomy ± IOL- Minimum 10												
Serial no	Date	Hosp. No	AXL	Keratometry	IOL Calculation	IOL Used	Scleral Tunnelling/Corneal Entry	Paracentesis	Capsule separation	IOL Insertion	Suturing of wound	Overall comments	Name of Supervisor	Signature-Supervisor
1														
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		PAEDIATRIC GLAUCOMA ASSESSMENT IN CLINIC ( Minimum 15)																												
S/N	Date	Ho sp No	Age/ Sex	VA		Pupil		Lens		Gonioscopy None/SL/ TM/SS/IR		Refracti on		Corneal Clarity/Diameter		Fundus Exam C:D		Axial Length		IOP Tonometer Type				CVF Normal/ Abnormal N/AB	OCT Vertical C:D	Diagnosis	Treatment	Comments	Name of Supervi sor	Signatur e of Supervis or
				R. E	L E	RE	LE	RE	LE	R. E	LE	R. E	LE	R.E	LE	R.E	LE	R E	L E	R E	L E	R E	L E							
				R. E	L E	RE	LE	RE	LE	R. E	LE	R. E	LE	R.E	LE	R.E	LE	R E	L E	R E	L E	R E	L E							
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PAEDIATRIC GLAUCOMA (Trabeculotomy & Trabeculectomy) WET LAB- 20														
S/N	Date	Conjunctival Flap	Superficial Scleral Flap	Schlemm's Canal	Canulation of Schlemm canal	Breaking of Canal Wall to Connect Anterior	Paracentesis	Deep corneoscleral	Peripheral Iridectomy	Suturing scleral	Suturing of conjunctival	Overall comment	Supervisor	
													Name	Signature
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PAEDIATRIC GLAUCOMA (Trabeculotomy & /or Trabeculectomy) 10

S/N	D at e	HOS P NO	AGE/SE X	Pre-Op IOPRE/ LE	Conjunctiva l Flap	Superficia l Scleral Flap	Schlemm' s Canal Deroofing	Canulation of Schlemm canal -SC	Breaking SC to Connect Anterior Chamber	Paracentesis	Deep corneoscleral block	Peripheral Iridectomy	Suturin g scleral flap	Suturing conjunctiva l Flap	VA 1ST DPO RE/L E	IOP 1MONT H RE/LE	Overall comments	Superviso r Name	Superviso r Signature
1.																			
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




















RETINOBLASTOMA EUA															
Serial No	Date	Hosp No.	Name of Patient	Age	Sex	VA RE    LE	Disease Group RE	Disease Group LE	Disease Stage	Treatment Goal	Treatment Plans	Treatment Outcome	Overall Comments	Supervisor Name	Supervisor Sign
1.															
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ENUCLEATION Wetlab/Live (Minimum 5/5)															
Serial No	Date	Hosp No.	Name of Patient	Age	Sex	Pre-op VA RE      LE	Indication	Optic nerve length	RB High risk signs present	Implant used-Yes/No & type	Prosthesis fitted	Histology	Overall Comments	Supervisor Name	Supervisor Sign
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ROP SCREENING (Minimum 30), TREATMENT (Minimum 5)																		
Serial No	Date	Hosp No.	Name of Patient	Gestational age	Chronological age	Postmenstrual age	Sex	Supplemental oxygen - flow, delivery mode,duration	Other ROP risk factors	ROP Yes/No	ROP Zone	ROP Stage	ROP plus ?	Mx Plan	Treatment procedure-LASER/Anti-VEGF	Refraction at 6 month	Supervisor Name	Supervisor Signature
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ROP SCREENING (Minimum 30), TREATMENT (Minimum 5)																		
Serial No	Date	Hosp No.	Name of Patient	Gestational age	Chronological age	Postmenstrual age	Sex	Supplemental oxygen - flow, delivery mode,duration	Other ROP risk factors	ROP Yes/No	ROP Zone	ROP Stage	ROP plus ?	Mx Plan	Treatment procedure-LASER/Anti-VEGF	Refraction at 6 month	Supervisor Name	Supervisor Signature
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STRABISMUS ASSESSMENT (Minimum 40)																				
S/n	Date	Hos p no.	Age/sex	Nystagmus	Facial asymmetry	Compensatory head postures	VA(type of chart)	Binocular function- stereopsis(titmus,tno, bagolini etc)	Hirschberg / modified krimsky test- ° / Δ	Cover test- type of strabismus	Ocular motility- duction, version, ac/a		Prism alternate cover test far/near, diagnostic positions	Fundus		Aetiology of strabismus	Refraction  Re      le		Surgical procedure planned yes/no	Name & sign of supervisor
1											X	X								
2											X	X								
3											X	X								
4											X	X								
5											X	X								
6											X	X								
7											X	X								
8											X	X								
9											X	X								
10											X	X								
11											X	X								

STRABISMUS ASSESSMENT (Minimum 40)																	
S/n	D a t e	Hos p no.	Age/se x	Nystagmu s	Facial asymmetry	Compensator y head postures	Va(type of chart)	Binocular function- stereopsis(titmus,tn o,bagolini etc)	Hirschberg / modified krimsky test- ° / Δ	Cover test-type of strabismus	Ocular motility- duction, version, ac/a	Prism alternate cover test far/near, diagnostic positions	Fundus	Aetiology	Refraction  Re      le	Surgical procedure planned yes/no	Name & sign of superviso r
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STRABISMUS ASSESSMENT (Minimum 40)																	
S/n	D at e	Hos p no.	Age/se x	Nystagmu s	Facial asymmetry	Compensator y head postures	Va(type of chart)	Binocular function- stereopsis(titmus,tn o,bagolini etc)	Hirschberg / modified krimsky test- ° / Δ	Cover test-type of strabismus	Ocular motility- duction, version, ac/a	Prism alternate cover test far/near, diagnostic positions	Fundus	Aetiology of strabismus	Refraction  Re      le	Surgical procedur e planned yes/no	Name & sign of superviso r
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30											✕ ✕						
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32											✕ ✕						
33											✕ ✕						

STRABISMUS ASSESSMENT (Minimum 40)																		
S/N	D a t e	Hos p No.	Age/S ex	Nystagm us	Facial Asymmet ry	Compensator y Head Postures	VA(Ty pe of Chart)	Binocular Function- Stereopsis(Titmu s,Tno,Bagolini Etc)	Hirschberg / Modified Krimsky Test- Δ	Cover Test- Type of Strabismu s	Ocular Motility- Duction, Version, AC/A	Prism Alternate Cover Test- Far/Near, Diagnostic Positions	Fundus	Aetiology Of Strabism us	Refraction		Surgical Procedur e Planned Yes/No	Name & Sign Of Supervis or
															Re	Le		
34.											<div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div><div>X</div></div>							
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STRABISMUS SURGERY Wet Lab ((Minimum 25 Muscles)																		
Serial Number	Date	Type of surgery-Rec/Res/Oblique(type )	Forceduction Test	Conjunctival Flap	Tenotomy	Muscle Pick	Muscle Exposure & Clearing	Suture Placement in Muscle	Muscle Dis-insertion	Sclera bite-Muscle re-Insertion	Sclera Marking	Suturing	Conjunctival Management	Overall Comments	Supervisor Name	Supervisor Sign		
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STRABISMUS SURGERY ((Minimum 20 Horizontals, 5 vertical/Oblique Muscles)																
Serial Number	Date	Type of surgery- Rec/Res/Oblique(type)	Eye Operated	Forced duction Test	Conjunctival Flap	Tenotomy	Muscle Pick	Muscle Exposure & Clearing	Suture Placement in Muscle	Muscle Dis- insertion	Sclera bite- Muscle re- Insertion	Sclera Marking	Suturing	Conjunctival Management	Supervisor Name	Supervisor Sign
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	COMMUNITY PAEDIATRIC OPHTHALMOLOGY- At Primary Health Centre (Minimum of 1)																
	<u>No of Personnel Trained of personnel in vision screening (task shifting (Minimum 10) &amp; Children who have Vision Screen (Minimum 50)</u>														-	-	
			<b><u>Personnel Trained</u></b>			<b>Number of Children who had vision screening</b>				<b>No of children Referred to and seen at Secondary/Tertiary Child Eye Centre</b>							
S/N	Date	Name of community	No trained	Sex /Age	Observation	Bruckner Red Reflex Test	Visual acuity	Vision Screener	Total number referred	No seen @ 1 week after referral	No seen @ 1 month after referral	Diagnosis	Treatment	Effectiveness of referral: Yes / No	Feedback	Supervisor Name	Supervisor Sign
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<b><u>COMMUNITY PAEDIATRIC OPHTHALMOLOGY- At Primary Health Centre (Minimum of 1 Centre)</u></b>																
<b><u>No of Personnel Trained in vision screening (task shifting (Minimum 10) &amp; Children who have Vision Screen (Minimum 50)</u></b>														-	-	
S/N	Date	Name of community	<b><u>Personnel Trained</u></b>		<b>Number of Children who had vision screening</b>				<b>Referral to Secondary/Tertiary Child Eye Centre</b>					Feedback	Supervisor Name	Supervisor Sign
			No trained	Sex /Age	Observation	Bruckner Red Reflex Test	Visual acuity	Vision Screener	No @ 1 week follow up	No @ 1 month follow up	Diagnosis	Treatment	Effectiveness of referral: Yes / No			
26.																
27.																
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46.																
47.																
48.																

49.																
50.																

PAEDIATRIC REFRACTION ((MINIMUM 20- INCLUDING CYCLOPLEGIC REFRACTION = 5 , APHAKIC/PSEUDOPHAKIC PTS = 5)																				
Serial Number	Date	Hospital Number	Age	Sex	Entry VA	Diagnosis	Retinoscopy- Net	R.E	Prescription	L.E	Transposition R.E	L.E	SPHERICAL EQUIVALENT R.E	L.E.	1PD RE	LE	Final VA	Other findings	Supervisor Name	Supervisor Sign
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	Low vision assessment (Minimum 10)																	
S/No	Date	Hosp No.	Name of Patient	Age	Sex	Presenting VA		diagnosis	Best corrected VA after refraction		Type of LVD for distance	Low Vision Device		Contrast/ Color/Glare	Patient Satisfaction	COMMENTS	Supervisor Name	Supervisor Sign
						Distant RE	Near RE LE		Distant RE LE	Near RE LE		Distant VA RE	Near VA RE LE					
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Journal Presentations-20								
Serial No	Date	Subject	Citation of Journal presented	Name & institution	Overall comments	Name of Supervisor	Signature of Supervisor	
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Seminar/Grand round/Conference Presentations-20								
Serial No	Date	Subject	Topic/ Diagnosis presented	Name & institution/Venue	Overall comments	Name of Supervisor	Signature of Supervisor	
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**Supervising consultants’s overall Comments**

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**Supervising consultants’s name & signature.....**

**Date..... Stamp.....**

**Head of Department’s Comments**

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**Head of Department’s name & signature.....**

**Date..... Stamp.....**

**Signature of Resident..... Date.....**

