

Antifungal-resistant dermatophytosis case report form

Unique patient ID (DCIPHER): _____

ARLN specimen ID: _____ | ARLN isolate ID: _____ | ARLN patient ID: _____

| Form completion data | |
|--------------------------------------|-------|
| Name of person completing this form: | _____ |
| Institution: | _____ |
| Email: | _____ |
| Telephone: | _____ |
| Date form completed: | _____ |

| A. Patient demographics | |
|---|--|
| 1. Age at DISC: (use months or days if patient was aged <2 years) | _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Unknown |
| 2. Sex at birth | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown |
| 3. Gender identity | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, non-binary, or another gender <input type="checkbox"/> Prefer not to answer/Decline <input type="checkbox"/> Unknown |
| 4. What is your race and/or ethnicity? (select all that apply and enter additional details in the spaces provided) | <input type="checkbox"/> American Indian or Alaska Native <i>Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.</i> _____ <input type="checkbox"/> Asian - provide details below <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <i>Enter, for example, Pakistani, Hmong, Afghan, etc.</i> _____ <input type="checkbox"/> Black or African American - provide details below <input type="checkbox"/> African American <input type="checkbox"/> Jamaican <input type="checkbox"/> Haitian <input type="checkbox"/> Nigerian <input type="checkbox"/> Ethiopian <input type="checkbox"/> Somali <i>Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.</i> _____ <input type="checkbox"/> Hispanic or Latino - provide details below <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Guatemalan <i>Enter, for example, Colombian, Honduran, Spaniard, etc.</i> _____ <input type="checkbox"/> Middle Eastern or North African - provide details below <input type="checkbox"/> Lebanese <input type="checkbox"/> Iranian <input type="checkbox"/> Egyptian <input type="checkbox"/> Syrian <input type="checkbox"/> Iraqi <input type="checkbox"/> Israeli <i>Enter, for example, Moroccan, Yemeni, Kurdish, etc.</i> _____ <input type="checkbox"/> Native Hawaiian or Pacific Islander - provide details below <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Chamorro <input type="checkbox"/> Tongan <input type="checkbox"/> Fijian <input type="checkbox"/> Marshallese <i>Enter, for example, Chuukese, Palauan, Tahitian, etc.</i> _____ |

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| | |
|---|---|
| | <input type="checkbox"/> White – provide details below <input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Irish <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> Scottish <i>Enter, for example, French, Swedish, Norwegian, etc.</i> _____ _____ |
| 5. Patient's country of primary residence (e.g., USA) | _____ <input type="checkbox"/> Unknown |
| 6. Patient's state, jurisdiction, or territory of primary residence | _____ <input type="checkbox"/> Unknown |
| 7. Patient's county of primary residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"): | _____ <input type="checkbox"/> Unknown |
| 8. Patient's city of primary residence | _____ <input type="checkbox"/> Unknown |
| 9. Patient's ZIP code of primary residence | _____ <input type="checkbox"/> Unknown |
| 10. Patient's type of health insurance at DISC | <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Military <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Incarcerated <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____ |

| B. Patient underlying risk factors & medical conditions present during the 2 years before DISC (unless other timeframe specified) | |
|--|--|
| 1. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Hematologic malignancy specify type: _____ <input type="checkbox"/> Solid organ malignancy specify type: _____ | 3. Other immunocompromising conditions <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Transplant in the last 2 years <input type="checkbox"/> Hematologic <input type="checkbox"/> Solid organ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chronic use of steroids <input type="checkbox"/> Medications/therapies that weaken the immune system <input type="checkbox"/> TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept) <input type="checkbox"/> Other (specify): _____ _____ <input type="checkbox"/> Cirrhosis |
| 2. HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, choose one of the below Ever had CD4 < 200 cells/mm ³ within past 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 4. Other conditions <input type="checkbox"/> Liver disease <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Diabetes <input type="checkbox"/> History of stroke, plegia, paralysis <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Chronic respiratory failure <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Other, specify: _____ | 5. Other potentially relevant underlying conditions? <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No <input type="checkbox"/> Unknown _____ _____ _____ _____ |

| C. Incident specimen data | |
|--|-----------------------|
| 1. Date of incident specimen collection (DISC)*: (mm-dd-yyyy) *This is the earliest date that a patient had a positive test for | _____ - _____ - _____ |

| | |
|---|---|
| antifungal-resistant dermatophytosis | |
| 2. Test type | <input type="checkbox"/> Culture <input type="checkbox"/> PCR |
| 3. Body site | <input type="checkbox"/> Tinea capitis (scalp, hair) <input type="checkbox"/> Tinea barbae (beard) or faciei (face) <input type="checkbox"/> Tinea manuum (hands) <input type="checkbox"/> Tinea unguium (toenails) <input type="checkbox"/> Tinea unguium (fingernails) <input type="checkbox"/> Tinea genitalis (genitals) <input type="checkbox"/> Tinea corporis (other parts of body such as arms or legs), specify: _____ <input type="checkbox"/> Tinea cruris (groin, inner thighs, or buttocks) <input type="checkbox"/> Tinea pedis (feet) <input type="checkbox"/> Other body site specify: _____ |
| 4. Genus and species | <input type="checkbox"/> <i>Trichophyton mentagrophytes</i> <input type="checkbox"/> Genotype VIII (<i>T indotineae</i>) <input type="checkbox"/> Other genotype, specify: _____ <input type="checkbox"/> Unknown genotype <input type="checkbox"/> <i>Trichophyton rubrum</i> <input type="checkbox"/> Other <i>Trichophyton</i> species Species: _____ <input type="checkbox"/> species unknown <input type="checkbox"/> <i>Microsporum</i> Species: _____ <input type="checkbox"/> species unknown <input type="checkbox"/> <i>Epidermophyton</i> Species: _____ <input type="checkbox"/> species unknown <input type="checkbox"/> Other genus (specify) _____ Species: _____ <input type="checkbox"/> species unknown |
| 5. Antifungal susceptibility testing | Drug, minimum inhibitor concentration (MIC), mg/L ($\mu\text{g/mL}$) Terbinafine (Lamisil) _____ Itraconazole (Sporanox) _____ Amphotericin B _____ Anidulafungin (Eraxis) _____ Caspofungin (Cancidas) _____ Fluconazole (Diflucan) _____ Flucytosine (5FC) _____ Ibexafungerp (Brexafemme) _____ Isavuconazole (Cresemba) _____ Micafungin (Mycamine) _____ Posaconazole (Noxafil) _____ Voriconazole (Vfend) _____ |
| Molecular determinant of resistance (e.g., SQLE): | _____ <input type="checkbox"/> Unknown |

| D. Patient diagnosis and outcomes | | |
|--|---|--|
| 1. Patient location at time of incident specimen collection: | | |
| <input type="checkbox"/> Hospital inpatient | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Long-term care facility (LTCF) |
| <input type="checkbox"/> Intensive care unit | <input type="checkbox"/> Emergency room | <input type="checkbox"/> Long-term acute care hospital (LTACH) |
| <input type="checkbox"/> Surgery/OR | <input type="checkbox"/> Clinic/Provider's office (specify) | <input type="checkbox"/> Autopsy |

| | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other inpatient _____ | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Podiatrist | |
| | <input type="checkbox"/> Primary care (adult) | |
| | <input type="checkbox"/> Primary care (pediatrics) | |
| | <input type="checkbox"/> Other provider type, specify _____ | |
| | <input type="checkbox"/> Unknown provider type | |
| | <input type="checkbox"/> Dialysis center | |
| | <input type="checkbox"/> Surgery | |
| | <input type="checkbox"/> Urgent care | |
| | <input type="checkbox"/> Observational/clinical decision unit | |
| | <input type="checkbox"/> Other outpatient _____ | |

2. Rash onset date (mm/dd/yyyy): ____/____/____

3. Indicate body site(s) affected.

Tinea capitis (scalp, hair)

Tinea barbae (beard)

Tinea manuum (hands)

Tinea unguium (toenails)

Tinea unguium (fingernails)

Tinea genitalis (genitals)

Tinea corporis (other parts of body such as arms or legs), specify: _____

Tinea cruris (groin, inner thighs, or buttocks)

Tinea pedis (feet)

Other body site, specify: _____

Unknown

4. Date of most recent follow-up for rash (within 90 days after DISC) (mm/dd/yyyy): ____/____/____

Compared with the patient's rash on DISC, what was the status of the patient's rash at most recent follow-up?

Worse

Neither better nor worse

Improving, but not fully resolved

Fully resolved

Unknown

E. Antifungal treatment: Did the patient receive antifungal drugs during the 90 days before to 60 days after the DISC?

Yes No Unknown (If yes, please complete the table below for each drug received)

| | | | |
|--|---------------------|---------------------|----------------------|
| <i>Systemic antifungals</i> | | | |
| Amphotericin B lipid complex (ABLC) | Fluconazole (FLC) | Micafungin (MFG) | Unknown drug (UNK-S) |
| Liposomal Amphotericin B (L-AmB) | Flucytosine (5FC) | Terbinafine (TRB-S) | |
| Amphotericin B colloidal dispersion (ABCD) | Griseofulvin (GSF) | Posaconazole (PSC) | |
| Anidulafungin (ANF) | Ibexafungerp (IBR) | Voriconazole (VRC) | |
| Caspofungin (CAS) | Isavuconazole (ISA) | Other systemic drug | |
| | Itraconazole (ITC) | (specify) (OTH-S): | |
| | | _____ | |
| <i>Topical antifungals</i> | | | |
| Butenafine (BTF) | Econazole (ECZ) | Naftifine (NFT) | Tavaborole (TVB) |
| Ciclopirox (CPX) | Efinaconazole (EFZ) | Nystatin- | Terbinafine (TRB-T) |

| Clotrimazole (CTZ) Clotrimazole-betamethasone dipropionate (CBM) | Ketoconazole (KTC) Luliconazole (LCZ) Miconazole (MCZ) | triamcinolone (NTC) Oxiconazole (OCZ) Sertaconazole (STC) | Terconazole (TCZ) Other topical antifungal (specify) (OTH-T): _____ Unknown drug (UNK-T) |
|---|--|--|---|
| Drug Abbrev | b. First date given (mm-dd-yyyy) | c. Last date given (mm-dd-yyyy) | e. Therapeutic drug monitoring (TDM) |
| | _____ - _____ - _____ <input type="checkbox"/> Start date unknown <input type="checkbox"/> Start date was >60 days before DISC | _____ - _____ - _____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown | <input type="checkbox"/> Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: <input type="checkbox"/> No |
| | _____ - _____ - _____ <input type="checkbox"/> Start date unknown <input type="checkbox"/> Start date was >60 days before DISC | _____ - _____ - _____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown | <input type="checkbox"/> Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: <input type="checkbox"/> No |

| E. Supplemental patient interview form: Note that "you" in these questions refers to the patient. | |
|--|--|
| 1. Have you traveled internationally during the two years before rash onset? | <input type="checkbox"/> Yes If yes, specify country/city/cities/dates: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 2. Have you had any known exposures to possible ringworm during the month before rash onset? | <input type="checkbox"/> Yes If yes, specify country/city/cities/dates: _____ If yes, select all that apply <input type="checkbox"/> Other person with possible ringworm <input type="checkbox"/> Animal with possible ringworm If yes, what type of animal? <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Environment (e.g., public showers, gyms, shared equipment), specify: _____ <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown Provide any details of exposure that you might be relevant and are not captured above: _____ |
| 3. How many people are in your household (including yourself) and how many developed signs symptoms of ringworm? | Number of people in the household _____ <input type="checkbox"/> Unknown Number of people in the household who developed possible ringworm _____ <input type="checkbox"/> Unknown |

| | |
|---|---|
| 4. Did you use topical steroids before this diagnosis? | <input type="checkbox"/> Yes If yes, name of drug(s), dose(s), duration(s): _____ <input type="checkbox"/> No |
| 5. Did you use topical and/or systemic antibacterial medications before this diagnosis (including those purchased over-the-counter)?* | <input type="checkbox"/> Yes If yes, name of drug(s), method(s) of administration (e.g., oral, topical), dose, duration: _____ <input type="checkbox"/> No |
| 6. Over the last week, how itchy, sore, painful, or stinging has your skin been?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all |
| 7. Over the last week, how embarrassed or self-conscious have you been because of your skin?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all |
| 8. Over the last week, how much has your skin interfered with you going shopping or looking after your home or garden?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 9. Over the last week, how much has your skin influenced the clothes you wear?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 10. Over the last week, how much has your skin affected any social or leisure activities?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 11. Over the last week, how much has your skin made it difficult for your to do any sport?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 12. Over the last week, has your skin prevented you from working or studying?* | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, over the last week, how much has your skin been a problem at work or studying? <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 13. Over the last week, how much has your skin created problems with your partner or any of your close friends or relatives?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |
| 14. Over the last week, how much has your skin caused any sexual difficulties?* | <input type="checkbox"/> Very much <input type="checkbox"/> A lot <input type="checkbox"/> A little <input type="checkbox"/> Not at all <input type="checkbox"/> Not relevant |

15. Over the last week, how much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time?*

- Very much
- A lot
- A little
- Not at all
- Not relevant

*Questions were adapted from the Dermatology Life Quality Index (DLQI); approval obtained from DLQI Administrator.

Additional comments:
