The CARE guidelines: consensus-based clinical case reporting guideline development

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ABSTRACT
A case report is a narrative that describes, for medical, scientific or educational purposes, a medical problem experienced by one or more patients. Case reports written without guidance from reporting standards are insufficiently rigorous to guide clinical practice or to inform clinical study design. Develop, disseminate and implement systematic reporting guidelines for case reports. We used a three-phase consensus process consisting of (1) premeeting literature review and interviews to generate items for the reporting guidelines, (2) a face-to-face consensus meeting to draft the reporting guidelines and (3) postmeeting feedback, review and pilot testing, followed by finalisation of the case report guidelines. This consensus process involved 27 participants and resulted in a 13-item checklist—a reporting guideline for case reports. The primary items of the checklist are title, key words, abstract, introduction, patient information, clinical findings, timeline, diagnostic assessment, therapeutic interventions, follow-up and outcomes, discussion, patient perspective and informed consent. We believe the implementation of the CARE (Case Report) guidelines by medical journals will improve the completeness and transparency of published case reports and that the systematic aggregation of information from case reports will inform clinical study design, provide early signals of effectiveness and harms, and improve healthcare delivery.

METHODS
Research design
We followed the Guidance for Developers of Health Research Reporting Guidelines13 and developed a three-phase consensus process.16 This consisted of (1) a premeeting literature review followed by interviews to generate items for a case report checklist, (2) a face-to-face consensus meeting for drafting a reporting guideline and (3) postmeeting feedback and pilot testing followed by finalisation of the case report guidelines.

Participants
We contacted 28 individuals who fulfilled at least one of the four criteria17–19 (1) publication of articles related to case reports; (2) publication of a manual, handbook or method guidelines related to case reports; (3) publication of a systematic review of methods or reporting related to case reports; and (4) publication of other reporting guidelines for clinical research.

Consensus process
Phase I: Four of the authors, the steering committee (JG, GK, DM and DR), searched the literature for publications on the role of case reports, recommendations for their publication and surveys on reporting quality. A letter was sent to 28 potential participants explaining the purpose of the meeting, details of the consensus technique, and requesting their participation in generating specific recommendations for case reporting. Twenty-seven people agreed to participate and were scheduled for a telephone interview and sent a selection of key articles on case reports. During the telephone interview, participants were asked (1) what information was required to be included in case-reporting guidelines, (2) the rationale for their suggestions and (3) for references that supported their reasoning.

Three of the authors (JG, GK and DR) grouped the recommendations from the literature search and interviews by theme for Systematic Reviews and Meta-Analyses, PRISMA).12 Empirical evidence suggests that a journal’s adoption of the CONSORT statement as a guide to authors is associated with an increase in the completeness of published randomised trials.13 Guidelines have been developed for adverse-event case reports14; however, general reporting guidelines for case reports do not exist. Our primary objective was to develop reporting guidelines for case reports through a consensus-based process.
together with their rationale, references and operational definitions. No quantitative scoring was performed.

Phase II: The face-to-face consensus meeting at the University of Michigan in Ann Arbor (October 2012) included 18 participants from phase I, one research assistant and two student observers. The meeting began with a review of the blinded recommendations elicited during the phase I interviews, in whole group and small group sessions. On the second day, open discussion of each potential item continued, during which clarifications, opinions, justifications, operational definitions and new ideas were expressed. By the end of the second day, the group had agreed upon a set of preliminary reporting recommendations.

Phase III: The draft checklist was refined by the steering committee and sent for two rounds of review to the complete group (phases I and II participants). The finalised reporting guidelines incorporated the feedback from the entire CARE group.

RESULTS
The CAse REport (CARE) guidelines checklist is structured to correspond with key components of a case report and capture useful clinical information (including ‘meaningful use’ information mandated by some insurance plans).

The checklist begins with a statement that describes the narrative of a case report. The meeting CARE group felt that a case report should tell a story using prose that has a consistent style across all sections, including the rationale for any conclusions and take-away messages.

We recommend a timeline (item 7) in the form of a table or figure that gives the specific dates and times of important components of the case. This might include family and medical history, genetic information, current symptoms, diagnostic test results, interventions and events that occurred during follow-up. The timeline should show how the key events of the case unfolded.

We created separate checklist items for diagnostic assessments (item 8) and therapeutic interventions (item 9) with the recognition that both items will often be relevant in a case report.

The group discussed at length whether to include the patient’s perspective on his or her experience. In the end, we advocated for patient-reported outcomes and experiences whenever possible (item 12). There was also discussion about the need for guidelines for patient-reported outcomes of their care. In a similar vein, a recent extension of the CONSORT statement was published for patient-reported outcomes in randomised trials; CONSORT-PRO.

Finally, we included an item on informed consent (item 13). We believe that authors have an ethical duty to obtain informed consent from the patient to publish patient information in a case report. Consent becomes informed when the patient or a relative reads the case report and approves its contents. If the patient cannot give consent and attempts to find a relative to give proxy consent have failed, the authors should seek permission to publish from an institutional committee. There may be other circumstances where an ethics committee or Institutional Review Board (IRB) approval may be necessary. The CARE guidelines are shown in the following table 1.

DISCUSSION
This 13-item checklist provides a framework to satisfy the need for completeness and transparency for published case reports. We attempted to strike a balance between adequate detail and the concise writing that is one of the appealing characteristics of a case report. Our consensus process resulted in a set of essential items for authors to consider when submitting a case report for publication.

While case reports have long been an important source of new ideas and information in medicine, it appears that case reports are likely to begin to play a role in the discovery of what works and for whom. BioMed Central launched the Journal of Medical Case Reports in 2007 and a Cases Database in 2012 with more than 11 000 published case reports from 50 medical journals. In 6 months, it has grown to more than 26 000 case reports from 212 medical journals. The CARE guidelines checklist is part of a growing effort to improve the reporting of case reports.

There is substantial empirical evidence that reporting guidelines improve the completeness of published scientific reports. A recent Cochrane review examining the influence of journal endorsement of the CONSORT statement on reporting included 53 publications assessing 16 604 randomised controlled trials and found that CONSORT-endorsing journals consistently have better overall reporting. However, the potential impact of the CONSORT statement and related reporting guidelines has not been fully realised. A study examining the instructions to peer reviewers of 116 health research journals found that only 41 (35%) provided online instructions to peer reviewers. Of those, only 19 (46%) mentioned or referred to reporting guidelines as a useful resource. In response, the authors provide several recommendations for editors to improve the peer review of submitted manuscripts, suggesting that journals have a responsibility to support peer reviewers.

The developers of reporting guidelines have a responsibility to plan a dissemination and implementation strategy that supports guidelines utilisation. Our efforts have several components:

- The CARE guidelines will be presented at international conferences and workshops including the Peer Review and Biomedical Publication Congress in Chicago on 10 September 2013.
- This article will be published simultaneously in multiple medical journals and outreach to the 212 journals depositing case reports into the BioMed Central Case Report Database.
- We will develop a more detailed explanation and elaboration article to outline the rationale for each item and include empirical evidence and examples of good reporting from published case reports.
- The CARE guidelines are being pilot tested, and preliminary results support the guidelines as currently written (personal communication with Helmut Kiene, Erica Oberg, Bill Manahan). Guidelines extensions for specialties are being developed.
- The CARE guidelines and related documents will be available on a dedicated website (www.CARE-statement.org), the EQUATOR Network website (www.equator-network.org) and translated into multiple languages.
- Authors, journal editors, peer reviewers and the wider medical community are encouraged to use the CARE checklist and provide feedback that can be incorporated into regular updates of the CARE guidelines.
- We will conduct and support research into the impact of the CARE guidelines on the reporting of case reports.

LIMITATIONS
The CARE guidelines and their development have several possible limitations. First, these guidelines were developed through a consensus method and thus represent the opinions of the participants. However, consensus was easily reached during our meeting, we referred to the empirical evidence where available, and we received feedback from a wide selection of individuals, beyond those involved
in our consensus meeting. Second, we recognise that causality determinations are a challenge for case reports even when following reporting guidelines. The CARE guidelines emphasise information quality independent of causality assessment. Different specialties, practitioners, and patients are likely to require extensions of the CARE guidelines with specialty specific information. We welcome discussions with groups interested in using the CARE guidelines as the basis for their specific reporting needs.

Though not mentioned in our guidelines, medical journals often require authors to address three issues: (1) potential competing interests, (2) de-identification of patient-related data and (3) ethics committee or IRB approval if obtained or necessary.

CONCLUSIONS
Anticipating a long future for case reports, we have provided guidance in the form of reporting standards for use by healthcare stakeholders around the world. The growth of case reports in an era in which clinical trials and systematic reviews dominate the tables of content of medical journals indicates that case reports have value, particularly with the increasing importance of individualised care. Unlike randomised controlled trials, case reports are individual reports related to the care of individual patients where the sample size is one. When systematically collected and combined into larger datasets, they can be analysed, enhancing the early discovery of effectiveness and harms.

We anticipate that the analysis of systematically aggregated information from patient encounters (now mandated by some insurance plans) will provide scalable, data-driven insights into what works for which patients in real time, facilitating comparisons across medical systems and cultures. Practitioners will soon be able to provide—and in some cases they are required to provide—patients with information from their encounters. This will transform how we think about ‘evidence’ and revolutionise its creation, diffusion and use—opening new opportunity landscapes. When it becomes clear how new data contributes to evidence, the stewardship needed to produce high-quality data will be more rewarding and our attitude towards ‘observation’ will shift. The CARE guidelines provide a framework to satisfy the need for precision, completeness and transparency.

Authors note Joel J Gagnier, University of Michigan, and David Riley, Global Advances in Health and Medicine, organised this consensus-based guideline-development project. The volunteer steering committee consisted of Joel J Gagnier, Gunver Kierle, David Moher, and David Riley.

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Contributors JIG and DR wrote the first draft of the article. DGA, JIG, GK, DM, DR and HS critically reviewed and edited drafts. The entire CARE group participated in parts or all of the guidelines development process and contributed to the editing and revision of the CARE guidelines and this article.

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REFERENCES