CARE case report guidelines

CARE Checklist of information to include when writing a case report

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Topic	Item	Checklist item description	Reported on Line
Title	**1**	The diagnosis or intervention of primary focus followed by the words "case report"	☑ 1-2
Key Words	**2**	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	☑ 29-30
Abstract (no references)	**3a**	Introduction: What is unique about this case and what does it add to the scientific literature?	☑ 10-11
	3b	Main symptoms and/or important clinical findings	☑ 12-15
	3c	The main diagnoses, therapeutic interventions, and outcomes	☑ 15-22
	3d	Conclusion—What is the main "take-away" lesson(s) from this case?	☑ 23-28
Introduction	**4**	One or two paragraphs summarizing why this case is unique (**may include references**)	☑ 32-46
Patient Information	**5a**	De-identified patient specific information.	☑ 49-56
	5b	Primary concerns and symptoms of the patient.	☑ 49-53
	5c	Medical, family, and psycho-social history including relevant genetic information	☐ 54-56*
	5d	Relevant past interventions with outcomes	☐ 54-56*
Clinical Findings	**6**	Describe significant physical examination (PE) and important clinical findings.	☑ 57-62
Timeline	**7**	Historical and current information from this episode of care organized as a timeline	☑ 263; Table 1
Diagnostic Assessment	**8a**	Diagnostic testing (such as PE, laboratory testing, imaging, surveys).	☑ 57-69; 87-99
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	☑ 70-75
	8c	Diagnosis (including other diagnoses considered)	☑ 64-75; 87-92
	8d	Prognosis (such as staging in oncology) where applicable	☑ 84-92; 159-178
Therapeutic Intervention	**9a**	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	☑ 77-86
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	☑ 77-86
	9c	Changes in therapeutic intervention (with rationale)	☑ 77-86
Follow-up and Outcomes	**10a**	Clinician and patient-assessed outcomes (if available)	☑ 100-105
	10b	Important follow-up diagnostic and other test results	☑ 94-105
	10c	Intervention adherence and tolerability (How was this assessed?)	☑ 100-105*
	10d	Adverse and unanticipated events	☑ 100-103
Discussion	**11a**	A scientific discussion of the strengths AND limitations associated with this case report	☑ 171-178
	11b	Discussion of the relevant medical literature **with references**.	☑ 114-170
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	☑ 108-178
	11d	The primary "take-away" lessons of this case report (without references) in a one paragraph conclusion	☑ 180-185
Patient Perspective	**12**	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	☐ 187*
Informed Consent	**13**	Did the patient give informed consent? Please provide if requested	Yes ☑ No ☐ Lines 196-198

* Explanatory notes on page 2. Line numbers refer to JMCR_revised_manuscript.docx.

CARE checklist explanatory notes

Manuscript: Extraspinal sacrococcygeal myxopapillary ependymoma mimicking pilonidal disease in an adolescent: a case report

Submission ID: 639553a1-3465-4fbc-98e6-a2de63bd5123

Source: Official English 2013 CARE checklist (https://www.care-statement.org/s/CARE-checklist-English-2013.pdf). The original checklist is retained on page 1 and completed with check marks and manuscript line references.

Line references: Continuous line numbers in JMCR_revised_manuscript.docx. Table 1 follows line 263; Word does not number individual lines within tables. A checked box means the item is reported. A horizontal mark means that information is partly reported or unavailable, as explained below.

Item 5c (lines 54-56): Medical and family histories are reported as unremarkable. Psychosocial history and relevant genetic information were not documented in the available record. These components are not marked as fully reported.

Item 5d (lines 54-56): Prior treatment details were not documented in the available record. Absence of documentation is not interpreted as absence of prior treatment.

Item 8d (lines 84-92 and 159-178): Tumor grade and proliferation index are reported. Microscopic margins and complete staging are not documented; prognostic interpretation is limited accordingly.

Item 9b (lines 77-86): The date, anesthesia, operative approach, capsule handling, estimated blood loss, and specimen dimensions are described. Drug dosage and a repeated medication schedule are Not applicable to the reported surgical intervention; anesthetic dosing and operation duration were not documented.

Item 10c (lines 100-105): Surgical tolerability is described through the uncomplicated postoperative course, discharge, and wound healing. Adherence to a repeated medication regimen is Not applicable to the single surgical intervention reported here. No formal adherence measure is reported.

Item 12 (line 187): A detailed patient perspective was not available. This item is marked as unavailable, rather than incorrectly classified as Not applicable or reported.

Item 13 (lines 196-198): Written consent for publication of the case report and accompanying images was obtained from the patient's legal guardians. The manuscript states that a copy is available for review by the Editor-in-Chief. The signed form is not included in the submission files.