Small Animal Surgery Case Report Guidelines

This document is aimed to give a general overview of case report writing. Please refer to the specific instructions for each report for more detail on what is required in each case. Please also refer to the assessment criteria for each case in order to ensure that your case meets the requirements.

General Overview
Case reports that you read in the literature are rarely simple and straightforward because the unwritten rule is that they need to be novel, provide new information and be generally considered to be of educational value. This is not the case with the case reports you submit. The modules are designed to be completed by practitioners working in first opinion practice. Thus, we are not looking for the type of odd or exotic case seen only in referral practice.

Case selection
This is clearly a vital part of the case report process, and indeed is a skill which needs to be developed in the modules. Choose an inappropriate case and you are simply making the task much harder for yourself. The case reports that you will be producing do not need to represent unusual cases, in fact it may be best that you stay away from very complicated cases. There will be guidelines as to the types of cases required as we go through, but remember the point of the case report is to demonstrate your overall approach, clinical reasoning processes, reflection and appropriate use of evidence based medicine. You may want to revise your A/FAVP.1 module where these are specifically discussed.

We are looking for a normal case approached logically and safely and well worked up, within the constraints of normal veterinary practice. If constraints, imposed by practice facilities or the economic abilities of your client, prevent you from carrying out certain tests then that should not preclude the case as a case report. It is perfectly acceptable to present a case where acceptable “corners were cut” due to lack of finances, facilities, operator skill, etc. if you acknowledge and explain this. But these must be acceptable corners, and the decision making process or clinical reasoning process must be adequately explained. You should mention any shortcomings in your discussion of the case. There does need to have been enough basic work up to demonstrate your clinical reasoning process adequately and it is preferable to have a reasonable follow up so as to give an idea of outcome, so case selection is still important.
Word count and Formatting issues:
Please format all text as Arial, Font size 11, Line spacing 1.5.

Please state your word count clearly at the end of your report.

Pay attention to the Harvard referencing guidelines and adhere to them. Proof read carefully. Your examiners are not being petty by noting errors, but are following University assessment procedures monitored by our external examiners.

Grading and feedback:
Case report skills develop over time and there will be detailed feedback provided by the assessor regarding areas of improvement- this should be used constructively for the following submission. Please bear in mind that some parts of the feedback will be tips and experiences of the assessor. Feedback comments do not always reflect criticisms or areas where marks have been deducted but are added for your benefit and as a valuable part of the feedback process.

Masters grading is set higher than undergraduate grading and a good mark on the rubrics is set at 65%, therefore to achieve >80% the work must be excellent. We recommend that you read the rubrics (assessment criteria) thoroughly.

Case report structure
For your case you should outline the following:
1. Signalment
2. History
3. Presenting complaint
4. Diagnosis (including diagnostic procedures)
5. Surgery report
6. Evidence for chosen surgery
7. After care and/or follow-up
8. Outcome and reflection
9. Reference list (using Harvard Style)

Some items are worthy of note:
• You are not expected to present the perfect case. You are expected to demonstrate your clinical reasoning and highlight where, on reflection, your approach could have been different (e.g. a more conservative approach, a different technique, more diagnostics, follow up, treatment) and in so doing demonstrate you have learned from the experience. However your management of the case should be logical and safe.
• Present the case as a scientific report (not as “I decided……, I thought….. etc”). This can be difficult to do at first but does provide a more professional final result.
• Write in sentences, not in note form.

Signalment, history and presenting complaint
• Keep your initial presentation of the case (History, clinical exam, investigations etc) brief and factual with no detailed explanation of reasoning, you can use the discussion to pick up and expand on those.
• The patient’s signalment could be placed in a table or listed as follows: Patient signalment (or patient identification): 3-year-old neutered female boxer, body weight 28kg, body condition score 3/5
• Don’t refer to the patient by name
• If it is not relevant to the case do not include unnecessary background details in the history (e.g. for a dog that has been hit by a car and is dyspnoeic, the vaccination status is irrelevant to the patient/vet at that particular point in time). In contrast where a patient has a cough, the worming history would be very relevant and should be included.
• Do not include details of normal findings on a clinical examination unless you want the reviewer to be aware that you have assessed some particular aspect of the examination that is relevant to that case (e.g. a normal cranial nerve examination in a dysphagic dog). It is sufficient to detail any abnormalities and to write that “the remainder of the clinical examination was unremarkable” in most cases. If you prefer, you may include the complete findings of your clinical examination, including normal values, in a table. Particularly where most findings were considered normal but you want to show that you specifically checked them e.g. a chronically pyrexic dog where you want to show that you had palpated lymph nodes, checked for a heart murmur, palpated all the joints etc. However temperature, pulse rate and respiratory rate should be included as a routine.
• Do not write long lists of differential diagnoses for every point on your problem list. Your list of differential diagnoses should demonstrate that you have a good sense of priority for the case that you are presenting. If the points on your problem list are likely to be related (e.g. inappetance and weight loss) then write a sentence to link them and write your list of differential diagnoses accordingly. If you do want to write a complete list of differential diagnoses for each point on your problem list (for your own benefit) then this should be placed in the appendix.
**Diagnosis (including diagnostic procedures)**

- You should show your decision-making process at all times, particularly in relation to justifying each diagnostic test that you perform.

- Full blood test results/clinical pathology results can be placed in a table in the appendix but you should discuss any abnormal or pertinent points in the text of the report. If a particular investigation was considered normal then this should still be stated within the text where relevant e.g. abdominal x-ray. Please do not scan images of lab reports/referral reports in as they can be hard to read and tricky to anonymise, please type the content into a table or simply type out the wording.

- Include copies of your radiographic and ultrasound images (see guidance below for more details). It is expected that for orthopaedic case reports a complete set of radiographs, including preoperative, immediate post-operative and at least one set of follow up radiographs are included. If this is not possible consideration should be given to selecting another, more suitable, case. Images should be of diagnostic quality and made of an adequate size for the reviewer to be able to see clearly to be able to assess your interpretation of these images. There are guidelines for images in the information on presenting reports. You may be able to experiment and see how your images look best. Larger images are easier for the examiner to assess so long as they can be uploaded correctly and without loss of detail so you may be able to include larger images than those suggested in the instructions.

- It is your clinical reasoning allied with a good clinical approach both in terms of examination and choice of diagnostic tests which is key to a good case report. Excessive testing for a particular case investigation does not suggest that you are being thorough; it suggests that you don’t have a good understanding, knowledge and sense of priority relating to the case that you are presenting.

**Surgical report**

- Try to include photos of lesions, masses, intraoperative findings, etc. where possible.

- Do not place details about sedation, anaesthesia, fluid therapy, analgesia, post-op care, etc in the appendix. The reviewer has no obligation to read the appendix. The appendix should be used to include case details that are not specific to that particular patient e.g. surgical preparation and scrubbing protocol. The anaesthesia, analgesia, fluid therapy, antibiosis, post-op care, etc is specific to each individual patient and should not be considered "standard".
• Don’t include details such as “the surgeon scrubbed and gloved” or “counted the swabs” etc because these are considered to be standard practice and minimal standards of care. The fact that you include these details suggests that this is “out of the ordinary.”

• Make sure that you refer to drugs correctly e.g. enrofloxacin (Baytril; Bayer) 5mg/kg orally once daily for 5 days. You only need to state the trade name and manufacturer on one occasion throughout your report and then you may simply use the generic name.

• Reference to Suture Material - The generic name should always be used with trade name and manufacturer in brackets and the suture size should be listed. Metric sizing should be used. There may need to be some flexibility for certain suture materials with highly complex generic names. The tradename and manufacturer need only be included the first time the product is mentioned. Where you are discussing medications or suture materials in general rather than stating that you actually used them, only the generic name should be given.

Discussion

• The discussion should not be a literature review, but rather a discussion of any points from your individual case management that could have been good, or bad, or done better, or to explain why the case was managed in a particular way, in order to demonstrate what you have learnt from managing the case. If you are reporting a case where you managed everything perfectly and can only reflect on how well you managed the case then this is not necessarily a good choice of case to choose for your case report. It is perfectly acceptable to use a case where you didn’t manage the case in a “text book” manner if you justify your decision making – this demonstrates better understanding, prioritising, etc than by presenting a case where everything was perfect!

• Be careful that you do choose relevant points to discuss that are appropriate to clinical practice. We understand that some of the literature can be misleading and sometimes there are recommendations in the veterinary literature/textbooks, etc that aren’t really practically sensible. The points you choose to discuss shows the reviewer your understanding of the case scenario so ensure that you do pick the points that you think are most relevant to the case.

• In all cases your reflection should be in the light of the current literature on that topic (read your case question and rubric to decide which area to focus on as different cases will have a different focus).

• Please make every attempt to cite the original literature where appropriate rather than other people’s interpretation of it. The assessor wants to be able to see that you can demonstrate your understanding and application of the study.

• Make sure that all the authors you list in your reference list are placed in the text (and vice versa).
• Please note the word count for each assignment, marks may be deducted for exceeding the required limit.

Posting comments on your peer’s case reports

• The purpose of the discussions on other certificate candidate’s case reports is to show that you can reflect on case management by other veterinary surgeons. We understand that you want to be supportive to your colleagues, and also that it can be difficult to make comments on cases if other candidates have already posted comments but the aim of posting discussions is NOT to purely congratulate each other.

Images and lab results – further guidance

All abnormal lab results and images which have been used to diagnose a condition should be included within the text of submitted case reports with appropriate labelling. If the images / lab results are normal and do not show the pathology relevant to the diagnosis they do not need to be included in the main case report and can be placed in the appendix. Full copies of all lab results must be included in the appendix normal radiographs / images need not be included if numerous.

For example, lab results, radiographic images, ECG traces, endoscope or ultrasound images which demonstrate pathology/ abnormalities should be included where possible. Inclusion of lab results and radiographic images is mandatory as these should always available. We recognise that still ultrasound images or images from endoscopic procedures may not have been recorded and may be unavailable. Assessors can only follow your reasoning process if they too are able to view the lab data and diagnostic images which you have utilised in your case work up and management. Where the case may have been referred for further investigation and you do not have access to images etc. a copy of the report or relevant section of this may be included in the appendix. Failure to include this information is likely to result in a grade reduction.

For orthopaedic cases where bone healing can only be assessed radiographically, the expectation is that preoperative, postoperative and follow up radiographs will be available. Those cases where follow-up radiographs would be expected but are omitted will not be able to reach the 50% pass mark. If you have further queries about a particular case please contact your module coordinator.

Giving Reference Ranges

These should be included for blood results and other laboratory data where it is provided by the manufacturer of the diagnostic equipment.
Vital findings such as temperature, pulse rate, respiratory rate do not need reference ranges. This is because reference ranges do not take into account the specific circumstances of the patient, i.e. age, excitement, stress, (patient size possibly depending on which resource you use!). Equally there are multiple references ranges in the literature and no single agreed standard.