August 29, 2024

# CREDENTIALS COMMITTEE GUIDELINES FOR APPLICATIONS

For certification to take the examination of the
American College of Veterinary Dermatology (ACVD)

Applicants should contact the Executive Secretary of the ACVD or check the ACVD website for the most current credentials as these are updated continuously. For certification to take the examination of the ACVD, each applicant must have completed the following:

I. Internship
   a. The candidate shall have served a minimum of one-year internship in a veterinary college teaching hospital, other institution, or an acceptable clinical practice.
      OR
   b. The candidate shall have completed a minimum of one-year of private practice (defined as practice equivalency) in an acceptable clinical practice as deemed appropriate by the mentor of their residency program.

II. Residency Training
   a. The candidate shall have completed a three-year residency in dermatology approved by the Education Committee. A letter from the Education Committee will be issued at the completion of the residency training stating that the candidate has satisfactorily completed this training.
   b. In addition, the Residency Completion Form, filled out by the candidate's mentor, will be submitted. This form indicates the date that the residency is or was completed and that the candidate will complete or has completed their residency in good standing.
   c. The primary mentor of an ACVD resident must have access to the resident's work for review and training purposes, including but not exclusive to:
      I. Case report
      II. Original research project (data and manuscript)
      III. Case log
   d. The primary mentor of an ACVD residency program must be included in all communications between the resident and the Credentials Committee other than the one-on-one meetings. All email correspondence between a resident and the Credentials Committee must include the primary mentor. Telephone communications either must directly involve the primary mentor or the mentor must be immediately updated regarding the topic of the specific communication.

III. Case Reports: Case reports assess a resident's ability to work through a case and demonstrate their critical thinking skills. This is also an opportunity for the credentials committee to assess the resident benchmarks. For this requirement, the candidate must have been the primary clinician throughout the diagnosis and management of the case.

Case Report Format Guidelines:

a. The candidate shall submit double-spaced typewritten summaries of one dermatologic case that they have personally handled and which demonstrates the resident's clinical skills, critical thinking, scientific knowledge and writing skills. The case must have been seen during the residency program. Case reports are meant to demonstrate both the candidate's writing skills and their ability to logically work through a typically complex dermatologic case. The case report must exhibit the thought process behind the resident's decision making and those decisions should be appropriate to the history, clinical signs, laboratory results, and treatments. The resident should demonstrate management to the point of stability or conclusion (cure or euthanasia). It is recommended that all case reports be reviewed by a non-medical individual for critique of grammar, spelling and syntax, as well as reviewed by their mentor(s) for both appropriateness of the case and justifications of clinical decisions. Case reports should solely be the work of the candidate but they should be reviewed by the candidate's mentor(s) prior to submission. The resident will submit an **electronic** copy of the final version of the report for the Credentials Committee, through the ACVD Executive Secretary, to grade. The resident will also submit to the ACVD Executive Secretary a certification of review and approval of the case report signed by the mentor (see case report cover page).

   The **electronic copy of the report** **(Microsoft Word document)** must be submitted via email, time stamped no later than 11:59 PM (23:59) Pacific Time of the due date (see timetable), to the Executive Secretary of the ACVD (executive_sec@acvd.org. Submissions time stamped after the due date will not be considered and will be returned to the resident for submission at the date of the subsequent deadline. It is the candidate's responsibility to make sure all deadlines are met and that all submitted materials have been received on time. Case report due dates are currently **January 15 and August 1** of each year.

   Candidates will be notified by the chair of the Credentials Committee of the status of the case report within **8 weeks** of the submission deadline. Three members of the Credentials Committee will review the case reports and each report will receive a written critique.

   Case reports will either pass, fail, or will require further explanation. If case reports require additional explanation, the resident will receive notification and a request for a point-by-point rebuttal letter, addressing each of the concerns of the committee and highlighting the changes made by the resident. This document must be the work of the resident and must be written and submitted by the resident within **30 days** of notification from the Credentials Committee. The case report itself should also be rewritten to reflect the concerns of the committee, while staying within the guidelines

stated in III. The case itself cannot be "updated" nor the follow up time extended on the rewrite. The rewritten report must stay within the timeline in the original case report. The case report will then be reviewed again, and will either be accepted or rejected. **If the case report is not accepted, it cannot be re-submitted in the future.**

Case reports may fail and be considered not redeemable if one or more major flaws are present. Major flaws can include, but are not limited to, decisions (or lack thereof) that could have led to potential harm to the patient or other medical reasoning flaws (e.g. major diagnostic or therapeutic flaws) made during the management of the patient. The majority (>50%) of the committee members must agree about the presence of these flaws in order for the case report to fail. Please refer to attached examples (Appendix 1).

**Office hours:**

The Credentials Committee Chair (in conjunction with the immediate past-chair) invites each individual resident (or mentors) for a one-on-one meeting. These virtual meetings can be scheduled year around to discuss case selection or the results of case reports. These meetings are optional, but highly encouraged for residents planning to submit a case report in a following session. The meetings should be initiated and scheduled by the individual residents by emailing the Credentials Committee Chair directly. Office hours are separate from Resident Meetings (see IV below). Residents and their mentors are welcome to contact the chair of the Credentials Committee regarding any concern for credentials (e.g. case report, publication requirements, etc.). After contacting, a virtual meeting with the chair, the resident, and the mentor(s) will be set if necessary.

**A.** Instructions for Preparation of Case Reports

See **Appendix 1**

B. Grading of Case Reports

a. Each case report will be blindly graded by three committee members individually. Case reports are graded using a grading rubric based on a 27-point scale (see attached sheet). Each case report must receive a score of ≥ 18 from 2 of the 3 reviewers to pass the first submission. A grading score of ≤13 will result in failure and the case report will not be eligible for resubmission. Case reports with a grading score between 14 and 17 will be returned to the resident for editing and resubmission. Upon resubmission it will receive a positive or negative score (acceptable or not acceptable). In order to pass, the case must receive a positive/acceptable score from 2 of the 3 reviewers. The resident will not receive the grading scores assigned by the reviewers, but if the case report does not pass they will receive an abbreviated grading rubric, notifying them which sections were deficient, and they will receive the individual reviewers' comments. In grading case reports, the Credentials Committee will evaluate numerous factors (see

below). **It is important that the applicants clearly communicate their thought processes during each step of the case report, as the evaluation process requires a thorough understanding of the candidate's problem-solving ability and dermatological skills.** Indicate additional diagnostic tests that would have been helpful but that were not performed. Indicate your reason(s) for not performing these tests. This does not mean that the resident should run or discuss running all diagnostic tests available on each patient, but rather is meant to encourage the resident to discuss the decisions they made during the management of the case.

b. Case reports that are resubmitted must still meet all case report submission guidelines. This includes but is not limited to the spacing, page and font size requirements. The case itself cannot be “updated” nor the follow up time extended on the rewrite. **All changes made to the original report should be highlighted by the candidate.**

c. With each rewritten report, the candidate should submit a letter addressing the concerns of the Credentials Committee. There is no page limit to this letter, however it should still be written in a clear and concise manner and be free of grammatical and spelling errors.

   i. **Structural organization and clarity (including grammar/sentence structure)**
      1. Case reports must be written in a professional and grammatically correct manner. Spelling and typographical errors should be eliminated; points will be deducted for the presence of these errors. The **minimum type size is 12 point**, double spaced with normal character spacing (equivalent to an estimated 270-300 words per page). The recommended font style is New Times Roman, Calibri or Arial. Case report margins must be one inch on all sides. Case reports that do not conform to these standards will be returned for reformatting before being graded, which will reduce the available opportunities for resubmission.

   ii. **Appropriateness/difficulty of each case**
      1. **Each case report must be sufficiently complex to demonstrate a good to exceptional level of dermatological knowledge in all aspects of diagnosis and management. Please review the provided examples of appropriate versus inappropriate case reports (Appendix 1) to aid in choosing the best case.** This does not mean that the case must be an unusual disease process. Common diseases **that present a diagnostic challenge and have good follow ups are acceptable and encouraged.** Avoid using cases with serious constraints due to client financial restrictions, cases with serious constraints due to problems with client compliance or poor follow up or cases where important diagnostics and therapeutic decisions were made

by the rDVM either prior to presentation or at reevaluation examinations. Although cases that respond favorably to therapy are easier to present and are encouraged, any case that adequately conveys significant and appropriate therapy and management will be considered. Therefore, the case chosen should be one that clearly presents a well-outlined diagnostic or therapeutic challenge for the resident. **Case reports over 20 pages (excluding title page, appendices, photos and references) will not be graded.**

iii. **History taking ability**

1. The history should be concise and thorough. Prioritizing of the differential diagnoses list should be complimented by historical findings. **Limit your list of differentials to the 5 to 6 disorders most likely related to the case being reported after taking into consideration the animal's history and clinical signs.** See the grading sheet for further details.

iv. **Physical examination, dermatologic examination and lesion description**

1. A full and complete physical and dermatologic exam should be performed at each patient visit with special attention given to dermatologic lesions. Appropriate dermatological terminology should be used to describe all dermatologic lesions. See grading sheet for further details

v. **Clinical reasoning and diagnostic plan/approach**

1. All appropriate (not excessive) diagnostic tests should be performed at an appropriate time. The overall approach should be logical, cost effective, and thorough. Justifications should be given for all tests that are performed. For example, "a health screen for metabolic/systemic disorders" **is not** an acceptable reason for a CBC/biochemical profile/urinalysis, but rather the candidate should be specific in what they are looking for in each test and how it relates to his/her differential diagnoses list. Include methodology of the test(s). All abnormal test results should be discussed/explained in the case report text (including those results that relate to non-dermatological problems or a result that will be pursued in the case). See grading sheet for further details.
2. Discussion of appropriate tests that may not have been performed should also be discussed; include reasons why the test was not performed. See grading sheet for further details.

vi. **Therapeutic Management and Critical Thinking**

1. The resident should provide a logical and convincing argument to justify the diagnostics selected and the treatment plan chosen. All treatments should be complete and justified. Remember to include total dosages in addition to dose in

mg/kg or mg/lb or mg/$m^2$ used. All products and medications should have the generic name, brand name (if applicable) and manufacturer recorded as well. Potential adverse effects of medications should be discussed. See grading sheet for further details.

**vii. Client Communications and education**

1. Client communications/follow up telephone and email consultations and re-examinations should be performed at appropriate times to support response to medication, risks of medications, revision of the differential diagnoses list and alteration of treatment. Prognosis should be discussed. See grading sheet for further details.

**viii. Final discussion and conclusions**

1. Each case report should conclude with a **concise** summary of the salient features that are unusual and unique to the case, highlight specific points of interest in the case, offer learning points for the future and justify the suitability of the case. **A broad review of the literature concerning the case in question is strongly discouraged.** See grading sheet for further details.

**ix. Appendix**

1. This section should include the results of all tests including hematology, serum biochemistry, cytology, cultures, radiology, serology, histopathological descriptions, etc. All abnormal laboratory values should be **appropriately marked**. Please ensure that no clinic or patient identifying information is included in the diagnostic results. See grading sheet for further details. The appendix should also NOT be used to convey information that should be present in the text of the case report, but it can be used to expand on information provided in the text.

**x. References**

1. Appropriate references should be included. The resident should be able to defend controversial decisions with references and demonstrate that they have used the most recent literature to write the report. See grading sheet for more details.

IV. Publications of original research:

[a] The candidate shall submit one article in the field of veterinary dermatology. The publication must be **accepted** for publication in a refereed, reputable journal in which they are the first author. **It is strongly recommended that the article be submitted no later than December 15th the year before** the candidate wishes to take the board examination. However, earlier submission is strongly encouraged. If the manuscript is not accepted for publication by the initial journal, the manuscript may then be submitted to a different journal as long as the **acceptance for publication** occurs by **June**

**30** of the year in which the candidate wishes to take the board examination. **A letter or e-mail message from the editor must confirm acceptance**. The letter and/or e-mail notification must be included in the credentials packet (see below). Acceptance is defined as either **FULL** acceptance or acceptance pending only EDITORIAL CHANGES. Letters or e-mails indicating that manuscripts are accepted or acceptable PENDING revisions to comply with REVIEWERS concerns will NOT be considered as meeting the Credentials Committee's criteria for "accepted". If the article is not accepted by **June 30**, the credentials packet will be considered incomplete and the candidate will not be eligible to sit for boards in that calendar year (see the appeals option below). Residents are encouraged to include a cover letter with their research submission notifying the journal that this research is part of their ACVD resident credentials packet that requires acceptance prior to June 30th

b. The publication must be an original or retrospective study based on work done during the candidate's residency and shall provide a significant and scholarly contribution to veterinary dermatology. **Review articles are not acceptable as original research publication.**

c. If the journal the candidate wishes to publish their work in is a journal that is not on the list of acceptable journals for publication, they must choose a journal that is indexed in MEDLINE (https://www.ncbi.nlm.nih.gov/nlmcatalog). The credentials committee should be notified by email of the journal the resident wishes to publish in for final approval.

V. Presentation of work

The candidate must present their original research at the North American Veterinary Dermatology Forum (NAVDF), The European College of Veterinary Dermatology (ECVD) Meeting, the Dermatology Session of the Australian and New Zealand College of Veterinary Scientists (ANZCVS) Meeting, the Dermatology Session of the Asian College of Veterinary Dermatology or the World Congress of Veterinary Dermatology (WCVD). The candidate will submit a copy of their abstract from the proceedings of the meeting in which their work was presented.

1. In the years of the WCVD, when the meetings mentioned above are not available, the resident can choose to present his/her research project at other ABVS-approved specialty meeting (e.g. ACVIM, ACVO, ACVM, ACVP) if their project pertains to those specialties.
2. As an alternative, the candidate can present at the WCVD only in the event that the WCVD occurs before August 15 of the year in which the candidate is planning to sit for the board examination. In this event, the credential packet of the candidate will be probationally approved (if complete) until the resident presentation has occurred. At that time, the candidate will notify the Executive Secretary about the presentation so that the Executive Secretary can update his/her packet and notify the credentials chair. Only then, the chair will notify the candidate, the Board

of Directors and the chairs of the Education and Examination committee about the completion of the above-mentioned candidate. The candidates will sign an acknowledgement that the time between receiving their credentials notification and taking their exam will be shorter than recommended by ABVS.

VI. Resident meetings

The Credentials Committee requires a brief virtual meeting with each individual first and second year resident (to be completed during year 1 and 2 of the residency). These meeting are strictly confidential, and material discussed will only be shared, with the resident's approval, with the Credentials Committee Chair/immediate past-Chair and other appropriate members of the Board of Directors or other committee Chairs (Education or Exam). The purpose of these meetings is to help answer questions on credentials requirements, go over potential questions and concerns for achieving the credentials, and offer support to the resident. Residents are encouraged to prepare a series of questions on topics that they want to discuss with the committee members. Attendance at these meetings is mandatory and will be recorded in the credentials packet checklist. Failure to attend these meetings will result in an incomplete credentials packet.

Residents whose third year will fall on a WCVD year will be notified during their first-year meetings that they may need to make alternative arrangements for their presentations and should plan ahead.

The first-year meetings are generally held in the spring of year 1 and the second-year meetings in the fall of year 2.

VII. Letters of Reference

a. The board-certified dermatologist primary mentor shall prepare a statement that the candidate has satisfactorily completed 2 or 3 years of residency training. If training was received by more than one veterinary dermatologist, each one shall submit a statement.

**VIII.** Submission of credentials packet **(All items are to be submitted electronically to the ACVD Executive Secretary)**

1. The candidate shall submit the following items to the ACVD Executive Secretary:

   a. Completed application (copy of application obtained from ACVD Executive Secretary or on the www.acvd.org website)
   b. Current and complete curriculum vitae
   c. Letter confirming acceptance of original research for publication (as explained above).
   d. Copy of the publication or article as submitted for publication.
   e. Copy of the abstract from the proceedings of the meeting in which the candidate presented their original research.
   f. Letter of satisfactory completion (or progress) of the residency from the ACVD Education Committee. This notification may arrive after the

credentials packet is submitted if the candidate submitted their final progress report to the Education Committee at the same time as their credentials packet.

g. The Residency Completion Form.
h. The letter from the chair(s) of the Credentials Committee stating that the case report has passed.
i. The applicant must send a check for the exam fee, payable to the ACVD, to the ACVD Executive Secretary by June 1 of the year the examination is given **OR** the applicant may pay the exam fee using a credit on the www.acvd.org website.
j. Complete the Form: Credentials Application Packet Checklist

2. A candidate who has failed to pass the Credentials Committee review the previous years need only re-submit the item(s) that was found to be deficient in addition to the appropriate fees (see section “iv” in this section)

**3.** All materials must arrive electronically with a time stamp no later than 11:59 PM (23:59) Pacific Time on **June 1st of the year** in which the candidate desires to take the examination. **It is the candidate’s responsibility to make sure all deadlines are met and that all submitted materials have been received on time.**

**All individuals who have completed their residencies must submit their credentials to the Credentials Committee and complete the credentialing process within five (5) years of the completion of their residency. Failure to submit credentials or failure to have your credentials accepted within this allotted time will trigger an automatic review of the individual's credentials by the Education and Credentials Committees.** Additional training and/or experience may be required before further applications can be made to the Credentials Committee.

Candidates must pass the examination within 5 years of being notified that they have passed credentials. If a candidate has not passed the examination after 3 attempts, or within 5 years of submitting their credentials, the candidate is required to undergo a re-credentials process prior to taking the examination again. Candidates must submit a request to the Executive Secretary for new credentials requirements within fourteen (14) days of the post-marked date of notification of examination results. The Executive Secretary will then notify the Credentials Committee of the candidate’s desire to apply for re-credentialing. Upon receipt of this request, the Credentials Committee will decide the requirements for each candidate to satisfy this process. These requirements will be strictly at the discretion of the Credentials Committee. The Credentials Committee will send the candidate their new credentials requirements within 60 days of the Executive Secretary’s receipt of the candidate’s request. These requirements for the re-credentials process will then be submitted to the Credentials Committee prior to the June 1 deadline. Acceptance of the re-credentials requirements will be reviewed as other credentials packets and the same methods of contact will be in effect.” **A candidate may sit for the examination no more than a total of 6**

**times.**

IX. Candidates submitting credentials by **June 1** will be notified of their acceptance or rejection by **July 1** by the chair(s) of the Credentials Committee. The chair(s) of the Examination Committee will notify successful candidates as to the time and location of the examination.

X. Candidates for examination will be required to **electronically** submit either:

- Seven (7) multiple-choice questions. Each of these must have two (2) complete^ references. (See complete^ reference information on the exam question requirement document in the exam folder on the website) **OR**
- One histopathology question in a multiple-choice format with electronic images of high quality (300 DPI) at appropriate low power (4x or 10x) to identify important patterns and high power (40x) to identify all characteristic microscopic findings, ACVP or ECVP boarded pathologist report (including morphologic description and diagnosis.
- Three (3) high quality (300 DPI) digital image questions in a multiple-choice format. Each image must be of a different patient and must be accompanied by disease identification.
- Questions must be sent to the ACVD Executive Secretary by **June 1** of the year in which the candidate wishes to sit for the certifying examination.

Exam question options and question templates are available on the www.acvd.org website. Repeat candidates must submit new questions each year.

XI. Appealing Credentials Committee Decisions

a. Credential Packets: If a resident would like to appeal the decision to deny credentials to a resident who has submitted a credentials packet; that appeal should be submitted by the resident, in writing, to the ACVD Board of Directors no later than **July 15th of that year**. Appeals to deadlines will not be considered.

b. **Original Submission of Case Report:** If a resident would like to appeal the Credentials Committee decision to fail a case report not able to be redeemed (denial of re-submission) and request for a re-evaluation of the originally submitted case report, the appeal must be presented by the resident, in writing, directly to the Board of Directors via the Executive Secretary. **The appeal must be submitted within 30 days of the notification of failure from the Credentials Committee.** The original report and Credentials Committee comments must be submitted with the appeal. The Board of Directors will evaluate the appeal and decide if the case report needs to be re-evaluated by the Credentials Committee. If so, the Board of Directors will assign the case to 3 members of the Credentials Committee that were not directly involved in the evaluation of the original

submission and be asked to review the case report. A Committee member who is a mentor of the appealing resident or works for the same practice as the appealing resident must be recused. If needed, the Board of Directors may appoint an ACVD member in good standing who has previously served on the Credentials Committee. The re-evaluated case report will be reviewed against the grading rubric and receive a positive or negative score (acceptable or not acceptable). In order to pass, the case must receive a positive/acceptable score from 2 of the 3 reviewers.

c. **Re-submission of Case Report:** If a resident would like to appeal the Credentials Committee decision to fail the resubmission of the case report, the appeal must be presented by the resident, in writing, directly to the Board of Directors via the Executive Secretary. **The appeal must be submitted within 30 days of the notification of failure from the Credentials Committee.** The original report, the re-submission, both sets of Credentials Committee comments, as well as any other communication between the resident and the Committee must be submitted with the appeal. The Board of Directors will then appoint an Appeals Committee comprised of three College members to review the Committee's decision. **The Appeals Committee will review the decision of the Credentials Committee and NOT grade the case report itself**. The individuals chosen for the case report Appeals Committee must be:
    i. Members of the ACVD in good standing
    ii. Previously served on the Credentials Committee for 2 full years
    iii. Not current members of a standing committee or the Board of Directors
    iv. Not a mentor of the appealing resident or work for the same practice as any of the current Credential Committee members.

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## Appendix 1 - Case Report Cover Page to be submitted with the Case Report

# CASE REPORT COVER PAGE

Applicant's Name:_____

Applicant's Contact Address:_____

_____

_____

Applicant's Contact Number:_____ E-mail: _____

Year in which the Applicant will complete the residency:_____
The Institutions Medical Record Number for this Case is:_____

Please have your mentor/s check one of the options below:
__ I/We **have** reviewed this case report prior to submission
__ I/We **have not** reviewed this case report prior to submission

I, the Applicant, verify by signing below that I have maintained primary case responsibility for the case described in this case report. Additionally, by signing, I verify that this case originally presented and was managed by me during my residency training period. (Please sign and print or type name)

_____
Applicant's Signature Date

I, (we), the mentor(s), verify by signing below that the Applicant has maintained primary case responsibility for the case described in this case report. Additionally, by signing, 1) I, (we) verify 1) the Institution's Medical Record Number for this case, 2) that this case originally presented and was managed by the Applicant during the residency training period. 3) Information filled out above is correct (Please sign and print or type name)

_____
Primary Mentor Date

_____
Co-Mentor Date

## Appendix 2 - Instructions for Preparation of Case Reports (Microsoft Word Document)

Instructions for Preparation of Case Reports:

1. The **cover page** of each case report must include:

    1) A statement that the candidate maintained primary case responsibility throughout the described period
    2) The institution's medical record number for the case
    3) Verification of the institution's medical record number by the mentor
    4) The applicant's name
    5) The applicant's current address
    6) The applicant's contact number and email
    7) The year in which the applicant's residency will be completed
    8) The signature of the applicant's mentor(s) approving the case report submission

The ACVD Executive Secretary will assign each case report a non-consecutive number. These steps must be taken to protect the candidate's anonymity and to ensure that each case report is graded on its own merits. It is the candidate's responsibility to help the Credentials Committee's attempts to maintain anonymity so all clues as to where the case was seen should be deleted from the case.

2. The **second page** of each case report should have only the title of the case report. This should be centered in the middle of the page and written in upper case letters in New Times Roman, Calibri or Arial 12 point. The title page should not contain any other identifying characteristics (for example: binder holes, underlining, page numbers, and other markings).

**3. Date sequencing**

The candidate should omit dates from the case report text. The time sequence should be listed as Day 0, etc.

**4.** Case report **length**

**The length of each case report is limited to 20 pages**. In order to maintain some continuity of style and anonymity of an individual's case reports, and to ease the reviewer's task, the following margins, font size, and word count are required:

1) Margins should be one inch on all sides (8.5 x 11 inch paper),
2) Type size should be no smaller than 12 point for an estimated 270-300 words per page, with normal character spacing,
3) The recommended font is New Times Roman, Calibri or Arial.
**4)** Case reports violating these rules may be disqualified and not

graded**.**

5) Page numbers should be located at the bottom right of each written page.

**The ACVD Executive Secretary prior to their dissemination to the Credentials Committee will review these materials to determine if they meet the formatting requirements.**

5. A **problem-oriented medical record approach** should be used, and the following format is **strongly** suggested for case reports: SIGNALMENT(age, sex, breed, color, weight).

HISTORY TAKING

Maintain anonymity and avoid the use of patient names.

PHYSICAL EXAMINATIONS

The initial presentation date should be labeled as "Day 0" with re-examinations labeled as the number of days since the initial presentation. Avoid the use of actual dates.

CLINICAL REASONING AND DIAGNOSTICS

This section must include, but is not limited to a problem list, a differential diagnoses list, and diagnostic plan. The differential diagnoses should explain and correlate with the problem list. Please list the problems together before giving the differentials for each one. **Limit the differential diagnoses list to the 5 to 6 disorders most likely related with the case being reported after taking into consideration the animal's history and clinical signs. The differential diagnoses should be ranked in order of likelihood.** Explain your decisions—remember we want your thought process throughout your case report. **Summarize this section with a tentative working diagnosis**. Discuss which tests were performed and how and why they were performed. Discuss tests that may **not** have been performed and **why.** Utilize this section to interpret and discuss all abnormal findings, not necessarily to state the results of each individual test. One may utilize the appendix to list test results and detailed histopathological descriptions.

THERAPEUTIC MANAGEMENT

This section should include all medications administered (including the dosage in mg/kg of body weight, frequency of administration, duration and side effects).

DISCUSSION AND CONCLUSION

A concise case summary; include unusual characteristics or points of interest, highlight specific points of interest in the case, offer learning points for the future and justify the suitability of the case.

REFERENCES

APPENDIX

Utilize this section to list test results and detailed description of cytology, histopathology, etc. Laboratory results should be listed in table form and in chronological order. Normal values for the particular reference laboratory should be given. **All abnormal values should be highlighted by listing values in a separate column, by bold print or by an asterisk.** Photographs, Kodachrome slides, or photomicrographs are optional and may be included.

**Re-examination visits** should also follow this format (exclude signalment).

All **telephone and email consultations** should include the number of days following the initial presentation, the history since the last examination/consultation, the assessment, and the treatment recommendations.

See the example sample case reports included in this packet. Please remember to go over the attached comments to the reports as well.

Also see grading sheet for further details.

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## Appendix 3 – case report rubric and examples

### ACVD Case Report Grading Rubric

Reviewer's Name: _____Date: _____

Case Report Code Number: _____ Total Point Score: _____

| Criterion | Inadequate | Deficient | Satisfactory | Excellent |
|---|---|---|---|---|
| Points awarded | 0 | 1 | 2 | 3 |
| **1) Structural organization and clarity** | Writing is unfocused, confusing, disorganized and fails to communicate effectively. Contains serious and frequent errors in grammar and spelling. May or may not include signalment nor maintain anonymity throughout text. Fails to follow formatting instructions. Uses too few or inappropriate references presented poorly. | Consistent grammatical and spelling errors, suffers from confusing organization but can be understood. May or may not include a complete signalment. May or may not maintain anonymity throughout text. Frequent errors in formatting. Provides few or faulty references. | Occasional grammar or spelling errors but still a clear presentation of ideas. Organizational flow is adequate. Provides a complete signalment. Maintains anonymity throughout text. Follows formatting instructions. Offers appropriate references. | Excellent demonstration of clarity, conciseness and logical writing. Writing style of high quality and largely free of grammar and spelling errors. Provides a complete signalment. Maintains anonymity throughout text. Follows formatting instructions. Provides excellent references taken both from traditional texts and the most up-to-date journals to defend and support differentials, diagnostics, treatments. |
| **2) History taking** | Fails to offer a clear summary of the initial presenting complaint(s), without a clear timeline, and provides a verbose or seriously deficient patient history that is unfocused, confusing, or irrelevant to the case. Routinely omits multiple integral details on patient and disease history. Fails | Consistent deficiencies are found throughout the patient history that is inadequately written and not fleshed out. On several occasions overlooks report guidelines pertaining to drug name, brand, and dosage. May or may not offer details on current | Describes the initial presenting complaint(s), and offers a summary of relevant referral history which includes most, though perhaps not all, salient details, including general systemic health, seasonality or patterns of disease, pruritus scoring (if applicable), familial and travel history, zoonotic history, endo and | Offers a concise statement of initial presenting complaint(s) and duration, with an exceptional, thorough, yet succinct referral history including general systemic health, seasonality or patterns of disease, pruritus scoring (if applicable), familial and travel history, zoonotic history, endo |

| | | | | |
|---|---|---|---|---|
| | to follow report guidelines with respect to drug name, brand, and dosage. May or may not offer details on current therapy. | therapy. | ectoparasitic history, vaccination and viral status, and past response to therapies. For the most part, follows report guidelines pertaining to drug name, brand, and dosage. Includes current therapy. | and ectoparasitic history, vaccination and viral status, and past response to therapies while following report guidelines pertaining to drug name, brand and dosage. Provides thorough details on current medications, supplements, diet, and environment. |
| **3) Physical examination skills** | Physical examinations, both general and dermatologic, are seriously deficient. Dermatologic terminology is very weak to inappropriate. Presentation of findings is erratic, disorganized, and minimal. Clinical progress, if assessed at all, is superficial at best. | Physical examinations, either general or dermatologic, are incomplete with regards to organ systems, and superficial in the manner in which findings are presented and developed. Dermatologic terminology is weak. Changes between examinations, either progress or set back, is not clearly presented nor developed. | Performs a fairly complete physical and dermatologic examination at each visit and presents the findings in a straight-forward manner. For the most part includes all vital signs except on a few occasions. Uses appropriate dermatologic terminology most of the time, with some room for further improvement. Able to differentiate obvious improvements and setbacks. | Consistently performs an excellent and complete physical examination and dermatologic examination which are presented in a clear, organized, and consistent manner. Always includes all vital signs. Elaborates key physical examination findings and associated subtleties. Uses accurate dermatologic terminology demonstrating strength for detail and capturing the more subtle nuances between examinations. |
| **4) Clinical reasoning and diagnostics** | Demonstrates poor reasoning with little to no consideration of pertinent factors that impact the diagnostic plan. The problem list is seriously deficient or highly inaccurate. Problem presentation is inconsistent and varies throughout text causing confusion to the reader. The differential diagnoses | Demonstrates deficient reasoning that fails to consider some pertinent factors that impact the diagnostic plan (with major omissions). The problem list has multiple inaccuracies. Problem presentation shows | Demonstrates fair to good reasoning that considers other pertinent factors that impact the diagnostic plan (with some omissions). Generates a good problem list that may sometimes show inaccuracies in format at each re-assessment. Considers the top 5 or more differential diagnoses and ranks | Demonstrates excellent reasoning that considers all pertinent factors that impact the diagnostic plan. Generates a complete problem list and maintains a consistent format at each re-assessment. Considers the top 5 to 6 differential diagnoses after taking into careful |

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| | considered are inappropriate, or weakly supported by the case. Little to no discussion on test findings. | inconsistencies throughout the text. Considers too few, or too many (> than 6) differential diagnoses without ranking or showing reasoning for the most likely differential. Discussion of tests performed is weak and there is minimal to no discussion on why other pertinent testing was not carried out. Testing specifics and methodology are lacking. | these. Good discussion of tests performed with fair reasoning for why other tests were not selected (though room for improvement is noted). Testing specifics and methodology are fair though not all details may be offered. Discusses abnormal test results in a reasonable manner. | consideration the patient's history and clinical signs and ranks these differential diagnoses with tentative/working diagnoses. Excellent discussion of tests performed and offers strong reasoning for why certain diagnostics were selected or omitted. Includes all specifics on testing including methodology. Offers a strong deliberation of normal and abnormal test results. |
| **5) Therapeutic management** | The medical treatment plan is wrought with serious flaws in reasoning and decision-making and does not consider the patient's overall systemic health, nor client needs. Medical choices are poorly explained, if explained at all, and are not supported by appropriate references. Monitoring parameters are lacking and patient follow up is inappropriate. May or may not follow specific guidelines on listing drug therapy including dose (mg/mg) of drug and dosing per kg per day (mg/kg/day). | The medical treatment plan has multiple flaws in reasoning and displays faulty decision-making that fails to consider the patient's overall systemic health and client needs. Medical choices are superficially explained, and supported by few references. Monitoring parameters are superficially acknowledged and patient follow up is minimal at best. May or may not follow specific guidelines on listing drug therapy including dose (mg/mg) of drug and dosing per kg | Formulates and executes a satisfactory medical treatment plan. Offers some discussion and fair reasoning for the choice of treatment and considers at least one alternative therapy. Provides a few references for making treatment choices but may not consider all aspects of the patient's health and client needs. Offers a brief discussion on the most common side effects and some monitoring parameters or carries out some testing as follow up. Mostly follows guidelines on listing drug therapy including dose (mg/mg) of drug and dosing per kg per day (mg/kg/day). | Formulates and executes a sound medical treatment plan with excellent discussion and reasoning for choosing specific drugs while carefully considering the health needs of the patient, client, and informative literature on the disease. Carefully considers all drug side effects and implements appropriate monitoring parameters and testing protocols for excellent follow up and management. Always follows specific guidelines on listing drug therapy including dose (mg/mg) of drug and dosing per kg per day (mg/kg/day). |

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| | | per day (mg/kg/day). | | |
| **6) Critical thinking** | Provides basic, superficial and flawed arguments that are not justified, or proposes inappropriate solutions with little consideration for the patient's needs. Makes inappropriate interpretations with little or no understanding of dermatologic principles and fails to recognize the limitations of recommendations made. Demonstrates poor knowledge and understanding of the issues and makes no attempt to integrate knowledge from the literature. | Provides superficial arguments that are poorly justified or propose marginally acceptable solutions. Demonstrates flawed interpretation or limited understanding of dermatologic principles or fails to recognize limitations of the recommendations made. Makes little connection between issues identified and evidence from the literature. | Provides a sufficient argument to justify the diagnostics selected and the treatment plan chosen, which addresses most of the issues identified. Demonstrates fair to good understanding of dermatologic principles, though may fail to consider some of the limitations of the plan. Makes appropriate although somewhat vague connections between some of the issues identified and the evidence from the literature. | Provides logical and convincing arguments to justify the diagnostics selected and the treatment plan chosen. Provides well documented evidence with a strong knowledge base and understanding of dermatologic principles, and presents a balanced and critical view while acknowledging limitations or shortcomings of the plan. Makes appropriate and powerful connections between identified issues and evidence from the literature. |
| **7) Client communication and education** | Provides a superficial and flawed discussion of the disease, fails to elaborate on treatment side effects, risk and prognosis. Fails to demonstrate appropriate patient follow up, with substandard and delinquent patient care and communication, infrequent or inappropriate follow up visits. | Provides a superficial discussion of the disease and may or may not include all treatment side effects, risk and prognosis. Fails to demonstrate appropriate patient follow up either with infrequent recheck visits, or inappropriate intervals for follow up, or relies too often on email, phone or primary veterinarian assessments. | Provides a solid discussion of disease overview, including drug risks, side effects, risk of contagion and prognosis to clients. Demonstrates adequate follow up with follow up rechecks and uses email or phone to follow up on patient progress. | Provides an excellent discussion of disease overview, complete with drug risks and side effects, risk of contagion and prognosis to clients. Offers parameters to monitor at home, demonstrates excellent follow up with appropriate recheck intervals, utilizing email and phone to stay up to date on patient progress. |
| **8) Discussion** | Inadequate and seriously deficient summary of the | Poorly written case summary that offers a superficial | Fairly well written case summary that describes the unique | Excellent case summary that is concise, yet highlights |

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| **and conclusion** | disease process that fails to highlight any salient points of interest, makes no connections with the literature, and offers few if any learning points. Fails to justify the suitability of the case selected. | description of the disease, is deficient in highlighting the unique characteristics of the case, may or may not offer points of interest, and may only superficially consider learning points for the future. Fails to justify the suitability of the case selected. | characteristics of the case selected, highlights a few points of interest, reflects on weaknesses and may or may not consider learning points for the future and makes few connections with the literature. Offers support for the suitability of the case selected. | the cases' unusual and unique characteristics, highlights points of interest, offers learning points for the future and makes appropriate and powerful connections with the literature. Strongly justifies the suitability of the case selected. |
| **9) Case selection and appropriateness** | Case selection was poor and seriously deficient and therefore did not allow for an adequate demonstration of the resident's skillset in problem assessment, clinical skills and reasoning, decision making, and prioritization during diagnostic work-up and therapeutic management. | Case selection was problematic which made it challenging to fully demonstrate the resident's skillset in problem assessment, clinical skills and reasoning, decision making and prioritization during diagnostic work-up and therapeutic management. | Case selection was fair and allowed for a good demonstration of the resident's skillset in problem assessment, clinical skills and reasoning, decision making, and prioritization during diagnostic work-up and therapeutic management. | Case selection was excellent and allowed for a complete and thorough demonstration of the resident's skillset in problem assessment, clinical skills and reasoning, decision making, and prioritization during diagnostic work-up and therapeutic management. |
| Total column score | 0 | 9 | 18 | 27 |

Grading cut-offs:

- ≥ 18 = PASS
- 14-17 = REWRITE
- ≤13 = FAIL

**Case report examples - a case that fully demonstrates a sophisticated approach to a patient not expected from most general practitioners.**

**Please note: this is NOT an exhaustive list, but a list intended to provide helpful examples as guidance for residents. A resident should always consult with their mentor in choosing a suitable case report.**

| **Acceptable** | **Unacceptable** |
|---|---|
| Atopic dermatitis (or other hypersensitivity such as cutaneous adverse food reaction or flea bite hypersensitivity) complicated by:<br>1. Bacterial infections<br>2. Demodicosis<br>3. Fungal infections<br>4. Viral infections<br>5. Other diseases e.g. s IMHA, ITP, diabetes mellitus, canine Cushing's syndrome | Uncomplicated atopic dermatitis |
| 1. Autoimmune or immune/inflammatory diseases complicated by resistant infections or adverse events, allowing you to demonstrate problem-solving skills.<br>2. Complicated drug eruptions, e.g. erythema multiforme complicated by methicillin resistant staphylococcal infections.<br>3. Unusual inflammatory diseases like Well's syndrome or Sweet's syndrome, demonstrating diagnostic and treatment approach | Uncomplicated autoimmune and immune-mediated/inflammatory diseases. E.g. uncomplicated sebaceous adenitis, uncomplicated pemphigus foliaceus<br><br>Uncomplicated and easily diagnosed, managed drug eruptions |
| Challenging endocrinopathies that allow you to demonstrate problem-solving skills. E.g. onset of hypothyroidism AND hyperadrenocorticism in an atopic dog | Uncomplicated and common endocrinopathies that affect the skin |
| Uncommon infections that require a comprehensive diagnostic and therapeutic approach, with follow-up. E.g. subcutaneous infections with pigmented fungi secondary to cyclosporine therapy, | Easily managed infectious diseases |
| Unusual parasitic diseases for your area e.g. leishmaniasis | Simple parasitic disorders e.g. uncomplicated demodicosis, scabies) |

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| Neoplastic disease (such as cutaneous T-cell lymphoma or SCC or hemangiosarcoma), or pre-neoplastic disease (such as actinic dermatosis) complicated by:<br>1. Bacterial infections<br>2. Demodicosis<br>3. Fungal infections<br>4. Viral infections<br>5. Other diseases e.g. IMHA, ITP, diabetes mellitus, canine Cushing's syndrome | Uncomplicated and easily diagnosed neoplasia and pre-neoplastic disease |

*Continued on next page…*

## Appendix 4 - Checklist ***

| Item Submitted | Receipt Date | Submit to: | Part of the credentials packet? |
|---|---|---|---|
| Case Report (electronic copies only) | Jan 15 or Aug 1 | Executive Secretary | No |
| Meeting with the Credentials Committee during the first and second year of residency | June 1 | Executive Secretary | Yes |
| Letter from ACVD Credentials Committee indicating that the submitted case report have passed review (if this option was chosen) | June 1 | Executive Secretary | Yes |
| Application | June 1 | Executive Secretary | Yes |
| CV | June 1 | Executive Secretary | Yes |
| Letter from ACVD Education Committee indicating successful completion of the ACVD residency requirements. | July 1 | Executive Secretary | Yes** |
| Residency Completion Form filled out by the candidate's mentor. | June 1 | Executive Secretary | Yes |
| Copy of the Publication | June 1 | Executive Secretary | Yes |
| Copy of the abstract from the proceedings of the meeting in which the candidate presented their original research. | June 1 | Executive Secretary | Yes |
| Proof of acceptance of the publication by June 30th of the year the candidate is submitting credentials | June 30 | Executive Secretary | Yes |
| Letter(s) of Reference | June 1 | Executive Secretary | Yes |
| Exam Payment | June 1 | Executive Secretary | Yes |

** May arrive at a later date to the Credentials Committee directly from the chair of the education committee

*** It is the candidate's responsibility to make sure all deadlines are met and that all submitted materials have been received on time.

ACVD Executive Secretary: Alexis Borich
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Nevada City, CA 95959
(619) 995-6572 cell (PST zone)
Email: Executive_sec@acvd.org