Journal of
Health and Medical Research

Editoial

Medical Case Studies & Clinical Challenges

James Mary
USA

Case studies are an invaluable record of the clinical practices of a profession. While case studies cannot provide specific guidance for the management of successive patients, they are a record of clinical interactions which help us to frame questions for more rigorously designed clinical studies. Case studies also provide valuable teaching material, demonstrating both classical and unusual presentations which may confront the practitioner. Quite obviously, since the overwhelming majority of clinical interactions occur in the field, not in teaching or research facilities, it falls to the field practitioner to record and pass on their experiences. However, field practitioners generally are not well-practised in writing for publication, and so may hesitate to embark on the task of carrying a case study to publication. These guidelines are intended to assist the relatively novice writer – practitioner or student – in efficiently navigating the relatively easy course to publication of a quality case study. Guidelines are not intended to be proscriptive, and so throughout this document we advise what authors "may" or "should" do, rather than what they "must" do. Authors may decide that the particular circumstances of their case study justify digression from our recommendations. Case presentation: This is the part of the paper in which we introduce the raw data. First, we describe the complaint that brought the patient to us. It is often useful to use the patient's own words. Next, we introduce the important information that we obtained from our history-taking. We don't need to include every detail – just the information that helped us to settle on our diagnosis. Also, we should try to present patient information in a narrative form – full sentences which efficiently summarize the results of our questioning. In our own practice, the history usually leads to a differential diagnosis – a short list of the most likely diseases or disorders underlying the patient's symptoms. We may or may not choose to include this list at the end of this section of the case presentation. The next step is to describe the results of our clinical examination. Again, we should write in an efficient narrative style, restricting ourselves to the relevant information. It is not necessary to include every detail in our clinical notes. If we are using a named orthopedic or neurological test, it is best to both name and describe the test (since some people may know the test by a different name). Also, we should describe the actual results, since not all readers will have the same understanding of what constitutes a "positive" or "negative" result. X-rays or other images are only helpful if they are clear enough to be easily reproduced and if they are accompanied by a legend. Be sure that any information that might identify a patient is removed before the image is submitted. At this point, or at the beginning of the next section, we will want to present our working diagnosis or clinical impression of the patient. Management and Outcome: In this section, we should clearly describe the plan for care, as well as the care which was actually provided, and the outcome. It is useful for the reader to know how long the patient was under care and how many times they were treated. Additionally, we should be as specific as possible in describing the treatment that we used. It does not help the reader to simply say that the patient received "chiropractic care." Exactly what treatment did we use? If we used spinal manipulation, it is best to name the technique, if a common name exists, and also to describe the manipulation. Remember that our case study may be read by people who are not familiar with spinal manipulation, and, even within chiropractic circles, nomenclature for technique is not well standardized. We may want to include the patient's own reports of improvement or worsening. However, whenever possible we should try to use a well-validated method of measuring their improvement. For case studies, it may be possible to use data from visual analogue scales (VAS) for pain, or a journal of medication usage. It is useful to include in this section an indication of how and why treatment finished. Did we decide to terminate care, and if so, why? Did the patient withdraw from care or did we refer them to another practitioner?. Discussion: In this section we may want to identify any questions that the case raises. It is not our duty to provide a complete physiological explanation for everything that we observed. This is usually impossible.