OPTOMETRISTS AND DISPENSING OPTICIANS BOARD
Te Poari o ngā Kaimātai Whatu me ngā Kaiwahakarato Mōhiti

PRESCRIBING IN GLAUCOMA: GUIDELINES FOR CASE REPORTS

Each case report is expected to provide a discussion on a patient with glaucoma, Ocular Hypertension, or who is a glaucoma suspect[1] seen by the optometrist and referred to an ophthalmologist. Each report should describe the clinical findings and summarize the treatment plan for the patient in a logical and coherent manner, and should comment on the significance of the findings and the rationale for the diagnosis and treatment plan. If there are any uncertainties or unusual features present these should also be commented upon. Reference to journal articles or text books are essential to support comments made and a short (7-10) reference list should be included.

The following three areas should be included in the case report:

- the basis on which the glaucoma was diagnosed or in the case of a glaucoma suspect, the basis on which it would be decided that the glaucoma suspect may be converting or have converted to a glaucoma patient.
- the basis on which it is decided that glaucoma is progressing or for glaucoma suspects, include the basis on which it would be decided that the patient was converting to glaucoma.
- include a discussion about the glaucoma drugs prescribed, including the rationale for the particular drug choice, and why other drugs were contra-indicated for the patient. In the case of surgical management, discuss why this was the most appropriate management for the patient.

The case reports should broadly follow the guidelines published by the Digital Journal of Ophthalmology (http://www.djo.harvard.edu/) and it would be useful to review some of the case reports presented on this open access website before preparing your cases for submission. It is anticipated that the length of each case report will be ~1,500 words.

It is essential to include the therapeutic management, as well as describing the condition. It may be desirable to detail several cases (patients) within one case report, in order to demonstrate the diversity of clinical presentations and/or management strategies.

[1] Only one of the case studies supplied may be a glaucoma suspect. The rest must be patients with diagnosed glaucoma or ocular hypertension.

Structure of the case report:

1. Abstract: Unstructured abstract (without references) up to 200 words which provides an overview of case.

2. Case report: presented in the following sequence –
    - Pertinent patient details, for example age and ethnicity. Please remove any details which may identify the patient so that patient confidentiality can be maintained.
    - Presenting complaint and history of present illness.
    - Pertinent medical and family history.
    - Examination including any specific diagnostic testing that was carried out to confirm the diagnosis of glaucoma or ocular hypertension.
    - Clinical course and progress of the disease.

4. Diagnosis: Provide your considered diagnosis giving the reasons that support this diagnosis and discuss any differential diagnoses. Photographs, visual fields, retinal nerve fibre layer results and any other relevant diagnostic testing results should also be included in this section.

5. Discussion: Discuss the causes of the condition, the possible sequelae, the systemic and ocular complications making use of journal articles and texts.

6. Management: State the therapeutic management undertaken and the reason this course of treatment was decided. Treatment options and prognosis must be discussed. Incorporation of basic science principles should be made in this section, as well as a brief discussion about the therapeutic drugs relevant to the case.

7. References: All of the references made in the case report should be appropriately identified both in the text and in a reference list.

7. Clinical record forms: De-identified clinical record forms and relevant referral letters and their responses should also be appended to the case report.