Template for presenting clinical evidence

This document is an example to be used for guidance only

For the CiPs where you are asked to submit cases, we recommend that you include a cover sheet for each case in your evidence bundle that gives a clear summary of the case and your reflections. This makes it clear what you are trying to demonstrate through submission of this case and associated documents. Please refer to the Specialty Specific Guidance for further details.

Example:

Case title	
Stage IIIC cervical cancer 3 rounds of cisplatin	
Summary of case	Provide a brief summary with relevant examinations and investigations summarised
Summary Stage IIIC squamous cell carcinoma of the cervix Chemoradiotherapy with Cisplatin 3 cycles given. External beam radiotherapy 45Gy in 25 fractions and Brachytherapy 4 fractions completed on the 30th November 2024. Post-treatment CT chest, abdomen & pelvis and MRI in January 2025 no evidence of residual disease. 55 year old lady was diagnosed of Stage IIIC squamous cell carcinoma of the cervix. She was planned for Cisplatin chemoradiotherapy followed by brachytherapy. She tolerated the first cycle of Cisplatin well and subsequently she completed the 3rd cycle well. I discussed with the radiotherapy team to treat her 10th February and the following day. She had radiotherapy on 11th February and was discharged. I discussed with her that she is not for further chemotherapy and conveyed this to the radiotherapy and the chemotherapy team and deleted her final cycle. She remains in remission and well on follow up.	
Treatment Plan	Include any supporting evidence (where relevant). Include here any changes to the plan or modifications of standard protocol, with appropriate reasoning
• Proposed treatment-Chemoradiotherapy with Cisplatin followed by brachytherapy	
Relevant Images Attached	Please summarise your involvement
1. New patient letter 2. Chemo notes1 3. Chemo notes 2 4. Chemo notes 3 5. Discharge summary 6. Email correspondence regarding appointments	

Reflection on case	Reflection involves thinking analytically about your practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible Your reflection should focus on one or more personal learning points or actions taken from this case. You can reflect on positive and negative experiences

This case provided a valuable opportunity to reflect on both the clinical and non-clinical aspects of oncology practice, particularly around patient communication, holistic care, and multidisciplinary working.

From a clinical perspective, the patient tolerated chemotherapy better than initially anticipated, despite the high disease stage and the potential for significant toxicity. Careful pre-treatment assessment, dose optimisation, and early management of side effects were essential in allowing her to complete the planned treatment without unnecessary delays or dose reductions. This reinforced the importance of proactive toxicity management and close monitoring, rather than a reactive approach once adverse effects become severe. A positive learning point from this case was seeing firsthand how anticipatory symptom control can preserve treatment intensity and ultimately contribute to improved outcomes.

A key area for reflection was communication. At diagnosis, the patient understandably found the prognosis and treatment plan overwhelming. In the early consultations, I recognised that I tended to focus heavily on clinical information and staging, which, while important, risked overshadowing the patient's emotional needs. Over time, I made a conscious effort to slow down consultations, check understanding, and invite questions. I also ensured that written information and follow-up discussions were offered. This adjustment led to a noticeable improvement in the patient's engagement and confidence in her care, highlighting how effective communication can directly impact the therapeutic relationship and treatment adherence.

This case also emphasised the value of multidisciplinary team (MDT) working. The patient benefited from coordinated input from clinical nurse specialists, dietitians, and supportive care services. Initially, referrals to supportive services were made after symptoms developed. Reflecting on this, I recognise that earlier MDT involvement could have further reduced symptom burden and anxiety. As a result, I have since adopted a more proactive approach to early referrals, particularly for patients undergoing intensive treatment.

Emotionally, this case was rewarding, as achieving remission in a patient with stage III disease reinforced the impact of evidence-based oncology care. However, it also served as a reminder of the uncertainty inherent in cancer treatment and the importance of remaining realistic while maintaining hope. Balancing optimism with honesty remains a challenging but essential skill in oncology practice.

Learning Points and Actions

Key learning points from this case include:

- The importance of proactive toxicity management to support treatment completion.
- The central role of clear, empathetic communication alongside technical clinical care.
- The benefit of early and integrated MDT involvement rather than reactive referral.

Actions taken and planned improvements:

- I now place greater emphasis on anticipatory side-effect management and early intervention.
- I consciously structure consultations to allow time for patient concerns and emotional processing.
- I routinely involve supportive services earlier in the treatment pathway for patients receiving intensive therapy.

Conclusion

This case has reinforced several core principles of good oncology practice while highlighting areas for personal development. Reflecting on both the positive outcomes and areas for improvement has strengthened my approach to patient-centred care. By applying these lessons, I aim to continue developing as a clinician and to improve the quality and experience of care for future patients.