

## Narrative Review Checklist

Section/Topic	Item No	Item	Reported on Page Number/Line Number	Reported on Section/Paragraph
<b>TITLE</b>				
Title	1	Identify the report as a Narrative Review or Literature Review.		
<b>ABSTRACT</b>				
Structured summary	2	Provide a structured summary with the subsections as: Background and Objective, Methods, Key Content and Findings, Conclusions.		
<b>INTRODUCTION</b>				
Rationale/background	3	Describe the rationale for the review in the context of what is already known.		
Objectives	4	Specify the key question(s) identified for the review topic.		
<b>METHODS</b>				
Research selection	5	Specify the process for identifying the literature search (eg, years considered, language, publication status, study design, and databases of coverage).		
<b>DISCUSSION/SUMMARY</b>				
Narrative	6	Discuss: 1) research reviewed including fundamental or key findings, 2) limitations and/or quality of research reviewed, and 3) need for future research.		
Summary	7	Provide an overall interpretation of the narrative review in the context of clinical practice for health professionals, policy development and implementation, or future research.		



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

Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)		
	10b	Important follow-up diagnostic and other test results		
	10c	Intervention adherence and tolerability (How was this assessed?)		
	10d	Adverse and unanticipated events		
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report		
	11b	Discussion of the relevant medical literature <b>with references</b>		
	11c	The scientific rationale for any conclusions (including assessment of possible causes)		
	11d	The primary “take-away” lessons of this case report (without references) in a one paragraph conclusion		
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received		
Informed Consent	13	Did the patient give informed consent? Please provide if requested	<b>Yes</b>	<b>No</b>