**Case report form:** Chromoblastomycosis in the United States

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**Patient demographic characteristics**

Unique patient ID: \_\_\_\_\_\_\_\_\_\_\_ (site\_####)

Site submitting case: \_\_\_\_\_\_\_\_\_\_\_\_\_

Location of residence for patient (ZIP Code): \_\_\_\_\_\_\_\_\_\_\_\_\_ OR [] Unknown

Age at diagnosis (years): \_\_\_\_\_\_\_\_\_\_\_\_

Assigned sex at birth: [] Male [] Female OR [] Unknown

Gender identity: [] Male [] Female [] Transgender, non-binary, or another gender[] Prefer not to answer/Decline OR [] Unknown

Race and/or ethnicity (select all that apply and enter additional details in the spaces provided):

[] American Indian or Alaska Native

*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.*

[] Asian – provide details below

 [] Chinese [] Asian Indian [] Filipino [] Vietnamese [] Korean [] Japanese

*Enter, for example, Pakistani, Hmong, Afghan, etc.*

[] Black or African American – provide details below

 [] African American [] Jamaican [] Haitian [] Nigerian [] Ethiopian [] Somali

*Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Hispanic or Latino – provide details below

 [] Mexican [] Puerto Rican [] Salvadoran [] Cuban [] Dominican [] Guatemalan

*Enter, for example, Colombian, Honduran, Spaniard, etc.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Middle Eastern or North African – provide details below

 [] Lebanese [] Iranian [] Egyptian [] Syrian [] Iraqi [] Israeli

*Enter, for example, Moroccan, Yemeni, Kurdish, etc.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Native Hawaiian or Pacific Islander – provide details below

 [] Native Hawaiian [] Samoan [] Chamorro [] Tongan [] Fijian [] Marshallese

*Enter, for example, Chuukese, Palauan, Tahitian, etc.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] White – provide details below

 [] English [] German [] Irish [] Italian [] Polish [] Scottish

*Enter, for example, French, Swedish, Norwegian, etc.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monthly household income (USD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation at time of presumed infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Industry at time of presumed infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Underlying medical conditions (active or present in the 2 years before symptom onset)**

Diabetes mellitus [] Yes [] No [] Unknown

Chronic kidney disease [] Yes [] No [] Unknown

 If yes, on dialysis? [] Yes [] No [] Unknown

 If yes, GFR < 60? [] Yes [] No

Liver cirrhosis? [] Yes [] No [] Unknown

Chronic hepatitis without cirrhosis? [] Yes [] No [] Unknown

 If yes, [] Hep B [] Hep C

Immunocompromising condition [] Yes [] No [] Unknown

[] HIV infection

 [] HIV infection without AIDS (CD4 ≥ 200)

[] HIV infection with AIDS (CD4 < 200) or chart diagnosis of advanced HIV disease

 [] Cancer diagnosis, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [] On chemotherapy, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of cancer diagnosis (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [] Transplantation,

 [] Solid organ, specify organ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Hematologic (stem cell)

Date of transplantation (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [] Immunosuppressive therapy, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [] Other immunocompromised condition, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other major underlying condition not listed (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Exposure** **history**

Has patient traveled or lived internationally in their life? [] Yes [] No [] Unknown

* + Country 1 \_\_\_\_\_\_\_\_\_\_\_\_; Approximate duration of stay (years):
	+ Country 2 \_\_\_\_\_\_\_\_\_\_\_\_; Approximate duration of stay (years):
	+ Country 3 \_\_\_\_\_\_\_\_\_\_\_\_; Approximate duration of stay (years):
	+ Country 4 \_\_\_\_\_\_\_\_\_\_\_\_; Approximate duration of stay (years):
	+ Country 5 \_\_\_\_\_\_\_\_\_\_\_\_; Approximate duration of stay (years):

Did the patient immigrate to the United States? [] Yes [] No [] Unknown

 If yes, date of immigration (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [] Unknown

 If yes, country immigrated from: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [] Unknown

Any traumatic inoculation recalled? [] Yes [] No [] Unknown

If yes, please describe geographic location (e.g., city, state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe the material involved (e.g., thorns, branches): \_\_\_\_\_\_\_\_\_

If yes, please describe any weather events (e.g., hurricane, flood): \_\_\_\_\_\_\_\_\_\_\_\_

If yes, please indicate approximate date of traumatic inoculation (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_

Most likely source of infection, according to clinician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diagnosis**

Did patient have health care facility visits (health center, hospital, etc.) for mycetoma symptoms before visit with mycetoma diagnosis? [] Yes [] No [] Unknown

If yes, how many visits? \_\_\_\_\_\_\_\_\_\_\_\_

Were there misdiagnoses before being diagnosed with mycetoma [] Yes [] No [] Unknown

What misdiagnoses, if any, did this patient have before being diagnosed with mycetoma (in the last 12 months):

* Please list all misdiagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Laboratory testing (associated with diagnosis)**:

[] Dermoscopy [] Not performed [] Unknown if performed

 date of procedure: \_\_\_\_\_\_\_\_\_\_\_\_

[] Potassium hydroxide preparation [] Not performed [] Unknown if performed

 date of preparation: \_\_\_\_\_\_\_\_\_\_\_\_; result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[]Skin or surgical biopsy [] Not performed [] Unknown if performed

 date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] Fungal culture [] Not performed [] Unknown if performed

date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Positive/Negative: \_\_\_\_\_\_\_\_\_\_\_\_\_ Organism(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

[] Broad range sequencing [] Not performed [] Unknown if performed

date of collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_; Type (e.g., 18s, ITS): \_\_\_\_\_\_\_\_\_\_\_\_

Positive/Negative: \_\_\_\_\_\_\_\_\_\_\_\_\_ Organism(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

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**Signs and symptoms noted in medical chart**:

|  |  |  |
| --- | --- | --- |
| Signs & Symptoms | Yes/No | Onset Date |
| Warty lesions |  |  |
| Raised and crusted lesions |  |  |
| Tumors |  |  |
| Infiltrative plaques |  |  |
| Nodules |  |  |
| Polymorphic lesions |  |  |
| Migraines |  |  |
| Pain  |  |  |
| Itching |  |  |
| Edema |  |  |
| Syncope |  |  |
| Vomiting |  |  |
| Other symptoms, please describe:\_\_\_\_\_\_\_ |  |  |

Please indicate the specific location(s) of the body of the chromoblastomycosis lesions (check all that apply):

[] Head and neck

[] Trunk

[] Upper limbs

[] Buttocks, perineum, genitals

[] Lower limbs

Additional comments on anatomical location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disease severity:

[] Mild (solitary plaque or nodule less than 5 cm in diameter)

[] Moderate (single or multiple lesions with nodular, verrucous or plaque morphology, less than 15 cm in diameter, and involving a single or two adjacent skin areas)

[] Severe (extensive involvement of adjacent or nonadjacent skin areas)

Did mycetoma cause any form of disability: [] Yes [] No [] Unknown

If yes, please fill out the table below:

|  |  |  |  |
| --- | --- | --- | --- |
| Disability | Yes/No | Onset Date | Number of days with disability |
| Inability to walk |  |  |  |
| Impacts mobility/ability to walk |  |  |  |
| Inability to work |  |  |  |

**Treatment**

Was the patient treated for chromoblastomycosis?

[] Yes [] No [] Unknown [] Missing/Not documented

**If yes**, list all therapeutic agents (e.g., antifungals, immune response modulators, antibiotics, steroids) in the table below:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  Therapeutic Agent Name  | Max Daily dose (mg/day)  | Route (e.g., IV, PO, IT)  |  Start Date  | Duration  of Therapy  | Therapy ongoing  at time of  abstraction  | Discontinued due to toxicity. **If yes, describe toxicity**  | Therapeutic Drug Monitoring (e.g., serum level of antifungal) |
|  |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |
|  |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |
|   |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |
|   |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |
|   |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |
|   |   |   |  \_\_\_ / \_\_\_ / \_\_\_\_\_\_  |  \_\_\_\_\_days  |  [] Yes [] No  | [] Yes [] No --------------------- ---------------------  | [] Yes [] No Level 1: Date: Value: Level 2: Date: Value |

Notes about treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the patient undergo surgical excision of the chromoblastomycosis lesion(s): [] Yes [] No [] Unknown

 If yes, date of surgical excision (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_

Did the patient have cryotherapy: [] Yes [] No [] Unknown

Did the patient have heat therapy: [] Yes [] No [] Unknown

Did the patient have light-based therapy: [] Yes [] No [] Unknown

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**Complications**:

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome | Yes/No | Onset Date | Notes (e.g., location) |
| Tissue fibrosis |  |  |  |
| Secondary bacterial infection |  |  |  |
| Squamous cell carcinoma |  |  |  |
| Internal organ involvement |  |  |  |
| Amputation |  |  |  |
| Lymphedema |  |  |  |

Did the chromoblastomycosis infection resolve? [] Yes [] No [] Since

If yes, what was the date of clinical resolution (disappearance of cutaneous manifestations with the exception of atrophic scarring) (mm/dd/yyyy):

If no, what was date of last follow-up (mm/dd/yyyy):

Did this patient die within 2 years after the chromoblastomycosis diagnosis? [] Yes [] No [] Unknown

If yes, was chromoblastomycosis a contributing factor in patient’s death? [] Yes [] No [] Unknown

Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix 2: Dermatology Life Quality Index Tool**

Dermatology Life Quality Index Questionnaire:

1. Over the last week, how itchy, sore, painful, or stinging has your skin problem been?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
2. Over the last week, how embarrassed or self-conscious have you been because of your skin problem?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
3. Over the last week, how much has your skin problem interfered with you going shopping or looking after your home or garden?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
4. Over the last week, how much has your skin problem influenced the clothes you wear?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
5. Over the last week, how much has your skin problem affected any social or leisure activities?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
6. Over the last week, how much has your skin problem made it difficult for your to do any sport?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
7. Over the last week, has your skin problem prevented you from working of studying
	1. Yes
	2. No
	3. Not relevant
		1. If no, over the last week how much has your skin problem been a problem at work or studying?
			1. A lot
			2. A little
			3. Not at all
8. Over the last week, how much has your skin problem created problems with your partner or any of your close friends or relatives?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
9. Over the last week, how much has your skin problem caused any sexual difficulties?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant
10. Over the last week, how much of a problem has the treatment for your skin problem been, for example by making your home messy, or by taking up time?
	1. Very much
	2. A lot
	3. A little
	4. Not at all
	5. Not relevant