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EDUCATIONAL EDITORIAL & PRACTICAL GUIDE

FROM AN INTERESTING PATIENT TO A PUBLISHABLE PAPER

A STEP-BY-STEP GUIDE TO HIGH-QUALITY RADIOLOGICAL CASE REPORTS

The SJORANM Practical Guide for Authors, Reviewers and Editors

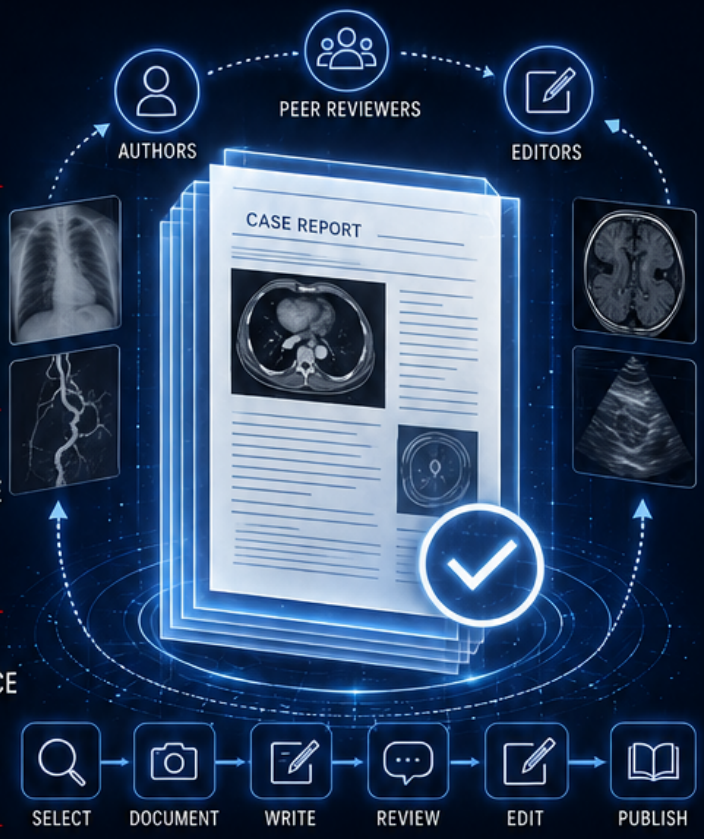
12-STEP WORKFLOW
From case selection to submission

ORIGINAL IMAGING
Primary diagnostic evidence required

PATIENT PERSPECTIVE
Dedicated section mandatory

EDITORIAL INDEPENDENCE
Transparent handling of editor-authored work

AI DISCLOSURE
Use must be declared; AI cannot be authors



12-STEP WORKFLOW

1. CASE IDENTIFICATION
2. ETHICS & CONSENT
3. IMAGE ACQUISITION
4. DATA CURATION
5. PATIENT PERSPECTIVE
6. LITERATURE CONTEXT
7. MANUSCRIPT WRITING
8. DISCLOSURES & ETHICS
9. PEER REVIEW
10. REVISION
11. ACCEPTANCE
12. PUBLICATION

THIS ISSUE

Special issue featuring only the SJORANM Case Report Guide

12-step workflow for authors, reviewers and editors

CASE REPORTING | CARE-RADIOLOGY | EDITORIAL WORKFLOW | PUBLICATION QUALITY

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From an Interesting Patient to a Publishable Paper:

A Step-by-Step Guide to High-Quality Radiological Case Reports

The SJORANM Practical Guide for Authors, Reviewers and Editors

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Abstract

Radiological case reports are most useful when they enable readers to reconstruct the clinical question, inspect the decisive original imaging evidence, follow the diagnostic reasoning, and evaluate how the diagnosis was confirmed and what happened afterwards. CARE-radiology provides the radiology-specific reporting framework. This Educational Editorial & Practical Guide translates CARE-radiology, CARE, ICMJE, COPE, the 2024 Declaration of Helsinki and CRediT into a 12-step SJORANM workflow for authors, reviewers and editors.

SJORANM requires **original diagnostic radiological images** as primary evidence and a dedicated **Patient Perspective** section (or a transparent explanation if unobtainable). Pathology is preferred when clinically relevant and available but is not mandatory when another credible reference standard exists. The framework distinguishes external reporting requirements, good scientific practice and journal-specific policy. Accompanying tools include author and reviewer checklists, a technical pre-check, standardised decision-letter modules and a CARE-radiology crosswalk. The aim is an educational, internally consistent and independently verifiable case report before peer review.

Keywords: case report; radiology; CARE-radiology; reporting quality; publication ethics; diagnostic imaging

How to use this guide

- **Authors:** Follow the 12 steps sequentially before writing. Complete the Author Checklist (Supplement 1) and preferably the CARE-radiology checklist.
- **Reviewers:** Use the Reviewer Checklist (Supplement 2) to structure comments and link deficiencies to specific steps.
- **Editors:** Apply the Technical Pre-check (Supplement 3) and Decision-Letter Modules (Supplement 4) for consistent handling.

Figure 1 provides a one-page overview of the entire pathway.

1. Why this guide is needed

Case reports remain valuable for recognising unusual disease manifestations, unexpected adverse events, diagnostic traps and clinically meaningful observations that may not yet be represented in larger studies. Their value lies not in statistical power but in the clarity, credibility and transferability of the observation. A well-constructed report can sharpen diagnostic awareness, generate hypotheses and support case-based education; a poorly documented report may be impossible to evaluate even when the patient history is genuinely interesting.

Radiological case reports carry an additional evidentiary burden because the figures are part of the primary data. Readers should be able to understand why imaging was performed, how the examination was acquired, what was found, which alternatives were considered and how the diagnosis was established. Missing sequence or phase information, imprecise localisation, weak annotation or unexplained discrepancies between imaging, surgery and pathology can therefore undermine the central claim.

Recurring editorial problems are strikingly consistent: unsupported claims of rarity; incomplete timelines; omitted imaging parameters or relevant negative findings; visually attractive but diagnostically incomplete figures; retrospective rewriting of the initial diagnostic reasoning; conclusions that exceed the follow-up; and late attention to consent, anonymisation or authorship. These defects generate avoidable revision cycles and inconsistent peer-review decisions.

CARE established a general framework for transparent case reporting, and CARE-radiology subsequently developed a radiology-specific guideline comprising 38 items across 16 domains [1-3]. CARE-radiology was developed through a multidisciplinary process including Delphi consensus and is listed by the EQUATOR Network for radiological case reports [3,8]. The SJORANM guide does not replace that standard; it converts it into a practical sequence that authors can follow before submission and that reviewers and editors can apply consistently.

2. Purpose, scope and status

This article is an Educational Editorial & Practical Guide, not a new reporting guideline. CARE-radiology already provides the formal radiology-specific reporting framework [3]. The SJORANM guide is an implementation and editorial-quality framework based on CARE, CARE-radiology, the current ICMJE Recommendations, the 2024 Declaration of Helsinki, COPE guidance, CRediT and explicit SJORANM policies [4-8].

The primary scope is the single-patient radiological case report across diagnostic and interventional radiology, neuroradiology, paediatric radiology, breast imaging, ultrasound, radiography, CT, MRI, nuclear medicine and hybrid imaging. At least one set of original, diagnostically relevant radiological images is mandatory. Pathological confirmation and radiology-pathology correlation are preferred when tissue is available or pathology is the most credible reference standard, but another appropriate standard (for example surgery, microbiology, genetics, treatment response, multidisciplinary

consensus or sufficiently documented follow-up) may be adequate. The guide distinguishes external reporting requirements, strongly recommended scientific practice and mandatory SJORANM policy. Submission of the SJORANM/CARE-radiology checklist is preferred but not mandatory; a dedicated Patient Perspective section is mandatory. If a direct patient perspective cannot be obtained, the reason must be stated and no patient voice may be invented.

Core principle
Every material statement in a radiological case report should be traceable to one of four sources: documented clinical information, an interpretable original image or examination result, a credible diagnostic reference standard, or appropriately cited scientific literature. A publishable case must also communicate a specific lesson that is useful beyond the individual patient.

3. What makes a case publishable?

A case report becomes publishable when it passes two editorial gates. Relevance asks whether the case contains a transferable lesson; verifiability asks whether the clinical course, original imaging, diagnostic reasoning, reference standard and outcome are documented well enough for an independent reader to evaluate the claim. Rarity does not compensate for weak evidence, and meticulous documentation does not compensate for the absence of an educational message.

Table 1. Editorial gates for assessing publishability of a radiological case report.

Editorial gate	Question to be answered	Minimum evidence
Gate 1 - Relevance	Why should a radiology reader care about this case?	A precise learning message with plausible relevance to diagnosis, imaging technique, intervention, management, safety or education.
Gate 2 - Verifiability	Can the reader independently assess whether the claim is credible?	A coherent timeline, original diagnostic imaging, transparent reasoning, an appropriate reference standard, outcome data, consent and a patient-perspective section.

Before drafting the title or abstract, the authors should be able to complete one sentence: “This case is worth reporting because it shows ...”. The answer should identify the educational phenomenon rather than merely name the diagnosis. Claims such as “first case”, “unique” or “extremely rare” require a focused, current literature search and should be avoided when they cannot be verified.

Educational value may arise from an atypical but clinically important manifestation, a diagnostic mimic or near-miss, an imaging protocol or intervention that changed management, an under-recognised complication, a meaningful imaging-pathology or imaging-surgery correlation, or a longitudinal course that clarifies response or recurrence. The authors should state which route applies and support it with selective literature.

The evidence chain should connect presentation, imaging indication, acquisition, findings, differential diagnosis, confirmatory evidence, intervention and outcome. Relevant negative findings, uncertainty, an initially incorrect interpretation or a contradictory pathological detail should not be concealed. Transparent diagnostic evolution is more educational than a retrospectively polished narrative in which the final diagnosis appears inevitable.

Conclusions must remain proportionate to a single observation. A case can demonstrate that an event occurred and can illustrate or generate a hypothesis; it generally cannot establish prevalence, diagnostic accuracy, causal effectiveness or superiority. Exact follow-up should be stated, and terms such as “curative”, “safe” or “no recurrence” must not exceed the observation period. Publication consent, privacy protection and the mandatory Patient Perspective are part of the scientific record rather than administrative appendices.

SJORANM editorial principle: novelty may attract attention, but completeness determines whether a case can be evaluated, and educational transferability determines whether it should be published.

4. Scientific, ethical and editorial foundation

Each recommendation is linked to its normative source so that journal-specific preferences are not presented as universal rules. Table 2 distinguishes the external standards, their primary function and their role in the SJORANM framework.

Table 2. Scientific, ethical and editorial frameworks underpinning the SJORANM guide.

Framework	Primary function	Role in the SJORANM guide
CARE	General structure and minimum transparency requirements for clinical case reports.	Adopted as the general reporting foundation.
CARE-radiology	Radiology-specific reporting guideline with 38 items in 16 domains.	Primary reporting framework for the published guide and author checklist.
EQUATOR Network	Repository and methodological framework for health-research reporting guidelines.	Used to position the SJORANM document as an implementation guide, not a newly developed reporting guideline.
ICMJE Recommendations, January 2026	Authorship, contributorship, conflicts of interest, protection of participants, manuscript preparation and AI disclosure.	Applied to authorship, declarations, consent, editorial independence and AI-assisted work.
WMA Declaration of Helsinki, 2024	Current ethical principles for medical research involving human participants.	Current version to be cited where applicable; older versions should not be used as the governing reference.

Framework	Primary function	Role in the SJORANM guide
COPE guidance	Publication consent, confidentiality and publication-ethics processes.	Applied to consent forms, identifiable material and editorial handling of ethical concerns.
CRediT taxonomy	Fourteen standardised contributor roles.	Recommended format for author-contribution statements.
SJORANM policy	Journal-specific submission, ORCID, image-quality and pre-check requirements.	Clearly labelled as journal policy. Includes mandatory original radiological imaging, a mandatory Patient Perspective section, preferred pathology when relevant, preferred but non-mandatory checklist submission, ORCID authentication and image-quality requirements.

5. The SJORANM 12-step pathway

The guide is organised as 12 practical steps. Each step defines a decision, the evidence that should be assembled and the minimum output expected in the manuscript. Table 3 summarises the complete pathway.

Table 3. The SJORANM 12-step pathway from case selection to submission.

Step	Decision	Required output
Step 1	Define the publication question	State in one sentence what the case teaches and why that lesson is relevant beyond the individual patient.
Step 2	Confirm ethics, consent, privacy and authorship	Obtain written publication consent, assess identifiability, determine whether ethics review or a waiver is required and agree on authorship before drafting.
Step 3	Build the complete source dataset and timeline	Collect the relevant history, examination findings, laboratory data, prior interventions, imaging dates and outcomes before selecting what will be reported.
Step 4	Identify the diagnostic reference standard	Specify whether the diagnosis rests on pathology, microbiology, genetics, surgery, treatment response, multidisciplinary consensus or sufficiently documented follow-up. Pathology is preferred when available and relevant, but not mandatory.
Step 5	Document imaging methods	Report modality, anatomical coverage, protocol, contrast administration, phases, sequences, technical parameters and post-processing to the level required for interpretation.
Step 6	Describe imaging findings systematically	Provide exact location, dimensions, compartment, morphology, signal or attenuation, enhancement, diffusion, vascularity, relationships and relevant negative findings.
Step 7	Show the diagnostic reasoning	Separate the initial interpretation, differential diagnoses, arguments for and against each diagnosis, diagnostic challenges and the final diagnosis.

Step	Decision	Required output
Step 8	Correlate imaging with pathology, surgery and clinical findings	Resolve discrepancies in localisation, extent and tissue composition. Correlate imaging with pathology when tissue is available and with surgery or clinical findings when pathology is absent.
Step 9	Report treatment, outcome and follow-up	Describe intervention, complications, response, recurrence status and exact follow-up duration without making claims that exceed the observation period.
Step 10	Write each manuscript section for a defined purpose	Construct title, abstract, introduction, case presentation, discussion, limitations, learning points and declarations without repetition or retrospective overstatement.
Step 11	Prepare figures and legends as evidence	Select diagnostic images, anonymize them, label panels and orientation, provide arrows and measurements, state sequence or phase and include scale bars for clinical and pathological images.
Step 12	Complete the final compliance check	Preferably submit the SJORANM/CARE-radiology checklist; verify internal consistency, references, declarations, the mandatory Patient Perspective section, ORCID authentication and image quality before editorial assessment.

5.1 Step 1 - Define the publication question

The first task is to define the transferable lesson. Before drafting, authors should be able to state in one precise sentence what the case teaches and why that lesson matters to a reader who did not treat the patient. Rarity alone is never sufficient.

Test that publication question against current literature using the diagnosis, imaging modality, anatomical site, age group, intervention and proposed pitfall as appropriate. “First reported”, “unique” and similar claims should be used only when the search strategy and date make them defensible.

A case is most useful when it changes recognition, interpretation or action: for example by showing an important mimic, a preventable delay, an imaging-sign limitation, an unexpected complication, a technically informative intervention or a discrepancy that clarifies disease biology. Rarity may strengthen the rationale but cannot replace the learning message.

Table 4. Step 1 decision questions for defining the publication question.

Question before writing	Proceed when ...	Stop and reconsider when ...
What exactly is the transferable lesson?	The answer can be stated in one precise sentence that goes beyond naming the diagnosis.	The answer is only the name of the diagnosis or “the case is rare”.
Who could use this lesson?	A defined group of radiologists, clinicians, trainees or interventionalists could recognize or manage a similar problem better.	The observation has no plausible relevance beyond the individual patient.

Question before writing	Proceed when ...	Stop and reconsider when ...
What evidence supports it?	Original imaging and a credible diagnostic reference standard are available.	The main claim depends on memory, assertion or unavailable images.
Is the conclusion proportionate?	The case illustrates an occurrence, mechanism, pitfall or hypothesis.	The authors intend to infer prevalence, diagnostic accuracy, causality or superiority from one patient.

5.2 Step 2 - Confirm ethics, consent, privacy and authorship

Resolve ethics, consent and privacy before writing and before figures are exported. Authors should report the applicable institutional ethics status - approval, waiver or a justified statement that formal review was not required. The 2024 Declaration of Helsinki is the current WMA statement for medical research involving human participants and should be cited where applicable; it should not be used to imply that every clinical case report automatically constitutes research requiring ethics approval [5]. CARE-radiology asks authors to report consent for the imaging procedure and for publication, together with ethics approval status [3].

Publication consent is distinct from consent to examination, treatment or surgery. It should address publication of text and images and the possibility of online identification. COPE emphasises that case reports are inherently identifiable and recommends explicit publication consent for identifiable cases [7]. The signed form should be retained by the authors or institution according to law and policy; the manuscript should state that consent was obtained.

Anonymisation requires more than deleting a name. Clinical photographs, screenshots, DICOM overlays, pathology labels, timelines and figure files should be checked for direct and indirect identifiers. Nonessential identifying details should be omitted, and masking only the eyes is not adequate anonymisation. Any protective alteration must preserve scientific meaning. Identifiable clinical data or images should not be entered into external AI systems unless institutional, legal and data-protection requirements explicitly permit it.

For minors or adults lacking decision-making capacity, use the legally authorised representative and seek assent when appropriate. For deceased or uncontactable patients, local law, institutional policy and journal ethics requirements determine whether publication can proceed; scientific interest alone does not remove the need for an ethically defensible basis.

Agree authorship early. Each author should satisfy the journal's adopted authorship criteria, approve the final manuscript and accept accountability for the work. ORCID authentication and a CRediT statement should make contributions transparent; contributors who do not qualify for authorship should be acknowledged rather than added honorarily.

AI-assisted technology used for drafting, editing, translation, literature organisation, image generation or other substantive work must be disclosed at submission and in the manuscript as required by current ICMJE guidance [4,9]. AI tools cannot be authors; human authors remain responsible for accuracy, originality, citation verification, confidentiality and the final text. AI-generated synthetic images must never replace primary diagnostic evidence. Any AI-assisted segmentation, enhancement or annotation must be disclosed and the unaltered source image made available.

CARE-radiology recommends the patient's perspective when available [3]. SJORANM adopts a stricter policy: a dedicated Patient Perspective section is mandatory. Whenever feasible, the patient should describe the experience of symptoms, diagnostic uncertainty, imaging, treatment or follow-up in their own words. If a direct perspective cannot be obtained, the reason should be stated; the text must never be invented or materially reconstructed.

Table 5. Step 2 minimum documentation for ethics, consent, privacy, authorship and patient perspective.

Step 2 item	Minimum documentation
Ethics determination	Name of committee or institutional process; approval, waiver or statement that formal review was not required; reference number and date when available.
Publication consent	Written consent for the case details and images, including online publication; archived according to local law and journal policy.
Privacy review	Text, tables and every image checked for direct and indirect identifiers; scientifically meaningful content preserved.
Authorship and contributions	Final author list agreed; ORCID authenticated; CRediT roles documented; all authors approve and accept accountability.
AI disclosure	Tool, purpose and extent of use stated when applicable; no AI system listed as an author or primary source.
Patient Perspective	Patient-authored or patient-approved section included; reason documented only when a direct perspective cannot be obtained.

5.3 Step 3 - Build the complete source dataset and timeline

Reconstruct the case from the source record, not recollection. Before drafting, assemble the relevant clinical notes, original image series and reports, laboratory or microbiology results, operative or interventional records, pathology, multidisciplinary decisions, treatment data and follow-up. This controlled source file is the evidence base from which the de-identified manuscript is produced.

The dataset should show what information was available at each decision point and should include relevant negative findings. Distinguish contemporaneously documented facts from retrospective interpretation and identify material information that is unavailable.

Build a timeline covering symptoms, key clinical and laboratory findings, each decisive imaging examination, provisional diagnoses, biopsy or surgery, pathology, treatment and follow-up. Published dates may be de-identified when necessary, but sequence and elapsed intervals must remain accurate.

Table 6. Step 3 source dataset required before writing.

Source domain	Items to collect before writing	Typical failure prevented
Clinical	Age range, sex where relevant, symptoms, duration, examination, comorbidities, medication, family history and relevant prior treatment.	A case presentation that cannot explain the imaging indication or differential diagnosis.
Laboratory and functional data	Relevant values with units, reference ranges and dates; microbiology, tumour markers or physiological testing when applicable.	Uninterpretable statements such as “markers were elevated” or “inflammation was present”.
Imaging	Original series, reports, dates, protocol details, priors, measurements and image annotations.	Figures that do not match the text or cannot demonstrate the stated finding.
Reference standard	Pathology, microbiology, genetics, surgery, multidisciplinary consensus, treatment response or follow-up evidence.	A final diagnosis asserted without showing how it was established.
Treatment and outcome	Intervention, dose or technique where relevant, complications, response, recurrence and exact follow-up.	Claims of cure or effectiveness unsupported by the observation period.
Patient voice and consent	Written consent, perspective statement and any patient-requested restrictions on identifiable detail.	Late ethical problems or a missing mandatory Patient Perspective section.

5.4 Step 4 - Identify the diagnostic reference standard

State explicitly how the final diagnosis was established. Histopathology is often the strongest reference standard for a mass lesion, but other appropriate standards include microbiology, genetics, operative findings, angiography, characteristic biochemical results, treatment response, multidisciplinary consensus or coherent longitudinal follow-up. The standard must match the claim; relevant prognostic characteristics such as stage or genotype should be reported when applicable [3].

Avoid circular confirmation. If the diagnosis rests only on the same imaging examination that is being presented as diagnostic, acknowledge that the diagnosis is presumptive and moderate the title and conclusion. When pathology or another confirmatory test is available, report the sampling method, relevant findings, interpreter and important limitations or discordance.

Table 7. Step 4 diagnostic reference standards by clinical question.

Clinical question	Potential reference standard	What must be stated
Focal tumour or tumour-like lesion	Histopathology from biopsy or resection; occasionally stable or resolving follow-up when biopsy is inappropriate.	Sampling method, site, key histology/IHC, concordance with imaging and limitations of sampling.
Infection	Culture, PCR, serology, operative findings or response to targeted therapy.	Specimen, timing relative to treatment, organism or assay and alternative explanations.
Vascular lesion	Angiography, surgery, Doppler follow-up, haemodynamic data or characteristic multimodality findings.	Anatomy demonstrated, flow features, intervention findings and post-treatment result.
Genetic or metabolic disorder	Molecular test, biochemical profile or accepted clinical criteria.	Exact test or criteria, variant classification where applicable and relation to imaging phenotype.
Imaging complication or treatment response	Procedure record, temporal relationship, objective follow-up and exclusion of competing causes.	Baseline, intervention, outcome measure, timing and uncertainty about causality.
No definitive external test	Multidisciplinary consensus plus longitudinal clinical-imaging evidence.	Why a definitive test was unavailable or inappropriate, who reached consensus and why the diagnosis remains qualified.

5.5 Step 5 - Document imaging methods

Report enough technical information for readers to understand how the finding was generated, what could reasonably be assessed and why an examination may have succeeded or failed. Do not reproduce a full DICOM header or vendor protocol unless a parameter is relevant to lesion conspicuity, diagnostic confidence, radiation exposure, procedural safety or reproducibility.

For each examination central to the report, state the indication, timing, modality, anatomical coverage, relevant comparison studies and important limitations. Contrast-enhanced examinations should report the agent and timing when relevant; MRI the field strength and decisive sequences; CT the pertinent acquisition or reconstruction features; ultrasound the transducer and Doppler technique when relevant; nuclear medicine the tracer, activity, uptake time and acquisition method; and interventional cases the image guidance, access, devices or materials and endpoint.

When several modalities are presented, explain the role of each - detection, characterisation, staging, biopsy guidance, treatment planning or response assessment. CARE-radiology also asks for the profession, relevant experience and training status of the specialist(s) responsible for image interpretation [3]. A concise statement such as “board-certified radiologist with X years of relevant subspecialty experience” is sufficient.

Table 8. Step 5 minimum imaging-method information by modality.

Modality	Minimum method information when relevant to the case
Radiography / fluoroscopy	Projection or view, weight-bearing or functional condition, relevant exposure or fluoroscopic technique, contrast route and dynamic manoeuvre.
CT / CT angiography	Scanner generation when relevant, anatomical coverage, non-contrast and contrast phases, contrast route and timing, slice thickness/reconstruction, multiplanar or 3D technique and dose information when central to the lesson.
MRI / MR angiography	Field strength, coil when relevant, imaging planes, decisive sequences, diffusion and susceptibility techniques, fat suppression, contrast agent and timing, temporal resolution or post-processing when relevant.
Ultrasound / Doppler / elastography	Transducer type and frequency, patient position, compression or dynamic manoeuvre, Doppler mode and scale/PRF when relevant, contrast-enhanced ultrasound or elastography technique.
Mammography / tomosynthesis / breast MRI	Views, breast density where relevant, tomosynthesis or synthetic reconstruction, ultrasound correlation, MRI sequences and contrast timing, localisation or biopsy guidance.
Nuclear medicine / SPECT / PET	Tracer, administered activity, uptake time, patient preparation, acquisition field, attenuation correction, reconstruction and quantitative metric such as SUV with method and time point.
Interventional radiology	Guidance modality, patient preparation and anaesthesia, access route, equipment/materials, key procedural steps, technical endpoint, complications and post-procedural imaging.
Post-processing / AI-assisted analysis	Software or method, input data, operator interaction, threshold or segmentation approach, validation status and whether the output influenced clinical decision-making.

5.6 Step 6 - Describe imaging findings systematically

Describe imaging findings in a reproducible order: exact location and compartment, dimensions, shape and margins, internal composition, signal/attenuation/echogenicity or tracer uptake, enhancement and vascularity, relationship to adjacent structures, complications and relevant negative findings. Distinguish features recognised prospectively from those appreciated only in retrospect.

Measurements should be traceable to the source examination and use consistent units. For interval change, report both measurements and elapsed time. Quantitative values such as ADC, SUV, Hounsfield units or Doppler velocity require acquisition context and should not be converted into universal thresholds from a single case.

Keep anatomy and terminology consistent across clinical examination, imaging, surgery and pathology. Terms such as dermal, subcutaneous, intramuscular, fascial or intraneural are not interchangeable. Relevant negative findings should be chosen

according to the differential diagnosis and reported only when the technique could assess them.

Table 9. Step 6 structured reporting domains for imaging findings.

Finding domain	Questions the report should answer
Location and extent	Where exactly is the lesion or abnormality? Which side, segment, organ, layer or compartment is involved? Is there superficial, deep or trans-spatial extension?
Size and morphology	What are the dimensions, shape, orientation and margins? Is the lesion focal, diffuse, infiltrative, pedunculated, cystic, solid or mixed?
Tissue characteristics	What are the density, signal, echogenicity, calcification, fat, blood products, diffusion, susceptibility or tracer-uptake features?
Enhancement and flow	Is enhancement absent, homogeneous, heterogeneous, peripheral, septal or delayed? What is the vascular pattern and was it assessed adequately?
Relations and complications	How does the finding relate to vessels, nerves, ducts, fascia, muscle, bone or adjacent organs? Are obstruction, rupture, haemorrhage, ischaemia or other complications present?
Relevant negatives	Which absent features materially reduce important differential diagnoses, and was the examination technically capable of excluding them?
Temporal behaviour	Is the abnormality new, growing, stable, resolving or treatment-responsive, and over what exact interval?
Diagnostic interpretation	Which findings supported the initial diagnosis, which created uncertainty and which later proved decisive?

5.7 Step 7 - Show the diagnostic reasoning

Preserve the chronology of diagnostic reasoning. Show what information was available at each stage, how the initial interpretation was reached, why alternatives were considered and what new evidence changed the working diagnosis. Do not project the final diagnosis backwards as though it had always been obvious.

Separate observations from interpretations. Identify which findings supported the initial impression, which were atypical or contradictory and which later test or event proved decisive. For each major alternative, briefly state the evidence for and against it and the next diagnostic action. Delayed or revised diagnoses should be described transparently and without blame.

Table 10. Step 7 components of transparent diagnostic reasoning.

Reasoning stage	What should be reported	What should be avoided
Pre-imaging context	Symptoms, risk factors, prior disease, laboratory data and the clinical question available before imaging.	Retrospective details that were not known when the first decision was made.
Initial imaging interpretation	The first reasonable interpretation and the findings that supported it.	Rewriting the initial report so that it matches the final diagnosis.
Focused differential diagnosis	Two to four clinically relevant alternatives with discriminating features.	An encyclopaedic list without prioritisation or explanation.
Diagnostic challenge	The missing, misleading or discordant feature that created uncertainty.	Calling the case “difficult” without identifying why.
Next diagnostic action	Why additional imaging, biopsy, surgery, laboratory testing or follow-up was selected.	A sequence of tests with no decision logic.
Final diagnosis and learning	The evidence that established or qualified the diagnosis and the transferable lesson.	Overstating certainty when the reference standard remains incomplete.

5.8 Step 8 - Correlate imaging with pathology, surgery and clinical findings

Correlation requires explanation, not mere juxtaposition of images. Align the anatomical site, sampled region, lesion dimensions, tissue components, invasive behaviour and temporal state across radiology, pathology, surgery and the clinical record.

When biopsy or resection is available, report the sampling method and site, key microscopic and immunohistochemical findings, margin or invasion status when relevant and whether the specimen adequately represents the imaging abnormality. Pathology is preferred when clinically relevant but is not mandatory for every radiological case.

Explain discordance actively. Sampling error, intralesional heterogeneity, treatment effect, haemorrhage or necrosis, orientation differences or incomplete resection may account for a mismatch. When pathology is unavailable, apply the same discipline to surgery, angiography, microbiology, genetics, multidisciplinary consensus, treatment response or longitudinal follow-up: state exactly which independent observation supports the imaging interpretation and what uncertainty remains.

Table 11. Step 8 domains for imaging correlation with pathology, surgery and clinical findings.

Correlation domain	Question to resolve	Minimum reporting expectation
Localisation	Do imaging, operative notes and specimen labels refer to the same side, organ, segment, layer or compartment?	State how the sampled or resected tissue maps to the displayed imaging abnormality.
Size and extent	Are imaging dimensions, gross specimen dimensions and reported extent compatible?	Explain shrinkage, fragmentation, partial sampling or interval change where relevant.

Correlation domain	Question to resolve	Minimum reporting expectation
Tissue composition	Which microscopic component explains T1/T2 signal, attenuation, echogenicity, diffusion, enhancement or tracer uptake?	Present the relation as demonstrated, probable or uncertain rather than assuming specificity.
Margins and invasion	Does pathology or surgery confirm, underestimate or contradict the radiological assessment of infiltration?	Describe the reference standard and its limits, including incomplete sampling.
Vascular or functional behaviour	Do Doppler, perfusion, angiographic or nuclear-medicine findings correspond to vascularity, receptor expression or metabolic activity?	Avoid equating a quantitative imaging value with a single histological feature without evidence.
Heterogeneity and sampling	Could the biopsy have sampled only one component of a mixed lesion?	Identify the target, needle path or specimen source and discuss representativeness.
Temporal change	Was the lesion altered by biopsy, therapy, haemorrhage, infection or surgery before correlation?	Use exact dates and avoid comparing observations made in different biological states as though simultaneous.

5.9 Step 9 - Report treatment, outcome and follow-up

A case report should not end with the diagnosis. State what was done, why it was done, whether imaging changed management and what happened afterwards. Treatment may include surgery, image-guided intervention, medication, radiotherapy, observation, rehabilitation or a decision not to treat.

Report intervention timing, immediate result, complications and their management, and the exact duration and method of follow-up. CARE-radiology asks for clinician-assessed and patient-assessed outcomes and important adverse or unanticipated events related to imaging or treatment when known [3]. If follow-up is limited to a telephone contact, clinical examination or single imaging study, state that plainly.

Use outcome language proportionate to the evidence: “no recurrence was identified at X months” is preferable to “cured”; symptomatic improvement does not by itself establish mechanism; and a response in one patient does not establish treatment efficacy. Revisit the Patient Perspective after treatment or follow-up whenever feasible, without converting the patient’s account into a clinician-authored outcome statement.

Table 12. Step 9 minimum reporting for treatment, outcome and follow-up.

Outcome domain	Minimum information	Common overstatement or omission
Therapeutic decision	Treatment, observation or no intervention; rationale; date; relevant alternatives considered.	“The patient was treated appropriately” without stating what was done.
Procedure or regimen	Key technical steps, access, device or material, dose or schedule where relevant.	Insufficient detail to understand the intervention or reproduce its essential method.

Outcome domain	Minimum information	Common overstatement or omission
Immediate result	Technical success, clinical response, post-procedural imaging and disposition.	Equating technical success with long-term clinical success.
Complications	Presence or absence of relevant adverse events, severity, timing and management.	Omitting complications or using “uneventful” without defining the observed period.
Follow-up	Exact duration, modality and frequency of clinical and imaging surveillance.	“Long-term follow-up” without a stated interval.
Disease status	Residual disease, recurrence, progression, stability or resolution at the last documented assessment.	Using “cured”, “definitive” or “excellent prognosis” beyond the available evidence.
Patient Perspective	Patient-authored or patient-approved description of experience and outcome; reason documented if unobtainable.	Replacing the patient’s voice with the clinician’s interpretation.

5.10 Step 10 - Write each manuscript section for a defined purpose

Each manuscript section should perform one defined task. Table 13 therefore serves both as a writing guide and as the recommended SJORANM manuscript architecture: the abstract summarises, the case presentation documents, the discussion interprets and compares, and the conclusion or learning points state only what the case supports.

Table 13. Step 10 recommended manuscript architecture and section-specific purpose.

Manuscript section	Defined purpose and required content	Frequent failure
Title	Name the principal diagnosis or phenomenon, add the relevant modality when useful, and identify the article as a case report.	Sensational wording, unsupported “first” claims, abbreviations or conclusions not established by the case.
Abstract	Provide the clinical context, decisive imaging finding, reference standard, intervention or outcome and one clear learning message.	Background review, unexplained technical detail, citations or claims broader than the report.
Introduction	Define the precise knowledge gap and why this case addresses it, using a focused literature context.	A generic textbook review or rarity claim without evidence.
Patient information and clinical findings	Report de-identified demographics, symptoms, relevant history, examination and laboratory data that explain the imaging question.	Irrelevant personal details, missing chronology or information that increases identifiability without scientific value.
Timeline	Show the sequence of symptoms, examinations, diagnoses, interventions and follow-up with exact or appropriately generalised dates.	A chronology that conflicts with the text or omits the interval that drives the interpretation.

Manuscript section	Defined purpose and required content	Frequent failure
Diagnostic assessment and imaging	Describe methods, findings, relevant negatives, differential diagnoses, uncertainty and the reference standard.	Mixing acquisition details, findings and discussion so that the evidence chain cannot be followed.
Therapeutic intervention	State what was done, why, when and with what essential technical details.	A one-line treatment statement detached from the imaging-based decision.
Outcome and follow-up	Report clinical and imaging response, complications, recurrence or progression and exact follow-up duration.	Claims of cure, efficacy or prognosis beyond the observation period.
Discussion	Interpret the case, compare it with the most relevant literature, explain discrepancies and state strengths, limitations and transferability.	Repeating the case presentation or turning the report into an unfocused narrative review.
Limitations	Identify missing pathology, incomplete testing, sampling limits, short follow-up, uncertainty or limited generalisability.	Treating limitations as ceremonial wording or concealing uncertainty.
Learning points	Provide two to five concise, actionable statements directly supported by the case.	General advice, unsupported recommendations or a restatement of the abstract.
Patient Perspective	Include a dedicated patient-authored or patient-approved account of the experience; document why it is unobtainable only when necessary.	A clinician-written summary presented as the patient's voice.
Declarations	Report consent, ethics approval or waiver, contributions, competing interests, funding, data availability and AI-assisted work.	Generic declarations that do not match the actual case, institution or author roles.
References and figure legends	Use selective, verified references; make every legend self-contained with modality, plane, sequence or phase, annotation and principal finding.	Unverified citations, excessive references or legends that merely repeat the Results text.

Build the Discussion around the publication question rather than a broad disease review. Explain what the case adds, how it agrees or conflicts with previous reports, why the imaging mattered, what cannot be concluded and how the lesson may transfer to similar cases. Selective references are usually stronger than an encyclopaedic review.

Keep laterality, anatomical level, measurements, terminology and diagnostic certainty stable across the manuscript. If terminology changed as the diagnosis evolved, explain the chronology. Distinguish the patient's experience from clinician-assessed outcomes and editorial interpretation.

5.11 Step 11 - Prepare figures and legends as evidence

Figures are primary evidence. SJORANM requires at least one set of original, diagnostically relevant radiological images; a screenshot of a report, schematic reconstruction or decorative photograph cannot replace the source images that

demonstrate the principal finding. Each figure should answer a defined diagnostic or procedural question.

Select the smallest set of images that proves the learning message. Use comparison images when temporal change, treatment response or a diagnostic pitfall is central. Multi-panel figures should follow a logical order with consistent orientation, cropping and labelling; annotations should guide without obscuring the finding.

Check image integrity and privacy before submission. Remove identifiers from DICOM overlays, screenshots, pathology labels and clinical photographs. Apply brightness, contrast or colour adjustments cautiously and consistently; retain the original source images. AI-generated images must not replace primary diagnostic evidence, and AI-assisted segmentation, enhancement or annotation should be disclosed with the unaltered source image available.

When included, histology should state stain and magnification and preferably include a scale bar; clinical photographs require publication consent and should include scale or orientation when size and location matter. A self-contained legend should identify modality, side and level, plane, sequence or phase, panel meaning, annotations and the principal finding.

Table 14. Step 11 SJORANM standards for figures and legends.

Figure element	SJORANM standard	Frequent defect
Original evidence	Display original diagnostic images from at least one relevant radiological modality.	Report screenshots, stock images or diagrams used in place of diagnostic images.
Image selection	Choose images that demonstrate the decisive positive finding, relevant negative finding, comparison or procedural endpoint.	Many near-duplicate panels or attractive images unrelated to the learning message.
Orientation and localisation	State side, plane, anatomical level and panel order; preserve orientation unless a justified transformation is disclosed.	Ambiguous laterality, inconsistent orientation or unexplained image rotation.
Annotations	Use consistent arrows, arrowheads, contours and labels; define them in the legend.	Cursor artefacts, annotations covering the lesion or inconsistent colours and symbols.
Measurements and quantitative data	Show scale and units; ensure values match the text and source examination.	Measurements copied from another series or values that cannot be located on the image.
Technical labelling	Identify sequence, contrast phase, tracer/time point, projection or Doppler mode when relevant.	Generic labels such as “MRI” or “CT” that do not explain the displayed information.
Image quality	Provide adequate resolution, windowing, cropping and panel size for diagnostic interpretation.	Pixelation, excessive black margins, compressed text or loss of subtle findings.

Figure element	SJORANM standard	Frequent defect
Anonymisation	Remove direct and indirect identifiers from all panels and embedded labels.	Names, dates of birth, accession numbers, facial identity or distinctive labels without consent and necessity.
Image integrity	Retain source images; apply only non-misleading adjustments; disclose substantive processing.	Selective alteration, cloning, deletion, undisclosed enhancement or inconsistent processing between comparison images.
AI-assisted output	Disclose segmentation, reconstruction, enhancement or annotation and display the original image where interpretation depends on the output.	AI-generated or synthetic imagery presented as the patient's original examination.
Pathology and clinical photographs	State stain, magnification and scale; link the panel explicitly to the radiological finding and consent.	Unlabelled microscopy or identifiable photographs without a defined educational purpose.
Legend	Make the legend self-contained, accurate and concordant with the figure and text.	A legend that repeats the diagnosis but does not explain modality, panel, annotation or finding.

5.12 Step 12 - Complete the final compliance check

Before submission, conduct four distinct checks: scientific completeness, internal consistency, ethics/privacy and technical presentation. Use the source record and original images rather than only the polished manuscript.

Table 15. Step 12 final compliance audit.

Final audit	Pass questions	Primary responsibility
Scientific completeness	Does the manuscript answer the publication question, show the diagnostic reasoning, identify the reference standard and report treatment and exact follow-up?	Corresponding author with the principal clinical and radiological authors.
Internal consistency	Do age, dates, side, anatomical level, measurements, terminology, diagnosis and follow-up agree across text, timeline, tables, figures and legends?	An author who did not write the first draft, followed by the corresponding author.
Ethics and patient voice	Are consent, ethics status, anonymisation and the mandatory Patient Perspective complete and accurate?	Corresponding author and, where required, the responsible institution.
Figure and technical quality	Are original images diagnostic, correctly labelled, anonymised, concordant with legends and free of artefacts or misleading processing?	Radiologist or nuclear-medicine physician responsible for the imaging evidence.
Pathology or alternative reference standard	Is the reference standard adequately described, and are sampling limits or discordance acknowledged?	Pathologist or relevant confirming specialist when available.
Authorship and declarations	Has every author approved the final version, confirmed contribution and accountability, authenticated ORCID and disclosed conflicts, funding and AI use?	All authors, coordinated by the corresponding author.

Final audit	Pass questions	Primary responsibility
Submission package	Are manuscript, figures, legends, preferred checklist, cover letter and any required consent or ethics documentation ready in the journal format?	Corresponding author or designated submitting author.

Submission of the SJORANM/CARE-radiology checklist is preferred and strongly encouraged, but not mandatory. When used, it should identify the exact manuscript location for each item, and “not applicable” should be justified briefly.

All authors should approve one controlled final version. Any late change to diagnosis, measurements, figures or declarations should be recirculated and checked for downstream inconsistencies. The corresponding author should retain publication consent, source images, key source references and ethics documentation according to institutional and legal requirements.

6. SJORANM implementation tools

The guide is accompanied by five operational supplements: an Author Checklist, Reviewer Checklist, Technical Pre-check/Hard-stop Form, Standardised Decision-letter Modules and a CARE-radiology Crosswalk. Figure 1 provides the one-page “12 Steps from Patient to Publication” workflow. Together, these tools translate the same standards across preparation, peer review and editorial decision-making.

7. Technical pre-check and hard-stop criteria

A manuscript should not enter scientific peer review when essential evidence, consent or interpretable imaging is missing, or when material contradictions make the report unevaluable. Technical return should be distinguished from scientific rejection; absence of the preferred checklist alone is not a hard stop. Table 16 summarises the principal triggers and editorial actions.

Table 16. Technical pre-check and hard-stop criteria before peer review.

Trigger	Editorial action
No documented publication consent	Return without peer review unless a lawful and explicitly justified exception applies.
Identifiable patient information in text or images	Return for complete anonymization and confirmation that scientific meaning has not been altered.
No clear final diagnosis or no credible reference standard	Request clarification or return as scientifically unevaluable.
Original diagnostic images missing or technically unusable	Return for diagnostic-quality figures with complete legends.
Clinical and imaging timeline materially incomplete	Return for reconstruction of the episode of care.
Major contradiction between text, images, surgery or pathology	Require reconciliation before external review.
Authorship, contribution or competing-interest information incomplete	Hold submission until declarations are complete.
Required ORCID authentication absent	Technical return under SJORANM journal policy.

Trigger	Editorial action
Unsupported claim of novelty is the sole rationale for publication	Request a clearly defined and literature-supported learning message before review.
No original or diagnostically relevant radiological imaging	Return as outside the scope of a radiological case report or request the original diagnostic imaging before review.
Mandatory Patient Perspective section absent	Return for a patient perspective or for a transparent explanation of why a direct perspective cannot be obtained.
Pathology unavailable where it would ordinarily be expected	Not an automatic rejection. Require a clear explanation and an alternative credible reference standard.

8. Development methodology and limitations

This Educational Editorial & Practical Guide was developed as a practical implementation framework rather than a new consensus reporting guideline. Recommendations were mapped to CARE-radiology, CARE, ICMJE, the 2024 Declaration of Helsinki, COPE, CRediT and explicitly labelled SJORANM policy, then translated into radiology-specific instructions and editorial tools.

The author group comprises Frank Mosler, Gerd Nöldge and Keivan Daneshvar. The manuscript is intended for independent external peer review before publication. No Delphi process, formal retrospective pilot study or validated measurement instrument was undertaken. These are deliberate limitations. The guide has not yet undergone empirical evaluation of the impact of its checklists on reporting quality or revision rates. Future work should assess usability and effect after implementation. These limitations should prevent the guide from being interpreted as a replacement for CARE-radiology.

9. Editorial independence and transparency

Because Frank Mosler is Editor-in-Chief and the journal is legally owned by SJORANM GmbH, and because other authors hold editorial roles, manuscript handling must be demonstrably independent. Consistent with COPE guidance for editor-authored submissions [11], an unconflicted handling editor will control reviewer selection, all correspondence and the final decision. The authors will have no role in those decisions, no access to reviewer identities and no influence on the editorial process. External peer review will be documented as for other substantive articles.

10. Operational implementation and standardised decision-letter modules

The 12-step pathway is intended to create a shared vocabulary for authors, reviewers and editors. Decision letters should identify the few decisive deficiencies, distinguish scientific concerns from technical incompleteness and refer to the relevant step or checklist item rather than asking authors simply to “improve the case report”.

Supplement 4 provides modular wording for technical return, major or minor revision, de novo resubmission, rejection and final technical acceptance. Editors should remove irrelevant text and add manuscript-specific scientific comments; the templates support judgement rather than replace it.

Table 17. Standardised editorial routes and operational principles.

Editorial route	When to use it	Operational principle
Technical return before peer review	A hard-stop or basic technical requirement is missing, but the scientific value has not yet been judged.	Return for completion; do not frame the action as scientific rejection.
Major revision	The case appears potentially publishable, but substantial correctable deficiencies prevent a reliable assessment or publication.	List the few decisive issues, link them to specific Steps and state that acceptance is not guaranteed.
Minor revision	The core evidence chain is complete and only limited clarification, wording, references or figure corrections remain.	Keep requests proportionate and avoid reopening resolved scientific issues.
Reject with invitation to resubmit de novo	The case may have educational value, but reconstruction is too extensive for a revision cycle.	Close the current submission while clearly identifying what a new manuscript would need to contain.
Reject	The case lacks a transferable learning message, a credible diagnostic basis, required original imaging, or contains an unresolvable ethical/integrity problem.	State the principal reason succinctly; do not create a pseudo-revision pathway when the core problem cannot be corrected.
Accept subject to final technical checks	Scientific and editorial issues are resolved.	Verify consent statement, Patient Perspective, ORCID, figures, legends, references and declarations before production.

11. The 12 Steps from Patient to Publication

Figure 1 condenses the pathway into a single-page workflow for authors, supervisors, reviewers and editors. It is intended as a rapid pre-submission and triage tool, not as a substitute for CARE-radiology or the detailed SJORANM checklists.

STEP 1 Define the publication question State what the case teaches and why that lesson matters beyond the individual patient.	**STEP 2 Ethics, consent, privacy and authorship** Secure publication consent, protect identity, clarify ethics requirements and agree on authorship.
STEP 3 Build the source dataset and timeline Collect the complete clinical record, relevant laboratory data, prior interventions, imaging dates and outcomes.	**STEP 4 Identify the reference standard** State how the diagnosis was established: pathology, microbiology, genetics, surgery, treatment response, consensus or documented follow-up.
STEP 5 Document imaging methods Report modality, anatomical coverage, protocol, contrast, phases, sequences and relevant technical parameters.	**STEP 6 Describe imaging findings systematically** Give exact location, size, compartment, morphology, signal/attenuation, enhancement, diffusion, vascularity and relevant negatives.
STEP 7 Show the diagnostic reasoning Separate initial interpretation, differential diagnoses, arguments for and against them, and the decisive evidence.	**STEP 8 Correlate imaging with other evidence** Reconcile imaging with pathology, surgery and clinical findings; explain discrepancies rather than hiding them.
STEP 9 Report treatment, outcome and follow-up Describe intervention, complications, response, recurrence status and exact follow-up duration without overclaiming.	**STEP 10 Write each section for a defined purpose** Build a concise title, abstract, introduction, case presentation, discussion, limitations, learning points and declarations.
STEP 11 Prepare figures and legends as evidence Use original anonymised images, clear labels, measurements, orientation, sequence/phase information and scale bars where relevant.	**STEP 12 Complete the final compliance check** Verify internal consistency, references, declarations, ORCID, mandatory Patient Perspective, imaging quality and preferably the checklist.

Figure 1. The 12 Steps from Patient to Publication. A practical SJORANM workflow for preparing, reviewing and editing radiological case reports.

12. Conclusion

High-quality radiological case reports should be judged not by rarity alone but by whether readers can reconstruct a coherent evidence chain from clinical question to original imaging, diagnostic reasoning, confirmation, management and outcome. CARE-radiology defines the radiology-specific reporting framework; the SJORANM 12-step pathway converts it into a practical workflow and makes journal-specific expectations explicit. SJORANM requires original diagnostic radiological images and a dedicated Patient Perspective section; pathology remains preferred when relevant but is not mandatory when another credible reference standard is provided. Consistent use should reduce avoidable revision, improve transparency and preserve the educational value of image-based case reporting. The framework should be reviewed after implementation in light of author, reviewer and reader experience.

13. Author contributions

The following CRediT statement [6] has been confirmed by all four authors and includes only roles applicable to this Educational Editorial & Practical Guide.

Conceptualization: Frank Mosler and Gerd Nöldge. Methodology: Frank Mosler, Gerd Nöldge, Keivan Daneshvar. Project administration: Frank Mosler. Writing - original draft: Frank Mosler. Writing - review and editing: Frank Mosler, Gerd Nöldge and Keivan Daneshvar. Supervision: Frank Mosler and Gerd Nöldge.

Author sign-off before submission: All authors have approved the final manuscript, author order, affiliations and CRediT roles and accept accountability for the published work.

14. Declarations

Ethics approval and consent to participate: Not applicable. This article is an editorial and practical reporting guide and contains no patient-level data, identifiable human material or research involving human participants.

Consent for publication: Not applicable to this guide. The manuscript contains no individual case details or patient images. The guide itself requires written publication consent for radiological case reports and a dedicated Patient Perspective section.

Competing interests and editorial roles: Frank Mosler is founder and Editor-in-Chief of the Swiss Journal of Radiology and Nuclear Medicine. Gerd Nöldge is Co-Editor-in-Chief, and Keivan Daneshvar is an Associate Editor. None of the authors will participate in reviewer selection, peer-review correspondence or the final editorial decision for this manuscript.

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Availability of data and materials: No research dataset was generated or analysed. All operational materials developed for the guide are included in the article and its supplements.

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Use of artificial intelligence: OpenAI ChatGPT and xAI Grok were used as AI-assisted tools for structural development, preparation and revision of draft text, language editing, literature organisation, checklist generation and Word-document preparation. Their use will be disclosed in the cover letter and manuscript in accordance with the January 2026 ICMJE Recommendations [4,9]. The human authors remain fully responsible for accuracy, originality, citation verification, editorial judgements and final content. The AI systems are not authors and are not cited as primary sources.

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Appendix - SJORANM Supplementary Checklists and Operational Tools

The following five operational supplements accompany the SJORANM 12-step pathway. Each is reproduced in full as a separate reusable checklist or editorial tool and may also be distributed independently.

Supplement 1 - SJORANM Author Checklist for Radiological Case Reports

Swiss Journal of Radiology and Nuclear Medicine - Supplement to the SJORANM Practical Guide

This practical self-audit accompanies “From an Interesting Patient to a Publishable Paper”. Submission is preferred and strongly encouraged, but not mandatory.

Table S1.1. Manuscript identification and version record.

Manuscript title	Corresponding author	Date / version

Table S1.2. Completion rule for the Author Checklist.

Completion rule
For each applicable item, enter Yes, No or N/A and provide the exact page, paragraph, table or figure. A “Yes” without a location is not considered a completed entry. Items marked No should be corrected before submission or explained in the cover letter.

Table S1.3. SJORANM Author Checklist requirements.

No.	Requirement	Status	Location / explanation
A. Publication value and scope			
1	One-sentence publication question states what the case teaches and why the lesson matters beyond the individual patient.		
2	Title identifies the principal diagnosis or phenomenon, includes the principal diagnostic imaging method(s), and contains the words “case report”; it avoids sensational or unsupported wording.		
3	Claims of rarity, novelty, “first report” status or uniqueness are supported by an appropriate literature search and phrased proportionately.		
4	The report has a clear radiological focus and includes at least one original, diagnostically relevant imaging modality.		
5	The conclusion is limited to what a single case can demonstrate and does not claim effectiveness, prevalence, causality or general superiority without supporting evidence.		
B. Ethics, privacy, authorship and patient involvement			
6	Informed consent for the imaging examination or procedure is reported as required by CARE-radiology and according to local clinical practice; any distinction between routine-care consent and research/procedural consent is stated when relevant.		
7	Written informed consent for publication of the case details and accompanying images has been obtained and archived.		
8	The consent process covers electronic, worldwide and open-access publication where applicable.		
9	Ethics approval, waiver or a justified statement that formal review was not required is reported accurately, including the responsible institution and reference number when available.		
10	All direct and indirect identifiers have been removed from the manuscript, figures, screenshots, image overlays, pathology labels and file metadata.		

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No.	Requirement	Status	Location / explanation
11	Special consent arrangements for minors, adults lacking decision-making capacity or deceased patients are documented where relevant.		
12	A dedicated Patient Perspective section is included.		
13	When a direct patient perspective cannot be obtained, the manuscript states transparently why it is unavailable.		
14	Authorship, author order and CRediT-style contributions have been agreed by all authors; all authors approve the final version and accept accountability.		
15	All authors have completed the ORCID authentication required by SJORANM policy.		
16	Use of AI-assisted technology in drafting, editing, literature organisation or figure preparation is disclosed where applicable; no AI tool is listed as an author.		
C. Source dataset and clinical timeline			
17	Relevant de-identified demographics, symptoms, duration, clinical findings and imaging indication are complete.		
18	Relevant laboratory, physiological, microbiological or tumour-marker data include values, units and dates where needed for interpretation.		
19	Relevant comorbidities, medication, prior procedures, family history, trauma or exposure history are reported without unnecessary identifying detail.		
20	Prior imaging, treatment and diagnostic decisions that materially affect interpretation are included.		
21	A chronological timeline links symptoms, examinations, imaging, interventions, reference-standard testing and follow-up.		
22	All material facts have been checked against the source record rather than recollection alone.		
23	Dates, age, side, anatomical site, measurements and terminology are consistent throughout the text, tables, figures and legends.		
D. Imaging methods			
24	The clinical indication and role of each central imaging examination are stated.		
25	The date or temporal relationship of each examination to symptoms, treatment and follow-up is clear.		
26	Modality-specific acquisition information is sufficient to understand how the decisive finding was generated.		
27	Contrast medium, radiopharmaceutical or tracer, route, dose and relevant acquisition timing are reported when applicable.		
28	Relevant reconstructions, planes, sequences, phases, post-processing or quantitative methods are described.		
29	Important technical limitations, artefacts or incomplete coverage are acknowledged.		
30	The profession, years of relevant work experience and relevant training status of the specialist(s) responsible for image interpretation are reported, as requested by CARE-radiology.		
E. Imaging findings and figures			
31	Imaging findings are described systematically, including exact location, side, segment, layer or compartment and extent.		
32	Lesion or abnormality dimensions are provided in appropriate orthogonal planes, with the measurement method clear.		
33	Morphology, density, signal, echogenicity, uptake, enhancement, diffusion, perfusion, vascularity or other relevant characteristics are reported.		

No.	Requirement	Status	Location / explanation
34	Relationships to adjacent organs, vessels, nerves, fascia, muscle, bone or other critical structures are described.		
35	Relevant negative findings and competing explanations are stated.		
36	Comparison with prior or follow-up imaging is described when available and clinically relevant.		
37	Every material imaging statement is traceable to an original examination and, where appropriate, to a displayed figure.		
38	Figures are of diagnostic quality and show the decisive positive findings and relevant negative or comparative findings.		
39	Orientation, laterality, planes, sequences, phases and panel labels are correct and consistent.		
40	Arrows, arrowheads, measurements and regions of interest are used sparingly and identify exactly what the legend describes.		
41	Clinical and histological photographs include scale bars when relevant; histology legends include stain and magnification.		
42	Figure legends are self-contained and state modality, plane or sequence, timing or phase, annotation and principal finding.		
43	Images contain no patient identifiers, accidental cursors, unrelated annotations or misleading alterations.		
F. Diagnostic reasoning and reference standard			
44	The initial imaging interpretation is reported honestly and is not rewritten to appear retrospectively obvious.		
45	Relevant differential diagnoses are listed with concise arguments for and against each.		
46	The manuscript explains how new information changed diagnostic confidence or management.		
47	Relevant prognostic characteristics, such as tumour stage or genotype, are reported when applicable.		
48	The final diagnosis and diagnostic reference standard are stated explicitly.		
49	Where biopsy, surgery or pathology is used, the sampling site, method, timing and relevant limitations are reported.		
50	Radiology-pathology, operative, microbiological, genetic or clinical correlation is explained when available and relevant.		
51	If pathology would ordinarily be expected but is unavailable, the authors explain why and identify an alternative credible reference standard.		
52	Discordant imaging, operative, pathological or clinical findings are acknowledged and reconciled rather than ignored.		
G. Treatment, outcome and follow-up			
53	Treatment, intervention, observation or decision not to treat is described with its rationale.		
54	Relevant technical details, regimen, device, material, dose or schedule are reported without unnecessary procedural detail.		
55	Complications, adverse events and important changes in management are stated.		
56	Clinical and imaging outcomes are described using defined observations rather than vague claims of improvement.		
57	The exact follow-up interval or last documented date is stated.		

No.	Requirement	Status	Location / explanation
58	Claims of cure, recurrence risk, prognosis or treatment success are proportionate to the duration and quality of follow-up.		
H. Manuscript structure, discussion and declarations			
59	The abstract accurately mirrors the case, reference standard, intervention or outcome and principal learning message.		
60	The Introduction defines the knowledge gap briefly and does not become a general textbook review.		
61	The Discussion compares the case with relevant literature, explains the findings and separates evidence from inference.		
62	Two to five concise Learning Points are directly supported by the case.		
63	Limitations are stated, including limitations of sampling, imaging, follow-up and generalisability.		
64	Declarations include publication consent, ethics, competing interests, funding, data availability, author contributions and AI-use disclosure.		
65	References are selective, relevant, current where needed and formatted consistently.		
66	If the optional SJORANM/CARE-radiology checklist is submitted, it identifies the exact manuscript page, paragraph, table or figure for each applicable item.		

Author certification: We confirm that the checklist has been completed against the submitted manuscript and that all authors have approved the final version.

Table S1.4. Author certification.

Corresponding author name	Signature or electronic confirmation	Date

Supplement 2 - SJORANM Reviewer Checklist for Radiological Case Reports

Swiss Journal of Radiology and Nuclear Medicine - Supplement to the SJORANM Practical Guide

This structured peer-review aid applies the same core requirements used in the SJORANM practical guide for authors, reviewers and editors.

Table S2.1. Manuscript and reviewer identification.

Manuscript ID / title	Reviewer	Review date

Table S2.2. Reviewer use rule.

Reviewer rule
The checklist supports, but does not replace, a narrative review. Major concerns should identify the missing evidence or contradiction and state what the authors must provide. Ethical, privacy or consent concerns should be raised confidentially to the editor.

Table S2.3. SJORANM Reviewer Checklist.

No.	Reviewer question	Assessment	Comments / required revision
A. Editorial relevance			
1	Is the central learning message explicit, clinically or technically relevant and useful beyond the individual patient?	Yes / Partly / No / N/A	
2	Is the radiological focus clear and supported by original diagnostic imaging?	Yes / Partly / No / N/A	
3	Are novelty and rarity claims supported and proportionate?	Yes / Partly / No / N/A	
4	Do the title, principal diagnostic imaging method(s), abstract and keywords comply with CARE-radiology and accurately reflect the case?	Yes / Partly / No / N/A	
B. Clinical record and timeline			
5	Are the clinical presentation, indication, relevant history, examination and laboratory data sufficiently complete?	Yes / Partly / No / N/A	
6	Is the sequence of symptoms, imaging, interventions, diagnostic confirmation and follow-up coherent?	Yes / Partly / No / N/A	
7	Are relevant prior examinations and treatments included?	Yes / Partly / No / N/A	
8	Are age, dates, side, anatomical site and measurements internally consistent?	Yes / Partly / No / N/A	
C. Imaging methods and findings			
9	Are the imaging methods described sufficiently for the reader to understand how the decisive findings were obtained?	Yes / Partly / No / N/A	
10	Are modality-specific technical details, contrast or tracer timing and relevant limitations reported?	Yes / Partly / No / N/A	
11	Are findings described systematically and anatomically precisely?	Yes / Partly / No / N/A	
12	Are relevant negative findings and relationships to adjacent structures included?	Yes / Partly / No / N/A	
13	Are comparisons with previous or follow-up imaging interpreted appropriately?	Yes / Partly / No / N/A	
14	Are the profession, years of relevant work experience and relevant training status of the interpreting specialist(s) reported as requested by CARE-radiology?	Yes / Partly / No / N/A	

No.	Reviewer question	Assessment	Comments / required revision
D. Figures and legends			
15	Do the figures show the decisive evidence and have adequate diagnostic quality?	Yes / Partly / No / N/A	
16	Are orientation, laterality, sequence or phase, panel labels and annotations correct?	Yes / Partly / No / N/A	
17	Are legends self-contained and concordant with the images and manuscript?	Yes / Partly / No / N/A	
18	Are privacy and image-integrity concerns absent?	Yes / Partly / No / N/A	
19	Are relevant prognostic characteristics (for example tumour stage or genotype) reported when applicable?	Yes / Partly / No / N/A	
E. Diagnostic reasoning and confirmation			
20	Is the initial interpretation and evolution of diagnostic reasoning transparent?	Yes / Partly / No / N/A	
21	Are the differential diagnoses appropriate and supported by the reported evidence?	Yes / Partly / No / N/A	
22	Is the final diagnosis supported by a clearly identified and credible reference standard?	Yes / Partly / No / N/A	
23	Are sampling limitations and uncertainty acknowledged?	Yes / Partly / No / N/A	
24	Where relevant and available, is radiology-pathology or alternative multimodal correlation convincing?	Yes / Partly / No / N/A	
25	Are discordant findings explained rather than omitted?	Yes / Partly / No / N/A	
F. Treatment, outcome and patient perspective			
26	Are treatment or management and their rationale described adequately?	Yes / Partly / No / N/A	
27	Are outcome, complications and exact follow-up duration reported?	Yes / Partly / No / N/A	
28	Are statements about cure, prognosis or effectiveness proportionate to the evidence?	Yes / Partly / No / N/A	
29	Is the mandatory Patient Perspective present, or is a transparent reason given for its unavailability?	Yes / Partly / No / N/A	
30	Is consent for the imaging examination/procedure appropriately reported in addition to publication consent, according to CARE-radiology and local practice?	Yes / Partly / No / N/A	
G. Discussion, reporting quality and ethics			
31	Does the Discussion compare the case with relevant literature and avoid an unfocused textbook review?	Yes / Partly / No / N/A	
32	Are the Learning Points specific and directly supported by the case?	Yes / Partly / No / N/A	
33	Are limitations and residual uncertainty stated?	Yes / Partly / No / N/A	
34	Are publication consent, ethics, competing interests, funding, contributions and AI-use declarations present or appropriately referred for editorial verification?	Yes / Partly / No / N/A	
35	Is the manuscript clear, concise and suitable for publication after the revisions identified below?	Yes / Partly / No / N/A	

Overall reviewer assessment

Table S2.4. Overall reviewer assessment.

Assessment field	Reviewer entry	Confidential note to editor, if needed
Principal educational contribution		
Major scientific or evidentiary concerns		
Required figure or imaging revisions		
Required reporting, ethics or declaration revisions		
Recommendation	Accept / Minor revision / Major revision / Reject	

Supplement 3 - SJORANM Technical Pre-check and Hard-stop Form

Swiss Journal of Radiology and Nuclear Medicine - Editorial Office Supplement to the SJORANM Practical Guide

This editorial-office form identifies submissions that cannot yet enter external scientific peer review and records the required action.

Table S3.1. Manuscript pre-check identification.

Manuscript ID / title	Checked by	Date

Table S3.2. Technical pre-check and hard-stop criteria.

Code	Classification	Trigger / finding	Required action
A1	Hard stop	Documented publication consent absent or explicitly uncertain.	Hold and return before peer review. A lawful exception must be documented and approved editorially.
A2	Hard stop	Patient is identifiable in text, figures, image overlays, labels or file metadata.	Hold and return for complete anonymisation; assess whether privacy can be protected without destroying scientific meaning.
A3	Hard stop	No original and diagnostically relevant radiological imaging is provided.	Return as outside the scope of a radiological case report or request original diagnostic imaging.
A4	Hard stop	Original images are unreadable, corrupt, too low in resolution or unrelated to the reported finding.	Return for diagnostic-quality figures and complete legends.
A5	Hard stop	No clear final diagnosis and no credible diagnostic reference standard or reasoned alternative.	Return as scientifically unevaluable until the evidence chain is reconstructed.
A6	Hard stop	Major contradiction exists between text, figures, side, anatomy, surgery, pathology or outcome.	Hold and require reconciliation before external review.
A7	Hard stop	Mandatory Patient Perspective is absent and no transparent reason is provided.	Return for the section or a documented explanation of why a direct perspective cannot be obtained.
A8	Hard stop	Required ORCID authentication is incomplete for one or more authors.	Technical return under SJORANM journal policy.
B1	Technical correction	Manuscript title, article category, structured abstract or keywords are missing or incorrectly formatted.	Return for correction before editorial assessment.
B2	Technical correction	Author names, affiliations, corresponding-author details or contribution statements are incomplete.	Hold until complete and internally consistent.
B3	Technical correction	Clinical and imaging timeline is materially incomplete.	Return for reconstruction of the episode of care.
B4	Technical correction	Imaging methods or figure legends omit essential modality, sequence, phase, timing, orientation, annotation information or other CARE-radiology image-detail information needed for interpretation.	Return for completion when the omission materially prevents appraisal; minor CARE-radiology reporting omissions may instead be addressed during revision.
B5	Technical correction	Declarations on ethics, publication consent, imaging/procedure consent where applicable, competing interests, funding, data availability or AI use are missing or unclear.	Return for completion before external review.
B6	Technical correction	References, tables or figures cited in the text are missing, duplicated or incorrectly numbered.	Return for file and citation correction.
B7	Technical correction	The uploaded files contain tracked changes, unresolved comments, accidental cursors or non-anonymised screenshots.	Return for a clean, publication-safe version.

Code	Classification	Trigger / finding	Required action
C1	Editorial triage	Unsupported rarity or novelty claim is the sole rationale for publication.	Request a precise, literature-supported learning message; decline if no transferable lesson can be established.
C2	Editorial triage	Pathology is unavailable where it would ordinarily be expected.	Not an automatic rejection. Require a clear explanation and an alternative credible reference standard.
C3	Editorial triage	Follow-up is absent or too short for the conclusions claimed.	Request proportionate wording and additional follow-up when necessary and feasible.
C4	Editorial triage	The case is adequately documented but offers no radiological or clinical learning value beyond a routine diagnosis.	Editorial rejection may be appropriate despite technical completeness.
C5	Editorial triage	The manuscript substantially duplicates a previously published case or lacks a clearly distinct contribution.	Clarify overlap; reject or request reframing according to publication ethics and editorial value.

Pre-check decision record

Table S3.3. Pre-check decision record.

Decision field	Entry	Date / initials
Outcome	Proceed to editorial assessment / Return for technical correction / Hold for ethics or privacy clarification / Editorial decline	
Items to be communicated to authors		
Responsible editor or staff member		
Date returned or advanced		
Re-check completed		

Table S3.4. Important distinction regarding pathology and original radiological imaging.

Important distinction
Absence of pathology is not, by itself, a hard stop. Pathology is preferred when relevant and available. When it is unavailable, the manuscript must explain why and provide an alternative credible reference standard. By contrast, absence of original radiological imaging is incompatible with this SJORANM radiological case-report pathway.

Supplement 4 - SJORANM Standardised Decision-Letter Modules for Radiological Case Reports

Swiss Journal of Radiology and Nuclear Medicine - Operational Supplement to the SJORANM Practical Guide

These modules provide reusable editorial language linked to the 12-step SJORANM pathway. They are not substitutes for manuscript-specific scientific judgement. Replace all bracketed fields, delete irrelevant passages and add the decisive scientific comments from the handling editor and reviewers.

Table S4.1. Common deficiencies, guide references and preferred editorial handling.

Common deficiency	Guide reference	Preferred editorial handling
No clear transferable lesson / unsupported novelty claim	Step 1	Editorial triage; revision only if a focused learning message can realistically be established.
Consent, privacy, ethics or authorship incomplete	Step 2	Technical return or hard stop until resolved.
Timeline / clinical source data incomplete	Step 3	Major revision or technical return depending on severity.
Diagnostic basis unclear	Step 4	Major revision; reject if no credible reference standard can be established.
Imaging protocol insufficiently documented	Step 5	Major or minor revision according to impact on interpretation.
Imaging findings incomplete or internally inconsistent	Step 6	Major revision.
Diagnostic reasoning absent or retrospectively simplified	Step 7	Major revision.
Imaging does not reconcile with pathology/surgery/clinical findings	Step 8	Major revision; reject if the inconsistency cannot be resolved.
Treatment/follow-up incomplete or conclusion exceeds observation	Step 9	Major or minor revision.
Manuscript structure / Patient Perspective incomplete	Steps 10 and 12	Revision; Patient Perspective required or reason for unavailability documented.
Figures, labels or legends inadequate	Step 11	Technical return or revision depending on severity.
Final compliance, ORCID, declarations or AI disclosure incomplete	Step 12	Final technical correction before acceptance/production.

A. Technical return before external peer review

Subject: Technical return before peer review - [Manuscript ID]

Dear Dr [Surname],

Thank you for submitting “[Manuscript title]” to the Swiss Journal of Radiology and Nuclear Medicine. The case may have potential educational value; however, the submission is not yet sufficiently complete to enter external scientific peer review. This is a technical return and does not constitute a scientific rejection.

Before resubmission, please address the following required items:

[Insert only the relevant deficiencies.]

Please revise the manuscript in accordance with the SJORANM Practical Guide, particularly Step(s) [X, Y, Z], and ensure that the revised files are internally consistent. If the missing requirement cannot be met, please explain this explicitly in the cover letter so that the editorial office can determine whether the manuscript remains eligible for consideration.

We will be pleased to reassess the technical completeness of a revised submission.

Kind regards,
[Handling Editor / Editorial Office]

B. Major revision after scientific review

Subject: Major Revision - [Manuscript ID]

Dear Dr [Surname],

Thank you for submitting "[Manuscript title]". The editors and reviewers consider the case potentially suitable for publication, but substantial revision is required before the manuscript can be reassessed. The present decision does not imply eventual acceptance.

The central issues are:
1. [Major scientific issue]
2. [Major reporting / imaging issue]
3. [Major figure / diagnostic reasoning / follow-up issue]

Please use the SJORANM Practical Guide as a structured revision framework, with particular attention to Step(s) [X, Y, Z]. A point-by-point response should explain how each reviewer and editorial comment has been addressed and identify the relevant page, paragraph or figure in the revised manuscript.

Please do not simply add text. Where the revision changes the diagnostic interpretation, timeline, figure selection or conclusion, ensure that the abstract, main text, tables, legends and learning points remain mutually consistent.

We look forward to receiving the revised manuscript.

Kind regards,
[Handling Editor]

C. Minor revision

Subject: Minor Revision - [Manuscript ID]

Dear Dr [Surname],

Thank you for your submission and for the work already completed. The manuscript is close to an acceptable form, but a limited number of corrections are required before a final decision can be made.

Please address the following points:
1. [Correction]
2. [Correction]
3. [Correction]

Where applicable, please consult Step(s) [X, Y] of the SJORANM Practical Guide. A concise point-by-point response and a clean revised manuscript will be sufficient.

Kind regards,
[Handling Editor]

D. Reject current submission, with invitation to resubmit de novo

Subject: Decision on [Manuscript ID] - Resubmission as a new manuscript may be considered

Dear Dr [Surname],

Thank you for submitting "[Manuscript title]". The underlying case appears potentially educational; however, the manuscript in its present form would require reconstruction beyond the scope of a conventional revision cycle. We therefore cannot continue with the current submission.

A substantially rebuilt manuscript may be considered as a new submission if the authors can address the following fundamental issues:

1. [Fundamental issue]
2. [Fundamental issue]
3. [Fundamental issue]

Before preparing a new submission, please use the SJORANM Practical Guide, particularly Step(s) [X, Y, Z], to reconstruct the complete evidence chain from clinical presentation and imaging methods to diagnostic reasoning, reference standard, outcome and figures. A new submission would receive a new manuscript number and would undergo fresh editorial assessment and peer review.

Kind regards,
[Handling Editor]

E. Rejection

Subject: Decision on [Manuscript ID]

Dear Dr [Surname],

Thank you for giving the Swiss Journal of Radiology and Nuclear Medicine the opportunity to consider "[Manuscript title]". After editorial assessment [and external review], we are unable to offer publication.

The principal reason for this decision is: [state the decisive reason clearly and specifically - for example, no sufficiently transferable learning message; diagnosis not supported by a credible reference standard; required original radiological imaging unavailable; or an ethical/integrity issue that cannot be resolved].

Because this concern affects the core publishability of the report rather than only its presentation, we do not believe that another revision cycle would be appropriate. We thank the authors for their submission and the work invested in preparing it.

Kind regards,
[Handling Editor]

F. Acceptance subject to final technical checks

Subject: Acceptance subject to final technical checks - [Manuscript ID]

Dear Dr [Surname],

We are pleased to inform you that the scientific and editorial assessment of "[Manuscript title]" has been completed successfully. The manuscript is accepted subject to final technical verification before production.

The editorial office will now confirm the final consent statement, mandatory Patient Perspective (or documented reason for unavailability), author ORCID authentication, figure quality and anonymization, legends, references, declarations and any required AI-use disclosure. Please respond promptly if the production team requests clarification or replacement files.

Thank you for your contribution to the Swiss Journal of Radiology and Nuclear Medicine.

Kind regards,
[Handling Editor]

G. Modular deficiency paragraphs

Table S4.2. Standardised modular decision-letter wording.

Module	Suggested wording
Consent / privacy / ethics (Step 2)	The manuscript does not yet document consent and/or the handling of potentially identifying information sufficiently. Please confirm written consent for publication, including accompanying images, report consent for the imaging examination/procedure as required by CARE-radiology and applicable local practice, and revise or remove any identifiers that are not essential to the scientific message. If institutional ethics review, a waiver or a justified statement that formal review was not required applies, state this precisely.
Patient Perspective (Steps 10 and 12)	A dedicated Patient Perspective section is required under SJORANM editorial policy. Please provide the patient's own perspective whenever obtainable. If a direct perspective cannot be obtained, state the reason transparently; do not reconstruct or invent a patient voice.
Imaging methods (Step 5)	The imaging technique is not documented in enough detail to permit reliable interpretation. Please provide the relevant modality, anatomical coverage, contrast administration, phases/sequences and technical parameters that materially affect the findings. CARE-radiology also requests the profession, years of relevant work experience and training status of the interpreting specialist(s); please add this information concisely.
Imaging findings (Step 6)	The imaging description should be revised systematically. Please reconcile side, anatomical location, dimensions, compartment, morphology, signal/attenuation, enhancement, diffusion/vascularity and relevant negative findings with the figures and legends.
Diagnostic reference standard (Step 4)	The basis of the final diagnosis is currently insufficiently defined. Please state explicitly whether the diagnosis rests on pathology, microbiology, genetics, surgery, treatment response, multidisciplinary consensus or documented follow-up, and describe the strength and limitations of that reference standard.
Diagnostic reasoning (Step 7)	The manuscript moves too directly from presentation to final diagnosis. Please reconstruct the actual diagnostic reasoning, including the initial interpretation, focused differential diagnoses, evidence for and against them, and the finding or event that established or changed the diagnosis.
Radiology-pathology / multimodal correlation (Step 8)	The imaging and confirmatory findings are not yet fully reconciled. Please explain how the imaging corresponds to pathology, surgery or clinical findings and resolve discrepancies in location, extent, tissue composition or terminology.
Treatment and follow-up (Step 9)	Please report the treatment, relevant complications, outcome and exact duration of follow-up. Conclusions should not imply cure, durable response or absence of recurrence beyond the documented observation period.

Module	Suggested wording
Figures and legends (Step 11)	The figures are part of the primary evidence and require revision. Please provide diagnostically interpretable original images, remove identifying information and cursor artefacts, label panels and orientation, add measurements/arrows only where helpful, and make each legend self-contained with modality, plane, sequence/phase and key finding.
ORCID / declarations / AI use (Step 12)	Please complete the final compliance information, including authenticated ORCID identifiers, author contributions, competing interests, funding, data availability and an accurate disclosure of any AI-assisted tools used in manuscript preparation, in accordance with journal policy.

Editorial use note: select only the modules that materially affect the submission. Generic checklist language should not replace case-specific scientific reasoning.

Examples of Learning Points (good vs. insufficient)

Good (transferable and specific):

- "In patients with acute abdominal pain and a history of prior abdominal surgery, mesenteric volvulus can mimic more common causes of small-bowel obstruction on CT; multiplanar reformations and identification of the whirl sign are decisive."
- "When diffusion restriction is present in a cystic pelvic mass, the differential must include mucinous adenocarcinoma even if enhancement appears mild; correlation with tumour markers and surgical exploration is mandatory."

Insufficient (too generic or non-transferable):

- "Rare tumours can occur in the abdomen."
- "Imaging is important for diagnosis."
- "Always consider the clinical context."

Supplement 5 - CARE-radiology Crosswalk

Swiss Journal of Radiology and Nuclear Medicine - Supplement to the SJORANM Practical Guide

Purpose: item-by-item alignment of all 38 CARE-radiology checklist items with the SJORANM 12-step pathway. The wording below is a concise paraphrase for implementation; the CARE-radiology publication remains the authoritative source [Wang et al., BMJ Evidence-Based Medicine 2024;29(6):399-408; https://doi.org/10.1136/bmjebm-2023-112695].

Interpretation note: CARE-radiology item 13 asks for the patient perspective when available. SJORANM deliberately adopts a stricter journal-specific rule: a dedicated Patient Perspective section is mandatory, with a transparent explanation when a direct patient perspective cannot be obtained.

Table S5.1. CARE-radiology-to-SJORANM crosswalk (38 items).

Domain	Item	CARE-radiology requirement (concise paraphrase)	SJORANM implementation
Title	1a	Diagnosis or phenomenon of focus appears in the title	Steps 1 and 10; Author Checklist
Title	1b	Diagnostic method(s) are included in the title	Step 10; Author Checklist
Title	1c	The words “case report” are included in the title	Step 10; Author Checklist
Keywords	2a	Three to six keywords identify the case report, diagnosis and diagnostic test/approach	Step 10; Author Checklist
Keywords	2b	Keywords avoid overly general/multiple concepts; established MeSH/ICD-11 terms and established abbreviations are preferred	Step 10; Author Checklist
Abstract	3a	Abstract states what is unique and what the case adds	Steps 1 and 10
Abstract	3b	Abstract summarises main imaging features and diagnostic/prognostic value of new technologies	Steps 5, 6 and 10
Abstract	3c	Abstract states one or more take-away lessons	Steps 1 and 10
Introduction	4	Introduction provides concise context/background and why the case is unique	Steps 1 and 10
Patient information	5a	Relevant demographic and physical characteristics are reported	Step 3
Patient information	5b	Primary symptoms, medical history and family history are reported	Step 3
Clinical course	6a	Disease course and treatments affecting imaging are reported; imaging time points are shown when multiple examinations exist	Steps 3 and 9
Clinical course	6b	Disease and imaging timelines are reported	Step 3
Diagnostic assessment	7a	Diagnostic methods, including physical examination, laboratory testing and other imaging, are reported	Steps 3 and 7
Diagnostic assessment	7b	Diagnostic challenges are reported when applicable	Step 7
Diagnostic assessment	7c	Diagnostic reasoning and differential diagnoses are reported	Step 7
Diagnostic assessment	7d	Surgical and pathological results are reported when applicable	Steps 4 and 8
Diagnostic assessment	7e	Diagnoses made outside radiology are reported together with how radiologists validated them	Steps 4, 7 and 8
Diagnostic assessment	7f	Relevant prognostic characteristics, such as staging or genotype, are reported	Steps 4 and 7
Imaging findings	8	Essential imaging findings, typical features and key identification points are described	Step 6
Image details	9a	Patient identifiers are removed	Steps 2 and 11

Domain	Item	CARE-radiology requirement (concise paraphrase)	SJORANM implementation
Image details	9b	Contrast agent, equipment, parameters, software and acquisition settings are reported	Step 5
Image details	9c	Resolution, magnification and image modifications/enhancements are described	Step 11
Image details	9d	Markers/labels identify key features and are defined in the legend/footnote	Step 11
Image details	9e	Specialists' profession, years of work experience and training status are reported	Step 5; Author and Reviewer Checklists
Image details	9f	AI tools used for image interpretation/analysis are disclosed with details	Steps 2, 5 and 11
Follow-up and outcomes	10	Clinician- and patient-assessed outcomes plus important adverse/unanticipated imaging or treatment events are reported when known	Step 9
Discussion	11a	Rationale for conclusions is provided	Step 10
Discussion	11b	Relevant medical literature is discussed	Steps 1 and 10
Discussion	11c	Strengths and limitations of the approach to the patient are reported	Step 10
Discussion	11d	Applicability to other people, populations or settings is discussed	Steps 1 and 10
Discussion	11e	Implications for practice, education and research are described	Steps 1 and 10
Conclusions	12	Key messages or lessons are presented	Steps 1 and 10
Patient perspective	13	Patient perspective on the examination(s) is reported if available	Step 9 and mandatory dedicated section under SJORANM policy
Informed consent and ethics	14a	Informed consent for imaging procedure and case-report publication is reported	Step 2
Informed consent and ethics	14b	Ethics approval status for publication of the case report is reported	Step 2
Funding	15	Funding/support and funder role are reported	Step 12 / Declarations
Conflict of interest	16	Conflicts of interest of all authors are summarised	Step 12 / Declarations

SJORANM-specific additions beyond CARE-radiology: mandatory original diagnostic radiological imaging; mandatory dedicated Patient Perspective section (or documented reason for unavailability); ORCID authentication; preferred but non-mandatory SJORANM/CARE-radiology checklist submission; pathology preferred when relevant but not mandatory; standardized technical pre-check and decision-letter workflow.