PERSONALIZED TREATMENT OPTIONS(TM)

Example Output Package

A fictional demonstration of how a complex case can be organized into prioritized opportunities, transparent evidence, practical tradeoffs, and clinician-ready questions.

SAMPLE CASE Avery Morgan (fictional) | Prepared July 2026

What this sample demonstrates

Artifact	What it contains	How it is used
Patient report	Plain-language orientation, priorities, and next questions.	Understand the search and prepare for clinical conversations.
Clinician brief	Condensed case context, opportunity rationale, cautions, and monitoring questions.	Support efficient review by the treating team.
Opportunity matrix	Ranked options with evidence, relevance, feasibility, and uncertainty.	Compare options without treating a ranking as a prescription.
Opportunity cards	A repeatable dossier for each shortlisted avenue.	Review rationale, limitations, safety context, and clinician questions.
Outcome frontier	A visual model of tradeoffs between modeled relevance and implementation feasibility.	Identify non-dominated options worth closer discussion.
Research appendix	Relevant trials and emerging directions, separated from established care.	Understand research status, access, and eligibility questions.
Safety log	Interactions, monitoring needs, evidence gaps, and exclusion reasons.	Keep cautions and uncertainty visible during review.
Evidence library	Linked source log, study type, applicability notes, and limitations.	Trace every material claim back to its source.

Important

Everything in this document is fictional and illustrative. It is not medical advice, a diagnosis, a treatment recommendation, or a promise that any particular analysis or opportunity will apply to an individual case.

The case in one page

A concise view of what was reviewed, the working question, and the most useful next discussions.

Working question

Which evidence-supported avenues may deserve discussion after persistent exertional intolerance, post-exertional worsening, sleep disruption, and cognitive symptoms have remained only partially responsive to standard supportive care?

Records represented in this fictional example

Artifact	What it contains	How it is used
Clinical history	Symptom timeline, diagnoses under consideration, prior consultations.	Establish chronology and avoid repeating failed avenues.
Treatment history	Medications, supplements, therapies, response, tolerance, and reasons stopped.	Separate untried options from previously ineffective or poorly tolerated ones.
Laboratory context	Selected routine labs and trends supplied by the fictional patient.	Identify context and monitoring gaps; no raw imaging interpretation.
Genetic context	A fictional consumer report with no diagnostic variant conclusion.	Generate questions only; confirm clinically before acting.

Top discussion themes

1. Improve measurement before changing multiple variables. 2. Revisit autonomic and sleep contributors. 3. Consider only one low-burden change at a time. 4. Define stop criteria and monitoring before any trial. 5. Keep investigational avenues separate from established care.

What this review does not conclude

The modeled ordering below does not prove that an option will work. It reflects the quality and directness of available evidence, fit with the fictional case, safety burden, feasibility, and uncertainty at the time of review.

Clinical discussion summary

Designed to be scanned quickly before a visit and used to focus, not replace, clinical judgment.

Domain	Fictional case signal	Discussion implication
Function	Marked post-exertional worsening with variable recovery time.	Favor pacing-compatible assessment and avoid simultaneous high-burden trials.
Autonomic	Orthostatic symptoms reported; structured measurements incomplete.	Confirm pattern and reversible contributors before disease-specific conclusions.
Sleep	Non-restorative sleep despite adequate opportunity.	Clarify sleep disorder contributors that could amplify symptom burden.
Treatment history	Several interventions tried briefly without standardized tracking.	Use one-variable trials, predefined outcomes, and explicit stop rules.

Focused questions for the treating team

- Which findings need confirmation before narrowing the differential?
- What baseline measures would make a time-limited trial interpretable?
- Which interactions, contraindications, or organ-function considerations change feasibility?
- What would count as benefit, non-response, or harm, and when should the trial stop?
- Are there established-care options that should precede emerging or repurposed avenues?

Safety escalation

New, severe, or rapidly worsening symptoms, emergency concerns, and medication changes require direct clinical care. This service does not provide emergency triage, prescribing, or medical supervision.

Prioritized avenues for discussion

Example structure only. Categories are intentionally generic and do not constitute recommendations.

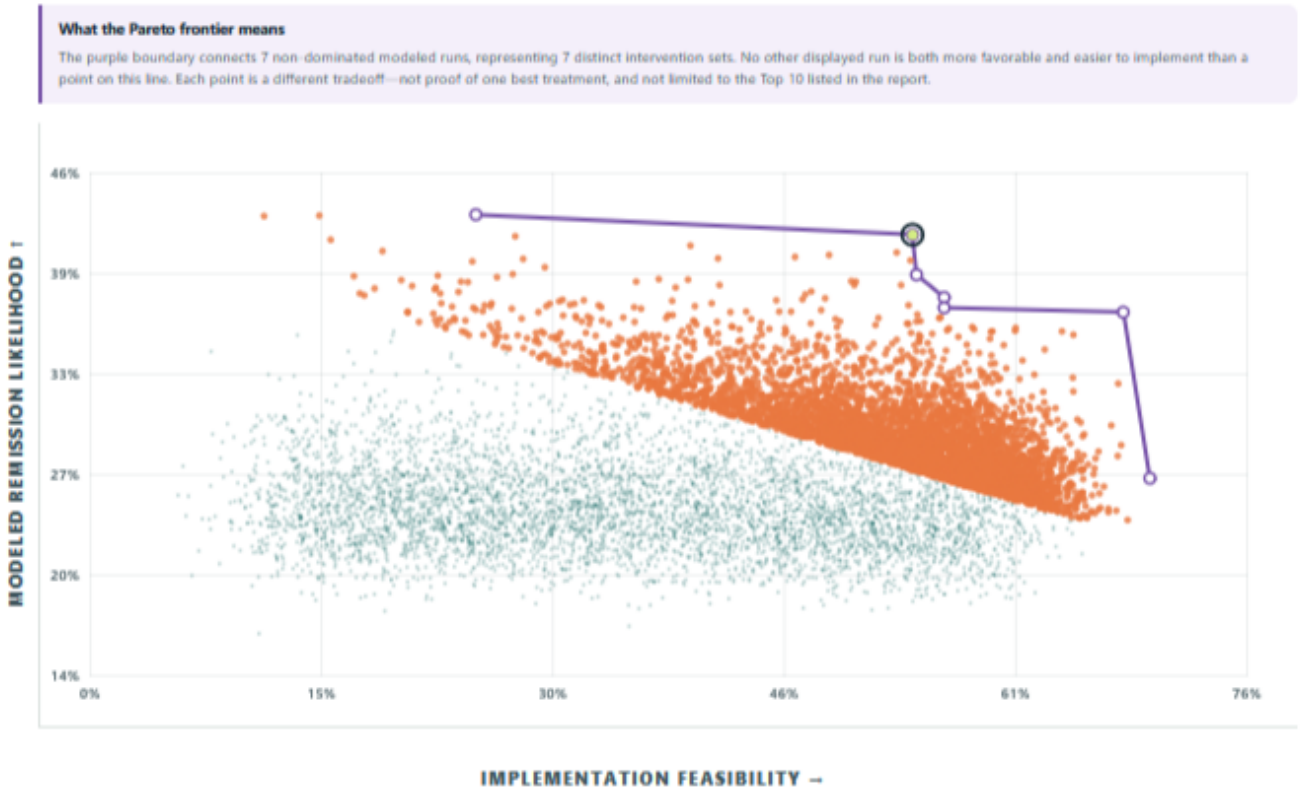
Priority	Opportunity	Evidence	Case fit	Burden	Key uncertainty
1	**Measurement-first baseline protocol**	Moderate	High	Low	Improves interpretability rather than symptoms directly.
2	**Autonomic evaluation pathway**	Moderate	Mod-high	Moderate	Symptoms are non-specific; objective pattern is incomplete.
3	**Sleep contributor reassessment**	Moderate	Moderate	Moderate	Benefit depends on identifying a treatable contributor.
4	**Low-burden supportive trial**	Limited-moderate	Moderate	Low	Indirect evidence and heterogeneous response.
5	**Emerging research avenue**	Early	Uncertain	High	Not established care; access and safety oversight vary.

How to read the matrix

Priority reflects the fictional case's current information, not a universal treatment hierarchy. A high rank can indicate that an avenue is worth clarifying first because it reduces uncertainty or makes later decisions safer and more interpretable.

Making tradeoffs visible

A frontier highlights options that are not simultaneously beaten on both modeled relevance and implementation feasibility.



Illustrative interpretation

The purple boundary connects non-dominated modeled runs. Moving along it shows tradeoffs: an option may score higher on modeled relevance but require more burden, uncertainty, monitoring, or access. Points below the boundary may remain relevant for reasons the model cannot capture; the visual is a decision aid, not an automated recommendation.

Model limitations

Inputs may be incomplete, evidence can be indirect, feasibility varies by person and clinician, and modeled likelihood is not an observed personal probability. Human review and clinical judgment remain essential.

What each avenue looks like in depth

Every shortlisted avenue is documented using the same transparent structure.

Opportunity

Structured measurement-first baseline before the next therapeutic change.

Why it may fit

The fictional history includes several short, overlapping trials with limited baseline measurement, making past response difficult to interpret.

Evidence signal

Methodological rationale is stronger than direct evidence for symptom improvement. The value is better attribution, safety monitoring, and clearer stop decisions.

Practical shape

Select a small number of meaningful outcomes; establish a stable baseline; change one variable; predefine duration, adherence expectations, and stop criteria.

Safety context

Measurement should not delay urgent care. Tracking burden should be reduced if it worsens symptoms or creates distress.

Uncertainty

Better measurement may not reveal a useful treatment effect and cannot eliminate confounding.

Clinician questions

Which outcomes matter most? What minimum duration is interpretable? Which safety measures are needed? What would trigger stopping?

Evidence-strength key

Artifact	What it contains	How it is used
Stronger	Multiple direct, higher-quality sources with consistent findings.	Still requires case-specific clinical judgment.
Moderate	Useful evidence with limitations in directness, size, or consistency.	Discuss fit, monitoring, and alternatives.
Early	Mechanistic, observational, pilot, or otherwise preliminary evidence.	Not equivalent to established benefit.

Research landscape appendix

Relevant research directions are documented separately so investigational activity is never mistaken for established benefit.

Research record	Status	Why surfaced	Questions before considering
Illustrative Trial A	Recruiting	Population and outcomes overlap with part of the fictional case.	Does the person meet criteria? What are travel, randomization, and washout requirements?
Illustrative Trial B	Active, not recruiting	Mechanism is relevant to one working hypothesis.	No current access. Results are not yet available and should not be inferred.
Emerging direction C	Early research	Preliminary biological rationale only.	What human evidence exists? What risks and monitoring needs remain unknown?

What a real appendix records

Registry identifier and link, sponsor, locations, recruitment status, study phase, intervention and comparator, key eligibility criteria, primary outcomes, last verification date, and why the study may or may not be relevant to the accepted case.

Critical distinction

A registered or recruiting study does not establish that an intervention is safe or effective. Trial participation requires the study team's screening and informed-consent process.

What could change the conclusion

Cautions are documented alongside opportunities rather than hidden in fine print.

Issue	Example flag	How it affects the review	Clinician question
Interaction	Concomitant therapy could alter exposure or tolerability.	May lower feasibility or exclude an avenue until reconciled.	Which current medications or supplements need formal interaction review?
Monitoring	Baseline measurement is missing.	Makes benefit and harm harder to interpret.	What baseline and follow-up measures are appropriate?
Evidence gap	Evidence is indirect or from a different population.	Lowers confidence and increases the need for caution.	Is the biological rationale strong enough to justify the burden?
Exclusion reason	Prior intolerance, contraindication, or excessive burden.	Can remove an avenue even when the evidence signal is interesting.	Is the exclusion definitive, modifiable, or still uncertain?

Uncertainty statement

The review records what is unknown, what information could resolve it, and whether uncertainty changes priority, feasibility, or safety. Lack of evidence is not treated as proof of benefit or proof of no benefit.

Emergency boundary

This service does not provide emergency triage, prescribing, raw imaging interpretation, or ongoing medical supervision. Urgent or rapidly worsening concerns require direct clinical care.

Traceable sources and applicability notes

The final package links material statements to source records and states why each source is or is not applicable.

ID	Source record	Use in review	Applicability note
E-01	Illustrative clinical guideline record	Established assessment pathway	Population and diagnostic criteria must be checked against the individual case.
E-02	Illustrative systematic review record	Overall evidence signal	Heterogeneity limits prediction for an individual.
E-03	Illustrative controlled study record	Effect and adverse-event context	Small sample and short follow-up reduce certainty.
E-04	Illustrative trial registry record	Emerging research landscape	A registered study is not evidence that an intervention works.

What accompanies the source log

Search date and scope, source type, population, intervention and comparator, major outcome, key safety finding, limitations, directness to the case, and the exact statement supported by the source.

Delivery format

The actual package is designed for both screen review and printing. Links are included where applicable, and the patient and clinician views can be shared separately.

End of fictional sample

A real review is shaped by the accepted case, supplied records, current evidence, and defined scope. Payment - or free founding-cohort participation - covers the rigor of the review, not discovery of a new treatment or a particular medical outcome.