ISVPS Case Report Writing Guidelines

Introduction

All Candidates for the General Practitioner Certificate (GPCert) or General Practitioner Advanced Certificate (GPAdvCert) must submit a case report at a designated time. The case report must be passed before the GPCert or GPAdvCert can be awarded. The case report is independent of any other assessment for the GPCert/GPAdvCert, so a good mark will not influence other parts of the certificate. Equally, a fail of the case report cannot be compensated for by a pass in another part of the examination. Candidates are required to pass the case report section of the General Practitioner Certificate/General Practitioner Advanced Certificate within four years of entering the qualification and are limited to three attempts. If the case report is failed, a new case report must be submitted for reassessment at the designated time taking into consideration the examiner's comments and feedback on the failed case report. **Revision of a previously submitted case report is not accepted.**

A case report takes significant time to write. It is recommended that thought be given to the subject during the first third of the CPD course. If there are problems in deciding the appropriate topic, this is the time to have them resolved. Discuss this with your lecturers and tutors. The writing should be undertaken as soon as possible after the halfway point of the course is reached. Case report abstracts will not be accepted (please see below).

Aim of the Case Report

The aim of the case report is to test the ability of the candidate to diagnose, treat and follow up a clinical case, and to record the various stages of diagnosis and management in a clear, concise and logical manner, which a professional colleague can easily understand. The examiner will assess your interpretation of diagnostic findings and your thought processes when managing the case, so all diagnostic tests and treatments must be justified to demonstrate this. The case report should include a discussion and review of the relevant literature as well as reflection on the case as a whole. It should be noted that the examiners will pay particular attention to the use of English, grammar and spelling.

Choice of Case

The case report MUST be the authors own, original work and they must be the SOLE author of the work. The case report must not have been previously submitted or be pending submission for publication.

The case chosen must have been managed predominately by the candidate. Additional input by colleagues in the practice or from a referral centre must be noted. Case reports may comprise a single case, or a group of related cases. It is not necessary for the condition/s reported to be uncommon or complicated. For example, a report of a simple

condition that requires sustained monitoring and treatment may give a better representation of a candidate's skills than a rare or complex one that ends with immediate euthanasia. It is the candidate's responsibility to ensure that the case they have chosen is appropriate for this assessment. ISVPS will not advise you on this aspect; appropriate case selection is considered an important part of the assessment process.

Please ensure that guidelines are followed closely to avoid deduction of marks. Failure to provide a word count (or if it is exceeded) or failure to adhere to the case report writing guidelines will result in your report being returned unmarked.

Case Report Format

All reports must be double spaced in **Arial font 12** and between **2,250-2,500 words of main text. A word count MUST be supplied (include on the front page of your case report).** All indications as to the identity of the owner of the patient, candidate, practice, or participating colleagues must be omitted from the report.

Please note that the title, summary, tables, text associated with images, appendices and references are **not** included in the word count. Please also be aware that any appendices are supplementary documents and important information relating to the case presentation MUST be included in the main body of the case report (information in the appendices will not be used as part of your case report assessment).

All acronyms must, on the first occasion, be given in brackets following definition of the term in full e.g. diabetic ketoacidosis (DKA). The International System of Units (SI) must be used throughout.

Headings

The case report must be divided into sections. The headings reflect the content of the section. The case report must follow a logical progression and contain each of the sections detailed below.

Title (*fewer than 20 words, **not included in word count***)

The title should accurately describe the case.

Abstract (not included in word count)

The abstract must contain a brief account of the information presented in the body of the report and an indication of its relevance. This should be approximately 150 to 200 words. It should convey the content to the reader who does not go further.

Introduction

The introduction must set the case in context and will usually contain references to previous reports of the condition(s) being presented.

History

Include patient signalment (species, breed, age, sex), the duration of the clinical problem, a succinct summary of relevant information provided by the owner/keeper at the time of initial consultation, and any available details of relevant previous problems, including the results of relevant tests undertaken.

Clinical Findings
A detailed description of your clinical findings must be provided, including the results of any specialised procedures, e.g. an ocular, neurological, orthopaedic examination, etc.

Problem list and differential diagnoses
A processed problem list must be provided together with a differential diagnoses list. This list should not be exhaustive but rather reflect a clinically relevant list of differential diagnoses appropriately ranked in relation to the case presented.

Diagnostic Techniques
All diagnostic tests must be appropriately justified. All laboratory tests carried out should be presented in chronological order and the results summarised (reference ranges must be included). Copies of laboratory reports may be included in the Appendices and must be referred to in the text (please ensure any identifying information is removed). Additional diagnostic tests undertaken, such as radiography, must be described in detail and the views taken listed. It is important to give details of any sedation or anaesthetics used for the procedure. The equipment used should be recorded, together with the practical aspects of the techniques employed. Interpretation of results of these tests should be reported in depth. The results of specialised tests not performed directly by the candidate, e.g. CT scan, may be recorded in less detail.
"Specialised tests" are considered all the tests that need a specialist in the diagnostic area to be performed. Routinely diagnostic tests considered fundamental for the subject of the GPCert must be performed and described by the candidate.
Use this section to explain how the diagnosis detailed below was reached.

Diagnosis
The final diagnosis that is reached, based on interpretation of all of the above sections, must be listed here. The reasons for the conclusion must be summarised here.

Treatment/Case Management
The choice of clinical management must be justified, and a prognosis given. If the choice of therapy is dependent on cost, this must be noted, and management choice justified. Details of all therapeutic procedures must be given. Where drugs are used, the generic name must be given. The first time it is mentioned, the trade name and manufacturer (as specified in the NOAH Compendium or equivalent in your country) should be placed in brackets. For example, Marbofloxacin 20mg/ml (Marbocyl 2% solution for injection; Vetoquinol UK limited). The dose (e.g. 2mg/kg), frequency (e.g. q24hrs) and route of administration (e.g. subcutaneously) of the drug must be clearly recorded. Where sutures are used, the suture material, size (in metric) and suture pattern must be recorded.
If treatment is to be sustained and monitored, the plan for future management, together with the anticipated time scale must be recorded.

Progress and Outcome
This section is self-explanatory. If further investigations were carried out, these should be reported here.

Discussion
The discussion must indicate both the candidate's knowledge of the relevant literature and their ability to compare this information with the findings in the current case. Where

differences are observed, an explanation must be offered. The discussion should not simply be a review of the literature.

The candidate must discuss in this section which other conditions were considered as differential diagnosis in the selected case. A clear explanation of why the final diagnosis was reached must be given. It may be necessary to record problems encountered during the management of this case, or why this is different from or similar to related cases. Case reflection is an important aspect of the case report and allows the examiner to more accurately assess your approach to the case and your thought processes. All lessons learned while dealing with the case should be discussed briefly for this reason.

References (not included in the word count)

References must be confined to publications directly relevant to the case reported and only those quoted in the text should be listed. If possible, reference should be made to original journal articles. In the absence of relevant journal publications, reference may be made to textbooks and review articles. Unpublished data (such as course notes) or personal communications should be used only as a last resort.

Text

The names of authors must appear in the text. Unless being used in the context of the sentence they should be bracketed. If there are two or fewer authors, both names should be written and followed by the year of publication e.g. Smith and Jones 2005. If there are more than two authors use “and others”, e.g. Smith and others 2005.

Reference List

All references quoted in the text must be listed immediately after the discussion. References must be listed in alphabetical order in the format shown below (Harvard style).

If more than one of the references is to the same author or authors, they should be placed in chronological order. If the same authors and the same date occur “a” and “b” should be used.

The reference must be written in full in the reference list, i.e. Name, Initials of All Authors (not just first two authors), Year, Title of Paper, Name of journal in full (*in italics*) and Volume in **bold**. If the part of the journal is given, place it in brackets (the part is not usually recorded) and then give all page numbers e.g.:

Smith, A., Jones, B. and Evans, C. (2005a) The importance of veterinary clinical evidence-based medicine to the results of various treatments for diabetes mellitus. *Veterinary Record* **178** (5) 221 - 225

With books quote the Author(s) of the section or chapter from which referenced, date of publication, Title of section or chapter, Name of book (*in italics*), Edition, Editors or authors, Place where published, Publisher, Pages e.g: -

Smith, A., Jones, G. and Evans, C. (2005a) The importance of veterinary clinical evidence-based medicine to the results of various treatments for diabetes mellitus. Chapter 22 in *Evidence Based Medicine* 2nd. Edition (Clark, C., Blair, A. and Brown, G.: Editors) Oxford, Blackwell Scientific Limited. pp. 350 - 380

If a **website** is quoted include the title of the page, website address and date accessed
e.g. DEFRA (2005) The Animal Health Regulations. Movement Records. www.defra.gov.uk/animalhealth/movementrecords/explanation/asp. Accessed December 1, 2009

NB: These reference instructions are based on Harvard System of Referencing a copy of which is available via the following link:

https://www2.le.ac.uk/offices/ld/resources/writing/harvard

Additional Information (all of the following are not included in the word count)

Appendices

Appendices can be used to include some of the results, specific protocols for diagnostic procedures, routine preventive measures, etc.

Tables and Figures

A table consists of numbers and/or words. A figure has something pictorial in it such as a graph, histogram, diagram or digital images. In each case the table or figure must have an explanatory title. Any abbreviations must be explained in each table and not be assumed to be common knowledge.

Usually it is best to place all tables and figures at the end of the main body of the text in appendices. Each table or figure should be numbered and must be referred to in the text of the report.

Illustrations

All images must be clearly titled and, where necessary, any abnormality arrowed or indicated. A full description of the illustrations must be given in a legend or caption below or alongside the image. Reference to the illustration must be made at the appropriate point in the body of the case report text. Illustrations can be headed as “Figures”, or by the type of illustration, e.g. Radiograph 1, Photograph 1.

Considerations about digital files

Candidate anonymity is an important aspect of ISVPS examinations. The ISVPS recognises that digital files (for example, DICOM files) often contain identifying information about the patient and clinic, which may compromise confidentiality. Candidates will not be allowed to refer to this as grounds for any appeal.
In no circumstances will files be accepted that include the candidate name; always ensure that only the patient name and signalment are included if it is not possible to remove these without compromising the quality of the image. Files which include the clinic name should be avoided where possible but will not be a cause for file rejection.

Advisory note

The case report is an important developmental exercise in gaining the General Practitioner Certificate. A case report should be able to be read and understood by others; it is suggested that once it is at a final draft stage you ask a professional colleague to read it. Ask them to see if they can understand it without having to ask you questions. The case report should, if properly written, have dealt with all potential questions.

Presentation and Submission of the Case Report
The case report must be typeset, using size **12 Arial font with double line spacing**. The word count must appear at the foot of the first page of the main text. The case report is to be uploaded onto the candidate's area of the ISVPS website by the set date given. **Please note that ISVPS uses Turnitin software to detect plagiarism.**

Marking
Overall, to obtain a pass a candidate must secure 50% or more of the available marks. Candidates with 49% or less will be deemed to have failed and will need to re-submit a **NEW** case report.

The ISVPS marking rubric is detailed in Appendix 1.
All case reports in the same discipline will be marked according to a standardised scheme.

Case Report Pass
When a candidate receives a pass mark for their report, this will be retained regardless of the results in the other parts of their assessments. The validity of the case report pass continues for three years so that, if failed, the examination can be re-taken without submitting a further case report.

Case Report Conditional Pass
A candidate may be awarded a conditional pass for their case report where minor technical errors are noted. The candidate must complete the advised technical corrections within the specified time frame (typically 2 weeks) for the case report to be deemed as passed.

Case Report Failure
A failure will mean that the candidate cannot gain the certificate until such time as the case report has been successfully completed, regardless of their results in the other parts of the General Practitioner Certificate examination. Usually, if a case report submission fails, the examiner will provide a summary of the strengths and weaknesses in order to help the candidate to write their **new** case report successfully.

Checklist for all cases:
- CASE REPORT ANONYMISED?
- Word count provided?
- Formal/scientific language?
- SI units used?
- Introduction briefly sets the scene?
- Clinical examination detailed and complete?
- Problem lists constructed based on history and clinical findings?
- Reasons for performing diagnostic tests explained?
- All abnormal results adequately explained?
- Do all tables, etc., include reference ranges and units?
- Logical approach followed?
- Drugs listed as outlined in ISVPS guidelines?
- Discussion compares and contrasts the case in question with theavailable

literature?

- References listed as shown in ‘The Harvard System of Referencing’?
- References used in the report match those listed in the reference list?
- Images of sufficient quality to add to the report?
- Images and figures adequately explained?
- Electronic copy submitted as a single PDF document to Turnitin