CARE guidelines

The CARE guidelines were developed by an international group of experts to increase the accuracy, transparency, and usefulness of case reports. Since the 2013 and 2017 CARE publications in the Journal of Clinical Epidemiology, these guidelines have been endorsed by multiple medical journals/publishers and translated into multiple languages. Online training in writing case reports following the CARE guidelines is available from Scientific Writing in Health and Medicine (SWIHM)- https://www.swihm.com/

The CARE guidelines support the efforts of the Equator Network to improve the transparency and accuracy of health research reporting. Healthcare stakeholder groups that benefit when CARE informed case reports are written include:

Patients reviewing therapeutic options.

Clinicians engaging in peer-to-peer communication.

Researchers developing testable hypotheses from clinical settings (e.g. Driggers 2016).

Educators who have access to “real-world” examples supporting case-based learning.

Authors provided with guidance on writing accurate and transparent case reports.

Medical Journals supported in the evaluation and publication of case reports.

The CARE guidelines for case reports help authors reduce bias, increase transparency, and provide early signals of what works, for which patients, and under which circumstances. Case reports following the CARE guidelines support the systematic measurement of:

The return on investment (ROI) in healthcare, tracking costs associated with outcomes.

Clinician and patient assessed outcomes.

The effectiveness of clinical practice guidelines (CPGs).

Title – The area of focus and “case report” should appear in the title

Key Words – Two to five key words that identify topics in this case report Abstract – (structure or unstructured) Introduction – What is unique and why is it important? The patient’s main concerns and important clinical findings. The main diagnoses, interventions, and outcomes. Conclusion—What are one or more “take-away” lessons? Introduction – Briefly summarize why this case is unique with medical literature references. Patient Information De-identified demographic and other patient information. Main concerns and symptoms of the patient. Medical, family, and psychosocial history including genetic information. Relevant past interventions and their outcomes. Clinical Findings – Relevant physical examination (PE) and other clinical findings. Timeline – Relevant data from this episode of care organized as a timeline (figure or table). Diagnostic Assessment Diagnostic methods (PE, laboratory testing, imaging, surveys). Diagnostic challenges. Diagnostic reasoning including differential diagnosis. Prognostic characteristics when applicable. Therapeutic Intervention Types of intervention (pharmacologic, surgical, preventive). Administration of intervention (dosage, strength,

duration). Changes in the interventions with explanations. Follow-up and Outcomes Clinician and patient-assessed outcomes when appropriate. Important follow-up diagnostic and other test results. Intervention adherence and tolerability (how was this assessed)? Adverse and unanticipated events. Discussion Strengths and limitations in your approach to this case. Discussion of the relevant medical literature. The rationale for your conclusions. The primary “take-away” lessons from this case report. Patient Perspective – The patient can share their perspective on their case. Informed Consent – The patient should give informed consent.

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https://www.care-statement.org/

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.

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.

- 1. The introduction should briefly summarize why this case report is important and cite the most recent CARE publication. (Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D, et al. The CARE Guidelines: Consensus-based Clinical Case Reporting Guideline Development. Glob Adv Health Med. 2013 Sep;2(5):38-43)

2. The discussion describes case management, including strengths and limitations with scientific references.

3. The conclusion offers the most important findings from the case. 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. WRITING A CASE REPORT Part 1 — Working Title, Timeline, Patient Narrative Part 2 — Introduction, Discussion (including limitations), Conclusion Part 3 – Abstract & Key Words, References, Acknowledgement, Informed Consent, Appendices

CARE-writer

https://care-writer.com/