WRITING A CASE REPORT

Introduction. Writing a case report accurately and transparently may be easier if written in a different sequence than when it is published.

First: Clearly identify the message you wish to communicate. Is this case report about an outcome, a diagnostic assessment, an intervention, a new or rare disease, etc.?

Second: Create a timeline of your case report—a visual summary of the case report (see examples of timelines that follow the CARE guidelines).

Third: Complete the remainder of the case report using specialty-specific information if necessary with appropriate scientific clarification. Write the abstract last.

Patient information should be de-identified and informed consent obtained prior to submitting your case report to a journal. If the patient is a minor or unable to give informed consent seek consent from a close relative.

Part 1 — Working Title, Timeline, Patient Narrative

1. Develop a descriptive and succinct working title that describes the phenomenon of greatest interest (symptom, diagnostic test, diagnosis, intervention, outcome).
2. Create a timeline as a chronological summary of an episode of care as a figure or table. This should begin with antecedents and past medical history through the outcome. Examples are available on the CARE website.
3. Narrative of the episode of care (including tables and figures as needed.)
   - The presenting concerns (chief complaints) and relevant demographic information.
   - Clinical findings describe the relevant past medical history, pertinent co-morbidities, and important physical examination (PE) findings.
   - Diagnostic assessments discuss (1) diagnostic tests and results; (2) differential diagnoses; and (3) the diagnosis.
   - Therapeutic interventions describe the types of intervention (pharmacologic, surgical, preventive, lifestyle) and how the interventions were administered (dosage, strength, duration and frequency). Tables or figures may be useful.
   - Follow-up and outcomes describes the clinical course of the episode of care including (1) follow-up visits, (2) intervention modification, interruption, or discontinuation; (3) intervention adherence and how this was assessed; and (4) adverse effects or unanticipated events. Regular patient report outcome measurement surveys at such as PROMIS® may be helpful.

Part 2 — Introduction, Discussion (including limitations), Conclusion

2. The discussion describes case management, including strengths and limitations with scientific references.
3. The conclusion offers the most important findings from the case.

Part 3 – Abstract & Key Words, References, Acknowledgement, Informed Consent, Appendices

1. Abstract. Briefly summarize in a structured or unstructured format the relevant information without citations. Do this after writing the case report. Information should include: (1) Background, (2) Key points from the case; and (3) Main lessons to be learned from this case report.
2. Key Words. Provide 2 to 5 key words that will identify important topics covered by this case report.
3. References. Appropriately chosen references from the peer-reviewed scientific literature.
4. Acknowledgements. A short acknowledgement section should mention funding support.
5. Informed Consent. The patient should provide informed consent and the author should provide this information if requested. Rarely, additional approval may be needed.
6. Appendices. If indicated.

Submission to a scientific journal

Follow journal submission requirements when writing and submitting your case report. You may wish to contact the journal before submitting your manuscript if you have any questions. (Download a partial list of journals that accept case reports.) Remember that journals that do not explicitly accept case reports may publish case reports as components of other articles such as brief reports or hypotheses.