- Wear a watch and dress professionally  
- 5 = excellent, 4 = good, 3 = satisfactory, 2 = marginal/safety concern, 1 = poor/fail  
- Diagnosis (5 points), Management (5 points – double weighted), Complications (5 points) = 15 pts per case  
- Approximately 6 cases per hour (15 x 6 = 90 points per hour) 72/90 = passing  
- Test structure: Hour 1, Hour 2, Break, Hour 3   
- Every hour, there are 3 standard questions (index cases) and 3 guest examiner questions  
- Maximum of 9 questions per hour  
- Average pass rate is 85% - can take the exam 3 times before having to retake the written boards  
- Two weeks after test, the passing level is determined based upon amalgamated scores  
- If fail, can take two more times  
- Be succinct in answers  
- If interrupted, don’t worry  
- LISTEN carefully; they are giving you pertinent information  
- the examiners want to keep things moving so you can finish the most cases possible

Always know the setting of the case (Office, ER, hospital, ICU)  
Every slide has pertinent information – 90% of the cases can be solved on the first slide  
History (usually on one slide, except in some cases)  
- other pertinent findings  
- Medications

ALWAYS START WITH ABC

Full physical examination – LOC, VS, CAB, CN, motor, sensory, reflex, palpate and inspect, Tinel/Phalen  
Imaging/labs/blood products – describe what you are seeing  
EMG/imaging (peripheral nerve cases)

Give top 3-5 differential diagnoses  
“I am suspicious of \_\_\_\_\_ and would like to see \_\_\_\_\_.”  
“It could be \_\_\_\_\_ and I would like to do this: \_\_\_\_\_.”

When planning surgery: check preop labs and meds, discuss plan, position, anatomic landmarks, “I will confirm with navigation”  
Give AED for cortical lesions

Craniotomy   
- Make sure you are on the CORRECT side  
- Mention going down to floor of temporal fossa for adequate decompression  
- When performing a craniotomy near the sinuses, make sure you mention caution  
- When crossing a sinus – position the head in relation to the heart  
- when operating on a post-craniotomy infection, always discard the bone flap (it is devascularized and will not heal well)

Spine  
- Always use neuromonitoring  
- Obtain baseline SSEP/MEP/EMG  
- check the papillary exam in patients presenting with UE radiculopathy (Horner’s syndrome in a patient with pancoast tumor)  
- if there is a neuro deficit and the imaging is negative, keep moving up the neuraxis (up to brain)  
- if a patient has severe pain following a trauma, think of aortic dissection  
- Make sure imaging shows correct level (ask for interpretation from radiologist)  
- if a lumbar drain is placed, think of SDH as a possible complication  
- if severe OPLL, go posterior!  
- use cross links  
- in a patient that has weakness without pain, think of ALS and get EMG  
- get a flexion/extension before doing laminoplasty  
- do not offer laminoplasty if the patient has neck pain  
- typical cases:   
 - 20F with MRI findings that correlate with clinical exam … MS  
 - 50M with weakness, no sensory findings, jaw jerk … ALS  
 - areflexic patient with ascending weakness … GBS  
 - B12 deficiency can present like spondylotic myelopathy

Peripheral nerve  
- Peripheral nerve is usually in hours 2 or 3  
- For complex peripheral nerve cases, ask for a picture  
- Do be safe, but don’t overdo conservative management  
- Always think of mimics  
- Do not allow a patient to talk you into a treatment that is wrong!  
- when performing a trauma case, do not forget to look for underlying vascular injury with a CTA

RESOURCES

AANS operative grand rounds  
CNS webinars  
Spinner webinar!!!