**CARE Checklist of information to include when writing a case report**

**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" 🞏*2 keywords, but**“case report” missing*

**Abstract (no references) 3a** Introduction: What is unique about this case and what does it add to the scientific literature? **🗹**

**3b** Main symptoms and/or important clinical findings **🗹**

**3c** The main diagnoses, therapeutic interventions, and outcomes **🗹**

**3d** Conclusion—What is the main “take-away” lesson(s) from this case? **🗹** *described under “discussion” in the Abstract*

**Introduction 4** One or two paragraphs summarizing why this case is unique (may includereferences) **🗹**

**Patient Information 5a** De-identified patient specific information **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**5b** Primary concerns and symptoms of the patient. **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**5c** Medical, family, and psycho-social history including relevant genetic information **🗹** *only medical information, other information concerning family, psycho-social or genetic information not known*

**5d** Relevant past interventions with outcomes **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**Clinical Findings 6** Describe significant physical examination (PE) and important clinical findings **🗹** *found in parts under “medical history”, but no PE was done by the authors of this case report*

**Timeline 7** Historical and current information from this episode of care organized as a timeline 🞏 *timeline table can be provided (if required), since the timeline is already described briefly under “medical history”*

**Diagnostic Assessment 8a** Diagnostic testing (such as PE, laboratory testing, imaging, surveys) **🗹** *found under “medical history”, “treatment” and “discussion of management”*

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**8b** Diagnostic challenges (such as access to testing, financial, or cultural) 🞏 *no specific challenges reported*

**8c** Diagnosis (including other diagnoses considered) **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**8d** Prognosis (such as staging in oncology) where applicable 🞏

**Therapeutic Intervention 9a** Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care) **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**9b** Administration of therapeutic intervention (such as dosage, strength, duration) **🗹** *found under “medical history”*

**9c** Changes in therapeutic intervention (with rationale) 🞏

**Follow-up and Outcomes 10a** Clinician and patient-assessed outcomes (if available) **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**10b** Important follow-up diagnostic and other test results **🗹** *found under “medical history”, “treatment” and “discussion of management”*

**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 **with references 🗹**

**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 **🗹 yes**