CARE Checklist of information to include when writing a case report

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”	Page 1, Line 1-2	Title
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	Page 3, Line 63	Key Words
Abstract (no references)	3a	Introduction: What is unique about this case and what does it add to the scientific literature?	Page 3, Line 45-47,58-61	Abstract
	3b	Main symptoms and/or important clinical findings	Page 3, Line 47-52	Abstract
	3c	The main diagnoses, therapeutic interventions, and outcomes	Page 3, Line 52-58	Abstract
	3d	Conclusion—What is the main “take-away” lesson(s) from this case?	Page 3, Line 58-61	Abstract
Introduction	4	One or two paragraphs summarizing why this case is unique **(may include references)**	Page 4, Line 69-77	Introduction
Patient Information	5a	De-identified patient specific information	Have de-identifited	Anonymous
	5b	Primary concerns and symptoms of the patient	Page 4, Line 79-82	Case Presentation
	5c	Medical, family, and psycho-social history including relevant genetic information	Not mentioned	Not mentioned
	5d	Relevant past interventions with outcomes	Page 4, Line 82-85	Case Presentation
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	Page 4, Line 89-92	Case Presentation
Timeline	7	Historical and current information from this episode of care organized as a timeline	Page 4, Line 79-89	Case Presentation
Diagnostic Assessment	8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys).	Page 4, Line 92-100	Case Presentation
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	Page 6-7, Line 131-137	Discussion
	8c	Diagnosis (including other diagnoses considered)	Page 4, Line 92-100;	CasePresentation &
	8d	Prognosis (such as staging in oncology) where applicable	Not applicable	Not applicable
Therapeutic Intervention	9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	Page 5-6, Line 100-112	Case Presentation
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	Page 5-6, Line 100-112	Case Presentation
	9c	Changes in therapeutic intervention (with rationale)	Page 5-6, Line 102-112	Case Presentation

Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	Page 6, Line113-114	Case Presentation
	10b	Important follow-up diagnostic and other test results	Page 6, Line113-114	Case Presentation
	10c	Intervention adherence and tolerability (How was this assessed?)	Not applicable	Not applicable
	10d	Adverse and unanticipated events	Page 7, Line 136-137	Discussion
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	Page 9, Line 190-193	Discussion
	11b	Discussion of the relevant medical literature **with references**	Page 6-9, Line 120-189	Discussion
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	Page 8-9, Line 158-189	Discussion
	11d	The primary “take-away” lessons of this case report (without references) in a one paragraph conclusion	Page 9, Line 190-193	Discussion
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	Page5,Line103-105	Case Presentation
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.

SCARE 2018 Checklist			
Topic	**Item**	**Checklist item description**	**Page Number**
Title	**1**	The words “case report” should appear in the title. The title should also describe the area of focus (e.g. presentation,	Page 1, line 1-2
Key Words	**2**	3 to 6 key words that identify areas covered in this case report (include "case report" as one of the keywords)	Page 3, line 63
Abstract	**3a**	Introduction — Describe what is unique or educational about the case (i.e. what does this work add to the surgical literature, and why is this important?).	Page 3, line 45-61
	3b	Presenting complaint and investigations – describe the patient's main concerns and important clinical findings.	
	3c	The main diagnoses, therapeutics interventions, and outcomes.	
	3d	Conclusion — Describe the main lessons to “take-away” from this case study	
Introduction	**4**	Background – summarise what is unique or educational about the case. Give reference to the relevant surgical literature and current standard of care. The background should be referenced, and 1-2 paragraphs in length.	Page 4, line 70-77
Patient Information	**5a**	Demographic details – include de-identified demographic details on patient age, sex, ethnicity, occupation. Where possible, include other useful pertinent information e.g. body mass index and hand dominance.	Page 4-5, line 79-89
	5b	Presentation - describe the patient’s presenting complaint (symptoms). Describe the patient’s mode of presentation (brought in by ambulance or walked into Emergency room or referred by family physician).	
	5c	Past medical and surgical history, and relevant outcomes from interventions	

	5d	Other histories – Describe the patient's pharmacological history including allergies, psychosocial history (Drug, smoking, and if relevant, accommodation, walking aids), family history including relevant genetic information.	
Clinical Findings	**6**	Describe the relevant physical examination and other significant clinical findings. Include clinical photographs where relevant and where consent has been given.	Page 4-5, line 79-89
Timeline	**7**	Inclusion of data which allows readers to establish the sequence and order of events in the patient's history and presentation (using a table or figure if this helps). Delay from presentation to intervention should be reported.	Page 4-5, line 79-89
Diagnostic Assessment	**8a**	Diagnostic methods – describe all investigations taken to arrive at methods: physical exam, laboratory testing, radiological imaging, histopathology.	Page 5, line 89-100
	8b	Diagnostic challenges – describe what was challenging about the diagnoses, where applicable, for example access, financial, cultural.	
	8c	Diagnostic reasoning – Describe the differential diagnoses and why they were considered.	
	8d	Prognostic characteristics when applicable (e.g. tumour staging or for certain genetic conditions). Include relevant radiological or histopathological images in this section.	
Therapeutic Intervention	**9a**	Pre-intervention considerations – if there were patient-specific optimisation measures taken prior to surgery or other intervention these should be included e.g. treating hypothermia/hypovolaemia/hypotension in a burns patient, Intensive care unit treatment for sepsis, dealing with anticoagulation/other medications, etc.	Page 5-6, line 100-113
	9b	Interventions – describe the type(s) of intervention(s) deployed (pharmacologic, surgical, physiotherapy, psychological, preventive). Describe the reasoning behind this treatment	

		offered. Describe any concurrent treatments (antibiotics, analgesia, anti-emetics, nil by mouth, Venous thrombo-embolism prophylaxis, etc). Medical devices should have manufacturer and model specifically mentioned.	
	9c	Intervention details – describe what was done and how. For surgery include details on; anaesthesia, patient position, use of tourniquet and other relevant equipment, prep used, sutures, devices, surgical stage (1 or 2 stage, etc). For pharmacological therapies include information on the formulation, dosage, strength, route, duration, etc. Include intra-operative photographs and/or video or relevant histopathology in this section. Degree of novelty for a surgical technique/device should be mentioned e.g. "first in human".	Page 5-6, line 100-113
	9d	Who performed the procedure - operator experience (position on the learning curve for the technique if established, specialisation and prior relevant training). For example, "junior resident with 3 years of specialised training"	
	9e	Changes – if there were any changes in the interventions, describe these details with the rationale.	
Follow-up and Outcomes	**10a**	Follow-up – describe 1) When the patients was followed up. 2) Where. 3) How (imaging, tests, scans, clinical examination, phone call), and 4) whether there were any specific post-operative instructions. Future surveillance requirements - e.g. imaging surveillance of endovascular aneurysm repair or clinical exam/ultrasound of regional lymph nodes for skin cancer.	
	10b	Outcomes - Clinician assessed and (when appropriate) patient-reported outcomes (e.g. questionnaire details). Relevant photographs/radiological images should be provided e.g. 12 month follow-up.	Page 6, line 113-114
	10c	Intervention adherence/compliance - where relevant how well patient adhered to and tolerated their treatment. For example,	

		post-operative advice (heavy lifting for abdominal surgery) or tolerance of chemotherapy and pharmacological agents	Page 6, line 113-114
	10d	Complications and adverse events – all complications and adverse or unanticipated events should be described in detail and ideally categorised in accordance with the Clavien-Dindo Classification. How they were prevented, diagnosed and managed. Blood loss, operative time, wound complications, re-exploration/revision surgery, 30-day post-op and long-term morbidity/mortality may need to be specified. If there were no complications or adverse outcomes this should also be included.	
Discussion	**11a**	Strengths – describes the strengths of this case	Page 6-9, line 120-192
	11b	Weaknesses and limitations in your approach to this case. For new techniques or implants - contraindications and alternatives, potential risks and possible complications if applied to a larger population. If relevant, has the case been reported to the relevant national agency or pharmaceutical company (e.g. an adverse reaction to a device)	
	11c	Discussion of the relevant literature, implications for clinical practice guidelines and any relevant hypothesis generation.	
	11d	The rationale for your conclusions.	
	11e	The primary "take-away" lessons from this case report.	
Patient Perspective	**12**	When appropriate the patient should share their perspective on the treatments they received.	Page5, Line103-105
Informed Consent	**13**	Did the patient give informed consent for publication? Please provide if requested by the journal/editor. If not given by the patient, explain why e.g. death of patient and consent provided by next of kin or if patient/family untraceable then document efforts to trace them and who within the hospital is acting as a guarantor of the case report.	Page 6, line 117 Page 5, line 104

Additional Information	**14**	Conflicts of Interest, sources of funding, institutional review board or ethical committee approval where required.	Page 10, line 205-212

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