CARE case report guidelines

CARE Checklist of information to include when writing a case report

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Topic	Item No	Checklist item description	Reported on Page Number/Line Number	Reported on Section/Paragraph
Title	1	The diagnosis or intervention of primary focus followed by the words “case report”	Page1/Line2-4	Title
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	Page2/Line5-6	Key words
Abstract (Structured summary)	3a	Background: state what is known and unknown; why the case report is unique and what it adds to existing literature.	Page1/Line21-28	Abstract/Paragraph1
	3b	Case Description: describe the patient’s demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups.	Page1/Line29-Page2/Line1	Abstract/Paragraph2
	3c	Conclusions: summarize the main take-away lesson, clinical impact and potential implications.	Page2/Line2-3	Abstract/Paragraph3
Introduction	4	One or two paragraphs summarizing why this case is unique **(may include references)**	Page2/Line32-Page3/Line6	Introudction/Paragraph 2-3
Patient Information	5a	De-identified patient specific information	Page3 /Line12	Case pesentation /
	5b	Primary concerns and symptoms of the patient	Page3 /Line12-14	Case pesentation /
	5c	Medical, family, and psycho-social history including relevant genetic information	Page3 /Line12-13	Case pesentation /
	5d	Relevant past interventions with outcomes	Page3 /Line12-13	Case pesentation /
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	Page3 /Line12-14	Case pesentation /
Timeline	7	Historical and current information from this episode of care organized as a timeline	Figure1	Figure1
Diagnostic Assessment	8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys).	Page 3 /Line14-22	Case pesentation /
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	NA(No diagnostic	NA(No diagnostic
	8c	Diagnosis (including other diagnoses considered)	Page4 /Line3-5	Case pesentation /
	8d	Prognosis (such as staging in oncology) where applicable	Page4 /Line9-10	Case pesentation /
Therapeutic Intervention	9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	Page4/Line8-9	Case pesentation /
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	Page4/Line8-9	Case pesentation /
	9c	Changes in therapeutic intervention (with rationale)	NA(No change in	NA(No change in

Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	Page4/ Line9-11	Case pesentation /
	10b	Important follow-up diagnostic and other test results	Page4 /Line10	Case pesentation /
	10c	Intervention adherence and tolerability (How was this assessed?)	Page4/Line8-9	Case pesentation /
	10d	Adverse and unanticipated events	Page4/Line9	Case pesentation /
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	Page5/Line8-12、18-21、	discussion/paragraph2-4
	11b	Discussion of the relevant medical literature **with references**	Page6/Line8-14	discussion/paragraph5
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	Page6/ Line16-21	discussion/paragraph6
	11d	The primary “take-away” lessons of this case report (without references) in a one paragraph conclusion	Page6/Line24-27	conclusion/paragraph1
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	NA(we lost contact with	NA(we lost contact with
Informed Consent	13	Did the patient give informed consent? Please provide if requested	**Yes** ☑	**No** ☐

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*As the checklist was provided upon initial submission, the page number/line number reported may be changed due to copyediting and may not be referable in the published version. In this case, the section/paragraph may be used as an alternative reference.