How to Write the Case Discussion

The following are instructions on how to write the Case Discussion;

1. The Case Discussion should be a ***brief*** narrative review of the case, based on the presenting signs and symptoms, and demonstrating appropriate clinical reasoning in the diagnosis and management. It should be patient-focused/patient-centered with emphasis on the critical issues influencing the decision-making in the case.

2. The discussion should include the following in proper sequence:
   A. Complete History and Physical Examination
      1) Chief Complaint
      2) History of Present Illness
      3) Past History
      4) Family History
      5) Personal and Social History
      6) Menstrual History
      7) Obstetrical History
      8) Systems Review
      9) Condition on Admission
      10) Physical Examination
   B. Laboratory Examinations/Ancillary Procedures
   C. Admitting Diagnosis
   D. Pre-operative Diagnosis
   E. Type of Operation; Operative Technique and Operative Findings
   F. Post-operative Diagnosis (include necessary post-operative discussion)
   G. Friedman's Curve or Partogram (for dystocia and failed induction cases)
   H. Course in the Ward/Post-operative Management
   I. Final Diagnosis
   J. Discussion Proper: basis for diagnosis, differential diagnosis/diagnoses; justification for choice of diagnostic tests; justification for choice of management, pre-operative management; discussion of operative findings, outcome and postoperative management, and future plans for the patient.
      Discussion proper should be limited to ONE PAGE with a minimum of 500 words and a maximum of 600 words (written in ARIAL font 12 pt, single space, portrait view).
   K. References/Bibliography – correct citation (superscript in text), using LATEST references and evidence from RECENT literature, not older than 5 years.

3. Attach the following documents for every case:
   A. Photocopy of the patient data sheet (if applicable, depending on Data Privacy Policy)
   B. Operative Record (EXACT contents of the OR Record, but without patient identifiers)
   C. Technique of Operation
   D. Histopathology Report, if applicable (EXACT contents of the histopathology results, but without patient identifiers; duly authenticated/stamped "Certified True Copy" by the Records Section)

4. The grading will be based on a discussion of the salient features of the case. "Copy-paste" and plagiarism are strictly not allowed. Typographical errors and poor grammar will entail deductions.

5. Use Arial Font 12 points, single space, and in portrait view.