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Japan University General medicine
Leadership and Education Roundtable

# 症例報告論文投稿のTips by JUGLER


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志水 太郎　（獨協医科大学）
佐々木 陽典（東邦大学）
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**J**apan **U**niversity **G**eneral Medicine **L**eadership and **E**ducation **R**oundtable

総合診療医教育

総合診療医像
= Core module

病院総合診療
専門医プログラム
WGメンバー

# 本企画の目的

1. 症例報告執筆について議論
2. 病院総合診療医の症例報告執筆スキルアップ
3. 領域の学術活動の活性化とレベルアップ

# 本日の
# アウトライン

導入

JUGLERの症例報告投稿先についての論文の紹介

症例報告執筆についてのディスカッション

掲載論文の紹介

Q&A

# 導 入

INTRODUCTION

# 症例報告していますか?

## なぜしないのか?

時間がない

どうやったよいかわからない

どのような症例を選ぶ?

## なぜするのか?

意義は?

他の業務とのバランスは?

業績のため?

# 症例報告の意義

## ◆自らの臨床知を深める

## ◆論文執筆の基礎を学ぶ

臨床研究の基礎
→論文執筆方法、臨床的思考の深め方、情報収集方法

## ◆学術領域全体の発展

新知見を発信することの重要性
学問の発展

臨床研究の基礎
論文執筆方法
臨床的思考の深め方
情報収集方法

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# 方法、コツは?

書き方は?

症例の
選び方は?

英訳の
しかたは?

誰に指導
してもらう?

**後ほど議論します!**

# 問題点は?

コード　@@@@

**コスト**
経済的・時間的

**英文校正料**

**Journalの選択**
(次ページで)

*Japan University General medicine Leadership and Education Roundtable*

# 総合診療領域の症例報告の特徴

- 領域が幅広い
- 診断学を扱う上での教訓を取り扱う
- まれよりも、なぜそうなったのか？思ったのか？など

このような理由から、
**投稿先の選択の段階でつまずく**ことも・・・

# 論文 by JUGLER

OUR PRODUCT

# JHGM 2020; 2: 99-103.

JUGLER

—Special contribution—

## To which journal should generalists submit a clinical case report?


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Kiyoshi Shikino MD, PhD[3)]   Yosuke Sasaki MD, PhD[4)]   Hiromizu Takahashi MD, PhD[5)]
Taro Shimizu MD, PhD, MPH, MBA[6)]

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6) Department of Diagnostic and Generalist Medicine, Dokkyo Medical University


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# ABSTRACT

## 診断や病態を詳細に検討した症例報告＝臨床研究の基礎

- **個々の症例の蓄積**

  →将来的には質の高い研究やエビデンスの構築
  →臨床研究の発展に貢献
  →学術研究の向上

## 総合診療医は、投稿先の選択に悩むことが多い

- **幅広い疾患や臨床環境をカバーしている**
- **主に臨床上の教訓や興味深い身体所見に焦点を当てている**

  →斬新なトピックを欠くことも

## 総合診療領域の症例報告投稿先リストを著者らの経験に基づき作成

# JHGM

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**Table 1** The target journals for case reports written by Japanese generalists

| Title | Publisher | PubMed Indexed | IF † (2018) | Type of Article | Open access | Limit number of authors | Word limit of main text | Word limit of title | Word limit of abstract | Limit number of pictures (figures) |
|---|---|---|---|---|---|---|---|---|---|---|
| American Journal of Case Reports | International Scientific Information, Inc. | Yes | NA | Case Report | Yes | NA | NA | NA | 250 words | NA |
| American Journal of Medicine | Excerpta Medica | Yes | 5.003 | Clinical Communication to the Editor (Case Report) | Yes | NA | 650 words | NA | Not required | NA |
| BMJ Case Reports | BMJ Publishing Group | Yes | NA | Images in... | No (Open access options available) | 4 | 500 words | NA | Not required | NA |
| | | | | Case Report | | 4 | 2,000 words | NA | 150 words | NA |
| Cleveland Clinic Journal of Medicine | Cleveland Clinic Educational Foundation | Yes | 1.885 | The Clinical Picture | No (Required free account) | NA | 500 words | NA | Not required | NA |

## IF、OA、字数制限、著者数、図表個数、投稿規定と投稿ページURL、APCなど

| Figure legend | Rreferences | Journal URL | Instructions to authors URL | Submission URL | Article publication Charges |
|---|---|---|---|---|---|
| Required | NA | https://www.amjcaserep.com/ | https://www.amjcaserep.com/instructions | https://www.amjcaserep.com/authorsPanelSubmissionStep1 | 995 USD |
| Required | NA | https://www.amjmed.com/ | https://www.amjmed.com/content/authorinfo | https://www.editorialmanager.com/AJM/default.aspx | None |
| Required | NA | https://casereports.bmj.com/pages/ | https://casereports.bmj.com/pages/authors/ | https://mc.manuscriptcentral.com/bmjcasereports | None (required fellowships) |
| Required | NA | | | | |
| Required | 5 | https://www.ccjm.org/ | https://www.ccjm.org/content/clinical-picture | https://www.editorialmanager.com/ccjm/default.aspx | None |

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# 討 論

DISCUSSION

# なぜ症例報告をする?

# Full、image、短報の違いってなに?

# 同意書はどうしてる?

# 雑誌の使い分けは?

# どうやって書いてる？ コツは?
# 症例報告作成の型

# どれくらい時間をかけてる?

# カバーレター/レスポンスレター のポイントは?

# 英訳の方法は?

# Rejectされた時の対応

# 執筆指導体制は
# どうなっていますか?

# 症例報告のネタを
# どうやって探していますか?

# 症例報告紹介

PRESENTATION

JGFM

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**IMAGES IN CLINICAL MEDICINE**

Journal of General and Family Medicine   WILEY

# Idiopathic mesenteric phlebosclerosis associated with herbal drugs presenting with asymptomatic fecal occult blood

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**KEYWORDS:** gardenia fruit, genipin, geniposide, ischemic colitis, Sanshishi

We report a case of idiopathic mesenteric phlebosclerosis (IMP) presenting with asymptomatic fecal occult blood. This case underscores the importance of recognizing IMP as a cause of asymptomatic fecal occult blood in countries where herbal drugs are used often.

A 77-year-old man visited our hospital for evaluation of asymptomatic fecal occult blood that was found during his annual public health checkup. He had undergone left total hip arthroplasty and was receiving treatment for hypertension, nonvalvular atrial fibrillation, and erythromelalgia. He had been simultaneously prescribed multiple Chinese herbal drugs that were manufactured by Tsumura & Co., Japan, including Oren-gedoku-to (TJ-15), Kami-shoyo-san (TJ-24), Keishika-ryukotsu-borei-to (TJ-26), and Bakumondo-to (TJ-29), for various symptoms such as pain and paresthesia of the extremities due to erythromelalgia and chronic cough.

Colonoscopy showed dark-purple, edematous mucosa and dilated veins at the ascending colon, which are typical findings of IMP (Figure 1). A computed tomography scan showed multiple linear calcifications distributed on the right-side mesenteric veins (Figure 2, red circles). In light of the typical combination of endoscopic and radiological findings, we diagnosed the patient with IMP and advised him to immediately discontinue the herbal drugs. Despite the discontinuation of the causative agents, the patient developed anemia due to a colonic ulcer associated with chronic ischemia of the right side of the colon three months after the IMP diagnosis. He was conservatively treated and scheduled for regular endoscopic and radiological observation.

IMP is a rare syndrome caused by chronic ischemic changes of the colon due to calcification of the veins of the colon and adjacent peritoneum.[1] Most cases have been reported from Asian countries, especially Japan and Taiwan, which have strong associations with the use of herbal drugs.[1] Previous studies clarified that herbal drugs containing gardenia fruit (Sanshishi) are one of the major causes of IMP. The currently assumed etiology of IMP is as follows: Geniposide, a component of gardenia fruit, is hydrolyzed to genipin by bacteria

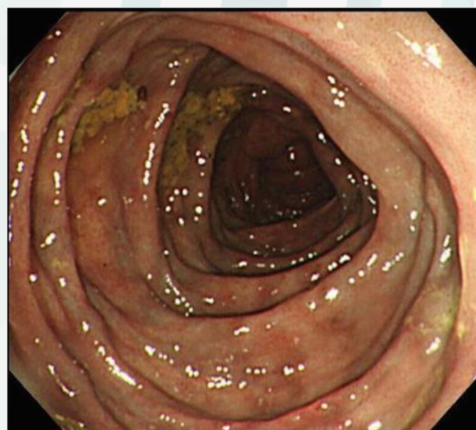

**FIGURE 1** Colonoscopy of the patient showed dark-purple, edematous mucosa and dilated veins at the ascending colon, which are typical findings of idiopathic mesenteric phlebosclerosis

ポイント

便潜血で受診した漢方薬による特発性腸間膜静脈硬化症

日本でCommon

+

欧米ではRare

→海外のMajor journalを狙えばよかったかも!?

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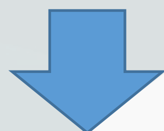
「珍しい写真でもない」



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Images in Clinical Medicine

# Supraclavicular Fat Pads as the Chief Complaint of Cushing's Syndrome

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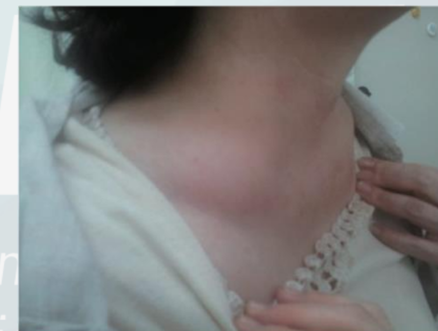
**Keywords:** supraclavicular fat pads, Cushing's syndrome, cervical mass

We report on a case of a woman who sought medical assistance for bilateral supraclavicular fat pads due to Cushing's syndrome. Our case underscores the importance of recognizing the cosmetic manifestations of Cushing's syndrome as a chief complaint and a trigger for diagnosis.

A 62-year-old, previously healthy woman, visited our office with the chief complaint of masses at the bilateral supraclavicular fossae (**Figure 1**). She noticed that the mass had gradually grown over the previous few months. She also complained of a general fatigue that had lasted for several months. She denied any pain or tenderness around the mass, dyspnea, recent weight gain, or fat accumulation at other sites. She had never been diagnosed as obese at previous health checks. At her first hospital visit, her height was 159 cm, body weight was 60.5 kg, and body mass index (BMI) was 23.9 kg/m$^2$. Physical examinations revealed non-tender, symmetric, soft lumps filling the supraclavicular fossae, and bipedal edema. Careful examination

**Figure 1.**



revealed mild fat accumulation at the nuchal area to the bilateral shoulder, which suggested a "buffalo hump"; however, "moon face" was not observed. Laboratory examination revealed elevated serum cortisol at rest and 24-hour urinary free cortisol and loss of diurnal variation of serum cortisol with low serum

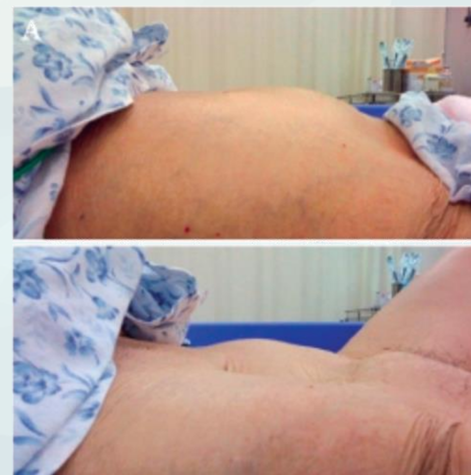
# Internal Medicine (1.0)

INTERNAL MEDICINE

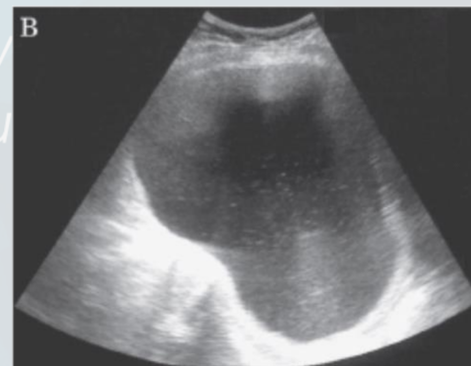
□ PICTURES IN CLINICAL MEDICINE □

Acute Urinary Retention

- 単純でコモンな臨床所見
- フィジカルの重要性を強調



Picture A.




Picture B.

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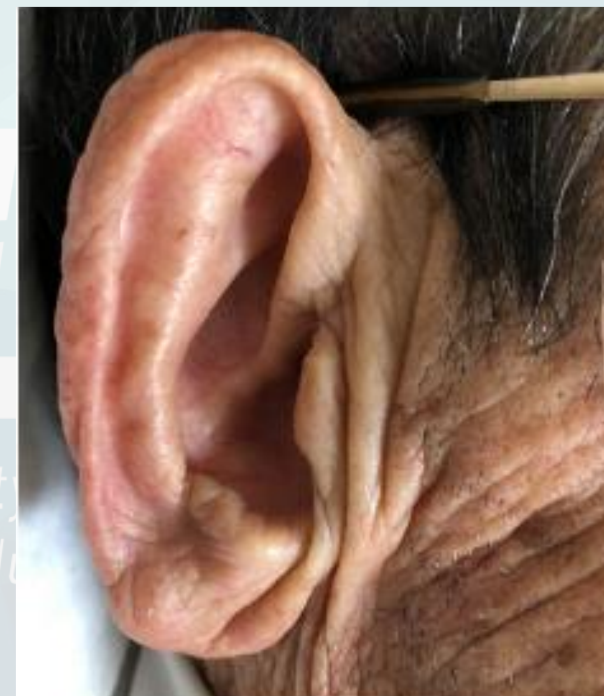
# *Internal Medicine (1.0)*

**Internal Medicine**
The Japanese Society of Internal Medicine

**Preauricular Vertical Creases**



・新しいフィジカルを開発・発見する
・発表する

# BMJ Case Rep

## Accessory axillary breasts versus axillary tumours: diagnostic challenge

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Accepted 29 August 2019

### DESCRIPTION

A 38-year-old woman with no medical history noticed swellings in both axillary regions 9 months previously. She visited another hospital because she had a slight fever and axillary discomfort due to gradual growth of the swellings during the last 3 months. She had no history of weight loss, appetite loss, nocturnal sweating, pregnancy or variation in the size of the swellings with her menstrual cycle. On the first visit to other breast surgery clinic, laboratory examinations revealed no abnormalities; inflammatory responses and antinuclear antibody were negative, and thyroid function was normal. Mammography and breast ultrasonography performed at the clinic revealed no abnormalities in her normally positioned breasts without detecting accessory axillary breast tissues. She was then referred to our department for a thorough examination. Physical examination did not show any abnormalities in normally positioned breast tissues or systemic lymphadenopathy. Soft and poorly marginated elevated lesions without tenderness were present in both anterior axillary areas, which were difficult to detect as masses on palpation (figure 1). Ultrasonography of the axillary areas revealed heterotopic, apparently normal breast structures (figure 2). MRI of the left axillary area also showed a normal breast structure without any abnormalities characteristic of tumours or inflammatory diseases (figure 3). The patient was consequently diagnosed with accessory axillary breasts.

The incidence of supernumerary or accessory breasts is reportedly about 1% and 5% in men and women respectively, which is lower than those of supernumerary or accessory nipples.[1] Supernumerary breast tissues are usually found along the milk lines extending from the axilla to pubic region.[2] Some cases of accessory breasts were pathologically diagnosed after surgical resection; they had been suspected to be lipomas because of their increase in size over time.[3] Pathological changes such as mastitis, fibrocystic disease, or even carcinoma, which is rare, can occur in accessory breasts even in the presence of normal histological breast structures.[4]

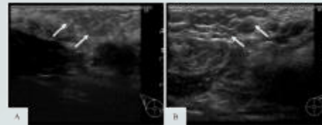


**Figure 2** Ultrasonography of the both axillary areas. (A) Right side, (B) Left side. (A, B) Ultrasonography of both sides of anterior axillary areas revealed heterotopic, but apparently normal breast structures (arrows).

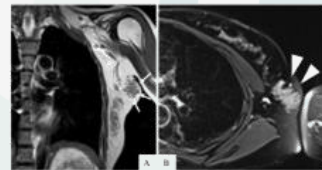


**Figure 3** MRI of left axillary area. (A) Coronal view of T2-weighted image reveals an isodense lesion in the left axillary area, and its appearance is similar to that of normal breast structure (arrows). (B) Axial view of T2-weighted and fat-suppressed image reveals high-density lesion (arrowheads), which is compatible with the findings of accessory breast tissue.

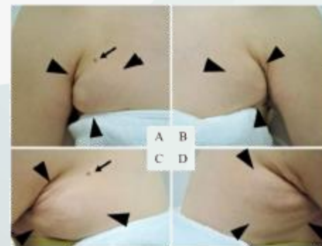


**Figure 1** Findings of both anterior axillary areas. (A–D) Soft and poorly marginated elevated lesions are present in both anterior axillary areas, which were difficult to detect as masses on palpation (arrowheads). (A, C) An accessory nipple is present on the right side (arrows).

**Learning points**

- Accessory axillary breasts are uncommon and can often be a diagnostic challenge.
- Carcinoma can occur in accessory axillary breasts, though such case is rather rare.
- Some cases of accessory breasts were pathologically diagnosed after surgical resection; they had been initially suspected to be lipomas.

Check for updates

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腋窩腫瘤

乳腺外科でマンモ、US正常

自分のUS診断：脂肪腫?

MRI診断：副乳

意外&恥ずかしかった!

他の情報と自分の思考過程を整理するために執筆

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# EJIM (4.329)

典型症例

本邦の医療系Webサイトでも報告有り

きれいな写真
(気合を入れて撮影)
+
本誌未掲載
+
必要な除外診断を完璧に

European Journal of Internal Medicine

journal homepage: www.elsevier.com/locate/ejim

Internal Medicine Flashcard

## Unilateral abdominal bulge with sharp pain

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ARTICLE INFO

Article history:
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Available online 24 February 2017

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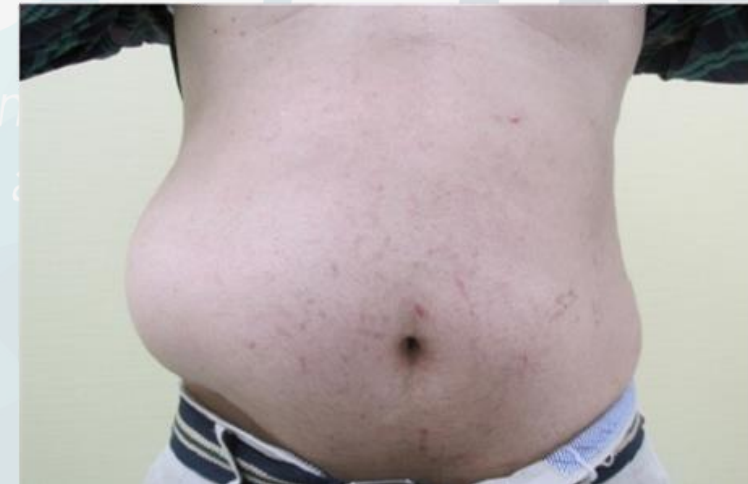
**1. Indication**

A 64-year-old man presented with sharp pain and progressive bulging in his right lower quadrant of the abdomen for three days (Fig. 1). He was smoker and he underwent appendicectomy about 50 years ago. There were no visible skin lesions, no paresthesia, and no bowel changes. The bulge increased in size with increased abdominal pressure, it seemed to be caused by abdominal paralysis. The remainder of the physical exam was normal. The patient did not have diabetes mellitus, and neither abdominal computed tomography nor spinal magnetic resonance imaging revealed abnormalities. One week later, the patient developed three vesicular and encrusted rashes in the area innervated by the ninth thoracic nerve.

**2. What is the diagnosis?**



# Postgraduate Medical Journal (2.078)

## Milian's ear sign of erysipelas

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Revised 23 March 2020
Accepted 25 March 2020

A 65-year-old woman presented with 2 days of acute onset fever, with left pinna pain, swelling and erythema (figures 1 and 2). She had no significant medical history. Physical examination revealed a body temperature of 38.0°C, facial rash sparing the nasolabial fold and Milian's ear sign. Laboratory data showed neutrophilic leucocytosis. Erysipelas was diagnosed and treated with oral amoxicillin (1500 mg/day). Within 10 days, the patient's symptoms improved.

Erysipelas is a common infection involving the upper dermis and lymphatics, whereas cellulitis involves the deeper dermis and subcutaneous fat.[1] Facial erythema spreading to the pinna is known as Milian's ear sign, a specific finding that differentiates erysipelas from cellulitis.[1–3] The pinna has no deeper dermis and subcutaneous tissue so redness there cannot be cellulitis.[1–3] The ear lobe contains fat and may develop cellulitis, but it does not typically spread to the cartilage in the rest of the auricle (helix, scapula, antihelix and so on). Erysipelas spares the nasolabial fold because the nasolabial fold has no upper dermis and lymphatics.

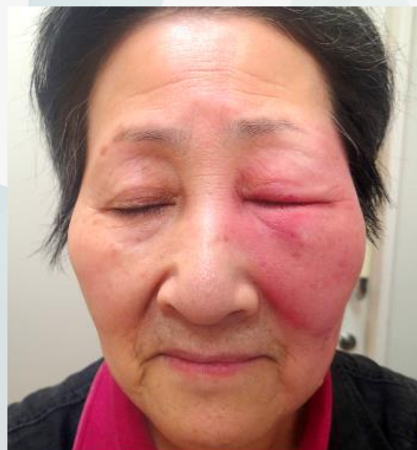

Figure 1 Facial rash sparing the nasolabial fold.

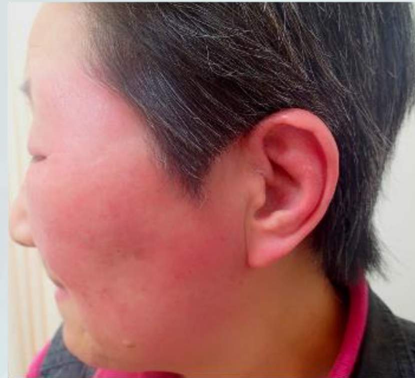

Figure 2 Swelling and redness of the left ear (Milian's ear sign).

Ear redness is generally associated with other disorders, including relapsing polychondritis. Relapsing polychondritis causes inflammation in the cartilage, resulting in auricle erythema.

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**Contributors** KS: cared for the patient and wrote the report. KS and MI: read and approved the final version of the report.

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**Competing interests** None declared.

**Patient consent for publication** Obtained.

**Provenance and peer review** Not commissioned; internally peer reviewed.

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Kiyoshi Shikino http://orcid.org/0000-0002-3721-3443

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3 Pakran J. Sparing phenomena in dermatology. *Indian J Dermatol Venereol Leprol* 2013;79:545–50.

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ここがポイント!

コモンディジーズの典型例

# Mayo Clinic Proceedings (7.199)

ここがポイント!

ALSのスプリットハンド

+

SAIDH合併

## Split Hand Syndrome and Syndrome of Inappropriate Antidiuretic Hormone

Kiyoshi Shikino, MD, PhD, and Masatomi Ikusaka, MD, PhD

From the Department of General Medicine, Chiba University Hospital, Chiba, Japan.

An 81-year-old man presented with a 2-year history of slowly progressive weakness of both hands. He had exhibited exertional dyspnea and dysphagia for the past 6 months. Manual muscle testing indicated motor weakness (abductor pollicis brevis [APB], 1/1; first dorsal interossei [FDI], 2/2; abductor digiti minimi [ADM], 2/4). Muscle wasting was noted in the APB and the FDI of the left hand, whereas muscle sparing was noted in the ADM; this condition was termed *split hand syndrome* (Figure). The patient exhibited exaggerated reflexes in all limbs, along with the Babinski reflex and fasciculations, which indicated a diagnosis of amyotrophic lateral sclerosis (ALS) based on the Airlie House criteria. His arterial blood gas measurements were $P_{CO_2}$ of 70 mm Hg, $P_{O_2}$ of 60 mm Hg, and $HCO_3^-$ concentration of 42.4 mmol/L. Pulmonary function tests indicated a mean vital capacity percentage of 34.4%, suggesting type II respiratory failure due to respiratory muscle dysfunction. Laboratory data revealed a serum sodium level of 125 mEq/L, urinary sodium level of 25 mEq/L, serum osmotic pressure of 251 mOsm/L, urine osmotic pressure of 483 mOsm/L, and antidiuretic hormone level of 4.4 pg/mL. Renal, liver, adrenal gland, and thyroid functions were normal. Thus, we diagnosed the patient with syndrome of inappropriate antidiuretic hormone (SIADH).

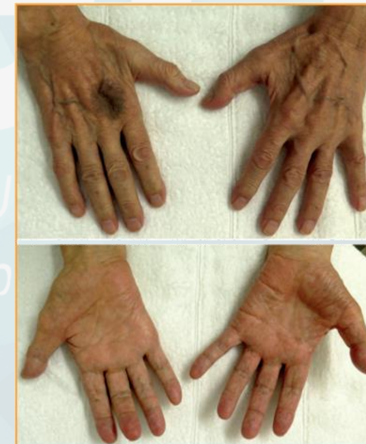

FIGURE. Palmar and dorsal aspects of both hands: the left hand revealed marked wasting of the thenar muscle and the first dorsal interosseous muscle, but sparing of the hypothenar muscle. This condition is also known as split hand syndrome.

Split hand syndrome involves wasting of the FDI and the thenar complex, but sparing of the hypothenar muscle. The FDI, thenar, and hypothenar muscles are innervated by C8-Th1, and the FDI and hypothenar muscles are innervated by the ulnar nerve. The dissociated involvement of the hand muscles cannot be anatomically explained. Split hand syndrome has a moderate sensitivity (52%) and a high specificity (87%) for the detection of ALS and can serve as a useful clinical clue for its early diagnosis.[1] In addition, ALS is rarely accompanied by SIADH.[2] Severe restrictive ventilator impairment may cause SIADH in patients with ALS.[2]

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# QJM(2.9)

OXFORD ACADEMIC

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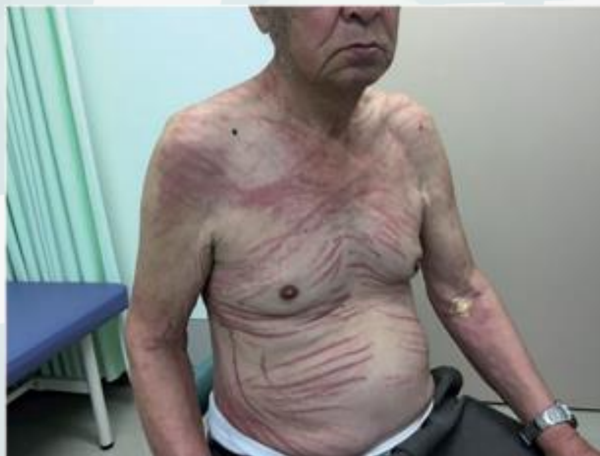
CLINICAL PICTURE

## Shiitake dermatitis

An 81-year-old Japanese man presented with gradual onset of extensive pruritic skin eruption. He had well-controlled diabetes and he denied any systemic symptoms or recent exposure to new medication. The patient reported eating a large amount of half-cooked shiitake mushroom (*Lentinula edodes*) as an ingredient of Sukiyaki in 12 h before developing the cutaneous lesions. On physical examination, pruritic erythematous to violaceous streaks were distributed in a flagellate pattern symmetrically mainly on the trunk without mucosal lesions (Figure 1). Based on the typical history and the specific rash resembling a whiplash mark, he was diagnosed with shiitake dermatitis caused by shiitake mushrooms. Shiitake is the second most consumed mushroom in the world and its intake can cause shiitake dermatitis about 5–60 h after consumption of raw or half cooked. Typical linear flagellated erythema is usually self-limited and only requires symptomatic treatment with antihistamines.

Photographs and text from: T. Watari, Postgraduate Clinical Training Center, Shimane University Hospital, Shimane, Japan; Y. Tokuda, Okinawa Muribushi Project for Teaching Hospitals, Urasoe City, Okinawa, Japan. email: wataritari@gmail.com

*Conflict of interest*: None declared.



## ポイント

- 椎茸食べて
- 鞭で打たれたような
- SMプレイ？
- オモロー！！

Japan University General medicine Leadership and Education Roundtable

**Watari T**, Tokuda Y. Shiitake dermatitis. QJM. 2017 Aug 23.
doi: 10.1093/qjmed/hcx173.

# QJM(2.9)

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CASE REPORT

**MRI thermal burn injury: an unrecognized consequence of wearing novel, high-tech undergarments**

T. Watari[1] and Y. Tokuda[2]

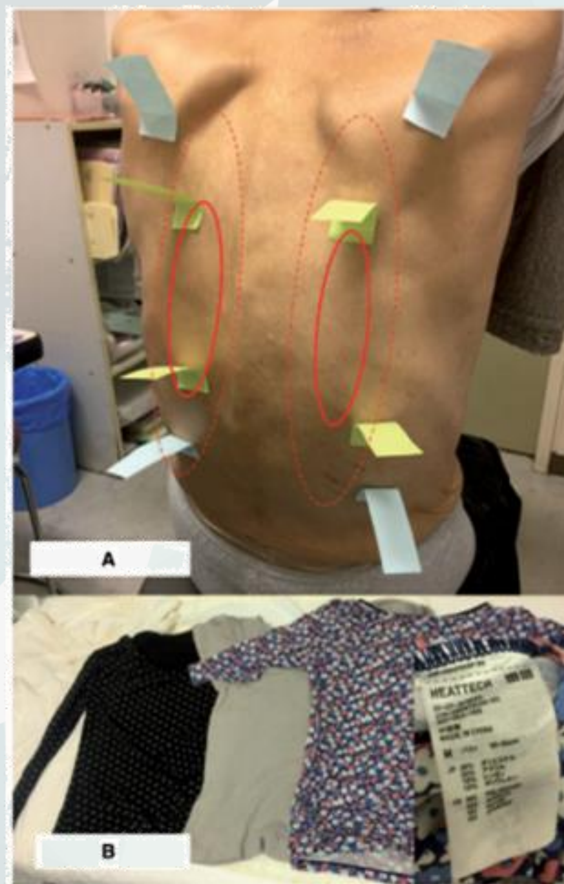


**Figure 1.** (A) One day after the completion of MRI of the patient's lumbar spine, no obvious dermatological findings were observed. However, a marked hyperesthesia-like area similar in appearance to a sunburn was observed, particularly in the centre of the ellipse. (B) The patient wore a total of four layers of novel underwear with Japanese heat-retardant technology during her imaging study. She reported wearing these undergarments during a follow-up appointment.

## ポイント

・MRIに入った後の原因不明のヒリヒリ感
・詳細な問診でヒートテック
・技師には常識
・医者は誰も知らず
・英語文献なし

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## ポイント

- Alvarado 2点
- 僕、見逃した？！
- 読影で虫垂炎穿孔
- 研修医が叱られた
- 外科教授たちに便培養依頼、反撃。
- エアロモナス腸炎で助かった〜

CASE REPORT

# *Aeromonas* enteritis: a great mimicker of acute appendicitis

K. Kishimoto and T. Watari

From the Postgraduate Clinical Training Center, Shimane University Hospital, Shimane, Japan

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**Learning point for clinicians**

*Aeromonas* infections are mostly community acquired due to exposure to freshwater or from eating raw fish, and usually develop in patients with hepatic disease. It can cause enterocolitis and potentially mimic appendicitis (pseudoappendicitis), resulting in unnecessary surgery.

## Case report

A 69-year-old man with a history of alcohol abuse was admitted to the emergency department complaining of diarrhoea and mild abdominal pain. He reported of a 5-day history of worsening continuous watery diarrhoea (more than 10 times per day) and colicky abdominal pain after eating raw fish with Japanese Sake. He stated that the mild abdominal pain which was initially generalized had radiated to his left side. His general appearance was good; blood pressure was 140/94 mmHg, heart rate was 88 beats/min, oxygen saturation was 98% on room air, respiratory rate was 23 breaths/min, and body temperature was 35.8°C. There were no abnormal findings in the patient's abdominal physical examination, including rebound tenderness, cough signs, tapping pain, heel drop sign, Murphy sign, psoas sign, or tenderness of McBurney's point and Lanz point. Laboratory data showed normal findings of liver and renal function tests, a white blood cell count of 9660/μl, and C-reactive protein level of 8.83 mg/dl. He was diagnosed with acute bacterial enteritis, and prescribed probiotics with follow-up in 5 days. However, he presented to another hospital due to prolonged mild abdominal pain and was referred to our hospital 2 days later. On admission, abdominal examination revealed moderate tenderness of the right lower quadrant without peritoneal signs. Abdominal computed tomography (CT) showed wide wall thickening of the caecum to the ascending colon and the

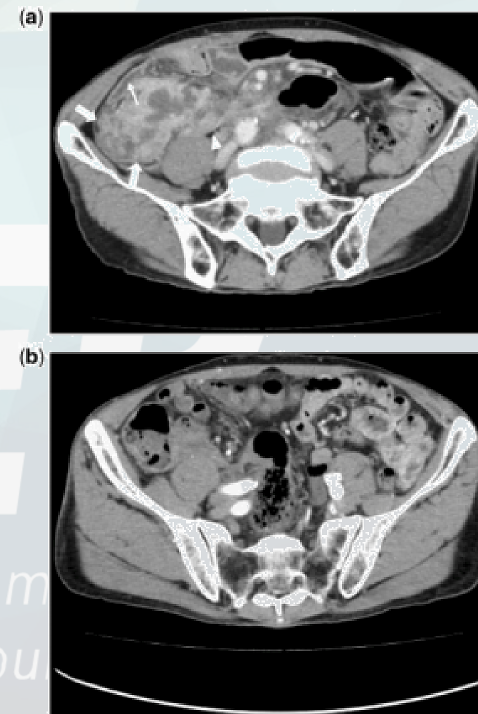


Figure 1. Contrast-enhanced CT. (a) ⇑ Wall thickening from the caecum to the ascending colon and ↑ peri-ileocaecal fluid with △ mesenteric lymph node enlargement (on admission). (b) Improving ileocaecitis and shrinkage of the abscess and lymphadenopathy (on the 15th hospital day).

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# まとめ

CONCLUSION

# JUGLERの7TIPS

**Tip 1**: Understanding the purpose of submitting case reports

**Tip 2**: Trying to uncover topics of clinical case

**Tip 3**: Capturing types of case report writing

**Tip 4**: Using the online translation tool

**Tip 5**: Setting up a mentoring environment

**Tip 6**: Understanding the characteristics of the journals

**Tip 7**: Thinking about what to do if you get rejected

# THANK YOU