The Title is Written with a Maximum of 15 Words and Includes the Words “Case Report”

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ABSTRACT

Background: Briefly explain why this case is clinically or scientifically important, what makes it unusual or educational, and what it adds to the existing literature.

Case Presentation: Summarize the de-identified patient characteristics, main concern(s), relevant clinical findings, diagnosis, key intervention(s), and important follow-up/outcome(s).

Conclusion: State the principal take-away lesson(s) from the case and the implications for clinical practice, nursing, midwifery, public health, education, or future research as appropriate.

KEYWORDS: Keyword1; Keyword2; Keyword3; Case Report; [2–5 keywords recommended, including “case report”].

INTRODUCTION

[Briefly summarize the clinical/scientific background and explain why the case is noteworthy. Identify the unusual presentation, diagnostic challenge, intervention, adverse event, rare condition, novel observation, or educational value. Use relevant literature to establish context and conclude with the purpose or key learning objective of presenting the case. Avoid an extensive literature review.]

CASE PRESENTATION

Patient Information

[Provide de-identified patient information relevant to the case, such as age range or age, sex/gender when clinically relevant, occupation or social context when relevant, and the main concerns/symptoms. Describe pertinent medical, obstetric, nursing, family, psychosocial, lifestyle, medication, allergy, and genetic history as applicable. Include relevant previous interventions and outcomes. Do not include direct identifiers or unnecessary identifying details.]

Clinical Findings

[Describe the relevant physical examination, clinical assessment, nursing/midwifery assessment, vital signs, anthropometric findings, mental status, or other important observations at presentation. Report only findings relevant to understanding the case and use standard units and terminology.]

Timeline

[Present the major events in chronological order. Include onset of symptoms, consultations, investigations, diagnoses, interventions, follow-up visits, complications, and outcomes. Use exact dates only when they do not risk identifying the patient; otherwise use relative time points (e.g., Day 1, Week 2, Month 3).]

Table 1. Timeline of the Case

Time / Date	Symptoms / Clinical Findings	Diagnostic Tests / Assessment	Treatment / Care	Outcome / Follow-up
[Day/Month/Year or relative time]	[Key symptoms/findings]	[Tests/assessment]	[Treatment/care/intervention]	[Outcome]
[Time point]	[Key symptoms/findings]	[Tests/assessment]	[Treatment/care/intervention]	[Outcome]
[Time point]	[Key symptoms/findings]	[Tests/assessment]	[Treatment/care/intervention]	[Outcome]

Diagnostic Assessment

[Describe the diagnostic methods used, including laboratory tests, imaging, clinical criteria, screening/assessment tools, pathology, or other investigations. State the final diagnosis and relevant differential diagnoses. Explain diagnostic reasoning when important. Describe diagnostic challenges such as access limitations, financial barriers, cultural factors, atypical presentation, or inconclusive findings. If prognostic characteristics are relevant, report them.]

Therapeutic / Care Intervention

[Describe the intervention(s) in sufficient detail to understand what was done. This may include medication (generic name, dose, route, frequency, duration), surgery/procedure, nursing or midwifery care, counseling/education, rehabilitation, nutrition, behavioral intervention, public-health action, or other management. Explain changes to the intervention and the reasons for those changes. For complex interventions, consider using an appropriate reporting extension or intervention-description guideline.]

Follow-up and Outcomes

[Report clinician-assessed and, when available, patient-reported outcomes. State the duration and frequency of follow-up, treatment adherence/tolerability, relevant repeat tests or examinations, clinical course, recurrence, complications, adverse or unanticipated events, and current status. Report objective measures where possible and explain any loss to follow-up.]

Patient Perspective (Optional but Recommended)

[When feasible and appropriate, include a brief de-identified account of the patient's perspective on the illness, diagnostic process, intervention, recovery, or care experience. Do not include identifying information. If a patient perspective was not obtained, this section may be omitted.]

DISCUSSION

Interpretation and Comparison with Literature

[Explain why the case is important and interpret the key findings in relation to existing evidence. Compare the case with previously reported cases, guidelines, or relevant studies. Discuss plausible mechanisms or explanations where supported. Clearly distinguish observations from hypotheses and avoid causal claims that cannot be supported by a single case.]

Strengths and Limitations

[Discuss the strengths and limitations of the case report, including completeness of records, diagnostic certainty, length of follow-up, missing information, inability to generalize, potential alternative explanations, and any limitations that affect interpretation.]

Clinical / Practice Implications and Take-away Lessons

[State the main lesson(s) for clinicians, nurses, midwives, public-health practitioners, educators, or researchers. Keep recommendations proportionate to evidence from a single case and indicate when further research is needed.]

CONCLUSION

[Provide a concise conclusion focused on the central learning point(s). Do not introduce new data. Avoid broad generalizations or claims of effectiveness based solely on a single case.]

DECLARATIONS

Ethics Approval: State the institutional policy or ethics committee determination applicable to the case report. If formal ethics approval was obtained, provide the committee name and approval number. If ethics review was not required, state this clearly in accordance with institutional policy. Ethical review requirements may differ between institutions and jurisdictions.

Informed Consent for Publication: Written informed consent for publication must be obtained from the patient or, where applicable, the parent/legal guardian or authorized representative. State that written informed consent was obtained. The consent should cover publication of the case details and any images or other potentially identifiable material. Do not submit the signed consent form unless requested by the journal; retain it securely according to institutional and journal policy.

Confidentiality and De-identification: Confirm that unnecessary direct and indirect identifiers have been removed or generalized. Do not include names, initials, medical record numbers, exact addresses, or other details that could reasonably identify the patient unless essential and specifically consented.

Author's Contribution Statement: Describe each author's contribution to patient care (where relevant), case conceptualization, data collection, literature review, drafting, critical revision, and final approval, consistent with the journal's authorship policy.

Conflicts of Interest: Declare any financial, professional, institutional, or personal interests that could influence the report. If none, state that the authors declare no conflicts of interest.

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Declaration of Artificial Intelligence (AI) Use: Disclose any generative AI or AI-assisted technologies used during manuscript preparation, including the tool name, purpose, and extent of use. Authors remain responsible for accuracy, confidentiality, citations, originality, and integrity. Do not enter identifiable patient information into generative AI systems unless expressly permitted by applicable privacy, institutional, and consent requirements.

REFERENCES

[References must follow American Psychological Association (APA) 6th Edition style, consistent with the journal template. Use reference-management software such as Mendeley or Zotero. The current journal template requires a minimum of 25 references, with at least 85% journal articles. References should be directly relevant to the clinical problem, diagnosis, intervention, and discussion; avoid an unnecessarily broad bibliography for a case report.]

Reporting guideline to cite: Gagnier, J. J., Kienle, G., Altman, D. G., Moher, D., Sox, H., Riley, D., & the CARE Group. (2013). The CARE guidelines: Consensus-based clinical case reporting guideline

development. Journal of Clinical Epidemiology, 67(1), 46–51.
https://doi.org/10.1016/j.jclinepi.2013.08.003
[Authors should prepare the manuscript using the CARE checklist. If the journal adopts this as a submission requirement, upload a completed CARE checklist as a supplementary file. Use a relevant CARE extension when applicable (for example, specialty-specific extensions).]