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

| Topic                              | Item No | Checklist item description                                                                 | Reported on Page Number/Line Number | Reported on Section/Paragraph                  |
|------------------------------------|---------|---------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------|
| **Title**                          | 1       | The diagnosis or intervention of primary focus followed by the words "case report"           | Page 1/ line 1-2                    | Title page                                    |
| **Key Words**                      | 2       | 2 to 5 key words that identify diagnoses or interventions in this case report, including "case report" | Page 3/line 42-43                  | Abstract and keywords                         |
| **Abstract**                       | 3a      | Background: state what is known and unknown; why the case report is unique and what it adds to existing literature. | Page 2/line 21-27                  | Abstract/ Paragraph 1                         |
| **Abstract**                       | 3b      | Case Description: describe the patient’s demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups. | Page 2/line 28-36                  | Abstract/ Paragraph 1                         |
| **Abstract**                       | 3c      | Conclusions: summarize the main take-away lesson, clinical impact and potential implications. | Page 2/line 37-41                  | Abstract/ Paragraph 1                         |
| **Introduction**                   | 4       | One or two paragraphs summarizing why this case is unique *(may include references)*          | Page 3/ line 44-60                  | Introduction/ Paragraph 1                    |
| **Patient Information**            | 5a      | De-identified patient specific information                                                  | Page 3/ line 62-63                  | Case-presentation/para                        |
| **Patient Information**            | 5b      | Primary concerns and symptoms of the patient                                                 | Page 4/line 64-72                  | Case-presentation/para                        |
| **Patient Information**            | 5c      | Medical, family, and psycho-social history including relevant genetic information            | Page 4/ line 64-67                  | Case-presentation/para                        |
| **Patient Information**            | 5d      | Relevant past interventions with outcomes                                                   | Page 4/line 68-70                  | Case-presentation/para                        |
| **Clinical Findings**              | 6       | Describe significant physical examination (PE) and important clinical findings              | Page 4/line 73-77                  | Case-presentation/para                        |
| **Timeline**                       | 7       | Historical and current information from this episode of care organized as a timeline        | Page 5/line 105                    | Case-presentation/para                        |
| **Diagnostic Assessment**          | 8a      | Diagnostic testing (such as PE, laboratory testing, imaging, surveys).                      | Page 4/line 77-Page                | Case-presentation/para                        |
| **Diagnostic Assessment**          | 8b      | Diagnostic challenges (such as access to testing, financial, or cultural)                  | Page 5/line 91-97                  | Case-presentation/para                        |
| **Diagnostic Assessment**          | 8c      | Diagnosis (including other diagnoses considered)                                            | Page 5/line 94-96                  | Case-presentation/para                        |
| **Diagnostic Assessment**          | 8d      | Prognosis (such as staging in oncology) where applicable                                     | N/A                                | No standard prognostic                        |
| **Therapeutic Intervention**       | 9a      | Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care) | Page 5/line 91-98                  | Case-presentation/para                        |
| **Therapeutic Intervention**       | 9b      | Administration of therapeutic intervention (such as dosage, strength, duration)             | Page 5/line 97-100                 | Case-presentation/para                        |
| **Therapeutic Intervention**       | 9c      | Changes in therapeutic intervention (with rationale)                                        | N/A                                | No change occurred                           |
| Follow-up and Outcomes | 10a | Clinician and patient-assessed outcomes (if available) | Page 5/line 99-101 | Case-presentation/para |
|------------------------|-----|------------------------------------------------------|-------------------|------------------------|
|                        | 10b | Important follow-up diagnostic and other test results | Page 5/line 102-105 | Case-presentation/para |
|                        | 10c | Intervention adherence and tolerability (How was this assessed?) | Page 5/line 101-102 | Case-presentation/para |
|                        | 10d | Adverse and unanticipated events | N/A | no other adverse |
| Discussion             | 11a | A scientific discussion of the strengths AND limitations associated with this case report | Page 8/line 163-166 | Discussion/Paragraph 5 |
|                        | 11b | Discussion of the relevant medical literature with references | Page 6/line 113- page | Discussion/Paragraph |
|                        | 11c | The scientific rationale for any conclusions (including assessment of possible causes) | page 7/line136-151 | Discussion/Paragraph |
|                        | 11d | The primary “take-away” lessons of this case report (without references) in a one paragraph conclusion | Page 8/line158-162 | Discussion/Paragraph 5 |
| Patient Perspective    | 12  | The patient should share their perspective in one to two paragraphs on the treatment(s) they received | NA | NA |
| Informed Consent       | 13  | Did the patient give informed consent? Please provide if requested | Yes ✓ | No □ |

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*As the checklist was provided upon initial submission, the page number/line number reported may be changed due to copyediting and may not be referable in the published version. In this case, the section/paragraph may be used as an alternative reference.