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”	1/1-2	title
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	2/52	abstract
Abstract (Structured summary)	3a	Background: state what is known and unknown; why the case report is unique and what it adds to existing literature.	2/33-38	abstract
	3b	Case Description: describe the patient’s demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups.	2/39-47	abstract
	3c	Conclusions: summarize the main take-away lesson, clinical impact and potential implications.	2/48-51	abstract
Introduction	4	One or two paragraphs summarizing why this case is unique **(may include references)**	3/73-85	Introduction/3-4
Patient Information	5a	De-identified patient specific information	4/87	Case presentation/1
	5b	Primary concerns and symptoms of the patient	4/89-91	Case presentation/1
	5c	Medical, family, and psycho-social history including relevant genetic information	N/A	N/A
	5d	Relevant past interventions with outcomes	4/87-89	Case presentation/1
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	4/90-92	Case presentation/1
Timeline	7	Historical and current information from this episode of care organized as a timeline	N/A	N/A
Diagnostic Assessment	8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys).	4/95	3D planning and guide
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	N/A	N/A
	8c	Diagnosis (including other diagnoses considered)	4/102-103	3D planning and guide
	8d	Prognosis (such as staging in oncology) where applicable	N/A	N/A
Therapeutic Intervention	9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	4/103-104	3D planning and guide
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	4-5/122-138	Surgical technique/1-2
	9c	Changes in therapeutic intervention (with rationale)	N/A	N/A

Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	6/139-141	Surgical technique/3
	10b	Important follow-up diagnostic and other test results	6/141-143	Surgical technique/3
	10c	Intervention adherence and tolerability (How was this assessed?)	N/A	N/A
	10d	Adverse and unanticipated events	N/A	N/A
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	6-7/151-169	Discussion/2-3
	11b	Discussion of the relevant medical literature **with references**	6-7/151-169	Discussion/2-3
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	7/170-173	Discussion/4
	11d	The primary “take-away” lessons of this case report (without references) in a one paragraph conclusion	7/171-173	Discussion/4
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	N/A	N/A
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.