McMaster University HEALTH SCIENCES

Michael G. DeGroote SCHOOL OF MEDICINE

AUTHOR GUIDELINES

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McMaster Evidence-Based Medicine Case Report Journal

The McMaster Evidence-Based Medicine Case Report Journal is a new peer-reviewed journal produced and published by the Michael G. DeGroote School of Medicine.

This document should provide you with most of the information you need to submit a case report to the **McMaster Evidence-Based Medicine (EBM) Case Report Journal.** You are expected to work *independently* (either as an individual or as a team). However, additional guidance is available from your local research team and Research Lead.

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Selecting a Topic for the EBM Case Report Journal

What kinds of cases are eligible?

Essentially, all cases are eligible so long as they aid you in demonstrating the use, potential use, and/or difficulty of using clinical evidence in the diagnosis and/or management of a patient.

Cases can be from any medical speciality or setting.
Cases can be a usual **or** an unusual[1] case or a condition encountered in practice.

For example, cases can include:

- Unique or poorly understood conditions or presentations for which there is some evidence to support diagnoses and/or management
- Well understood conditions or presentations for which there is new evidence to support diagnoses and/or management
- Conditions or presentations for which there is conflicting or difficult to apply evidence to support diagnoses and/or management.

Cases need to be real, and will most likely be those that your encountered in a clinical clerkship within your region.

How to select a case?

You can either start by considering cases you find interesting or unique. Many common conditions can be interesting to you. You are not expected to report on a 'once in a lifetime' case. In fact, we don't generally recommend that you focus on a rare event. Common presentations are interesting because they can highlight the use of evidence to make decisions. It gives you (and readers) an opportunity to reflect on patient management and decision-making.

Also, you can start by considering clinical evidence or guidelines that you find new, exciting, interesting, or important - perhaps a new drug or new diagnostic procedure. Then think about cases where the new drug or new diagnostic procedure might be relevant. You case report would evaluate the relevance of this new evidence for that case.

Case reports can include cases where things went well (good news), or where things did not go well (bad news) but usually they are mixed in terms of message. Remember that many of the best case reports are those that report on mistakes, misinterpretations, and/or unintended consequences. *Many case reports highlight the challenge of applying the evidence to a specific case and focus on the uncertainty rather than a definitive solution. They often focus on how clinical opinion and patient wishes are mixed with clinical evidence.*

[1] If the case is very unusual than you must get patient consent because it would be hard to protect their identity.

What kind of 'evidence' should be included?

Evidence should be from peer-reviewed journals or clinical care guidelines that are based on peer-reviewed studies or systematic-reviews**.**

The 'evidence' may pertain to:

- The development or modification of an intervention or diagnostic technique to deal with a clinical problem. Here, you want to concentrate on the evidence for the new or modified intervention, the direct application to the patient, and the setting in which it was used. Remember that the patient history and examination should indicate why the patient is appropriate for the new or modified intervention.
- An approach to the intervention or diagnosis of a condition or presentation that is based on existing evidence. Here, you want to concentrate on the evidence for the diagnostic approach or diagnostic interpretation and why it is appropriate for the patient and setting. If the approach to intervention or diagnosis was originally developed for another condition or setting, than explain how it could be overlooked or why it was relevant in your case (if relevant). Be sure to comment on how the evidence was identified and used, or should have been identified and used.
- Conflicting, missing, or incomplete evidence relating to a common, unique, or complicated patient case. Here, you want to concentrate on describing the case and the potential evidence that could, should, or was applied. Be sure to also concentrate on how/why the evidence is conflicting, missing, or incomplete. Remember to suggest how the evidence can be improved to benefit cases like the one you are presenting.
- Your case report might include a combination of the above.

Style / Format Guidelines

FOLLOW THESE GUIDELINES CLOSELY!!
The Main Manuscript guidelines headings below should be the headings in your paper.

General Considerations
Please ensure that all patient data has been de-identified or that you obtained the necessary patient consent if you are including any identifiable patient data or images.

Make sure:

- **Font size is 12, and Font is Calibri**
- **Single spacing only.**
- **Margins are about 1 inch.**
- **Keep all formatting simple … complicated formatting is very bad.**

COVER PAGE

Title. Do not include the words "a case report" or "an evidence-based case report" in the title. Describe what is of greatest interest to you about the case or evidence. This could be the presentation, the diagnosis, a test result, the intervention, or the outcome**.**

Authors Information. List the full names, degrees, affiliation, and contact of each author, in order of presentation.

Word Count. Approx. 2,000 words. Give the word count for the entire paper, excluding title page, title, abstract and references.

Keywords. List 2-4 keywords that best describe your paper and will help potential readers search for and find this case report.

Funding Sources/Disclosures. List any disclosures.

Acknowledgments. List any acknowledgments (people, or organizations that helped you)

Author contributions. List contributions, for example:
TS and DM led paper. APC supervised the paper and was the attending for the case. TS led the manuscript. All authors contributed to the final manuscript and approved its content.

See "Example Case Reports – Example Cover Page" for an example of how your cover page should be organized.

MAIN MANUSCRIPT

Title. Again

Abstract. In about 200 words summarize the following information, if relevant:

1. Rationale for this case report
2. Presenting concerns of the patient (such as chief complaints, symptoms, or diagnoses)
3. Interventions (such as diagnostic, preventive, prognostic, therapeutic exchange)
4. Outcomes
5. Main lesson(s) to learn from this case report. Emphasize the learning points

Introduction. Briefly summarize the background and context of this case report. Cite literature as needed. Why is this case important and why did you write it up? State the objectives of your case report.

Case Presentation. Describe the patient characteristics (such as the relevant demographics—age, gender, ethnicity, occupation) and their presenting concerns, with relevant details of related past interventions.
This is the patient's story – but please be sensitive to patient confidentiality.

- How did they present?
- What is the relevant history? Why is this relevant?
- Explain your findings and how they influenced your decisions

Do not use abbreviations for diseases or investigations. If relevant, describe the:

- Medical, family, and psychosocial history
- Other pertinent co-morbidities and interventions (other therapies including self-care)
- The physical examination (PE), focused on the important findings, including any results from testing

Diagnostic Focus and Assessment (<u>if relevant</u>):

1. Diagnostic methods (including laboratory testing, imaging results, questionnaires, referral diagnostic information)
2. Diagnostic challenges (such as limited ability to complete an evaluation, patient availability, cultural)
3. Diagnostic reasoning including other diagnoses considered
4. Prognostic characteristics (such as staging in oncology) where applicable

Therapeutic Focus and Assessment (<u>if relevant</u>):

1. Types of interventions (such as pharmacologic, surgical, preventive, lifestyle, self-care)
2. Administration and intensity of the intervention (including dosage, strength, duration, frequency)

Follow-up and Outcomes (<u>if relevant</u>):
Always include follow up data where you can; it gives readers a clear understanding of outcome The follow-up period should be defined.

Please describe the clinical course of this case including all follow-up visits as well as:

1. Intervention modification, interruption, or discontinuation, and the reasons
2. Adherence to the intervention and how this was assessed
3. Adverse effects or unanticipated events

Please describe

1. Patient-reported outcomes
2. Clinician assessed and reported outcomes
3. Important positive and negative test results

The Evidence. Please describe the strengths and limitations of this case report, including case management, and the scientific and medical literature related to this case report. Discuss the rationale for your conclusions such as potential causation and the ways this case might be generalized to a larger population. Finally, what are the main findings of this case report and what are the 'take-away' messages?
This is the opportunity to describe the evidence for or against what happened with the case, or how the evidence was used in the case. Describe any guidelines and their relevance, diagnostic pathways (use diagrams if you'd like) and other interesting points.
Did you have to make an exception? Did you have to adapt the evidence?

Learning Points. (3 to 5 bullet points)
THIS IS A REQUIRED FIELD
These are the most crucial part of the case – what do you want readers to remember when seeing their own patients?

Tables and Figures.
Illustrative or summary information about the case, or evidence.
Examples:

- Summarize case presentation findings
- Create a timeline that includes specific dates and times in a table, figure, or graphic.
- Chose appropriate images to illustrate your point (maintaining patient confidentiality)
- Summarize the evidence in a table

References.
Include only relevant references including guidelines. Limit to 20 or less.

Patient Consent and Privacy Declaration.
You **MUST** give us a copy of the sign patient consent form, or otherwise tell us how to anonymized the patient details. See Patient Charts & Patient Privacy below.

Example Case Reports

Unfortunately there are no perfect examples, but the attached examples should help you determine 1) what content to include in your case report, and 2) the general style they use.

Note: You must use the style guidelines above! … but read the example to help you learn about how others have described things.

The below examples can be read at https://drop.mcmaster.ca/s/q3Lsb8nKQgJvKOo

Example 1: "When to Wean: Towards Implementing Stability Criteria for Preterm Infants Supported on NCPAP in the NICU"

- Approx. 3,300 words, good example of a longer report
- Good use of tables and figures

Example 2: "Radiation Therapy for Recurrent Borderline Resection Positive Phyllodes Tumour of the Breast"

- Approx. 1,500 words, a good example of how to condense content into less than 2,000 words without sacrificing content

Example 3: "Identification of Risk Factors and Early Intervention for Post-Concussion Syndrome in Adolescents"

- Approx. 1,700 words, another example of concise writing

Example 4: "Delayed Diagnosis of Polymyalgia Rheumatica"

- Approx. 2,500 words, good example of a slightly longer report
- Great example of tables and figures

Example Cover Page

Does this treatment improve clinical outcomes?

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Acknowledgements:

Author contributions: JD led paper. JP supervised the paper and was the attending for the case. JA led the manuscript. All authors contributed to the final manuscript and approved its content.

Patient Charts & Patient Privacy

Note - You do not need to get ethics approval to access a patient chart and publish a case report.

How to access patient charts:

In most cases, you will need to review a patient chart to recall details that you will need to describe the case. Also, you will need the details in order to sufficiently anonymize/modify non-relevant details that can identify the patient (see below).

Follow these steps and instructions:

- You may only access patient chart with the consent of your preceptor and/or the attending/supervising clinician
- You **must** access the patient chart with the direct supervision of your preceptor and/or the attending/supervising clinician
- The preceptor and/or the attending/supervising clinician should be a coauthor on the case report or acknowledged.
- You must follow all relevant privacy guidelines from the institution you are collecting the case from.

In most cases, your preceptor and/or the attending/supervising clinician will have easy access to the electronic and patient chart. In some cases, she or he will have to request it from the records department on your behalf. Follow the institutions guidelines.

Note: If you – through your preceptor - are trying to access a chart from Grand River Hospital and the patient is already discharged, then you must to complete a "Request To Review Personal Health Information Form" and follow the policy. A pre-filled form is available at https://drop.mcmaster.ca/s/q3Lsb8nKQgJvKOo

Ensure patient privacy:

From an ethics standpoint, case reports are not considered 'research' even though they are published in research journals. Case report – like case studies, etc - are educational contributions. **You do not need to get ethics approval to access a patient chart and publish a case report.** However, **patient privacy is crucial.**

Where possible you should get patient consent using the attached Consent Form. *Note: if the patient case is very unique, than you must get patient consent.*

In most cases you will need to access a chart from a patient case from the past. In this situation, the case must be sufficiently anonymized such that the details of the case cannot associated with any particular individual. You must complete the Patient Privacy Declaration Form (attached) and take steps to anonymize the case.

You should omit or modify any non-relevant detail, for example:

- Never give the patients name
- Never give irrelevant encounter details, such as name of the clinical site, staff names, unique site details, date of encounter, month of encounter, etc
- Modify or omit irrelevant patient personal details such as gender, age, martial status, family details, ethnicity, etc
- Modify or omit irrelevant clinical details such as irrelevant co-morbidities, unique details, etc

Consent Form

For a patient's consent to publication of information about them in the McMaster Evidence-Based Medicine Case Report Journal

Name of person described in article or shown in photograph: _____

Subject matter of photograph or article:

_____

Title of article:_____

Corresponding author:_____

I_____ [**insert full name**] give my consent for this information about MYSELF/MY CHILD OR WARD/MY RELATIVE [**circle correct description**] relating to the subject matter above ("the Information") to appear in the journal and associated publications.* I have seen and read the material to be submitted to the journal I understand the following: (1) The Information will be published without my name attached and journal will make every attempt to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after me if I was in hospital or a relative - may identify me. (2) The text of the article will be edited for style, grammar, consistency, and length (3) The Information may be published in the journal, which is distributed. The journal goes mainly to doctors but is seen by many non-doctors. (4) The Information will also be placed on the journal website (5) *The Information may also be used in full or in part in other publications and products published by the journal. This includes publication in English and in translation, in print, in electronic formats, and in any other formats that may be used by the journal. (6) The journal will not allow the Information to be used for advertising or packaging or to be used out of context. (7) I can revoke my consent at any time before publication, but once the Information has been committed to publication ("gone to press") it will not be possible to revoke the consent.

Signed: _____

Witness: _____

Date: _____

Patient Privacy Declaration Form

Title of article:

Student author(s):

Supervising author (preceptor, attending clinician, responsible clinician, etc):

Place where patient case was accessed:

Describe how the case was anonymized such that the patient could not be readily identified from the information presented.
e.g., What information did you omit or modify and why. Also describe why you are confident that you have sufficiently anonymized the case.

(Make sure you include everything, or the case report might be rejected outright)

Signed - Student author(s):_____

Signed - Supervising author:_____

Date: _____

Peer Review Information

As a peer-reviewed journal, all submissions must achieve journal standards in order to be accepted for publication. Peer-reviewers are subject matter experts sought specifically for your case report. They will judge the accuracy and merits of your submission.

Case reports that don't meet standards will be rejected outright.

Case reports that meet standards will be published (though publication is often conditional on completing edits based on the review).

Peer-reviewers are basing their assessment on the following:

- Is the submission clear?
    - Are the objectives clear?
    - Does is flow well?
    - Are the prose clear and ordered?
    - Are there too many spelling and sentence errors?
- Does the submission conform to style guidelines?
    - Sections format
    - Citations
    - Reference List
    - Tables and Figures
- Does the submission reflect the literature?
    - Are statements supported by literature?
    - Do cited statements accurately reflect the literature?
    - Is the literature misinterpreted?
    - Did the author(s) fail to include enough of the relevant literature?
- Are the clinical details of the case logically presented and complete?
    - Is the case presented clearly?
    - Are the relevant details included?
    - Are there illogical elements in the case presentation?

Authors will receive anonymous comments from reviewers with instructions on how to proceed. Comments will be from one of the following categories:

- *Major Compulsory Revisions* – the author must respond to these revisions before a decision on publication can be reached
- *Minor Essential Revisions* – such as mislabeled figures or the incorrect use of a term, which authors can be trusted to fix
- *Discretionary Revisions* – recommendations for improvement, which the author can choose to ignore

How to Submit Your Report

Your report should be submitted to ebmcr@mcmaster.ca as a word document (.doc or .docx). Other file formats will not be accepted.

Before submitting your report, please review the style guidelines again. Reports that do not conform to the style guidelines or that do not include an appropriate cover page will be returned to the author immediately.