

Checklist for Case Reports Focusing on Differential Diagnosis / Critical Decision Making

Emphasis is on the differential diagnosis and critical decision making aspect of patient care. May cover the process and logic associated with differential diagnosis (ie, clinical decision making), unusual or difficult diagnostic/prognostic events, missed diagnoses, etc. Concentrate detail in patient history and physical examination and in conclusion or decisions made based on the examination. Challenge readers to deduce the diagnosis and to determine how the diagnosis relates to care of patient. May include interventions and outcomes, but detailed description is not expected there.

I. Title

- States that the manuscript is a case report.
- Maximum length = 150 characters (including punctuation and spaces)

II. Abstract

- Word limit = 300 words or fewer
- Structure: Background and Purpose, Case Description, Outcomes, Discussion

III. Body of Manuscript

A. Background and Purpose

- Provide scholarly discussion on the current issues related to the diagnostic/prognostic aspect of the case (eg, current state of knowledge, problems with differential diagnoses, mimicking or missed diagnoses).
- Provide rationale for why the diagnostic/prognostic approach needs to be demonstrated in a case.
- End with a purpose statement that clearly indicates the focus is related to diagnosis/prognosis (eg, "The purpose of this case report is to demonstrate the diagnostic process in ...").

B. Case Description: Patient History and Systems Review

- Provide detailed demographic characteristics, history, and summary of systems review (eg, chief complaints, other relevant medical history, prior or current services related to the current episode, co-morbidities) to demonstrate that the patient is appropriate for the diagnostic/prognostic approach.

Use relative dates (eg, years or months or days relative to onset of injury or to start of treatment) rather than absolute dates (ie, calendar dates). Reader will more easily grasp the chronology of events when the amount of time since the event or start of treatment is reported (don't force the reader to calculate the amount of time).

Explain patient/family goals for physical therapy.

C. Clinical Impression #1

Explain the primary problem.

Describe the potential differential diagnoses.

Identify additional information (not provided in the initial patient interview or history) that needed to be requested from the patient; explain how this additional information pertains to the diagnostic/prognostic aspect of the case.

Describe the plan for the examination (eg, test selection).

Explain why this particular patient is a good candidate for the purpose of the case report.

D. Examination

Describe examination procedures that are consistent with clinical impression #1 and with the diagnostic/prognostic focus of the case.

Clearly explain the rationale for using each test and measure.

Describe the examination procedures so that others could replicate them; wherever possible, include figures, tables, and supplemental appendixes and videos.

Cite available studies on reliability and validity of measurements. If not available, acknowledge this fact, and provide a presumptive argument for the potential of reliability and validity.

Clearly explain all examination data.

E. Clinical Impression #2

Provide a statement confirming or denying the initial impressions.

Give a working diagnosis/prognosis.

Indicate the plan of action (eg, proceed with intervention, further testing, referral for other consultation).

State why the patient continues to be appropriate for the case. If the decision is to proceed to treatment, state the plan for intervention based on the current data.

Include the plan for follow-up evaluation of outcomes (measures, time points). If further examination is required, address this next, indicating the additional tests and why particular tests are chosen.

F. Clinical Impression #3 (optional)

If further examination was performed, state how the course of action was revised based on the additional information.

G. Intervention

(If the case report does not have an intervention associated with it, proceed to the outcomes section.)

- Provide a general description of the physical therapy and/or medical/surgical interventions provided (eg, surgery, radiation therapy).
- Provide a general description of the intervention strategy, tactics, and procedures.
- Use tables, figures, and appendixes for the details, including only enough detail for reader to understand what was done; extensive details should not be necessary.
- Clearly link the intervention back to the diagnostic/prognostic decision-making process.

H. Outcome

- Briefly describe the outcome measures, and cite evidence for reliability and validity.
- If reliability and validity have not been estimated for a measure, acknowledge this, and make presumptive arguments that the measurements would be reasonably reliable and valid for the purpose of the case.
- Present the outcomes over the time points indicated in the follow-up plan above.
- Compare follow-up outcomes to baseline. Tables and figures can be used to enhance the description.

I. Discussion

- Provide a scholarly, critical analysis of how the diagnostic/prognostic dilemma—if any—was resolved, and how the process guided further decision making from a treatment and/or prognostic perspective.
- Compare the case to other relevant reports in the literature, and provide rationale for how this case makes a novel contribution and improves existing diagnostic/ prognostic decision-making strategies.
- Offer suggestions for future research.

IV. References

- Cite references as appropriate.

V. Tables and Figures

- Tables and figures are used to supplement the clinical case.
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