Dynamic Chiropractic

HEADACHES & MIGRAINES

Reporting to the Literature

Many of the doctors attending seminars I give on head pain and TM disorders bring in difficult head pain cases for discussion. Invariably, we are able to sort through the difficulties to establish pathways towards solutions and successful outcomes. As a clinician, I find these cases genuinely interesting and each deserves to be reported into the literature. Last month we developed the reasons why the DC should write to the literature and described the various reporting formats. We had also given the doctor a few strategies to make writing easier and more enjoyable. One of the most popular and enjoyable formats used by clinicians is the case report.

Writing the Case Report

The case report is simply the story of a patient with a specific health problem. The case is reported because the patient's problem is unusual or illustrative. Every DC has a case report in his office right now.

Make the Purpose of the Case Report Clear

To satisfy the case for publication, the grounds for reporting must be clear. In other words: "Patient (A) presented with problem (1,2,3) and was treated by method (X). Traditionally patients with problem (1,2,3) follow a certain and known course; however, my unique insight (say, for example, into treatment) leads to the use of method (X). Method (X) altered and improved the patient's outcome." This sketch is but one of the many possible, but it serves us well as an example.

Select a Single Case Or a Collection of Similar Cases

There are two main criteria for making this selection. First, the case is a rare example of a problem. How do you decide if the case is a rare one? Simple. Follow this rule of thumb: If you haven't heard of the case before, assume it to be rare until proven otherwise. The second selection criterion is to use the case or collection of cases for their illustrative (teaching) purposes. The case must offer some important lesson. In other words -- your insight.

Your insight into the case will be typically about diagnosis or treatment. However, other areas may prove fruitful. For example, with the emergence of third-party interests (primarily insurance carriers) into our healthcare delivery system, important insights into patient documentation or problem-solving procedures are certainly welcome.

Begin the Case Report

After you have selected the case on the merits described above, you simply need to write the report. But, you ask, "What should I include?" The answer is simple: the facts of the case and your insight.

Remember that the purpose of writing the case report is either because of its rarity or its illustrative quality. Hence, your criteria for inclusion of material are already defined.

The simplest report to write is the rare case report. If the case is rare, you simply include the

pertinent facts supportive of its rarity. Your insight is simple: "This case is rare."

The inclusion criteria for the illustrative case is also standardized but a little more elaborate. First, let's talk about the facts. Where do you get them? The facts come from the patient record and include the following areas:

Patient identification (age, sex, race)
Chief complaint

History of present illness (use excerpts from the "OPQRST" format) Past medical history (relevant portions) Family history (relevant portions) Physical examination (relevant portions) Laboratory and "special studies" results (relevant portions) Reports from consultants Impressions or diagnosis Therapy and course of treatment (protocol and progression) Final outcome or case disposition

The Standard Outline for Case Presentation

Fortunately, the formula for writing a case report is readily available and easy to follow. Hence, the doctor is able to merely "plug" the data into the formula; add a little individual effort; and presto, the case is ready to send off for consideration for publication. The outline or formula is as follows:

The Introduction: This is a brief (one or two paragraph) description of the case, in order to acquaint the reader or place the case into perspective with other similar cases.

Literature Review: This section is important for many reasons, not the least of which is to show the reader where he may get more information on the case or to show the reader how cases such as this have been handled in the past.

Case History: This is the story of the patient, using the facts of the case. where do the facts come from? You're right. (See above.) This is the section where the clinician is tempted to use jargon; however, please refrain from doing so. Think of yourself as Sgt. Friday of Dragnet fame -- "Just the facts, Ma'am, just the facts."

Discussion: Save your opinions for this section. Where possible, support your opinions with references. Otherwise, say, "My opinion on this is ..." Remember the reader is reading this to see how you handled this case. The discussion serves to give the reader a deeper understanding of your insight. You may want to explain how you developed this insight or help the reader travel through the sophisticated portions of the case. Use references whenever possible.

Summary: This is a quick-and-dirty synopsis of the case. Very little, if anything, new should be presented here.

References: No case report can be submitted without references. These references are the ones used in the introduction, literature review, and discussion portions of the report.

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