THE UPLEDGER INSTITUTE INTERNATIONAL

Case Report Short Form

Goals of Case Reports

- To provide a forum for individuals to present their case experiences and to enhance professional development.
- To develop responsibility for the profession of CranioSacral therapists to further the advancement of the field and to place CST as a viable therapy within the professional community of integral health practitioners.
- To share information and to gather a data base that could eventuate as a long range research study with significant numbers for statistical reliability.
- To increase the awareness of CST to the general population and its relevance to specific and general health conditions, revealing the benefits and outcomes.

Six Steps

Step 1: Introduction

Step 2: Describe the Patient/Client

Step 3: Describing the Intervention

Step 4: Discussion

Step 5: Create Abstract

Step 6: References

Note: All the criteria suggested in this outline may not apply to every study.

Please submit your Case Report and Abstract to UII at casereport@upledger.com.

Include: Name, Professional Title, Address, Phone, Email, and indicate your profession.

Step 1: Introduction

a. Introduce topic of CST
b. Why? = Few Published Case Reports
c. Theoretical Concept of CST = Explain the aspects of CST that relate to your case.
   Example: Tension of intracranial membrane (ICM) system affects brain function and may contribute to learning disabilities.
d. Literature that supports case report related to your purpose = Check UI website and/or pub med.
e. Gap in literature that your case report will fill.
   Example: No present research on CST and Learning Disabilities. (LD)
f. Purpose:
   Example: To describe CST as an intervention in patients with LD and reports of CST efficacy by client's family and teacher (s).

Step 2: Describe the Patient/Client

a. Provide a Consent Form
b. History includes:
   1) Chronologically based description of symptoms, reason for seeking care, functional limitations and disability.
   2) Types of Data to include in history only as to what influenced your clinical decision-making process or that are important as related to their diagnosis.
      Example: Hand dominance would be important if case report on patient with Lateral Epicondylitis but not for a patient with headaches.

Types of Data:

1. General Demographics
    - Age
    - Sex
2. Social History
    - Family/caregiver resources/support
    - Cultural beliefs
3. Employment
    - Body postures
    - Repetitive motions
4. Living Environment
    - Assistive or adaptive equipment
      Example: crutches, cane, foot orthotic
5. General Health Status
    - General Health perception
    - Physical Function
      Example: mobility, sleep functions
    - Psychological Function
      Examples: depression, anxiety, memory loss, meaningful conversation.
6. Medical History
7. Surgical History
8. Current Condition
    - Date of onset.
    - Mechanism of injury or disease
    - Symptom onset and progression
    - Prior interventions
9. Functional Status
    - ADL's
    - Work function
10. Medication
    - Current and/or previous.
    - Medications for other conditions.

c. Tests and Measures
    1) Pain
    2) Depression
    3) ROM
    4) Muscle Strength Testing
    5) Blood pressure
    6) Photos of posture, wound healing, edema changes.
    7) Functional Measures:
        - Number of steps.
        - Continuous hours slept or frequency of awakening during the night.
        - Change from crutches to cane or cane to without assistive device.
        - Balance tests
        - Dressing with/without assist
        - Bed mobility
    8) Subjective Data
        - Pain: constant or intermittent/frequency
        - Pain scale 0 to 10.

Step 3: Describing the Intervention

a. Rationale for Treatment
    - Is based on published research reports, biological plausibility or a theoretical argument published in a book, journal or online. A reference to their description could be helpful.
      Example 1: Birth trauma may cause abnormal tensions in the ICM.
      Example 2: Continuity of fascia and translation of abnormal forces over time from knee to temporal bone causing vertigo (Mary Ellen Clark example).
b. How was CST applied:
    - Include length of time for each technique.
    - Session duration.
    - Do this so completely that another therapist could replicate the intervention with a similar patient.

c. Outcomes/Results/Analysis
    - Do post-test of all initial measures. More measurements improve reliability and validity of treatment.
    - Include objective measures.
    - Include functional measures.
    - Include subjective measures.
    - Can use text, simple table(s), line graphs, scans (CT, MRI, Thermo, Spec), radiographs (x-rays) and/or photographs to summarize.

Step 4: Discussion

a. Link the Case to Its Purpose

    Example: Individuals with LD are not commonly treated with manual therapy.

b. Relate the case to the literature.

    Example: Cite literature related to drug therapy or behavioral interventions for individuals with LD.

c. Offer Alternative Explanations

    Example: "Touch Therapy" is relaxing and promotes ease in learning. Offer research that clarifies this, if available. For example, cite a touch therapy study that promoted ease in learning but only for one day's duration.

d. Address strengths and/or limitations in your treatment plan.

    Example 1: Would increased frequency of CST application at outset have made a more rapid change in one of your specific measures such as more efficient reading?

    Example 2: Would an increased frequency of treatment at the outset have decreased pain levels even more?

e. Include recommendations for further study.

    Example 1: Additional research addressing the effectiveness of CST on children with only one type of learning disability.

    Example 2: Additional variables such as social interaction could be assessed following treatment.

Step 5: Create Abstract

a. Although the abstract appears at the beginning of the article, write it last.
b. In one paragraph, in 150 to 200 words, summarize what your case study was about. This is a concise description about the type of patient you treated, what you did, duration, measurements and results.
c. It should include Introduction, Methods, Results and Conclusions without designating each of these areas.
d. Separately include 5-7 Key Words so that others can quickly reference your report.
   Example: learning disabilities, dyscalculia, dyslexia, reading disorders, dysgraphia.

Step 6: References

a. References are required. The strength of your case report is dependent in part on the strength of your citations.
b. Use "primary sources" or first-hand accounts of research procedures.
c. Use peer-reviewed journals to lend credibility. Most professional journals are peer-reviewed.
d. Databases through University or Public libraries.
e. Medical Websites can be referenced with date found on web.
f. Use APA-style (American Psychological Association) reference format found at http://www.indiana.edu/~citing/APA.pdf.

Examples of pre-and post measurements

Examples of pre-and post measurements to quantify the changes that occurred due to the treatment. Have pre-measurements planned and prepared for the client. Here are some other examples of meaningful measurements that you could also use.

McGill Pain Rating Index (PRI) - A questionnaire is used to evaluate a person's pain level and pain triggers. It was developed by Dr. Melzack at McGill University in Montreal, Canada.

Visual Analog Scales - Numeric Pain Rating Scale (NRS) - This is perhaps one of the most commonly used pain scales in healthcare. The client rates their pain level on a scale from 0 to 10 - 0 indicates the absence of pain, while 10 represents the most intense pain possible.

The Beck Depression Inventory (BDI) - created by Dr. Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used instruments for measuring the severity of depression. The questionnaire is designed for individuals aged 13 and over.

Range of Motion, use of Goniometers.

Photos of pre- and post- changes

Blood Pressure

Strength testing

Functional Changes - Bed mobility, gait with/without assistive device, sit to stand, housekeeping, self-care, get dressed (various garments), dry hair

Medication forms with patient reporting on name, dose and frequency, which will assess changes in medications that might occur during course of treatment

Other simple measures:

- number of steps
- number of hours slept
- number of hours in pain, etc.