CARE case report: pre-submission self-check

A self-check in our own words, organised by the 13 CARE topics. It does not replace the official checklist from **care-statement.org**, which journals may require at submission.

Done	Check	Page no.
Title		
[ ]	The words 'case report' appear in the title.	
[ ]	The title names the main condition, intervention or observation of interest.	
Keywords		
[ ]	A small set of keywords (CARE suggests two to five) includes 'case report'.	
Abstract		
[ ]	States what is new or why the case matters.	
[ ]	Summarises presenting concerns, key findings, diagnoses, interventions and outcomes.	
[ ]	Ends with the main take-away lesson.	
Introduction		
[ ]	Briefly explains why this case is worth reporting, with a few key references.	
Patient information		
[ ]	De-identified demographics only (no names, initials, dates of birth, record numbers).	
[ ]	Main concerns and symptoms in the patient's terms where possible.	
[ ]	Relevant medical, family and psychosocial history, including past interventions and their results.	
Clinical findings		
[ ]	Relevant physical examination findings are described.	
Timeline		
[ ]	Key events are organised as a timeline (a table or figure helps), using relative time such as 'day 0, day 14' rather than calendar dates.	
Diagnostic assessment		
[ ]	Tests and investigations are described.	
[ ]	Diagnostic challenges (access, cost, cultural factors) are noted where relevant.	
[ ]	The diagnostic reasoning, including differentials considered, is explained.	
[ ]	Prognostic characteristics are stated where applicable.	
Therapeutic intervention		
[ ]	Type of intervention (for example drug, surgical, lifestyle) is stated.	
[ ]	Administration details: dose, strength, duration.	
[ ]	Any changes to the intervention are reported with the reason.	
Follow-up and outcomes		
[ ]	Clinician-assessed and, where available, patient-assessed outcomes.	

[ ]	Important follow-up test results.	
[ ]	Adherence to and tolerability of the intervention, and how it was assessed.	
[ ]	Adverse and unanticipated events.	
Discussion		
[ ]	Strengths and limitations of how this case was managed.	
[ ]	The relevant medical literature is discussed.	
[ ]	The rationale for the conclusions, including any causal reasoning, is made explicit.	
[ ]	The main take-away lessons are stated.	
Patient perspective		
[ ]	The patient's own perspective on their care is included where they wish to share it.	
Informed consent		
[ ]	Written informed consent for publication was obtained (or the journal's alternative route documented), and you can provide it if asked.	

Timeline grid (relative time)

Relative time	Event (history, finding, test, intervention, outcome)	Source in notes

De-identification sweep

[ ]	No names, initials, record or hospital numbers anywhere (text, tables, figure labels, file names)
[ ]	No calendar dates; timeline in relative time
[ ]	Images cropped or masked; specific consent for any potentially identifiable image
[ ]	Image metadata (DICOM headers, EXIF) stripped
[ ]	Indirect identifiers (exact age, location, occupation, rare details) generalised where not clinically essential
[ ]	Details omitted, not altered, to protect anonymity
[ ]	Consent obtained on the form the journal requires and stored securely

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