Case Report Guidelines: Equine B & C Modules

This document is aimed to give a general overview of case report writing across all modules. **PLEASE NOTE: The preferred case report structure can vary between modules and within the same module.** Refer to the specific instructions for individual reports for more detail on what is required in each case and 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. 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 necessarily 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 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. 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. Management of the case should be logical and safe.

General writing tips and formatting

Present the case as a scientific report written in the third person (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.

Format all text as Arial, Font size 11, Line spacing 1.5.

Follow the “Cite Them Right” referencing guidelines available on the module and adhere to the Harvard referencing scheme. Proof read carefully. Your examiners are not being petty by noting errors, but are following University assessment procedures monitored by our external examiners.

Signalment, history, presenting complaint and examination

Don’t refer to the patient by name, use “the patient” or similar.

Keep the initial presentation of the case brief and factual. If it is not relevant to the case do not include unnecessary background details in the history e.g. for an animal presenting with a traumatic injury, the worming status may be irrelevant to the patient/vet at that particular point in time. In contrast where a patient presents with diarrhoea, the worming history would be very relevant and should be included.

You should demonstrate that you have carried out a complete and logical clinical examination **relevant to the case report type you are writing**. It is not always necessary to 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 animal). A case where an animal is systemically unwell may require a more detailed clinical examination report, whereas in some surgery reports this section may be quite brief. A dermatology case would require a full dermatological examination report and a neurological case would usually need to include a detailed neurological examination. Vital parameters should be included in all cases as routine. Check specific case report instructions for more information.

Problem list and differential diagnoses

Do not write excessively 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. Ensure that you consider relevant differential diagnoses for EACH problem that you identify in order to show a logical approach. Once you make a final diagnosis you should then go back and ensure that it explains all of the problems identified. If not you need to rethink your diagnosis or consider concurrent disease. Each problem should be explained by your final diagnosis.

In some cases, notably many surgical cases, the problem list and differential diagnosis list will be much shorter compared to complex medical cases, you should use your judgement as to what is appropriate for your specific case.

Please place your problem list and differential diagnosis list in descending order of importance to your case in order to demonstrate that you can prioritise your findings. Usually it is helpful if the most specific clinical finding is listed first.

Diagnosis and treatment

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

Make sure you do not overlook initial patient stabilisation, if relevant.

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.

Make sure that you refer to drugs, suture materials, etc. correctly e.g. phenylbutazone (Equipalazone; Dechra) 2.2 mg/kg orally twice 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. When discussing medications or suture materials in general terms, rather than stating that they were given to your patient, use only the generic name, e.g.meloxicam would have been an alternative non-steroidal anti-inflammatory drug to have chosen ….

Images and lab results

Test results and images which demonstrate pathology/ abnormalities should be included where possible. Inclusion of laboratory data and radiographic images is mandatory as these should always available. We recognise that ECG recordings, still ultrasound images or images from endoscopic procedures may not have been recorded and may be unavailable. Having said that, should such non-mandatory images be a vital element of the diagnostic process then they need to be included. Assessors can only follow your reasoning process if they too are able to view the results and diagnostic images which informed your choices. E.g. A cardiac case, in which an ECG trace was key to the diagnostic process, should have the ECG included.

Ensure lab results and images are labelled appropriately. If results are normal / 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. Where a case was 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.

Radiographic and ultrasound 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. 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.

Failure to include this information may result in a penalty or in extreme cases may result in cases being failed. If you have further queries about a particular case please contact your module coordinator.

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.

Surgical report (relevant surgical modules only)

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."

When referencing 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.

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. That said, any pertinent points raised in the discussion should be discussed with reference to the published literature. Avoid going into a lot of detail about aspects e.g. a disease process or treatment that were not relevant to your specific case.

In all cases your **reflection should be in the light of the current literature** on that topic (read specific case report instructions to decide which areas to focus on).

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 cited in the text (and vice versa).

Word Count

Please note the word count for each assignment, marks may be deducted for exceeding the required limit. State your word count clearly at the end of your report.

The word count DOES NOT include your reference list, words used for labelling images (which are best written in italics), or information in the appendix. Nor does it include laboratory data in tables (e.g. blood results). It DOES include citations within the text and words within tables.

Tables can be a useful addition to a case report. Tables used for data such as blood results will NOT be included in the word count, however any comments on those values WILL be included in your word count. You can also use tables for lists of the problems and differential diagnoses but the words used WILL be included in your word count.

Image labelling is very important and will not be included in your word count. Labels should include what the image is, including the view if a radiograph, and a summary of the important findings from that image. Those findings should also be discussed within the body of your report where they will count towards the word count, but where repeated for the purposes of image labelling, the labelling will not count.

Tables and image labelling should not be misused in order to save on the word count and should not include detailed reasoning processes, these should be written in the body of the report in text form.

Appendices

Please remember that the appendix is for **supplementary information only**. Any information critical to the understanding of the case should be placed in the main text. The appendix can be used for complete lab results, standard protocols, and normal radiographs. All items in the appendix should be referred to somewhere in the main body of the report.

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 but should always remain polite and constructive.

A note on 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.