European Veterinary Dental College

EVDC Guidance Document

Case Reports

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This document:

- **Comes into force on 1st August 2012**
- **Supersedes previous case report documents dated prior to 1st august 2012**
- **Is superseded by future case report documents coming into force after 1st August 2012**

Case Reports

The latest version of this document is available from the College web site : http://www.evdc.info/

Introduction

The applicants for entry into the European Veterinary Dental College (College) must submit two high standard case reports. These case reports are a required part of the application to provide a means of evaluating the applicant's level of competence. Case reports allow assessment of the applicant's ability to think through and perform procedures, and make clinical decisions that are supported by published literature or for which a valid justification can be provided by the author. Each case report should demonstrate proficiency, skill, expertise and theoretical knowledge in the proper management of a clinical case.

These case reports may be submitted for pre-approval prior to application for College membership. Pre-approval is strongly recommended. Submissions made for pre-approval will be evaluated anonymously. This is not possible when case reports are submitted with an application for College membership. Please note that submissions made for pre-approval must be submitted at least 4 months before a membership application will be submitted.

As a case report may not be approved, it is wise to keep a "back-up" list of suitable cases that have available illustrations and follow-up, so that an additional case report can be prepared if necessary.

Submission

All case reports must be submitted as PDF documents using the College Training Management System (TMS).

Case report content

A case report must be a well-written and well-documented English language clinical paper about a patient that the applicant has managed well by current standards. The paper must be well organised in a manner similar to that commonly used for publication. The case description should be sufficiently detailed for a reader to repeat described procedures.

When reviewing a case report, the Credentials Committee (CC) does not just consider the technical skill and diagnostic ability of the applicant but also their ability to evaluate the patient as a whole. Approval of a case report depends on documentation of excellence and thoroughness in managing the patient from presentation through to and including follow-up.

When considering whether a patient may be appropriate for a case report, one should keep in mind the need for documentation of the patient (photographs, radiographs, etc.), and the need for documented follow-up. It is not necessary to select a complex case, or one in which advanced technology or procedures were used. However, since the standard required is that of an entry level specialist, cases that are commonly performed by veterinarians who are not specialists, such as routine scaling and extraction cases, are not appropriate.

All case reports should be written as anonymous documents even if they will be submitted at the time of applying for College membership.

Assessment of case reports

The standard by which a case report is evaluated will be the same whether the case report was submitted for pre-approval or with an application package. It is strongly recommended that applicants read through the requirements for case reports given below very carefully before selecting a patient and preparing a case report.

Review prior to submission

Whilst a case report must be the work of the trainee, assistance should be sought to review the manuscript for errors, omissions and correct use of English. One of the reviewers should be the trainee's supervisor.

After the case report is prepared, it should be thoroughly reviewed again by the author prior to submission, using the evaluation criteria set out in the "Case report evaluation form" detailed below.

General Requirements

These requirements are applied to all case report submissions for consistency, whether or not they are submitted anonymously.

1. The trainee must have been the primary clinician during the described treatment.
2. The described case or cases must be included in the applicant's case log.
3. The trainee must be the sole author of the submitted case report.
4. The case report must be written in English.
5. The case report must not have already been published or submitted for publication. *Once a case report has been approved, it may be revised and submitted for publication if the author so wishes*.
6. The case report must not include any reference to the author's name, practice, institution or any other information that would potentially identify the author or their location.
7. Drugs and materials must only be referred to using generic names, not by trade names, and no mention should be made of manufacturers or their location.
8. Each case report must have a specific, different dental/oral surgery clinical discipline as its primary topic i.e. one of periodontics, endodontics, restorative dentistry, oral surgery, orthodontics or oral medicine.
9. The report title must start with the discipline, for example:
"*Endodontics: Standard Root Canal Therapy of a Maxillary Canine Tooth in a Dog*"
10. The techniques and materials used must meet the standard of care that would apply to an entry-level veterinary dental specialist at the time of submission of the case report.
11. It is strongly recommended that before it is submitted the case report is reviewed by someone whose first language is English. The reviewer must not make any contribution to the clinical or scientific content of the case report. *This review is necessary when the author's first language is not English as idiosyncratic language use may reduce or breach anonymity and makes reading more difficult for reviewers*.

Format and Content of a Case Report

1. **Title:**
   The title of the case report includes the discipline followed by a brief description, for example,
   "*Oral Surgery: Rostral Maxillectomy for Treatment of Plasmacytoma in a Cat.*"
2. **Introduction:**
   Introduce the topic of the case report. A brief statement describing why this particular case was selected may be relevant. A concise literature review is not required in the introduction, though it may be appropriate depending on the subject of the case report.
3. **History:**
   a. Describe the patient including indications of species, breed, age and sex.
   b. Describe the presenting problem or chief complaint, as reported by the client.
   c. Describe past dental history and home oral hygiene.
   d. Describe past medical history if relevant.
   e. Describe lesion(s)/problem(s).
   f. Describe any other relevant problems.
4. **Diagnostics:**
   a. Include details of physical and oral examination findings, laboratory results, radiographs, CT, etc.
      i. Demonstrate attention to the patient as a whole, so report appropriate pre-operative diagnostics and laboratory tests.
      ii. Demonstrate appropriate investigation of the subject of the case report.
   b. Illustrate with diagnostic images as appropriate.
      i. Clinical photographs.
      ii. Radiographs.
      iii. CT/MRI/Ultrasound scans.
      iv. Other.
   c. Do not include unnecessary illustrations.
      i. If a full-mouth radiographic series was obtained, only directly relevant and/or representative radiographs should be included.
      ii. When multiple images were obtained of a local or distant field, include only representative images. For example, with 3 radiographic view metastasis screening of the thorax, only one representative view would be necessary.
   d. An interpretation of all the illustrations must be presented, either within the main text or in a legend accompanying the illustration.
   e. It is NOT appropriate to include copies of dental charts as these compromise anonymity.

5. **Diagnosis and/or Problem List:**
    a. Provide an accurate assessment including provisional and/or definitive diagnoses for all the lesions relevant to the case report using appropriate classifications, if applicable.
    b. Include information on how the various diagnoses were, or could be, either confirmed or ruled-out.
    c. Mention all other lesions observed in or around the oral cavity.
6. **Treatment Plan:**
    a. Describe the range of possible treatment methods for the primary condition/s, along with their expected prognoses. Justify the instituted treatment plan based on the information available.
    b. Address any potential genetic implications of the condition.
    c. Other lesions should be briefly discussed and their treatment or non-treatment justified.
7. **Treatment:**
    a. Briefly describe anaesthetic and patient support protocols used, including:
        i. Pre-operative, intra-operative and post-operative drugs (using generic names), dosages and route of administration.
        ii. Intravenous fluid support.
        iii. Body temperature support.
        iv. Monitoring techniques and frequency.
        v. Pay particular attention to any need for pain recognition and management.
    b. Describe the oral/dental procedures in detail, including:
        i. Technique, equipment, instruments and materials, using correct terminology and generic names.
        ii. For procedures involving surgery, describe the incision (location, type, length) and pertinent anatomical landmarks; describe suture pattern and material.
        iii. Include intra-operative and post-operative images as appropriate, (radiographs, photographs, etc.) with interpretation of the findings.
        iv. Describe the recognition, severity and management of any complications.
    c. If other lesions were treated, briefly summarize the treatment. Illustration is not required for treatment of lesions not directly relevant to the subject of the case report.
8. **Post-operative Care:**
    a. Describe immediate post-operative patient care.
    b. Describe instructions given to the client, including oral hygiene measures and medication dispensed for home use.
9. **Follow-up:**
    a. Describe the timing, extent of examination, and results of follow-up examination.
        i. The minimum follow-up period expected for endodontic, periodontal surgery and surviving oncology surgery cases is six months.

ii. The minimum period expected for restorative dentistry and soft tissue surgery cases is three months.

iii. Longer follow-up is strongly encouraged as it will usually augment the case report.

b. Appropriate follow-up radiographs and clinical images should be included.

c. Include an assessment of the treatment and revision of the short and long-term prognoses as appropriate.

d. Describe client compliance with instructions and efficacy of oral hygiene measures.

10. Discussion:

a. Briefly review the literature on the disease condition and/or procedure that is the subject of the case report.

b. Discuss important aspects of the diagnostic work-up, technique and results and compare these with previously published data.

c. Discuss alternative treatment plans, if applicable.

d. Comment on the results in the short-, medium- and, if they are available, long-term.

e. If applicable, discuss:

i. the likelihood of recurrence of the condition/lesions

ii. the ethics of providing the treatment (e.g., genetic problems)

iii. any unusual features of or difficulties encountered during the management of the case.

f. Provide appropriate references to support statements.

11. Conclusion (optional):

What conclusion, if any, can be drawn from this case?

Editorial Details

1. **Page size and text style**

   The following are recommended to maximise readability of manuscripts and maximise anonymity.

   a. Page size- A4 (210 x 297 mm)

   b. Page margins- 25 mm

   c. Line spacing- 1.5 x

   d. Font size- 12 pt

   e. Font- Times or Times New Roman.

   f. Paragraph style

      i. 6 pt spacing after paragraph, and/or

      ii. 5 mm indent on first line of paragraph

2. **Length**

   a. The expected length of a case report is 12 to 15 pages including the main text, illustrations and references, with each being limited as below.

      i. The main text content should not exceed 3000 words.

      ii. The illustrations should not exceed the equivalent of 5 pages.

      iii. The reference should not exceed 2 pages.

   b. Reports that are longer than expected may be returned unconsidered.

   c. Pages are to be clearly numbered at the right of the page footer.

3. **Illustrations**

   a. Provide illustrations to support the case report, with appropriate figure legends.

   b. Illustrations of specific small details are expected to be at approximately life size.

   c. Figures must be of good quality when viewed on-screen at 200% scale.

   d. It is easier for reviewers when figures are interspersed in the text close to the figure citation rather than grouped as a set at the end of the report. This also minimises the need for duplication of information between the main text and figure legends.

4. **References:**

   a. References must be citations of specific works that are in the public domain, e.g. journal articles, textbooks or meeting proceedings books.

   b. References must be numbered consecutively in the order in which they are first mentioned in the text. Identify them in the text using Arabic numbers either as superscripts or in parentheses.

   c. The layout of the reference list must be in the form of "*Reference number, Authors, Title, Source*", for example:
   1. Lantz GC, Cantwell HD, VanVleet JF, Cechner PE. Unilateral mandibular condylectomy: experimental and clinical results. *J Am Anim Hosp Assoc* 1982; 18: 883-890.

2. Frantar B, Pavlica Z. Temporomandibular dysplasia (jaw locking) in Irish setter: case reports. Proc 7th Europ Congr Vet Dent, Ljubljana 1998; 39-41.
3. Nelson RW. Diabetes mellitus.
In: Ettinger SJ, Feldman EC, eds. Textbook of Veterinary Internal Medicine, 5th ed. Philadelphia: WB Saunders Company, 2000; 1438-1460.

d. Personal communications are not considered appropriate as references.

5. PDF file production:

a. To maintain anonymity, the document's properties must NOT contain any identifying information, so, it is necessary to use a PDF generator that is licensed in a generic manner, not to an individual or business.

b. Text resolution- 300dpi

c. Graphics resolution- 200dpi (for on-screen viewing, not printing)

Submission and Process Following Submission of a Case Report

1. **Case reports are to be submitted on-line using the College TMS:**
    a. As individual PDF files with no other content.
    b. With a file size of under 5 MB.
    c. With clear, easily readable text content.
    d. With image quality sufficient for clear on-screen viewing at 200% size.
2. **Case reports may be submitted at any time but are assessed at set times of the year:**
    a. Those submitted with an application for College membership will be assessed with accompanying documents following the published membership application submission deadlines.
    b. Those submitted for pre-approval will be assessed immediately following each published pre-approval submission deadline.
3. **Document type when uploading:**
    a. When submitted as part of a credentials application package, the case report must be submitted as an "Application for membership & credentialing information" file.
    b. When submitted for pre-approval, the case report must be submitted as an "Anonymous case report".
4. **Supervisor checking:**
    a. When a case report is uploaded it must be checked for suitability and anonymity by the author's supervisor.
        i. If all is well, the supervisor sets it as "OK" in TMS.
        ii. If there is a problem, the supervisor must inform the author.
    b. Once set as OK:
        i. If it is submitted as an anonymous document for pre-approval, the file becomes available for checking by the College Secretary.
        ii. If it is submitted as an "Application for membership & credentialing information" file, it becomes available to the CC.
    c. The author should inform the Secretary that the file is available for assessment.
        i. Immediately if it is an anonymous document submitted for pre-approval.
        ii. On completion of submission of all relevant documents if it is part of a membership application package.
5. **Secretary checking:**
    a. When notified of the presence of an anonymous upload the Secretary will check the document for obvious breaches of anonymity.
        i. If there is a problem, it is referred back to the author.
        ii. If it is OK, it is made accessible to the CC which is informed of its presence in TMS.

6. **CC Assessment**
    a. Members of the CC are allocated to assess anonymously submitted case reports as soon after the submission deadline as committee members are free to perform the task.
        i. In the case of documents submitted for pre-approval, immediate assessment may not be possible due to the CC's pre-existing work load. *Applications for College membership are subject to separate assessment timetables.*
        ii. Delay of start of assessment should not exceed 6 weeks after the submission deadline.
        iii. The assessment process itself can take 6 weeks.
        iv. If the author has not had the results of assessment within 3 months of the deadline following submission of the case report they should contact the College Secretary.
    b. If there are minor points requiring clarification, an enquiry will be sent to the author via the Secretary. This may delay availability of the assessment result.
    c. The results of the assessment will be recorded in the College TMS.
        i. If the case report has not been approved, a brief summary of the reasons will be provided both in TMS and by email.
7. **Resubmission of a rejected case report is not permitted.**

Rebuttals and Appeals

If a case report is not approved, the author may submit a rebuttal of the CC's decision to the College Secretary who will pass it on to the CC maintaining the author's anonymity where appropriate. A rebuttal must explain why the applicant considers each of the reasons listed by the CC for not approving the case report is inappropriate.

Please refer to the Constitution and Bylaws for further information.

EVDC Case Report Evaluation Form

File ID:

Discipline:

Case Report Title:

Assessors are required to provide reasons for any negative answers **OK?**

1. **Is the signalment complete?** { }
   Species, breed, age, sex.
2. **Adequate description of history, presenting problem and clinical exam?** { }
   Chief complaint, physical examination and other relevant findings.
3. **Are appropriate diagnostics included?** { }
   Oral examination, lab work, radiographs, histology, etc.
4. **Is assessment and/or diagnosis of the case appropriate?** { }
   Diagnosis/differentials, discussion of confirmation and rule-out.
5. **Is the treatment plan appropriate for the problem?** { }
   Discussion of appropriate options.
6. **Are anaesthetic protocol and peri-operative care sufficient and appropriate?** { }
   Pre-anaesthetic assessment, anaesthesia, monitoring, homeostasis, analgesia.
7. **Is the dental/oral treatment appropriate and likely to succeed?** { }
   Currently accepted techniques, management of complications.
8. **Is any choice and use of dental/other materials appropriate?** { }
   Details given, choices explained in discussion if appropriate.
9. **Are the included illustrations sufficient and appropriate?** { }
   Identification of all significant findings seen in illustrations.
10. **Is post-operative care adequate and appropriate owner instruction given?** { }
    Recovery from anaesthesia, discharge instructions, pain management.
11. **Is the re-examination or follow-up appropriate?** { }
    Sufficient frequency and appropriate timing and type to verify procedure outcome.
12. **Is the discussion satisfactory?** { }
    Justification of diagnosis, treatment, materials, alternatives, etc.
13. **If relevant, is genetic counselling discussed?** { }
    Possibility/likelihood of hereditary condition or predisposition.
14. **Is the referencing appropriate and sufficient?** { }
    Main points referenced, suitable references, correctly numbered references.

Result of assessment:

All sections OK	*Recommend*	*APPROVAL*
Not all OK	*Recommend*	*Request clarification / Do not Approve*

Name of assessor: **Date:**

Reasons if not recommending approval: