

CASE STUDY/REPORT OUTLINE

There are 2 types of Case Reports:

RETROSPECTIVE REPORTS: These are the most common and easiest because there is no preconceived expectation or design. As an example, after adjusting spinal subluxation there appears to be a favorable therapeutic response on a coexisting middle ear effusion on one or two patients. If the apparent connection between these two entities has not been previously noted the physician may present the case in published form for the benefit of similar patients, physicians and the physician profession.

PROSPECTIVE REPORTS: These are less common because they require reading the literature related to the topic beforehand and giving forethought to which assessment procedures would yield the best measure of the clinical results. As an example, enough children with middle ear effusions have responded favorably to your adjustments that you decide to devise an accurate assessment and outcome protocol for the next few patients with that presentation. A good measure in this case would be tympanometry before and after a series of adjustments, and then compare the response rate to pharmaceutical response rates.

I. The Benefits of Publishing Case Reports: Personal and Professional

1. Case reports are not difficult to write (usually 700-900 words)
2. Case reports require minimal literature search
3. Writing a case report is an easy way to be introduced to clinical research
4. Publishing a case report will make you a more credible expert witness
5. Publishing a case report will make you better able to critically evaluate other papers
6. Case reports represent the first phase of clinical research. They provide the basis, stimulus, and direction for further research
7. Case reports published in refereed, indexed scientific journals is a way to advance the profession and contribute to the pool of scientific knowledge
8. Case reports may help to establish new protocol and standards of care

II. Why Report a Case or Cases?

The case presents useful information to other clinicians, such as:

1. The case(s) presents a unique disease or syndrome
2. The case(s) illustrates an unexpected (unreported) causal relationship between two or more clinical conditions, eg., (subluxation(s) and asthma)
3. The case(s) illustrates an unexpected (unreported) favorable or adverse effect of treatment. eg., (adjusting a subluxation(s) and the favorable effect on a coexisting asthma)

III. Have Similar Cases Been Reported? (The Literature Search)

A minimum literature search would include:

1. Reviewing the subject catalogue for texts on the topic you selected
2. Reviewing Index Medicus on your topic or do a search on PubMed, Cochrane library, Scholar Google, or requesting a Medline search (on line computer search of Index Medicus, You may wish to cross reference your topic with the "key words" . It may be more practical to limit the search to the last five to ten years and limit it to English language papers.
3. Reviewing the Index to your specific field literature
4. Reviewing the Research Archives in your area of interest.

IV. Case Report Format

Reviewing previously published case reports in the journal to which you wish to submit would be very helpful with regard to format. Patient anonymity is critical.

1. Introduction

The introduction consists of a paragraph stating why the case is worth reporting. That is, how the case meets the criteria mentioned earlier and how the literature search supports it. It may also be educational, i.e., review the known etiologic factors, patient profile, presentation and course as well as standard therapies and their effectiveness.

2. History

This is derived from subjective data such as follows, and consists of a narrative of the salient features of the case.

A. The Chief Complaint

1. Biographic Information

- a. Age
- b. Race
- c. Sex
- d. Occupation
- e. Chief Complaint
- f. Its course, frequency, and duration

2. Present Illness/Details of the Complaint

- a. Date of onset, duration, course of/or frequency of the complaint
- b. Mode of onset; i.e., setting and circumstances
- c. The type of pain, sensation or dysfunction to include radiations

- d. The anatomical location of the complaint
- e. The quality, character or severity of the complaint
- f. Factors which aggravate or relieve the complaint
- g. Other complaints or systemic dysfunctions
- h. Previous treatment for the complaint and effectiveness

B. Comprehensive Health History

1. Past History
2. Occupational History
3. Social History
4. Habits
5. Family History
6. Marital History

Only information pertinent to the chief complaint should be included in a case presentation, narrative report or case report for publication.

C. Review of Systems

1. Skin, hair and nails
2. Head and neck
3. Endocrine system
4. Lymphatic system
5. Respiratory system
6. Cardiovascular system
7. Hematologic
8. Gastro-intestinal system
9. Genito-urinary system
10. Menstrual-obstetrical system
11. Musculoskeletal system
12. Neurologic system
13. Psychiatric

Only information pertinent to the chief complaint or the system of the chief complaint should be included in a case presentation, narrative report or case report for publication. These would usually be reported abnormalities.

3. Examination and Assessment

This consists of a narrative based on objective findings such as physical examination, special studies, previous medical records, consultation reports and includes your assessment.

A. Begin with an introductory paragraph which includes some pertinent observations derived from general inspection and vital signs.

1. General Inspection

- a. Gait
- b. Posture
- c. Body type and fecies
- d. Nourishment and hydration
- e. Apparent wellness or illness
- f. Appearance in relation to stated age
- g. Skin discolorations, rashes, nodules, etc.
- h. Apparent edema
- i. Venous distention or other vascular markings
- j. Apparent respiratory distress
- k. Mental status

2. Vital signs

- a. Temperature
- b. Pulse
- c. Respiration
- d. Blood pressure

B. Subsequent Paragraphs

1. Present other pertinent exam findings in an orderly fashion, i.e., orthopedic, neurologic, etc. Only information (usually abnormalities) pertinent to the case need to be reported.
2. Present pertinent special studies in an orderly fashion, i.e., x-ray findings and/or laboratory findings (present pertinent routine tests first then more complicated tests)

C. Assessment

1. Formulate problem lists
3. Cluster signs to symptoms
4. Synthesize data collected
5. Offer a clinical impression or clinical impressions

4. Treatment

This consists of a narrative summarizing your therapeutic program, which may include some of the following. It should also describe which signs and symptoms changed in what time frame.

A. Plan/Therapeutic Program

1. Program of adjustments

2. Physiotherapy
3. Supports
4. Work instructions
5. Sleep instructions
6. Activity instructions
7. Exercise instructions
8. Diet instructions
9. Etc.

B. The patient's clinical course - which signs and symptoms were altered and the patient's current status.

C. Potential complications

5. Discussion and Conclusion

This consists of an unbiased narrative of the following:

- A. Point out the salient features of the case
- B. Does the case support or contradict previous knowledge?
- C. What significance or conclusions can be drawn regarding similar cases?
- D. Can you offer a hypothesis regarding the mechanisms (optional)?
- E. What further studies can you suggest?

Your report may also include tables, graphs, illustrations and legends. These would appear in the order that they appeared in your article or in some cases, as part of the text. Refer to the journal to which you wish to submit for requirements.

6. References

All citations should be listed in the same order they occurred in your article, and in the style the journal you choose recommends.

V. Finishing Touches

1. **Title** ~ Select a concise but descriptive title for your article.
2. **Abstract** ~ A brief description of content, purpose, and outcome of your article. This is for the convenience of the reader and appears at the beginning of your article.
3. **Key Words** ~ Author should select what he/she thinks are key words. The reference desk librarian can help you. They select standard key words as used by the National Library of Medicine to index articles.
4. **Submit your paper** ~ Be sure it's in accord with the manuscript requirements of the

journal you select for submission. These appear in previous publications of the journal. Select a journal whose subscribers will be interested in your paper. One or more rewrites and resubmissions is the general rule for everyone.