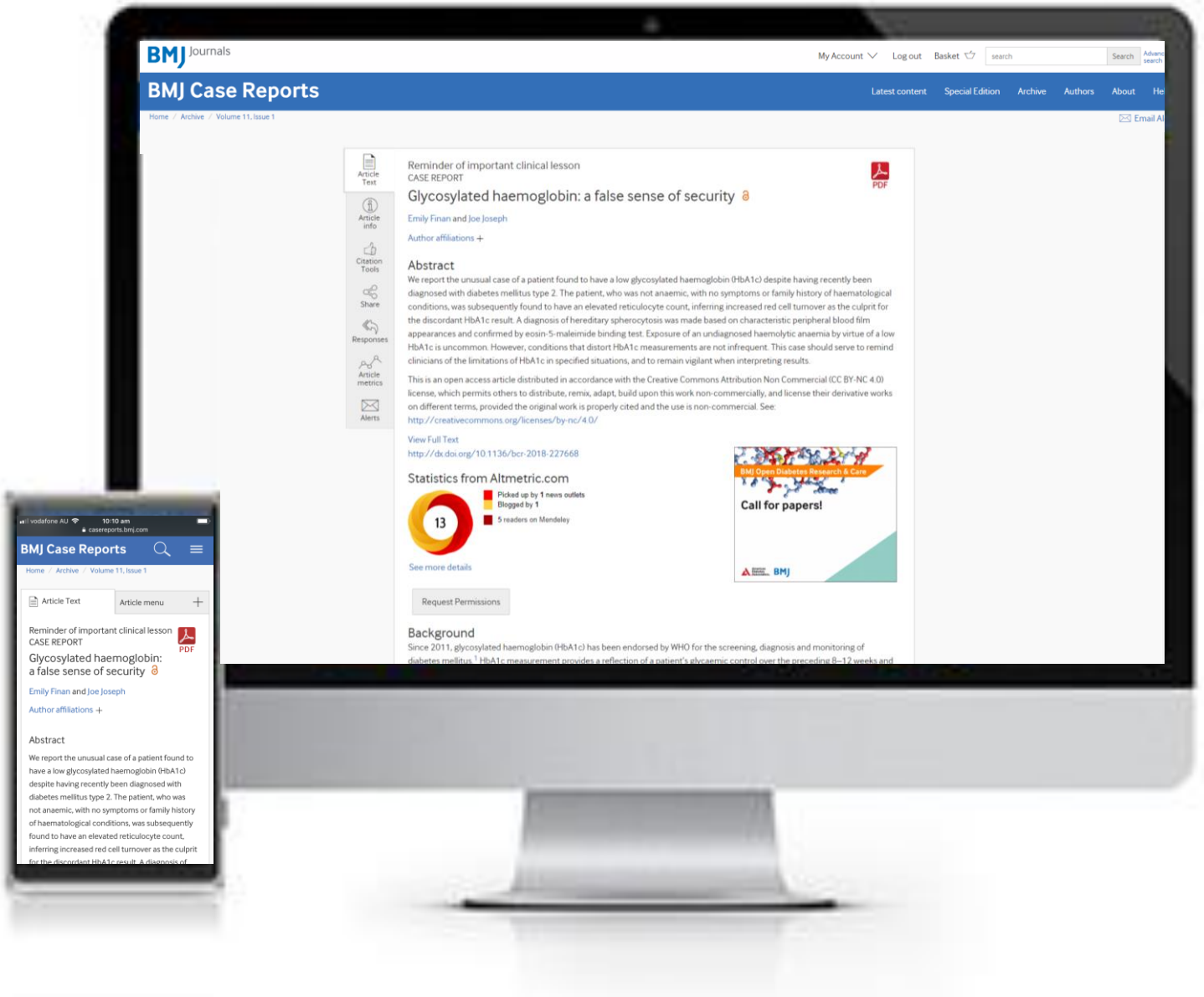
BMJ Case Reports

Publishing, sharing and learning through experience

Agenda

- Introduction to BMJ Case Reports
- Website demo
- How to write a good case report
- How to submit a case report
- Questions

Introduction to BMJ Case Reports



casereports.bmj.com

What is BMJ Case Reports?

- The largest single collection of medical cases in the world
- Over 20,000 case reports published from over 120 countries
- An invaluable educational resource for all healthcare professionals, providing clinically important information on common and rare conditions
- All cases are peer-reviewed and published cases are indexed on MEDLINE, PubMed Central, Scopus, Embase and Google Scholar
- Key 2019 publishing statistics:
  - Acceptance rate: 54%
  - Average time from submission to first decision: 66 days
  - Average time from acceptance to publication: 17 days

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Benefits to users

- An invaluable educational resource for all healthcare professionals
  - Vast database of real-world clinical scenarios
  - Reuse material personally and for teaching without further permissions
  - Easily download images into PowerPoint presentations
  - Learning Points included in each case
  - Educational Q&As

- A supportive introduction to medical publishing for first-time authors
  - Submit as many case reports as you like
  - Simple submission steps
  - Rigorous-yet-sympathetic peer review and rapid publication
  - Gain international recognition and publicity for your cases

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Specialties covered (clinical)

Anaesthesia	Geriatric medicine	Palliative care
Cardiovascular medicine	Haematology (incl blood transfusion)	Pathology
Complementary medicine	Immunology (including allergy)	Pharmacology and therapeutics
Dentistry and oral medicine	Infectious diseases	Prison medicine
Dermatology	Intensive care	Psychiatry
Diagnostics	Neurology	Radiology
Drugs and medicines	Nursing	Rehabilitation medicine
Ear, nose and throat/otolaryngology	Nutrition and metabolism	Renal medicine
Emergency medicine	Obstetrics and gynaecology	Respiratory medicine
Endocrinology	Oncology	Rheumatology
Gastroenterology	Ophthalmology	Sexual health
General practice / family medicine	Orthopaedics	Sports and exercise medicine
Genetics	Paediatrics	Surgery
		Urology

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Specialties covered (non-clinical)

Ethics	Occupational and environmental medicine
Ethnic studies	Public health
Health economics	Smoking and tobacco
Health informatics	Sociology
Medical education	Statistics and research methods
Medical management	

Types of cases covered

- Full text
- ‘Images in…’ – 1 or 2 striking/clinically important images with a brief description
- Global health – e.g. expedition medicine, humanitarian aid, refugee health, conflict, violence, telemedicine, e-health, health innovations

Findings that shed new light on the possible pathogenesis of a disease or an adverse effect	Other full case
Learning from errors	Rare disease
Medical student electives	Reminder of important clinical lesson
Myth exploded	Unexpected outcome (positive or negative) including adverse drug reactions
New disease	Unusual association of diseases/symptoms
Novel diagnostic procedure	Unusual presentation of more common disease/injury
Novel treatment (new drug/intervention; established drug/procedure in new situation)	Video reports

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Top 10 most read cases published in 2019

Fetus in fetu in an adult woman
‘Dragon horn SCC’
Boerhaave’s syndrome in an ultra-distance runner
Plant-based dietary approach to stage 3 chronic kidney disease with hyperphosphataemia
Pseudomembranous conjunctivitis: unveil the curtain
Sore throat turned to be a bronchogenic carcinoma with superior vena cava syndrome
Uvular necrosis as a cause of throat discomfort after endotracheal intubation
Shrinking of a Tarlov cyst
Sepsis-induced digital ischaemia in a professional pianist, in the absence of vasopressors
Re-expansion pulmonary oedema in pneumothorax

Data correct as at 22 January 2020

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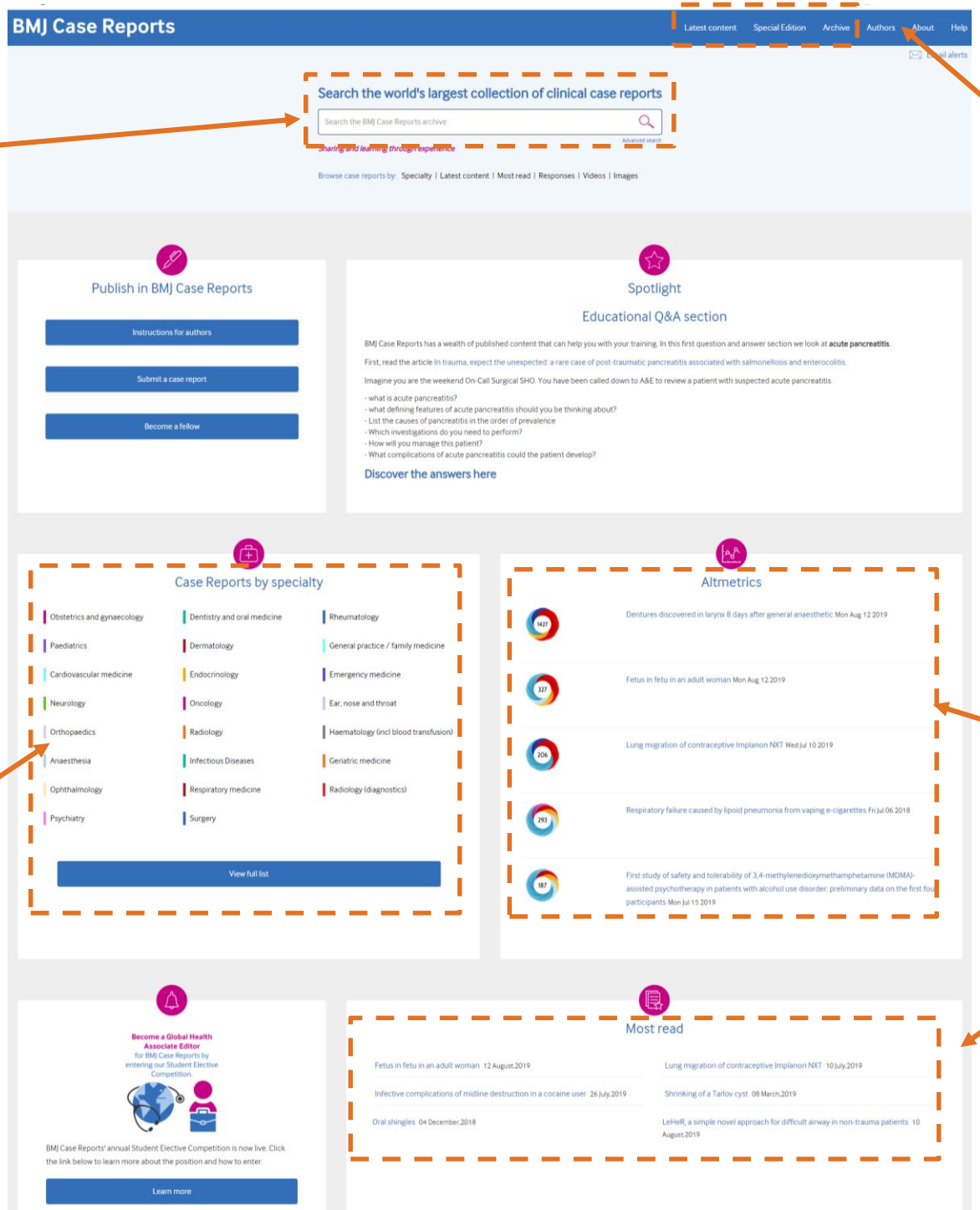
Website demo

Browsing and searching for cases

Find a case using the search bar or click ‘Advanced search’ for more options



View cases published in the last month or the full archive

Browse cases by specialty

View cases receiving the most attention online

View most read cases

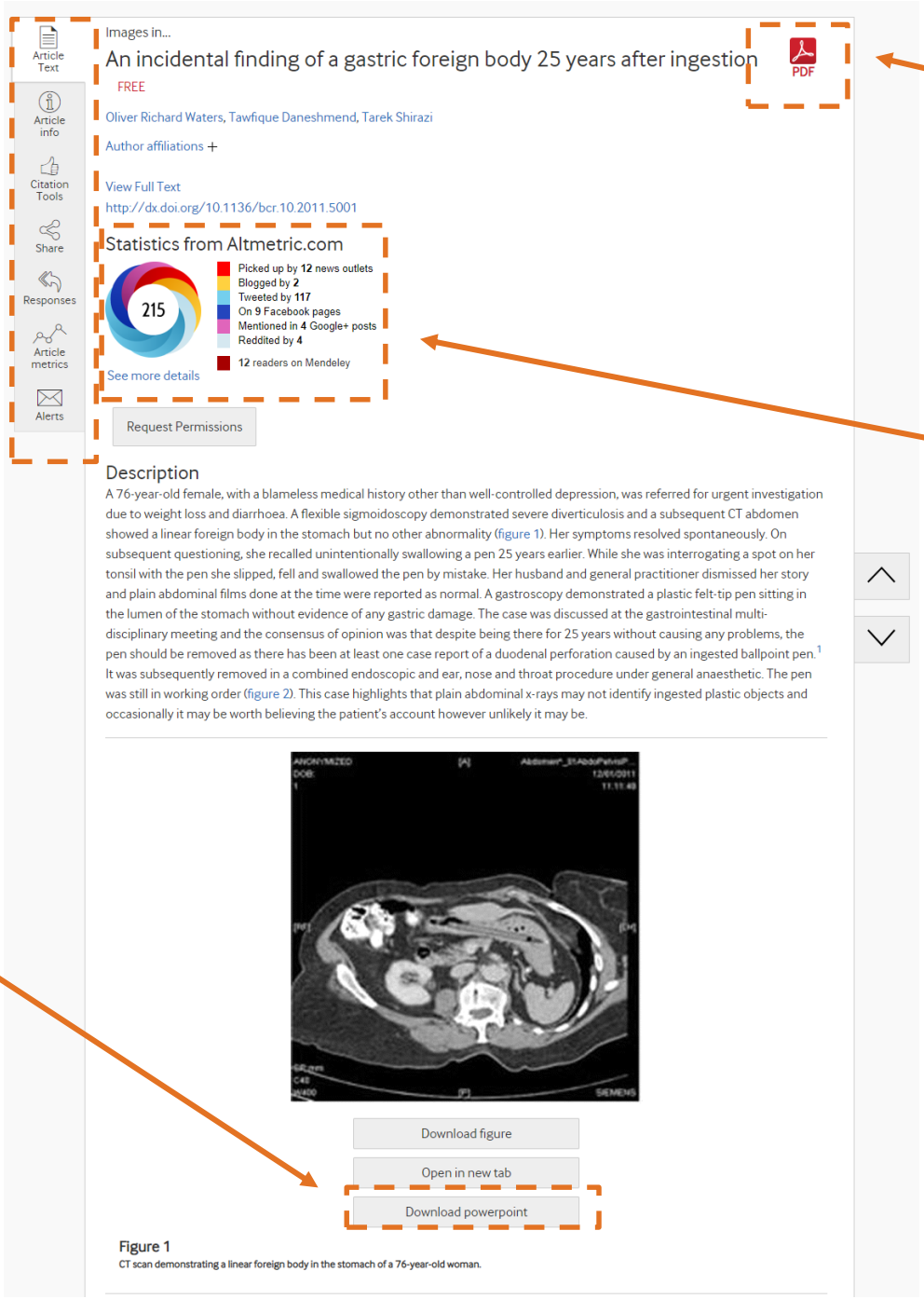
Example of an ‘Images in…’ case

Additional options for every article including citation tools, social sharing, responses, article metrics and alerts

View a PDF of the article

Altmetrics summary shows how much attention the article is receiving online

Automatically download image into a PowerPoint slide



How to write a good case report

Handy hints

- Know what the editors are looking for – view the Author Instructions and Author FAQs
- Explore some of the published cases
- Read the Guide to Writing and Publishing a Case Report
- Follow the templates provided – Full Case, Images In… or Global Health
- Use simple language and grammar
- Seek help from your senior colleagues
- Further tips available on the BMJ Author Hub

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What are the editors looking for?

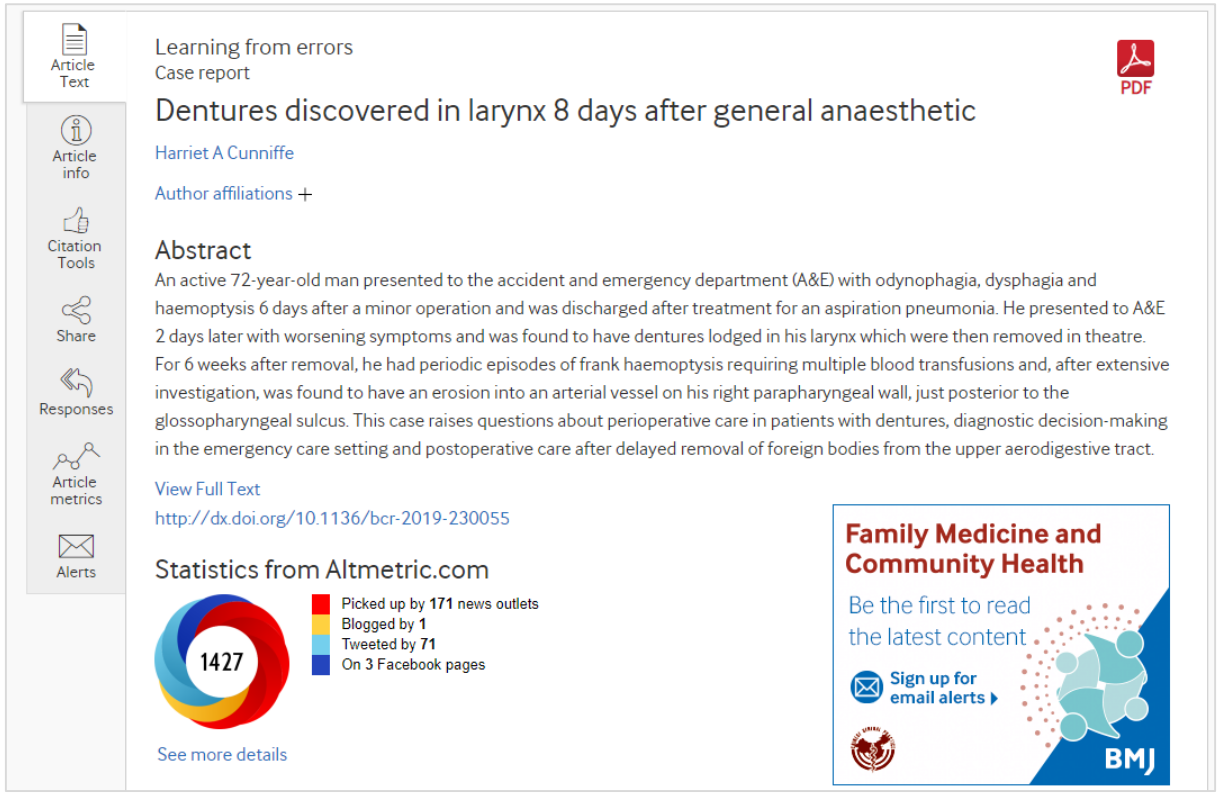
- Healthcare workers, including medical students and junior doctors, must find the cases to be relevant, engaging and a valuable learning resource
- Valuable clinical or ethical lessons
- Common cases that present a diagnostic, ethical or management challenge
- Cases where there are pitfalls to learn from

Typical BMJ Case Report structure

- Abstract
- Background
- Case presentation
- Investigations
- Differential diagnosis
- Treatment
- Outcome and follow-up
- Discussion
- Learning points/take home messages

Title and abstract

- You do not need to include ‘case report’ in the title
- Keep the title clinical and straightforward
- The abstract will be freely available online
- Use up to 150 words to summarise the case presentation and outcome
- Emphasise the learning points



Background

- Why do you think this case is important – why did you write it up?
- Why is the case of interest to readers?
- Is this a prevalent health problem?
- Is there a clear message?

Background

Full or partial dentures are used by approximately one in five people aged between 18 and 74 years.[1] According to the literature, eating, maxillofacial trauma and dental treatment procedures are the main reasons for an aspirated tooth or denture,[2–4] and while ethanol intoxication, dementia, stroke and epilepsy are predisposing factors, the majority of cases occur in patients with no known risks.[2 3] Foreign bodies in the upper aerodigestive tract (UADT) can pose a diagnostic challenge, as the delayed symptoms may mimic other common conditions like asthma, recurrent pneumonia, upper respiratory tract infection and persistent cough.[5]

Endoscopic removal of foreign bodies in the aerodigestive tract using rigid scopes under general anaesthesia is considered the gold standard; however, there have been reports of patients requiring tracheotomy for removal.[6] Complication rates from foreign body removal were not found to be related to method of removal but were associated with delayed removal (presentation >24 hours after symptoms onset), pharyngeal location, the foreign body being a fish bone and radiolucency.[7] In older patients (aged >10 years), the most common complication is retropharyngeal abscess, followed by pulmonary complications (aspiration, pneumonia, pneumonitis, pulmonary collapse), local infection (oesophagitis, cellulitis, ulceration) and perforation. There is also a risk of bleeding secondary to granulation tissue or erosion into a major vessel but such a case has not yet been reported.[8] At present, there is little advice regarding follow-up after removal of foreign bodies in high-risk cases. This case is important as it highlights a number of key learning points for anaesthetists, theatre staff, emergency physicians and ear, nose and throat (ENT) surgeons alike.

Case presentation

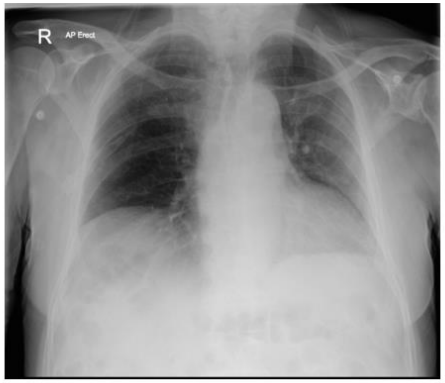
- Presenting features, medical/social/family history
- This is the patient's story – be sensitive to patient confidentiality
- How did they present?
- What is the relevant history? Why is this relevant?
- Explain your findings and how they influenced your decisions
- Do not use abbreviations for diseases or investigations

Case presentation

This case report concerns an active 72-year-old retired electrician who lives independently with his wife, has never smoked and whose only medical history is chronic obstructive pulmonary disease (COPD), well controlled with occasional salbutamol use.

He presented to the accident and emergency department (A&E) with odynophagia, dysphagia and haemoptysis 6 days after excision of a benign abdominal wall lump. He had not been able to swallow any solid food since his general anaesthetic. Oropharyngeal examination was normal, chest X-ray showed changes consistent with his COPD, haemoglobin was stable and inflammatory markers were mildly raised. He was treated for lower respiratory tract infection and concurrent pain secondary to intubation and discharged with clarithromycin, difflam mouthwash and a 5-day course of prednisolone.

He returned to A&E 2 days after this with worsening pain in his throat, ongoing haemoptysis, a hoarse breathy voice and being unable to swallow the medication he was discharged with. He was also feeling short of breath, particularly when lying down, and had taken to sleeping upright on the sofa. He was now requiring 2 L oxygen via nasal cannula to maintain his saturation. His chest X-ray showed some hazy opacification in the left hemithorax (see figure 1). He was admitted under the medics for aspiration pneumonia, who referred him to ENT on initial clerking. On ENT examination, the patient had a soft neck with full movement and no lymphadenopathy and a normal oropharynx. Flexible nasendoscopy examination revealed a metallic semicircular object overlying the vocal cords and completely obstructing their view. The object was pressed against the epiglottis and had caused erythema and swelling with evidence of erosion that was likely the cause of the haemoptysis. On explaining this to the patient, he revealed that his dentures had been lost during his general surgery admission 8 days earlier and consisted of a metallic roof plate and three front teeth. Lateral and anteroposterior neck X-rays revealed this to be the foreign body (see figures 2 and 3). He was taken to the emergency theatre where the dentures were removed. Postoperatively, his oxygen requirements continued to increase, so he was started on optiflow and continued treatment for an aspiration pneumonia. His oxygen was weaned, and he was discharged 6 days later.



Download figure

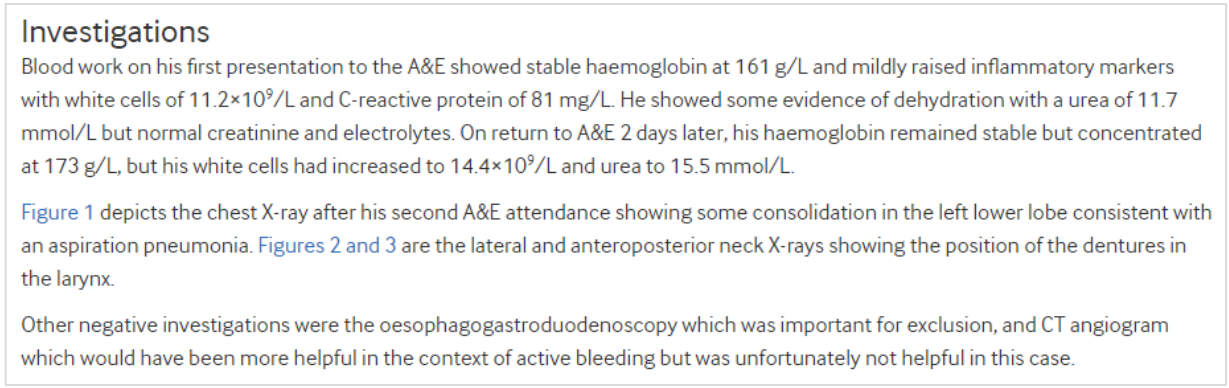
Open in new tab

Download powerpoint

Figure 1
Anteroposterior (AP) chest X-ray.

Investigations

- If relevant. All investigations that create a background/baseline picture are relevant
- All investigations that are crucial to management decisions should be discussed in full
- Choose appropriate images and videos to illustrate your point (maintaining patient confidentiality)



Investigations

Blood work on his first presentation to the A&E showed stable haemoglobin at 161 g/L and mildly raised inflammatory markers with white cells of 11.2×10^9/L and C-reactive protein of 81 mg/L. He showed some evidence of dehydration with a urea of 11.7 mmol/L but normal creatinine and electrolytes. On return to A&E 2 days later, his haemoglobin remained stable but concentrated at 173 g/L, but his white cells had increased to 14.4×10^9/L and urea to 15.5 mmol/L.

Figure 1 depicts the chest X-ray after his second A&E attendance showing some consolidation in the left lower lobe consistent with an aspiration pneumonia. Figures 2 and 3 are the lateral and anteroposterior neck X-rays showing the position of the dentures in the larynx.

Other negative investigations were the oesophagogastroduodenoscopy which was important for exclusion, and CT angiogram which would have been more helpful in the context of active bleeding but was unfortunately not helpful in this case.

Differential diagnosis

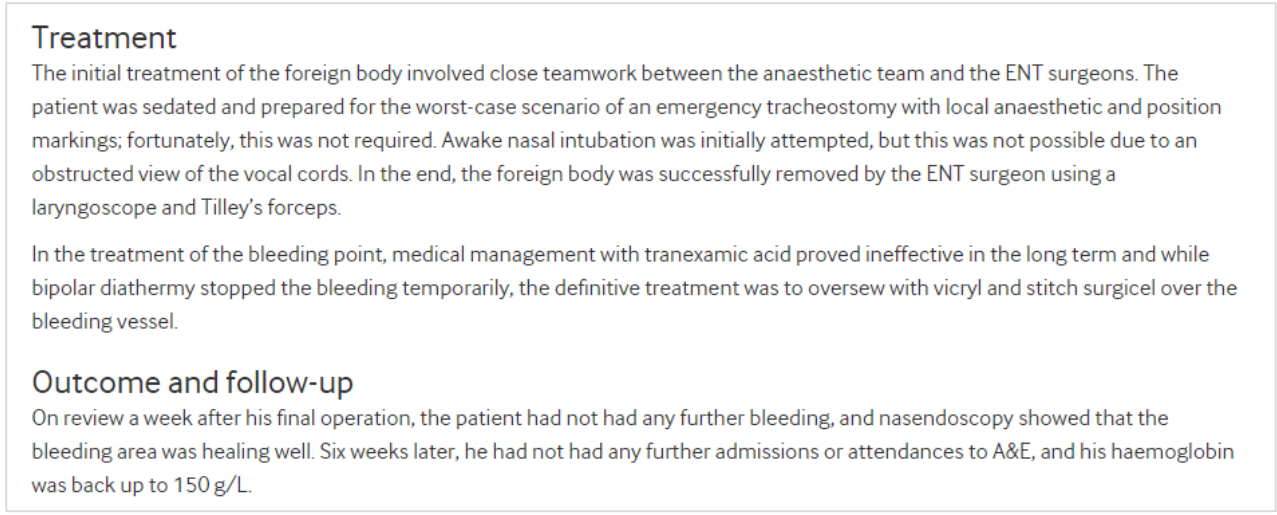
- If relevant. Please don’t list these
- Show how the final diagnosis was derived
- What are the consequences to management or treatment for the differential diagnosis?

Differential diagnosis

The initial diagnosis of aspiration pneumonia was probably an accurate diagnosis, based on the chest X-ray, but certainly did not explain all his symptoms. When he returned with further haemoptysis and requiring oxygen, he was also investigated for a pulmonary embolism, but his D-dimer was found to be negative, so he was admitted under the medical team for the aspiration pneumonia. It was not until the medical team saw him, and he reiterated his presenting complaint of odynophagia and dysphagia, that ENT were asked to perform nasendoscopy, and the primary diagnosis was made.

Treatment, outcome and follow-up

- Include pharmacological and non-pharmacological treatment
- Always include follow up data where you can to show the outcome of the treatment
- The follow-up period should be defined
- Please state if the patient has died even if not directly related to your case



Treatment

The initial treatment of the foreign body involved close teamwork between the anaesthetic team and the ENT surgeons. The patient was sedated and prepared for the worst-case scenario of an emergency tracheostomy with local anaesthetic and position markings; fortunately, this was not required. Awake nasal intubation was initially attempted, but this was not possible due to an obstructed view of the vocal cords. In the end, the foreign body was successfully removed by the ENT surgeon using a laryngoscope and Tilley's forceps.

In the treatment of the bleeding point, medical management with tranexamic acid proved ineffective in the long term and while bipolar diathermy stopped the bleeding temporarily, the definitive treatment was to oversew with vicryl and stitch surgicel over the bleeding vessel.

Outcome and follow-up

On review a week after his final operation, the patient had not had any further bleeding, and nasendoscopy showed that the bleeding area was healing well. Six weeks later, he had not had any further admissions or attendances to A&E, and his haemoglobin was back up to 150 g/L.

Discussion

- Include very brief review of similar published cases
- Describe mechanisms of injury, guidelines and their relevance, diagnostic pathways (can use diagrams) and the points of interest of the case
- A brief summary of relevant clinical guidelines is appropriate
  - Did you make an exception?
  - Did you have to adapt the guidelines?

Discussion

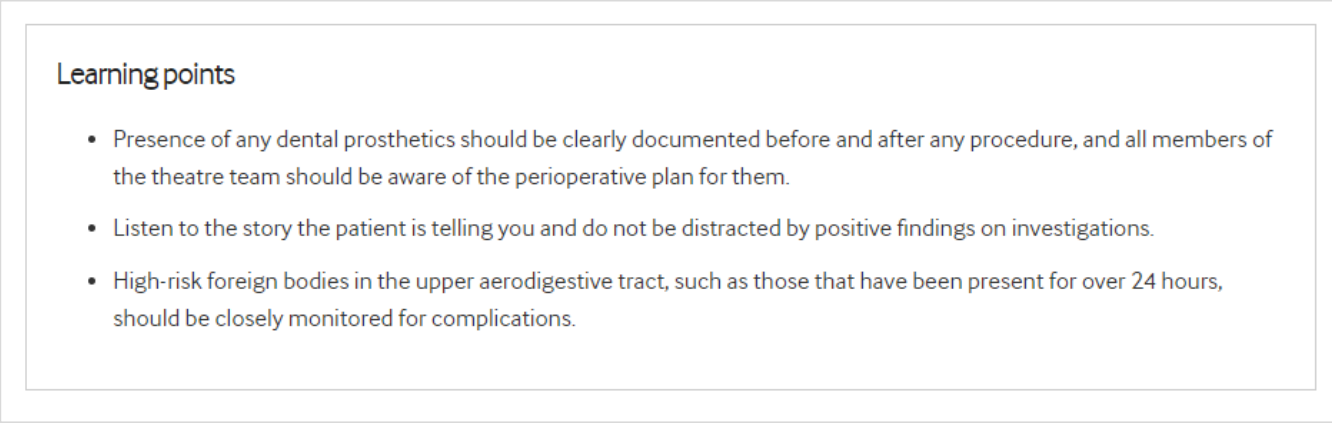
There have been documented cases of iatrogenic foreign bodies in the UADT in both dentistry[9] and anaesthesia, including teeth,[10] a latex glove[11] and a denture that was aspirated into the larynx on intubation, in a case of bilateral maxillary fractures, which sadly ended in fatality after extubation.[12] A 15-year review of 83 cases of aspirated dentures identified that in 12 (14%) cases the dentures were found in the hypopharynx or larynx, and in 6 (7%) cases the dentures were aspirated during general anaesthetic.[3]

There are no set national guidelines on how dentures should be managed during anaesthesia, but it is known that leaving dentures in during bag-mask ventilation allows for a better seal during induction,[13] and therefore, many hospitals allow dentures to be removed immediately before intubation, as long as this is clearly documented.

In addition to reminding us of the risks of leaving dentures in during induction of anaesthesia when the Swiss cheese model of errors aligns, this case also highlights a number of important learning points. The first is to always listen to your patient. It has long been known that one gets the majority of the information needed to form a diagnosis based on the patients' history; this was shown in a study of 80 patients where the final diagnosis was established after only the history in 82.5% of cases.[14] However, with easy access to imaging and laboratory tests, we are all sometimes guilty of relying on these investigations. Although one should not underestimate the power of hindsight, looking back through this man's A&E notes, he was clear that the reason he attended A&E was a sore throat and difficulty swallowing, and therefore, the positive findings on blood work and chest X-ray acted as a distraction. This concept is known as anchoring, a cognitive bias where a positive finding, such as consolidation on a chest X-ray, usually at the beginning or end of the decision-making process, alters our subsequent judgements so that other findings fit into the model we have created.[15] Another relevant concept is something called 'zebra retreat' where a diagnostician retreats from making a correct diagnosis because of self-doubt about entertaining such a remote or unusual diagnosis.[15] This is essential to prevent unnecessary investigations but occasionally results in situations like the one described in this report.

Learning points/take home messages

- 3 to 5 bullet points
- Compulsory field
- This is the most crucial part of the case
- What do you want readers to remember when seeing their own patients?



Learning points

- Presence of any dental prosthetics should be clearly documented before and after any procedure, and all members of the theatre team should be aware of the perioperative plan for them.
- Listen to the story the patient is telling you and do not be distracted by positive findings on investigations.
- High-risk foreign bodies in the upper aerodigestive tract, such as those that have been present for over 24 hours, should be closely monitored for complications.

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Other sections

- References (Vancouver style)
- Figure/video captions
- Patient’s perspective

Research and publishing ethics

- You must have signed informed consent from patients (or relatives/guardians) before submitting to BMJ Case Reports
- Please anonymise the patient's details as much as possible
- Consent forms are available in 19 languages from https://casereports.bmj.com/pages/authors/#consent

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Consent form

For a patient's consent to publication of images and/or information about them in BMJ publications.

Name of patient: _____

Relationship to patient (if patient not signing this form): _____

Description of the photo, image, text or other material ***(Material)*** *about the patient.* ***A copy of the Material must be attached to this form****:* _____

Provisional title of article in which Material will be included: _____

CONSENT

I_____ *[PRINT FULL NAME]* give my consent for the Material about me/the patient to appear in a BMJ publication.

I confirm that I: *(please tick boxes to confirm)*

- ☐ ***have seen the photo, image, text or other material about me/the patient***
- ☐ ***have read the article to be submitted to BMJ***
- ☐ ***am legally entitled to give this consent.***

I understand the following:

(1) The Material will be published without my/the patient's name attached, however I understand that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - for example, somebody who looked after me/the patient or a relative - may recognise me/the patient.

(2) The Material may show or include details of my/the patient's medical condition or injury and any prognosis, treatment or surgery that I have/the patient has, had or may have in the future.

(3) The article may be published in a journal which is distributed worldwide. BMJ's publications go mainly to doctors and other healthcare professionals but are also seen by many others including academics, students and journalists.

(4) The article, including the Material, may be the subject of a press release, and may be linked to from social media and/or used in other promotional activities. Once published, the article will be placed on a BMJ website and may also be available on other websites.

(5) The text of the article will be edited for style, grammar and consistency before publication.

(6) I/the patient will not receive any financial benefit from publication of the article.

Patient consent form 050419

Email address: _____ *Telephone no:* _____

Date: _____

Patient consent form 050419

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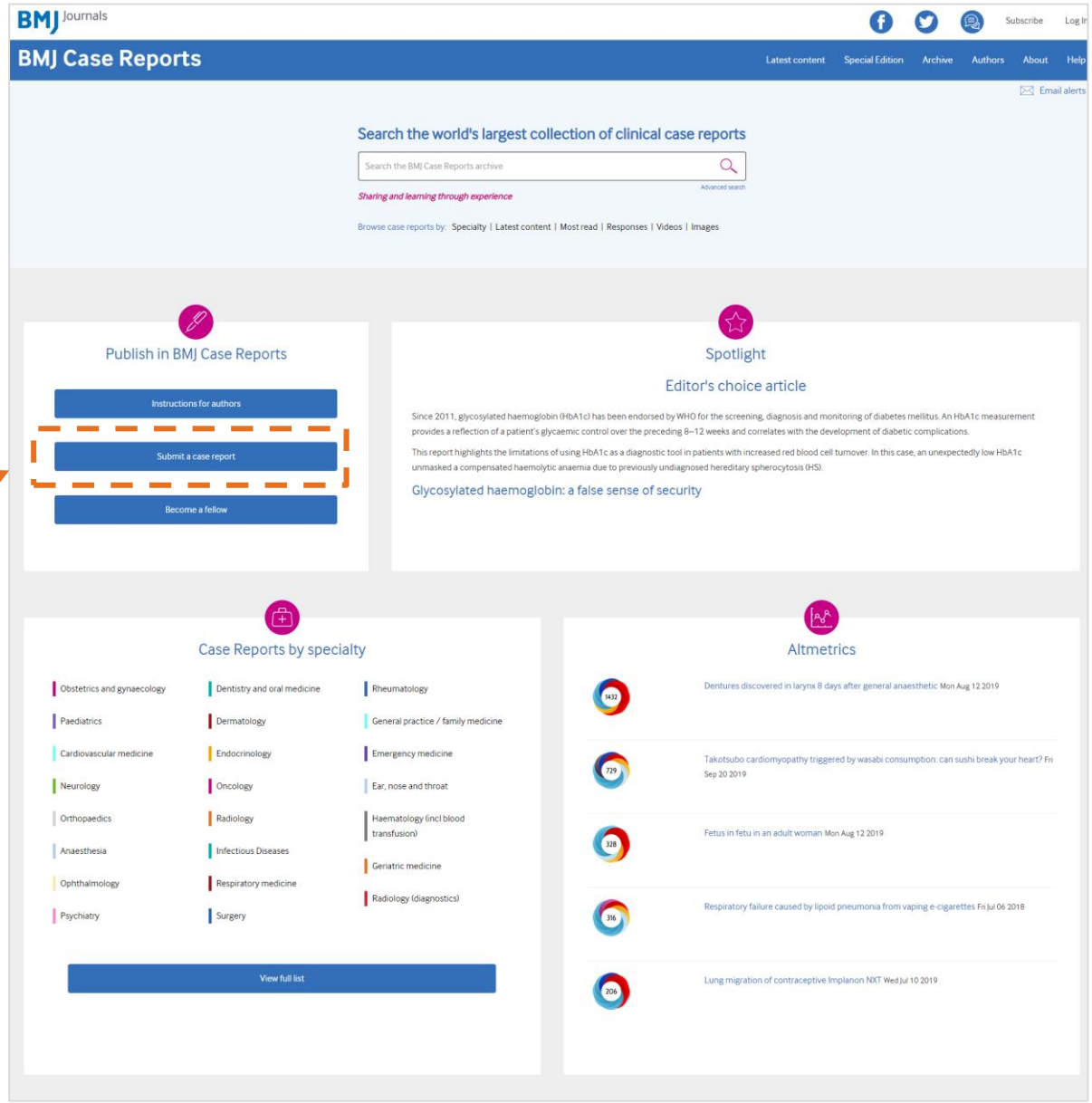
How to submit a case report

3 easy steps to submit a case

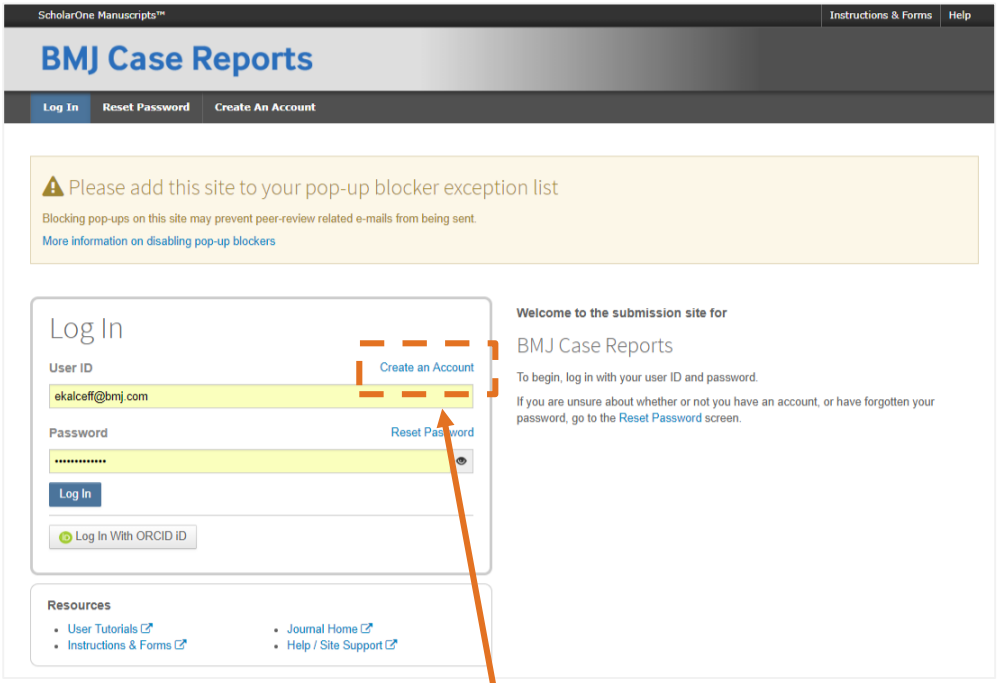
- Complete a simple Word template
- Obtain a signed patient consent form
- Submit online

How to submit your case

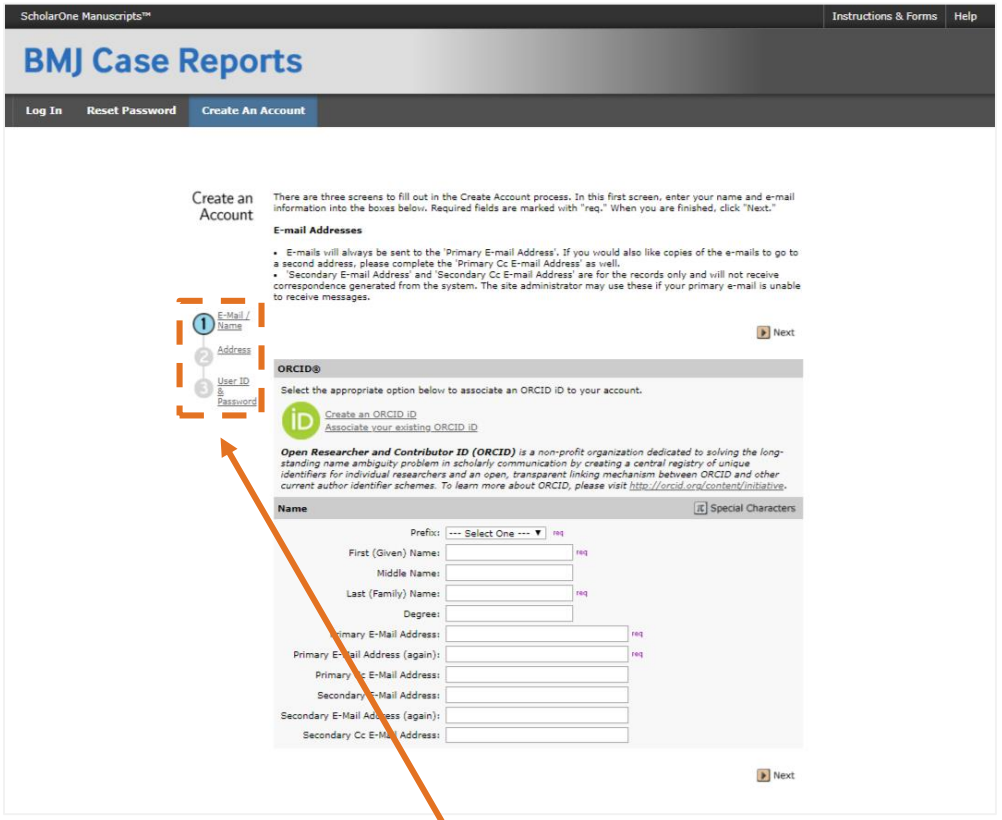
Click on ‘Submit a case report’



Register on the submission system

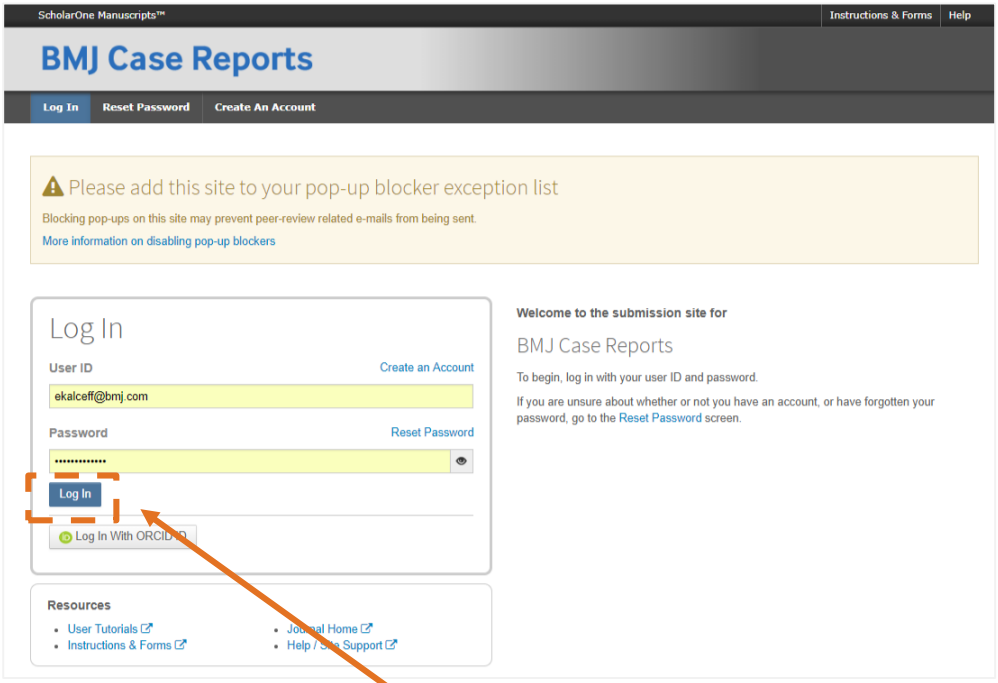


All authors need to register on the submission system (ScholarOne Manuscripts). Click on ‘Create An Account’…

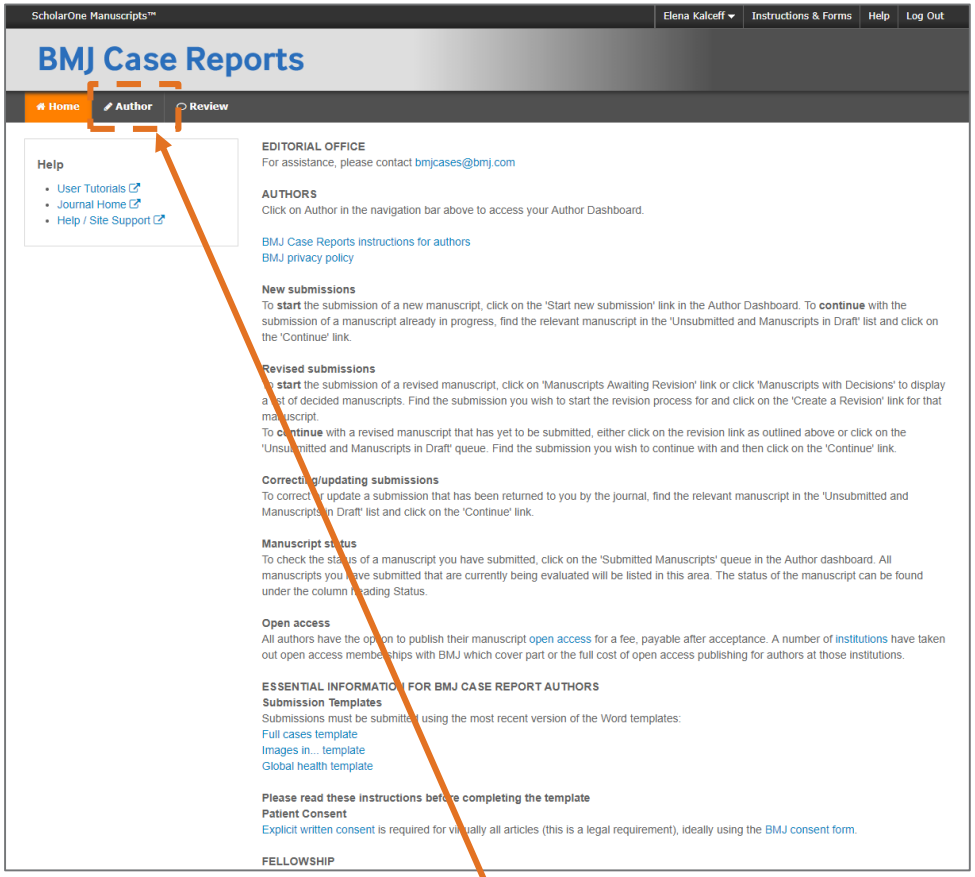


… and complete all 3 steps of the registration process. Ensure you complete all required fields. At the end of Step 3 on the ‘User ID & Password’ page, click on ‘Finish’ to complete your registration.

Login and navigate to Author Dashboard

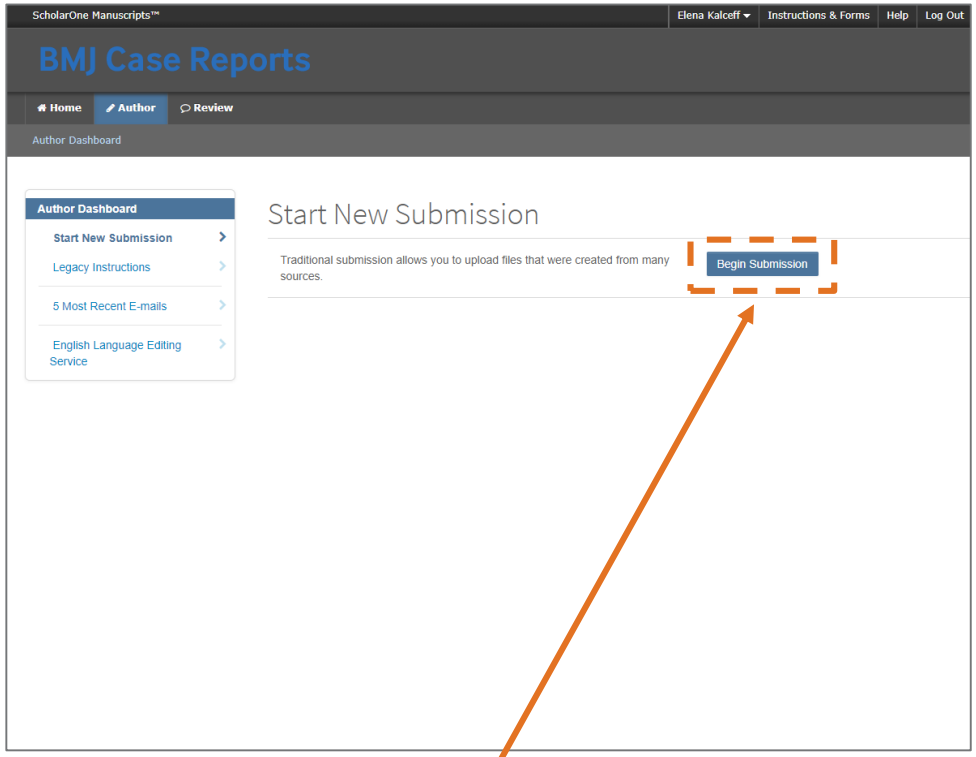


Once you have registered, enter your User ID and Password and click ‘Log In’.

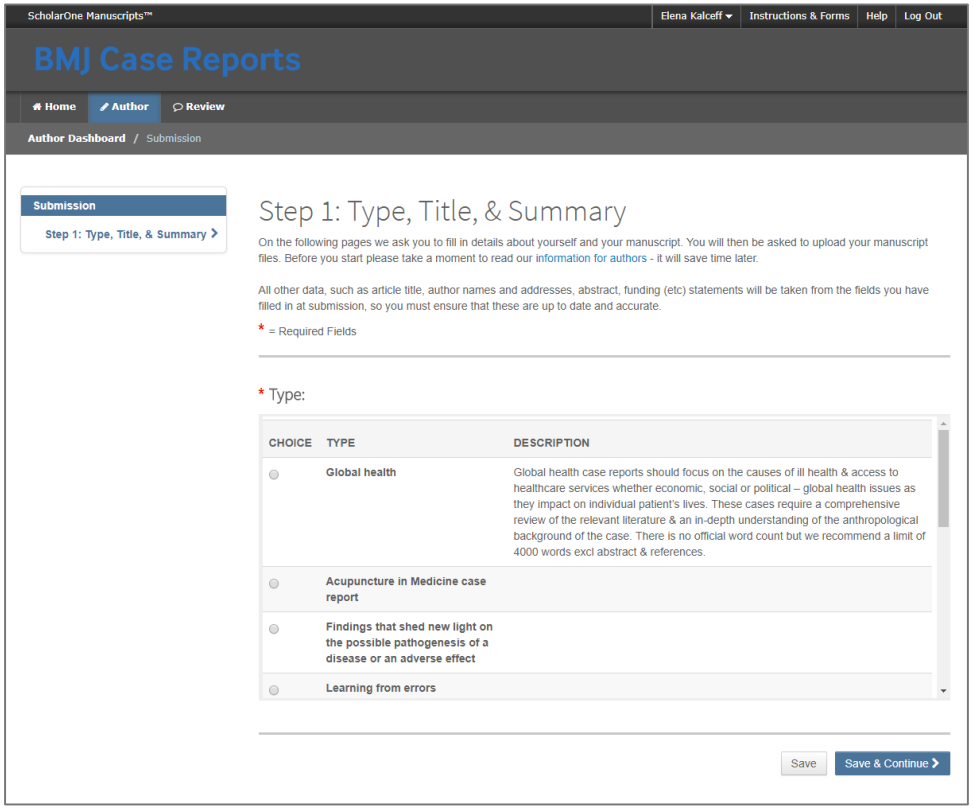


Once logged in, click on ‘Author’ in the navigation bar at the top of the page.

Complete the submission process

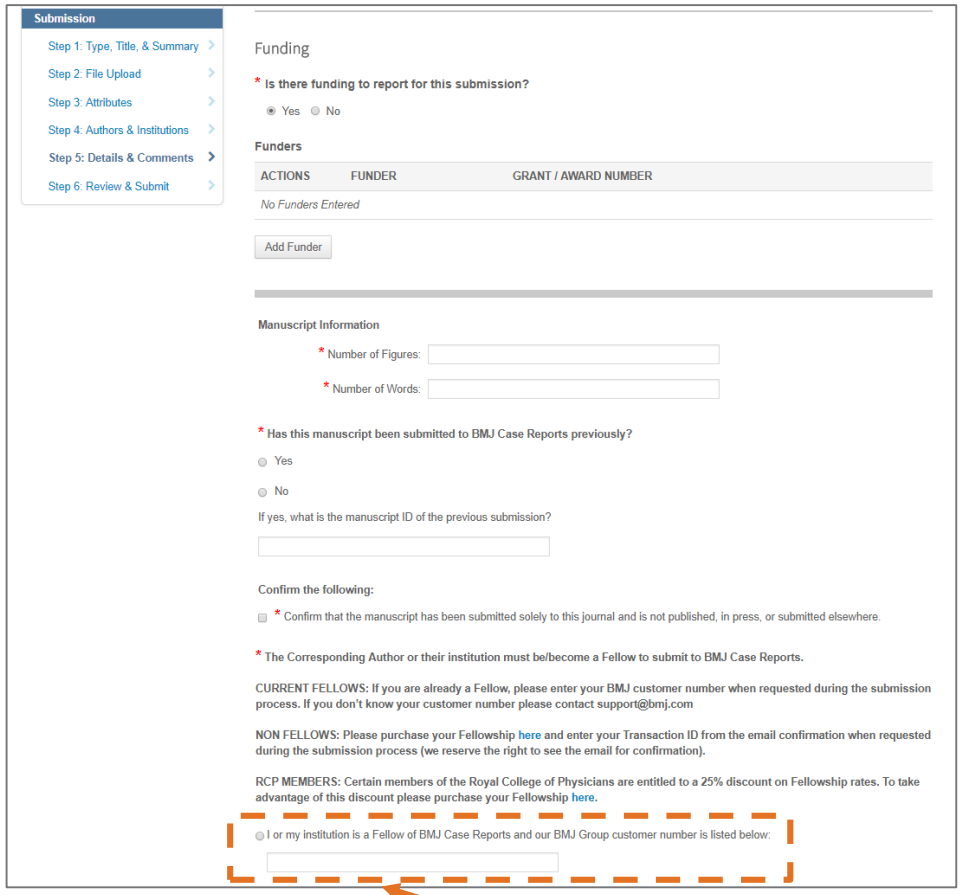


Click on ‘Begin Submission’ to start the submission process.

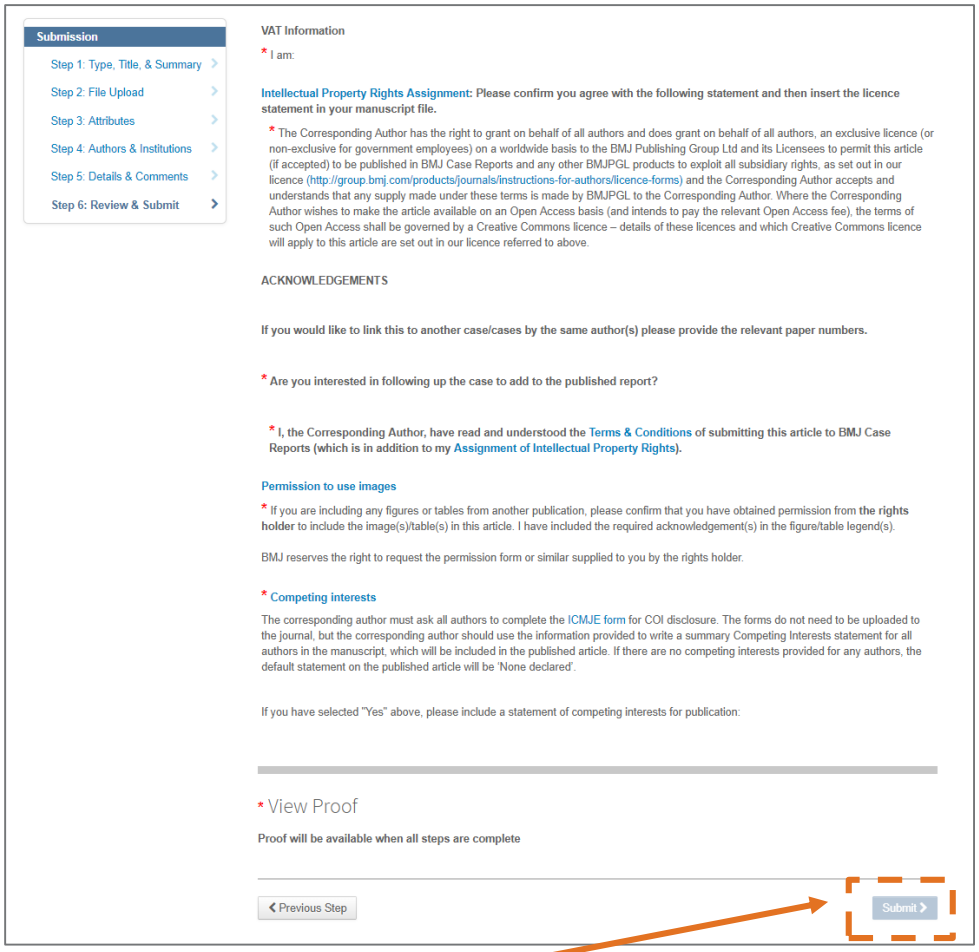


Complete all 6 steps of the submission process. You will need to upload a signed patient consent form alongside your article. You can download this from https://casereports.bmj.com/pages/authors/#consent

Enter your Institutional Fellowship Code



In 'Step 5: Details & Comments', enter your Institution's Fellowship Code in the box provided in the Funding section. Ask your Librarian for your Fellowship Code.



To submit your paper, ensure all sections are completed correctly, then click on 'Submit' at the end of Step 6.

Thank you

Any questions?

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