

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
 - 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
 - B. Physical Examination
 - C. Laboratory Examinations/Ancillary Procedures
 - D. Admitting Diagnosis
 - E. Pre-operative Diagnosis
 - F. Type of Operation; Operative Technique and Operative Findings
 - G. Post-operative Diagnosis (include necessary post-operative discussion)
 - H. Friedman's Curve or Partogram (for dystocia and failed induction cases)
 - I. Course in the Ward/Post-operative Management
 - J. Final Diagnosis
 - K. 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).
 - L. 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.