SCARE 2018 Checklist			
Topic	**Item**	**Checklist item description**	**Page Number**
Title	**1**	The words “case report” should appear in the title. The title should also describe the area of focus (e.g. presentation,	
Key Words	**2**	3 to 6 key words that identify areas covered in this case report (include "case report" as one of the keywords)	
Abstract	**3a**	Introduction — Describe what is unique or educational about the case (i.e. what does this work add to the surgical literature, and why is this important?).	
	3b	Presenting complaint and investigations – describe the patient's main concerns and important clinical findings.	
	3c	The main diagnoses, therapeutics interventions, and outcomes.	
	3d	Conclusion — Describe the main lessons to “take-away” from this case study	
Introduction	**4**	Background – summarise what is unique or educational about the case. Give reference to the relevant surgical literature and current standard of care. The background should be referenced, and 1-2 paragraphs in length.	
Patient Information	**5a**	Demographic details – include de-identified demographic details on patient age, sex, ethnicity, occupation. Where possible, include other useful pertinent information e.g. body mass index and hand dominance.	
	5b	Presentation - describe the patient’s presenting complaint (symptoms). Describe the patient’s mode of presentation (brought in by ambulance or walked into Emergency room or referred by family physician).	
	5c	Past medical and surgical history, and relevant outcomes from interventions	

	5d	Other histories – Describe the patient's pharmacological history including allergies, psychosocial history (Drug, smoking, and if relevant, accommodation, walking aids), family history including relevant genetic information.	
Clinical Findings	**6**	Describe the relevant physical examination and other significant clinical findings. Include clinical photographs where relevant and where consent has been given.	
Timeline	**7**	Inclusion of data which allows readers to establish the sequence and order of events in the patient's history and presentation (using a table or figure if this helps). Delay from presentation to intervention should be reported.	
Diagnostic Assessment	**8a**	Diagnostic methods – describe all investigations taken to arrive at methods: physical exam, laboratory testing, radiological imaging, histopathology.	
	8b	Diagnostic challenges – describe what was challenging about the diagnoses, where applicable, for example access, financial, cultural.	
	8c	Diagnostic reasoning – Describe the differential diagnoses and why they were considered.	
	8d	Prognostic characteristics when applicable (e.g. tumour staging or for certain genetic conditions). Include relevant radiological or histopathological images in this section.	
Therapeutic Intervention	**9a**	Pre-intervention considerations – if there were patient-specific optimisation measures taken prior to surgery or other intervention these should be included e.g. treating hypothermia/hypovolaemia/hypotension in a burns patient, Intensive care unit treatment for sepsis, dealing with anticoagulation/other medications, etc.	
	9b	Interventions – describe the type(s) of intervention(s) deployed (pharmacologic, surgical, physiotherapy, psychological, preventive). Describe the reasoning behind this treatment	

		offered. Describe any concurrent treatments (antibiotics, analgesia, anti-emetics, nil by mouth, Venous thrombo-embolism prophylaxis, etc). Medical devices should have manufacturer and model specifically mentioned.	
	9c	Intervention details – describe what was done and how. For surgery include details on; anaesthesia, patient position, use of tourniquet and other relevant equipment, prep used, sutures, devices, surgical stage (1 or 2 stage, etc). For pharmacological therapies include information on the formulation, dosage, strength, route, duration, etc. Include intra-operative photographs and/or video or relevant histopathology in this section. Degree of novelty for a surgical technique/device should be mentioned e.g. "first in human".	
	9d	Who performed the procedure - operator experience (position on the learning curve for the technique if established, specialisation and prior relevant training). For example, "junior resident with 3 years of specialised training"	
	9e	Changes – if there were any changes in the interventions, describe these details with the rationale.	
Follow-up and Outcomes	**10a**	Follow-up – describe 1) When the patients was followed up. 2) Where. 3) How (imaging, tests, scans, clinical examination, phone call), and 4) whether there were any specific post-operative instructions. Future surveillance requirements - e.g. imaging surveillance of endovascular aneurysm repair or clinical exam/ultrasound of regional lymph nodes for skin cancer.	
	10b	Outcomes - Clinician assessed and (when appropriate) patient-reported outcomes (e.g. questionnaire details). Relevant photographs/radiological images should be provided e.g. 12 month follow-up.	
	10c	Intervention adherence/compliance - where relevant how well patient adhered to and tolerated their treatment. For example,	

		post-operative advice (heavy lifting for abdominal surgery) or tolerance of chemotherapy and pharmacological agents	
	10d	Complications and adverse events – all complications and adverse or unanticipated events should be described in detail and ideally categorised in accordance with the Clavien-Dindo Classification. How they were prevented, diagnosed and managed. Blood loss, operative time, wound complications, re-exploration/revision surgery, 30-day post-op and long-term morbidity/mortality may need to be specified. If there were no complications or adverse outcomes this should also be included.	
Discussion	**11a**	Strengths – describes the strengths of this case	
	11b	Weaknesses and limitations in your approach to this case. For new techniques or implants - contraindications and alternatives, potential risks and possible complications if applied to a larger population. If relevant, has the case been reported to the relevant national agency or pharmaceutical company (e.g. an adverse reaction to a device)	
	11c	Discussion of the relevant literature, implications for clinical practice guidelines and any relevant hypothesis generation.	
	11d	The rationale for your conclusions.	
	11e	The primary "take-away" lessons from this case report.	
Patient Perspective	**12**	When appropriate the patient should share their perspective on the treatments they received.	
Informed Consent	**13**	Did the patient give informed consent for publication? Please provide if requested by the journal/editor. If not given by the patient, explain why e.g. death of patient and consent provided by next of kin or if patient/family untraceable then document efforts to trace them and who within the hospital is acting as a guarantor of the case report.	

Additional Information	**14**	Conflicts of Interest, sources of funding, institutional review board or ethical committee approval where required.	