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Case Report Checklist for Unique Pathological Presentation

Case describes the overall management of an unusual case or a condition that is infrequently encountered in sports physical therapy practice or poorly described in the literature. The entire care of the patient—from start to finish—is described, with no one aspect of care receiving greater focus.

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 a scholarly discussion of the importance of the topic, noting what has been published in the literature about the clinical problem and the key evaluation and treatment procedures.
- ☐ Provide rationale for why this case is needed.
- ☐ End with a purpose statement that is supported by the background information.

B. Case Description: Patient History and Systems Review

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

- ☐ 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 or condition, with a focus on the uniqueness of the problem/condition in the patient presented.
- ☐ 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 a 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 impression, based on the examination data.
- ☐ Indicate the next plan of action (eg, proceed with intervention, further testing, referral for other consultation).
- ☐ State why the patient continues to be appropriate for the case.
- ☐ State the plan for intervention based on the current data, providing the plan for follow-up evaluation of outcomes (measures, time points).

F. Intervention

- ☐ Describe the intervention, including how the intervention plan was developed and how it was applied to the patient, in sufficient, sequentially staged detail that others will be able to replicate the procedure.
- ☐ May use tables, figures, and appendixes to enhance the detailed description.
- ☐ Provide the parameters of the intervention (ie, intensity, frequency, and duration) and rules for progression.
- ☐ State changes in treatment over time, along with the rationale for the changes.
- ☐ List any co-interventions that the patient may have received but that are not directly related to the purpose of the case; detailed descriptions may not be necessary.

G. Outcome

- ☐ If not already in the examination section, provide operational definitions of the outcome measures and their purpose, and cite evidence for reliability and validity. Priority is given to

validated outcome measures. 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.
- ☐ Compare follow-up outcomes to baseline, and any known outcomes available for the problem/condition.
- ☐ Use tables and figures to enhance the description.

H. Discussion

- ☐ Reflect back on how the intervention may have assisted in addressing the target problem. This should be done in the context of other co-interventions that may have been provided. The key points of development and application should be tied back to the rationale for the treatment and literature on previous treatment approaches for a similar problem.
- ☐ Avoid any definitive cause-and-effect statements about interventions.
- ☐ Avoid making definitive generalizations to other patients.
- ☐ Speculate on potential implications for clinical practice.
- ☐ Offer suggestions for further research.

IV. References

- ☐ Cite references as appropriate

V. Tables and Figures

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